Improving Medication Adherence in the Alabama Black Belt

Principal Investigator

Monika M. Safford, MD

Joan & Stanford I. Weill Medical College of Cornell University

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Study Team Roster

Principal Investigator: **Monika Safford, MD**
1300 York Avenue, F2006
New York, NY 10065
T.212.746.3026
F.212.746.1014
mms9024@med.cornell.edu

Site Principal Investigator: **Andrea Cherrington, MD MPH**
1717 11th Ave South
Medical Towers 612
Birmingham, AL 35205
T. 205.996.2885
F. 205.975.6753
acherrington@uabmc.edu

Biostatistician: **Joshua Richman, MD PhD**
1922 7th Ave South
KB 428
Birmingham, AL 35233
T. 205.97501932
jrichman@uabmc.edu

Consultant: **Debra Clark, MS**
Director
Health and Wellness Education Center of Sumter County
P.O. Box 1247
Livingston, AL 35470
T. 205.652.6557
clarkdeb@uab.edu

Background and Significance

Medication nonadherence is both common and costly. In diabetes, clinical trials have proven that medications that lower blood glucose, lipids and blood pressure can lower risks for blindness, kidney disease, amputation, stroke and heart attack.[1-3] However, adherence to these medications is suboptimal; in many health systems, as many as half of diabetic patients do not take recommended medications as directed.[4] The annual costs of medication nonadherence have been estimated to total $290 billion.[5] For diabetes, one analysis estimated that the VA alone could save between $0.66-1.16 billion annually if medication nonadherence could be eliminated.[6] Despite the modest success of some interventions, decades of research on how to improve nonadherence have not yielded substantial changes in medication adherence rates. A 2008 Cochrane review of interventions to improve medication adherence concluded: **"Current methods of improving adherence for chronic health problems are mostly complex and not very effective, so that the full benefits of treatment cannot be realized. High priority should be given to fundamental and applied research concerning innovations to assist patients to follow medication prescriptions for long-term medical disorders."**[7]

Medication nonadherence is especially problematic in hard-to-reach populations living with diabetes. For example, the Southeast has the highest stroke and coronary heart disease mortality in the US, along with the highest prevalence of obesity and diabetes.[8] These problems hit black Americans the hardest: blacks have both higher stroke and coronary heart disease mortality in the Southeast than whites, and blacks are more likely to have diabetes.[8] Nowhere is this situation more dire than in rural areas, which typically have very scarce resources for chronic disease management. One such area is the Alabama Black Belt, whose residents simultaneously fall into 3 high risk groups targeted by AHRQ's *Health Disparities* report: minority, poor and rural.[9,10] The region has the highest prevalence of diabetes in the state, one third of the population lives below the federal poverty line, functional illiteracy is high, and distances and travel are major barriers to good health care.[10] The Black Belt includes Tuskegee, site of the infamous 1932-1972 syphilis study, thus deep-seated mistrust of the healthcare system remains common among today's Black Belt residents, 75% of whom are black. Internet connections are sporadic, and most families do not have access to computers. Table 1 shows the substantial mismatch of need and resources in this region. In 2011, there were 2 certified diabetes educators in an 8-county area that includes our community partners; all are Health Professional Shortage Areas. The result of this mismatch is sobering: fully 29 of the 32 Alabama counties with the highest diabetes mortality rates are rural counties.[11] The Black Belt Action Committee reported that in 2007, diabetes mortality was 38.7/100,000 population, contrasted to the US rate of 24.6/100,000.[11] Worse, this rate is 50% higher among Alabama's blacks compared to whites.[11] Further, these communities have requested diabetes programs at every community coalition meeting held by UAB researchers over the pat 15 years; these statistics and the call from the community informed our original selection of community partners.

Table 1. Characteristics of our target communities in rural Alabama Black Belt counties

	Population	% Black[1]	% <Poverty[1]	Diabetes Prevalence[2]	PCP/10,000[3]
Target Counties					
Choctaw	15,922	44.4	24.5	13.5	3.4
Dallas	46,365	69.4	34.7	11.9	10.1
Lowndes	11,147	73.7	31.4	12.2	1.5
Marengo	20,692	52.0	25.9	11.7	5.5
Perry	11,861	68.8	35.4	17.5	4.3
Pickens	19,746	43.0	27.7	14.9	5.0
Sumter	14,798	73.6	38.7	12.2	3.6
Wilcox	13,183	72.2	39.9	12.2	3.1
ALABAMA	4,802,740	26.3	19.0	11.8	20.6
US	314,918,000	12.6	15.9	8.3	25.7

[1]2010 Census; [2]2008 Alabama Department of Public Health and BRFSS; [3]PCP=Primary Care Providers per 10,000 people, from Board of Medical Examiners of Alabama and Kaiser Family Foundation.

People living with diabetes in the Black Belt have a high prevalence of medication nonadherence. Diabetic black individuals participating in the national population-based REasons for Geographic And Racial Differences in Stroke (REGARDS) epidemiology study are contrasted with those participating in the Encourage study in Table 2.[12] Medication nonadherence as assessed by Morisky's scale was more prevalent in the Black Belt sample, as were lower levels of education and income, demonstrating that diabetic black Americans living in the Black Belt are particularly disadvantaged.[13] However, there is currently little understanding of the barriers to better adherence in this population, and no data on effective strategies to improve the situation.

Table 2. Black individuals with diabetes from the REGARDS (national, 2003-7) and Encourage (Alabama Black Belt, 2010) studies.

Characteristics	REGARDS	Encourage
N	3692	337
Mean Age, years±SD	65.0±8.6	58.7±12.5
Female, %	60.8	77.1
Education ≤ High School, %	53.9	75.8
Income < $20,000, %	31.3	46.0
Insulin Use, %	31.9	40.9
Nonadherent, %	30.7	56.4

Potential for improving health care and outcomes. To improve medication adherence, we may need a fundamental re-examination of the model within which adherence is conceptualized. The biomedical model views medications as biochemical substances that modify diseased biological processes, improving disease outcomes. From this perspective, failing to take medications that have been proven effective is irrational. However, patients do not view medications this way, and failing to understand the patient perspective may be one reason why adherence interventions have demonstrated such modest success to date.

An alternative perspective is a biopsychosocial framework based on the work of Corbin and Strauss, and of Charmaz.[14,15] Corbin and Strauss interviewed hundreds of people living with chronic disease, thus their framework is highly patient-centered. They proposed that three essential elements interactively stabilize and reinforce each other to create the sense of well-being: 1) our **Body**, 2) our personal vision of our **Biography** through life, and 3) our **Conceptions of self**. This inter-related triad has been called the BBC chain to emphasize how interlinked each element is (Figure 1). Our conceptions of self are how we view ourselves, including our roles in the family, at work and in our communities, as well as our social and spiritual identities. Our biography, referred to by Corbin and Strauss as biographical time, is our image of what our lives will look like into the future in order to fulfill our conceptions of ourselves. Illness causes our bodies to fail, impacting this biography and forcing us to rewrite it and reconfigure our conception of self. Three types of work are created: work to preserve, restore and recast our self-image and identity; work to rewrite the biography; and the work of mourning for the passing of our old self and its previous hopes, dreams and identities. The reconfiguration of our self-view is extremely stressful, and people take varying amounts of time to establish a new equilibrium, with some never achieving enough balance to feel well again. This could explain why so many people deny that they have the disease, and don't take medications as recommended even years after their diagnosis.

Viewed from this perspective, we can make sense of the decision not to take beneficial medicines. Adams interviewed asthmatics to better understand why so many fail to take effective medications as prescribed.[16] Three groups of patients emerged: the deniers, the accepters and those in between. The deniers refused to acknowledge that they had asthma at all, despite admitting that they had symptoms and needed rescue therapy; some had been doing this for years. For these people, taking the preventive medication would legitimize their diagnosis, which they equated with debility and unacceptable biographies. On the other hand, the accepters had integrated their body failure into their lives and **viewed medications as the route to maintaining their concept of self and biography.** In between were those who had not fully accepted their condition and the attendant medications, but who did not fully deny it either. On hearing about the Corbin and Strauss model, one of our peer supporter community members said:

"This is really what it's like. I have diabetes myself and I went through that. In the beginning you don't want to accept it, you say I don't believe it, I don't want it. Then slowly you come around. I see it a lot in my clients. I tell them my own story and they do like that. It makes them feel like they're not alone. You just keep at it and eventually they do get it. I think it's a really good idea."

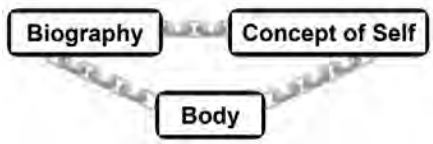


Figure 1. The Body-Biography-Conceptions of Self (BBC) chain.

It is not clear that any interventions have been designed from this patient-centered perspective. A workshop on Patient-Centered Medication Management was convened by the AHRQ-sponsored Centers on Research and Education in Therapeutics in October 2012 and included patients, health system managers, pharmacists, Pharmaceutical companies and researchers. Attendees heard results of a literature review on patient-centered medication adherence interventions using the Institute of Medicine and Planetree organization's definitions of patient-centered care/approaches.[17-19] The results were striking: the voluminous literature on medication adherence and several excellent reviews revealed very few studies on patient-centered interventions, none using Corbin and Strauss' framework. Conference attendees brainstormed and prioritized research gaps, including a call for studies on the trajectory of chronic medication-taking behavior and factors that can favorably influence that trajectory. Our study directly responds to this call from this multi-stakeholder group, including many patients.

We briefed our community partners about this conference, and together we developed this proposal. They thought that hearing the stories of "people like me with problems like mine" could be a powerful influence on the trajectory of mediation taking behavior. Bandura's Social Cognitive Theory posits that behavior is influenced by watching others and the consequences of their behavior, a concept which underlies the power of peer storytelling.[20] Many people living with chronic diseases actively seek out others struggling with similar issues as demonstrated by websites like Patientslikeme.com, saying, "***I joined because I didn't want to feel alone anymore. Simply put. And I knew that I could be helpful [by sharing] my experience***."[21]

The peer supporters who worked with us in past studies were very enthusiastic about including videotaped storytelling in this intervention. They thought that watching the stories of how others overcame their resistance to having diabetes and how they overcame barriers to medication adherence would be intensely reassuring to people struggling to do the same. Viewers of peers telling stories often develop para-social relationships with the storytellers, "a sense of friendship, attraction, and involvement with the person or character."[22-24] The more engaging the story, the more listeners are transported into the story and achieve "homophily", or a feeling of relatedness to the storyteller. Thus, unscripted stories told by peers that show how they overcame similar real-world struggles are most engaging.[25] Peer story telling had a remarkable effect on lowering blood pressure in an urban setting, but peer story telling has not been examined for diabetes or in rural settings.[26,27] We will videotape community members with diabetes discussing their perceptions of common barriers to disease acceptance and medication adherence (emerging from the focus groups, see below), and to tell their own story of how they overcame them.

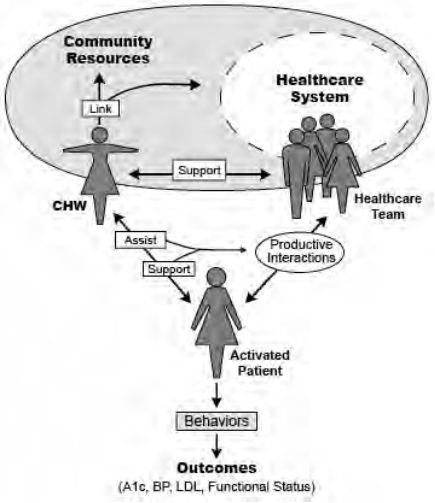


Figure 2. Conceptual model of Community Health Workers (CHW) and their roles.

Our community partners strongly recommended that our program should provide education. Knowledge of diabetes and self-care is extremely limited in our partnering communities; 55% of Encourage participants had diabetes knowledge scores below 50% at baseline. We agree that because of the complexity of self-management for diabetes, viewing stories of how other people overcame barriers to medication adherence (including accepting their disease) may be most impactful if they are integrated into an education program.

According to Adult Learning Theory, adults learn best when they can build on experiences from their own lives. Although education is a critical first step, community members strongly advised adding a one-on-one coaching component to assure that the educational content was understood and to engage participants in discussions about the stories they heard. In our past work, education was incorporated better after a discussion with a peer coach. Peer coaches, sometimes called community health workers (CHW), peer advisors or promotoras, are here conceptualized as people with diabetes who live in the same community and who have in-depth understanding of the day-to-day challenges of living with diabetes. They receive training, including motivational interviewing, to coach other community members with diabetes on how to improve self-management within the context of their own lives, helping them to overcome challenges within their community

(Figure 1). Interacting with a live peer coach is a potent experience because participants have discussions with someone like them, facilitating the process of internalizing the DVD content and stories they heard, and working on an action plan to overcome their barriers to medication adherence. Therefore, we will add telephonic individualized peer coaching to the educational/storytelling DVD.

Peer support is being more widely evaluated for diabetes,[28,29] but, to our knowledge, not within the Corbin and Strauss framework to improve medication adherence. Two RCTs of peer support interventions for diabetes showed improvement in A1c with peer support compared to nurse case managers or usual care, suggesting that peer supporters can help others in their community to optimize their self-care practices.[30,31] One trial was limited to veterans, and the other was conducted in a group of city clinics, so their generalizability to rural settings without a health system is unclear. Nevertheless, these studies suggest that peers could be powerful motivators to help people with self-regulation and recognize their medicines as a powerful strategy for staying as well as they can as long as they can.

Among the Institute of Medicine's top quartile of priority areas for comparative effectiveness research were interventions to reduce health disparities in diabetes using community-based approaches. In July 2013, CMS announced that CHW services could be covered by state Medicaid programs, and CHW interventions are increasingly being integrated into health systems.[32-43] CHW interventions hold great hope for the elimination of health disparities, since people within the communities are the agents of change, overcoming trust barriers. Although we will study a specific population that demonstrates dramatic disparities in health outcomes (i.e., rural black Americans with diabetes), this intervention would serve as a model that could be adapted to other cultures, communities, disease states and health systems. Improved medication adherence would improve the physiologic measures that are used to assess the quality of healthcare provided, and these measures include the proportion of diabetes patients with controlled A1c levels. Clinical trials like the Diabetes Control and Complications Trial and the United Kingdom Prospective Diabetes Study showed that control of A1c lowers microvascular outcomes, and other clinical trials have shown that blood pressure and lipid control lower cardiovascular disease outcomes.[3,44-49] Improved adherence would therefore not only impact health care performance as currently assessed and publically reported, it would also delay or avoid complications of diabetes, improving quality of life and functioning, which are the ultimate measures of healthcare performance. The impact on healthcare performance would therefore be profound; as mentioned above, it could lower healthcare costs by as much as $290 billion.[5]

Technical merit . Project Overview. We will build on our ongoing partnerships with people living in Alabama's Black Belt, learning together how to improve outcomes for individuals with diabetes. In the first year of the study we will conduct focus groups with people with diabetes and medication nonadherence to learn more about their beliefs and attitudes toward living with diabetes and the medications used to treat the disease. Using this information and working within the Corbin and Strauss framework, we will collaboratively create DVDs of peer storytelling integrated into a diabetes education experience, and the peer coaching protocol, drawing on Social Cognitive Theory and Adult Learning Theory. We will pilot test the intervention, and we will implement the randomized controlled trial (RCT) comparing the effectiveness of the intervention with usual care. In years 2 and 3, we will recruit 500 individuals with diabetes who report medication nonadherence, group randomize them to one of the 2 trial arms, and collect baseline and follow-up data 6 months later. Control patients will receive comprehensive diabetes education on conclusion of the 6 month period. During all 3 years, we will also work with community coalitions in our partnering communities to obtain ongoing input, share knowledge of community resources, create a resource bank website to facilitate the peer coaches' work, and plan for dissemination of the interventions.

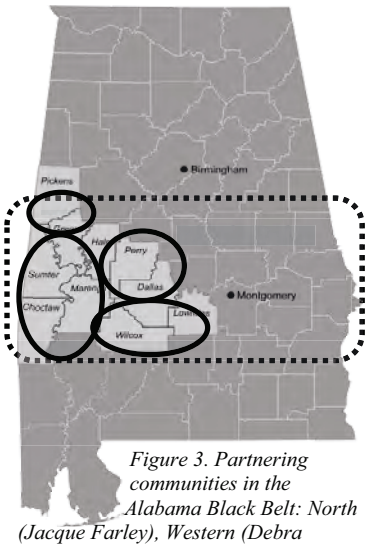


Figure 3. Partnering communities in the Alabama Black Belt: North (Jacque Farley), Western (Debra Clark), South Central (Ethel Johnson).

The setting and our partnership. Booker T. Washington described the Black Belt as "a part of the country which was distinguished by the colour of the soil. The part of the country possessing this thick, dark, and naturally rich soil was, of course, the part of the South where the slaves were most profitable, and consequently they were taken there in the largest numbers. Later and especially since the (Civil) war, the term seems to be used wholly in a political sense—that is, to designate the counties where the black people outnumber the white."[50] The Black Belt runs in an arc across central Texas up to Maryland. In Alabama, it is a 200-mile wide belt across the southern half of the state (Figure 3).

Since 2008, we have conducted two trials of diabetes interventions in partnership with Black Belt communities with Ethel Johnson as community coordinator for communities in the South Central Black Belt, and Debra Clark as community coordinator for communities in the Western Black Belt. The Encourage Trial (2008-2011), funded by Peers for Progress, recruited 424 (target 400) individuals with diabetes (75% blacks) and was designed to assess whether education plus volunteer peer-delivered support resulted in better outcomes than education alone. Both trial arms experienced nonsignificant improvements in A1c and blood pressure over one year, but intervention arm participants experienced greater weight loss.[51] Peer volunteers and participants greatly enjoyed participating in this study, and both communities requested additional similar programs. Responding to a call from our peer supporters for better interventions to help people living with both diabetes and chronic pain to exercise, we developed a project that was funded by AHRQ in 2010. We called this the Healthy Living trial, which engages individuals with both diabetes and chronic pain. The cognitive behavior training intervention is delivered by CHWs and includes DVDs with diabetes education content and embedded peer stories about living with diabetes and chronic pain. While this proposed research differs substantially from these past studies in the targeted population (diabetes and medication nonadherence) and the intervention (designed to improve adherence), we build on a research partnership that includes a tested and durable collaborative approach to research in which community members are research team members, and we routinely reach out through discussion groups, interviews and focus groups for community input on study design, intervention development, recruitment and data collection.

Study Aims

Improving medication adherence is one of the greatest challenges in modern medicine. Despite decades of research on the topic, as many as half of patients with chronic diseases are not taking medications as recommended, and costs of nonadherence have been estimated at $290 billion annually. One reason for this persistent finding could be that interventions rarely acknowledge medications within the larger context of the lived experience of illness. Drawing on hundreds of patient interviews, Corbin and Strauss showed that chronic illness is a fundamentally destabilizing influence that forces us to confront the potential limitations of our "new", chronically ill self. Accepting our illness may be a crucial step in embracing medication adherence and other self-management behaviors as ways to restore balance following this disruption. The Corbin and Strauss framework is not often used to develop and test interventions to improve medication adherence, and this is the central objective of this proposal.

Medication adherence is especially critical in regions like rural Alabama, where residents have among the worst health outcomes in the US. Rates of cardiovascular mortality, diabetes and obesity are very high, but resources are scarce and the area's predominately black residents have deep-seated mistrust of the healthcare system (the region includes Tuskegee, site of the infamous syphilis study). This project was designed in collaboration with our community member partners and builds on a 5-year partnership of community-engaged research on diabetes peer coaching interventions and our experience with peer storytelling. We will test the hypothesis that an intervention designed within the Corbin and Strauss framework can improve adherence and health outcomes compared to usual care.

Our Aims are:

Aim 1: With our community partners, using qualitative research methods, build on already developed culturally tailored education material to develop the medication adherence intervention. The intervention will consist of educational DVDs with integrated storytelling about how community members accepted their disease and overcame barriers to medication adherence, plus one-on-one telephonic peer coaching. Activities include conducting focus groups with patients; creating the DVDs and the coaching intervention protocol; training peer coaches; and pilot testing.

Aim 2: Conduct a randomized controlled trial with 500 individuals with type 2 diabetes and medication nonadherence. The trial will compare the effect of usual care and the intervention on medication adherence and physiologic risk factors including A1c, blood pressure and low density lipoprotein cholesterol (primary outcomes), and quality of life and self-efficacy (secondary outcomes).

This innovative approach would be a major shift in how we help patients in under resourced areas living with chronic diseases commit to taking medications, improving health and eventually reducing health disparities.

Study Hypothesis

An intervention designed within the Corbin and Strauss framework can improve adherence and health outcomes compared to usual care.

Aim 1: Collaborative intervention development.

Aim 2: Cluster RCT with 500 individuals with type 2 diabetes and medication nonadherence, test the hypothesis.

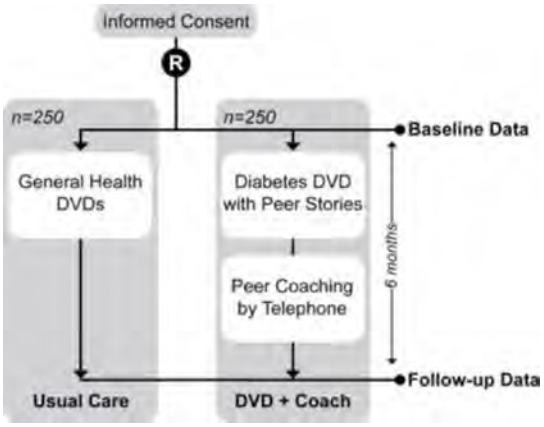
Outcomes:
Primary = medication adherence, A1c, blood pressure, low density lipoprotein cholesterol

Secondary = quality of life, self-efficacy

Study Design

We will compare usual care to viewing an educational DVD including peer storytelling and a 6-month telephone-delivered peer coaching intervention. We propose to use an RCT design because we aim to test the effectiveness of the intervention on medication adherence and A1c, blood pressure and cholesterol.

The trial will be cluster-randomized to reflect the clustering of patients within tightly knit small rural communities. People talk frequently within these communities, and if two participants from the same town are in different trial arms and compare notes, this could change their behavior and threaten the validity of the study. Each of the anticipated 80-100 towns will therefore be group-randomized in blocks to avoid contamination across trial arms. We considered using physician practices as clusters, but we have learned that it is common for different family members to attend different practices many miles from home.



Study population

The priority population for this project lives in rural counties located in the Alabama Black Belt, which is heavily burdened by diabetes and lacking in primary health care providers and resources.

Inclusion Criteria

Individuals who meet the following criteria will be eligible to participate in the study.

- Adults aged 18 or older
- Have been told by a doctor or nurse that they have diabetes
- Take oral medications for their diabetes
- Medication non-adherent
- Has a primary care doctor

Exclusion Criteria

- Not community-dwelling
- Less than 18 years of age
- Are pregnant
- Have end-stage medical conditions with limited life expectancy
- Do not have a primary care doctor
- Expect to move out of the area in the next 6 months
- Cannot speak English

Study Outcomes and Measures

Primary Outcomes

The primary outcomes will include medication adherence. We will use the Morisky scale, which has been widely used and corresponds well to physiologic measures,[13] but self-report is subject to recall and social desirability biases. Because of all the shortcomings related to assessment of adherence, we will also assess the result of improved adherence: better risk factor control. Three physiologic measures, A1c, blood pressure and LDL-cholesterol make up the "*A-B-C's*" of diabetes care, which will be assessed here. The "*A-B-C's*" of diabetes are a central focus of diabetes education, and the intervention will address medication adherence to control all three risk factors.

Secondary Outcomes

Secondary outcomes will be health-related quality of life and self-efficacy. *Quality of life* will be assessed through the validated Short-Form 12 (SF-12), a generic measure of health-related quality of life. We will assess diabetes-specific quality of life using the validated Diabetes Distress Scale.[52] *Self-efficacy* in taking medications will be assessed using the Self-efficacy for Appropriate Medication Use[53] and the Perceived Diabetes Self-Management Scale,[54] which is associated with A1c.

We will also assess the number of physician office visits, hospital stays and emergency visits in the previous 6 months, but do not anticipate that the short duration of the study will be able to detect significant differences between trial arms. Nevertheless, we will collect these data to build toward future longer term intervention studies. In addition, during the in-home visit we will transcribe the name and dose of all diabetes, blood pressure and lipid medications at baseline and follow-up to detect whether regimens have been intensified as a result of exposure to the interventions.

Additional Measures

To understand the pathways through which the intervention is exerting its effects, we will collect additional measures guided by our conceptual framework. Our initial list of candidate measures is organized by theoretical construct and the Corbin and Strauss framework. Where available, we have selected validated scales that have been tested in low-literacy populations.

Patient characteristics	Age, sex, race, ethnicity, income, education, internet use, smoking status
	Duration of diabetes
	Insulin use
	Comorbidities
Health Care Access	Health insurance
	Distance from home to doctor
	Access to care question
Medication Adherence	4-item Morisky Medication Adherence Scale
Barriers to medication adherence	Medication Barriers Scale
Diabetes distress	Diabetes Distress Scale (DDS4)
Diabetes knowledge	Spoken Knowledge in Low Literacy in Diabetes (SKILLD)
Depressive Symptoms	Personal Health questionnaire (PHQ8)
Health related quality of life	Short-Form 12 (SF12)
Perceived stress	Perceived Stress Scale (PSS-10)

Self Efficacy	Self Efficacy for Appropriate Medication Use Scale (SEAMS)
	Perceived Diabetes Self-Management Scale (PDSMS)
Self care behaviors	Diet questions
	Exercise Questions
Social Support	Chronic Illness Resources Survey
	Social Support Scale
Trust	Trust in medical researchers
Numeracy	Subjective Numeracy Scale (SNS)

Process Measures

A careful assessment of intervention implementation can provide insights into which aspects of the intervention were particularly effective. We will use cell phones provided by the study to track the frequency and amount of time spent on coaching sessions, as well as how closely they were implemented on schedule. Additional process measures will come from the peer coach Workbooks for each participant. These will include notes from each session as well as data entered for specific activities. We provide a chapter from our current trial's Peer Coach Workbook in the Appendix to give a general idea of how these workbooks capture process data. We also monitor intervention implementation on an ongoing basis through weekly teleconferences with peer coaches, and weekly outreach to each peer coach individually throughout the intervention period. We provide updates on the progress of the study, collaboratively troubleshoot problems, and provide ongoing advice, which often stems from other peers or the community coordinators. We also address specific concerns with the help of our community coordinators (e.g., finding participants whose telephone numbers have changed).

Randomization

We will use a block randomization scheme for randomization. The units of randomization are towns identified by zip codes. We will group towns by size (small and not small) within each of the 4 regions, resulting in 8 strata. We will balance the strata so that at least 3 towns are in each stratum. With 55 towns in the two regions participating in the 400-member Encourage study, we conservatively estimate at 80-100 towns with the addition of two more regions, providing sufficient sample as well as clusters

As participants agree to enroll and provide informed consent, they will be randomized as a representative of their town. That is, the first member of a given town will determine the randomization status of that town. All subsequent town residents will be placed into the same trial arm as the first participant from that town. Informed consent will be obtained from all participants. We will obtain verbal consent over the telephone at the time of the baseline telephone interview. Formal written informed consent will be obtained at the time of the in-home data collection visit. Participants will view a video providing information about the study with the opportunity to call a toll-free number for questions.

Program Descriptions

Control Participants: General Health Videos

Participants in the control arm will receive a general health education DVD and handout. The DVD contains videos on the following topics: Dementia and Alzheimer's, Breast Cancer, Colorectal Cancer, Osteoporosis and Fall Prevention, Eye Health, Oral Health, Foot Care, and Driving Safety. A copy of the handout is included as Appendix A.

Intervention Participants: Living Well with Diabetes

Peer Advisors Recruitment

Peer advisors are individuals who live and work in our target communities. Peer advisors are hired by Health and Wellness Education Center in Livingston Alabama. Peer advisors will be trained in motivational interviewing, basics of communication and goal setting. In addition, peer advisors will complete an 8-week study protocol training supervised by Ms. Debra Clark of Health and Wellness Education Center and lead by Dr. Cherrington and study staff.

Peer advisor candidates are recruited by 3 methods.

1. Community coordinators identify individuals in their community or social networks who they believe would be great peer advisors.
2. Current peer advisors refer individuals from their communities or social networks.
3. Participants of previous studies with peer advisors express interest in being a peer advisor.

After an individual is referred, UAB staff or the local community coordinator completes a Peer Advisor Candidate Screening Form (see Appendix B).

After the screening form is completed, the principal investigator, community coordinator, study coordinator, and the UAB staff (who completed the screener) meet to review the form and discuss each candidate.

- If the candidate is not asked to move forward in the training, the reason is documented. These individuals are notified in person by the community coordinator.
- If the individual is considered to be a good candidate but is unavailable for the scheduled training, permission is obtained from the individual to contact them for future programs.
- Individuals who are considered a good candidate to a be peer advisor is scheduled for an upcoming training.

Peer Advisor Retention

As is the recruitment efforts, peer advisor retention efforts will be coordinated between UAB Birmingham-based staff, UAB community-based staff (community coordinators), and the Health and Wellness Education Center. Retention activities consist of the following:

1. Ensure timely payment for work
2. Provide ongoing support and continuing education/retraining with opportunities for practicing skills
    a. UAB Birmingham staff: Weekly group conference calls
    b. UAB Birmingham staff: Weekly individual calls to collect process measures, monitor progress

    c. Community coordinator: weekly individual contact to provide support, identify issues early
    d. Provide support and identify ways to reduce/help with workload during periods of stress in peer's lives.
3. Be respectful of peer advisors' time and schedules
    a. Keep mandatory conference calls and individual calls on time, short as possible, and reschedule only if necessary.
    b. Provide assistance as needed in scheduling sessions with participants
4. Recognize and thank peers for their work
    a. Holiday celebrations:
        i. face-to-face dinner or lunch 1-2 times per year
        ii. send notes/cards for birthdays and holidays
    b. Identify ways to celebrate in the local media the peer advisor's work in the community
5. Engage peers in leading and presenting for other community activities (ex: Black Belt Institute, Coalition meetings, and as opportunities become available)

Living Well with Diabetes Program Description

Participants enrolled in the intervention arm will receive a Living Well DVD, which contains 6 video lessons that cover 6 content areas (1-diabetes basics, 2-healthy eating, 3-physical activity, 4-diabetes medications, 5-blood pressure & cholesterol medications, and 6-stress and your health), and an Activity Workbook. The participant will use the activity book when communicating with their peer advisors during the sessions.

Every session, the peer and participant will discuss the participant's medication goals. During week 1, the participant will set a medication related goal. During week 2, the participant will set a goal related to healthy eating. During week 3, the participant will set a goal related to exercise. The peer and participant will review the previous week's goal and progress of the goal. If the participant met the goal and ready to extend the goal, the peer advisor will help the participant set a new goal. If session has a video, the peer and participant will discuss the educational content in the video.

During the check-in sessions, no new topic areas are introduced. The peer advisor will review the previous week's goals. Peer will review goal's progress and assess barriers and help problem solve any barriers. New goals will be set if the participant is ready to extend the goal.

Intervention participants also receive 13-16 telephone contacts from a Peer Advisor.

Months 1-3 are the intensive phase. During the first 8 weeks of the intensive phase, peer advisor contacts will occur weekly. During weeks 9-12, the peer contact will occur bi-weekly.

Months 3-6 are the maintenance phase. During this phase, the peer contacts will occur monthly. No new content areas are introduced. Participant will continue to work on the goals set during the first 3 months of the program. The peer advisor will call monthly during the "check-in session". During these sessions, the peer and participant will review goals set, goal progress, assess barriers and help problem solve barriers. If participant is having trouble with their health goals during this phase, the peer and participant can decide that more contacts than monthly contacts are needed. For these participants, the peer advisor will provide a 'mini-intensive' phase, during which calls will be increased to weekly.

The participants will be allowed to telephone the peer advisors with questions or concerns between sessions. During session 1, the peer advisor makes sure that the participant has the correct contact number. The peer will let the participant know that it's okay to call between sessions if they have questions. They will let them know that they may not be able to take the participant calls all the time, but the peer will return their calls as soon as they can.

The schedule and topics for each week are listed below.

Mon	Week	Session Topic	Mon	Week	Session Topic
1	1	Introduction to the program, diabetes basics	4	13	*No session**
	2	Healthy eating		14	*No session**
	3	Physical activity		15	*No session**
	4	Diabetes medications		16	Check-in session 3 (no new topic)
2	5	Blood pressure & cholesterol medications	5	17	*No session**
	6	Stress and your health		18	*No session**
	7	Check-in session 1 (no new topic)		19	*No session**
	8	Practice and planning for the future, part 1		20	Check-in session 4 (no new topic)
3	9	*No session*	6	21	*No session**
	10	Check-in session 2 (no new topic)		22	*No session**
	11	*No session*		23	*No session**
	12	Practice and planning for the future, part 2		24	Check-in session 5 (no new topic)

Months 1-3 = Intensive phase; Weeks 1-8 weekly contact; weeks 9-12 biweekly contact
Months 4-6 = Maintenance phase; monthly contacts
**The last 3 months of the program is the maintenance phase during which no new content areas are introduced. The participant continues to work on the goals (3 goals – 1) goal to overcome barriers to taking medications, 2) health eating goal, 3) exercise goal) set during the first 3 months of the program. The Peer Advisor will check in with the participant monthly. If participant is having trouble with their health goals during this phase, the peer and participant can decide that more contacts than monthly contacts are needed. For these participants, the peer advisor will provide a 'mini-intensive' phase, during which calls will be increased to weekly.*

Copies of the tools used by the peer advisors (Peer Advisor Manual and Client Plan Book) and participants' Activity Book are included in Appendix C.

Recruitment of Participants

We will use respondent-driven sampling for recruitment. Flyers and interest cards are distributed by the community coordinators to their recruitment team. Flyers include the general purpose of the study and inclusion and exclusion criteria. Interested individuals sign an interest card with their contact information, which is forwarded to the research team based in Birmingham.

Prospective participants are screened for eligibility by a member of the research team over the telephone. Adults age >18 years with type 2 diabetes who respond "yes" to any question on the 4-item Morisky scale who are willing to watch a DVD and work with a peer coach to improve their diabetes self-care will be eligible for the study. Exclusion criteria include nursing home residence, plans to move away in the next year, and advanced illnesses such as hemodialysis, cancer or dementia. *The participant eligibility screening script is included in appendix D.*

Recruitment Methods

Participants will be recruited by 4 methods.

1. Community member calls UAB after seeing an advertisement (i.e., radio ad, newspaper ad, flyers, heard about the study at a community event or community meeting)
2. Community recruiter
    a. Individuals calls UAB after hearing about the study from a recruiter
    b. Individual completes a participant interest card and the card is submitted to a community coordinator
3. Community Coordinator
    a. Have individuals complete interest cards
    b. Collects interest cards from community recruiters.
    c. Collects interest cards from primary care practices / community organizations who recruit
4. Primary care practices
    a. Flyers will be posted in local partner practices.
    b. Research assistant in the waiting room

Community Recruiters. Community recruiters have been identified the community coordinators or peer advisors. Recruiters are asked to identify individuals in their social networks that may be interested in participating in a study to help them better care for their diabetes. Before they begin recruitment, community recruiters are given an orientation by the community coordinator and if needed, study coordinator. The recruiters are provided instructions and a checklist on how to complete the information sheet.

Community recruiter submits interest cards to their community coordinator who submits the cards to UAB staff. The community coordinator meets each community recruiter at minimum 1 time per week to arrange card pick-ups.

Community Coordinators. Community coordinators present the study to groups at local community events, health fairs, churches, etc. The individuals that they recruit complete an interest card or are asked to call the study's phone number.

During weekly calls, coordinators and study staff discuss upcoming opportunities in the communities to recruit participants for the study. A recruitment calendar is maintained with the event's name, the date and time, and the responsible study member who is attending the event.

Community coordinators also coordinate these following recruitment activities: radio announcements, putting up flyers, newspaper ads, church announcements, and working with local primary care providers.

Community coordinators or recruiter will call us with the individual's name and submit the interest cards. UAB staff will add the names to the recruitment tracking log.

For every individual referred that enrolls in the study, community recruiters receive a $5.00 VISA gift cards. These cards are bundled and sent periodically.

Recruitment at Primary Care Practices. Passive recruitment at practices will consist of flyers posted in primary care practices in the local communities. Interest cards and interest card boxes will be placed in secure and monitored locations. Community coordinators will check-in with the practices and the boxes at minimum once per week.

Active recruitment at willing practice via site visits by UAB research staff. As practice schedules allows, research assistant or community coordinators will sit in the waiting room of the practice. Practice staff will walk interested patients to the research assistant who will present the study and complete the screening if the participant is interested in the study. The community coordinator will arrange for specific days in which the research assistants can visit the practices.

Recruitment Flyer is included in appendix D.

Eligibility Screening

After the potential participants sign the interest card or call UAB, study staff will conduct an eligibility screening over the telephone using the *"Telephone Eligibility Screening Script" in appendix D*. If individuals are eligible for the study and interested in enrolling in the study, he or she will be scheduled for the telephone interview.

Study Enrollment, Informed Consent, and Data Collection

Telephone Interview

A waiver of documentation of informed consent for the telephone interview has been approved. The potential participant will be mailed the informed consent form that will be reviewed prior to the interview. The telephone interviews will be scheduled at the earliest date and time after the screening interview that the participant is available, allowing for 2-3 days needed for the participant to receive the informed consent document in the mail. Trained UAB study staff members will conduct the telephone interviews.

The telephone interview will begin with the interviewer reviewing the informed consent form with the participant. If the participant agrees to participate in the study, the interviewer will complete the baseline assessments. *Telephone interview is included in appendix E.*

Interviews will be completed in the Preventive Medicine Research 510 suite. As such, the program coordinator and/or data coordinator will listen to interviews in progress. Furthermore, a random selection of interviews will be quality checked. For these interviews, the program coordinator or data coordinator will listen in to the entire interview.

In-Person Biometric Data Collection Visit

After the interview is completed, the in-person data collection visit will be scheduled. Participants will be given the option of meeting at a community location or have UAB staff members come into the home to collect biometric data. Community locations most convenient for the participants and have private spaces available will be selected. Example locations include private rooms in community centers and church meeting rooms. UAB staff members, trained in the biometric study protocols will attend the biometric data collections. Data collectors for the study are trained and certified by study investigators. Training and certification for each data collection component are outlined in the biometric protocol. In summary, the data collector to be trained and certified, the following is necessary:

1. Read the biometric protocol *(Biometric protocol included in appendix F.)*
2. Attend Living Well training session on techniques
3. Practice on other staff or volunteers
4. To be certified, complete exam on 2 volunteers, observed by study investigator

During the screening, participants will be asked not to not drink any caffeine (from coffee, tea, or soda), should not eat or do any heavy physical activity, smoke, ingest alcohol for 30 minutes prior to recording the blood pressure.

During the in-person data collection visit, the participant will sign the informed consent. The following measures are collected during this visit: hemoglobin a1c, LDL-cholesterol, blood pressure, weight, and height.

Hemoglobin A1c will be measured using the A1cNow+ system, National Gycohemoglobin Standarization Program Certified, CLIA-waived system that provides Hba1c results using a fingerstick test.

LDL-Cholesterol will me measured using the Cardiochek PA analyzer, CLIA-waived system that provides LDL cholesterol results using a fingerstick test.

Blood pressures will be measured using the following protocol. Patient will be asked to sit quietly for 5 minutes. 2 BP measures, using an automated BP machine, will be taken. Measures will be taken 1 minute apart.

Data will be collected in this order.

1. Blood pressure:
    a. 5 minute rest
    b. blood pressure measurement 1 taken
    c. 1 minute rest
    d. blood pressure measure 2 taken
2. Fingerstick for A1c and LDL cholesterol measurements
    a. A1c measured using the A1cNow+ machine
    b. LDL cholesterol measured using the Cardiochek PA analyzer
3. During this visit, we will also make a list of all medications the participant is currently taking.
4. Provide participant with health report card

After the completion of the in-person data collection, the participant will be given the materials for the program. If the participant is in the control condition, they will be given a general health education DVD. Participants in the intervention condition will be matched with their peer advisor and given an activity book that they will use during their sessions with their peer advisors. All participants will receive their portable DVD player at the end of the data collection visit. Participants will receive a Health Report Card that provides their a1c, LDL-cholesterol, blood pressure, and weight data. If needed, participant in the intervention arm will receive a study phone.

Participants will be asked by the research staff at the in person data collection visit if they would like to use a study phone. Study phones will be taken back at the 2nd in-person study visit. *Copies of the consent, in-person data collection form, and Health report card are included in Appendix F.*

Participant Compensation

Participants will receive a portable DVD player and a $20.00 VISA giftcard. Participants will receive the DVD player at the first in-person data collection visit and the giftcard at the second in-person data collection visit.

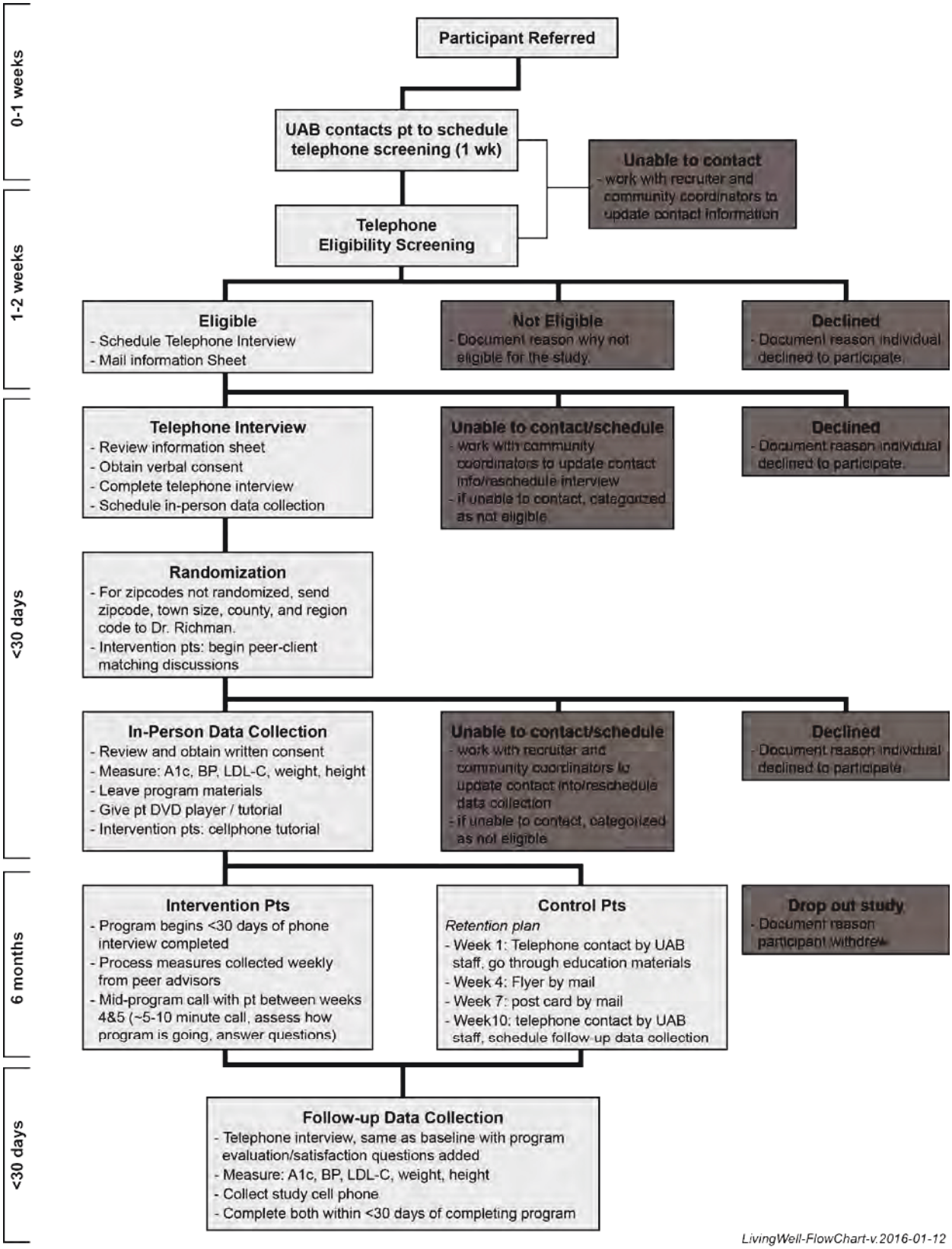
Participant Retention

During the 6 months of the trial, UAB staff will contact all participants 2-3 times. During these brief 5-minute calls, the staff will answer participant questions, update contact information, and provide help if needed in accessing study education materials. Participant retention plan will be a mixture of telephone and mail contacts as shown below:

Month	Control Participants	Month	Intervention Participants
1	Phone Call: Welcome to the study, answer questions	1	*No contact*
2	Postcard: Reminder to look at videos	2	Phone Call: answer questions, identify problems, update contact information
3	Phone Call: answer questions, identify problems, update contact information	3	*No contact*
4	Postcard: Keep in touch post card card	4	*No contact*
5	Phone Call: answer questions, identify problems, update contact information	5	Phone Call: answer questions, identify problems, update contact information
6	Postcard: reminder of upcoming data collection	6	*No contact*
All participants will receive postcards for birthdays, holiday cards (Thanksgiving, Christmas)			

During month 6 (control participants) or after the final session with the peer advisor (intervention participants), study staff will contact the participant to schedule their follow-up telephone interview and in-person data collection. *Copies of postcards and telephone contact scripts are included in Appendix G.*

The figure below shows the study flow from recruitment to the completion of the study.



Analysis

Data management

Data is being entered into a Redcap Database. Validity checks and skip patterns maximize the quality of data entry and text entry is minimized. In-home visit data will be transcribed onto a form during the visit and faxed daily to the UAB research office. A tracking system will be implemented to monitor study progress using Redcap.

Power Calculations and Sample Size

This study is powered to detect clinically meaningful differences in changes in medication adherence, A1c, blood pressure and LDL-cholesterol between either of the intervention arms compared with the usual care arm. The secondary outcomes are based on surveys (disease acceptance, quality of life). To consider the clustering of patients within town, we used a variance inflation factor $D = [1 + \rho(m - 1)]$, where m is the number of participants per community and ρ is the intra-class correlation (ICC). We conservatively estimate that we will have at least 80 clusters, corresponding to an average of 6-8 participants per cluster, with ICC=0.01 and 0.05 yielding D=1.084 and 1.419, respectively. Dividing the sample size per group N by D gives N_{Eff}, the effective sample size. In the Encourage study, those reporting nonadherence at baseline demonstrated ICCs in the range of 0.001-0.015 for most measures. To be conservative because we include new communities, we present power calculations for ICC=0.01-0.05. We observed 20% attrition over one year in the Encourage study and although attrition is likely to be lower over 6 months, we assume 20% attrition here, leaving 200 participants per group. Table 7 displays the detectable differences in adherence proportions and the difference in mean changes between groups detectable with 80% power using 2-sided X^2 and t-tests with α=0.05. We used variances based on the Encourage sample reporting nonadherence at baseline. We hypothesize that the intervention will result in improved medication adherence. Because eligibility requires low adherence at baseline, we expect low acceptance at baseline. Starting with low baseline values by design eliminates ceiling effects and allows us to reasonably anticipate large changes in the intervention groups and only modest changes in the control arm, as was seen in a storytelling intervention directed at blood pressure.[27] For N=200 per group, the difference in rates of medication adherence treated as a binary outcome detectable with 80% power depends on the proportion observed in the intervention group. If adherence is only 20% in the intervention group, then we can detect as different rates among the control group of 8.8-10.1%, depending on ICC. These rates are both lower than we anticipate for the intervention group and considerably higher than we expect in the control group. Assuming 200 participants per group we will have 80% power using 2-sided t-tests to detect differences of 0.28-0.32 standard deviations for continuous outcomes. Using variance estimates from Encourage data for change in the Diabetes Distress Score, another validated psychometric instrument, this translates into detecting differences as small as 3.7-4.4% of the range. Similarly, detectable differences for change in A1c are in a clinically meaningful range from 0.41-0.48%. We anticipate detectable differences for systolic blood pressure of 3-4 mmHg, and for LDL-cholesterol of 6.7-8.1 mg/dL.

Data Analysis

The main hypothesis to be tested is that participants in the intervention group will have higher medication adherence and significantly greater improvement in A1c, blood pressure, LDL-cholesterol, and measures of quality of life; and fewer barriers to adherence compared to control patients. While medication adherence can be considered as a continuous variable, we will follow the literature and treat adherence as a binary outcome by classifying participants as non-adherent if measured adherence is <80% and adherent otherwise. Therefore, unadjusted testing of the main hypothesis will use two-sided X^2 tests and statistical modeling will use logistic

regression. The other primary outcomes (A1c, blood pressure, LDL-cholesterol) and the secondary study outcomes of physical and mental functioning, as measured by the SF-12, diabetes distress, and barriers to adherence are all continuous or ordinal measures. As such unadjusted hypothesis tests for these outcomes will use t-tests or the Wilcoxon-Mann-Whitney test, as appropriate, and statistical modeling will use linear regression. Analysis will begin by calculating ICCs for each outcome to assess the magnitude of clustering; if the ICCs are found to be significantly non-zero with $p<0.05$ or with a point estimate greater than 0.01, testing of main hypotheses will use unadjusted regression models (logistic or linear, as appropriate) with Generalized Estimating Equations (GEE) to account for clustering. All regression models for outcomes with non-negligible ICCs will use GEE to account for clustering due to randomization at the town level, and will be repeated using mixed models treating the towns as random effects with results examined for consistency.

The primary analysis will test the hypothesis that medication adherence treated as a binary outcome will be greater in the treatment arm than the control arm at follow-up. As above, the primary unadjusted hypothesis test will use either a X^2 test or logistic regression with GEE depending on the magnitude of observed ICCs. Statistical significance will be judged by $p<0.05$ for either the X^2 test or the coefficient for study group in regression models. The intervention group will be compared to the control group; further analyses will use logistic regression with GEE to model adjusting for any covariates that were imbalanced between groups at baseline, and will then proceed to examine regression models adjusted for the covariates described in Table 6.

Analysis for A1c, blood pressure and LDL-cholesterol and the secondary outcomes will be very similar to the analysis of medication adherence described above. We note that we will also be able to analyze adherence as a continuous outcome as a secondary analysis using the following approach. For each of these continuous or ordinal measures, we will begin by calculating the change from baseline to 6-month follow-up for each participant. These change scores will be the units of analysis and we hypothesize greater change among the intervention groups compared to the control group. We will proceed to examine summary statistics, histograms, and scatter plots of the measured outcomes for outliers and data trends. We will then test for unadjusted differences in changes between the intervention and control groups using t-tests, Mann-Whitney-Wilcoxon tests, or regression models with GEE to account for clustering, as appropriate for the variable and ICC. Similar to above, we will then proceed with more sophisticated analyses in stages, first adjusting for baseline values of outcome variables, then for any factors that were imbalanced at baseline and finally adjusting for covariates mentioned above.

Safety Assessments

This study does not involve any new treatments of care, but rather focuses on standard care delivered in a new way. It is possible that the interventions will result in better compliance with medication treatment, resulting in over-control of diabetes or blood pressure. This could result in low blood sugar or low blood pressure and resultant symptoms. Therefore, we will monitor potential adverse events of this nature. We will monitor symptoms of low blood sugar in both trial arms at the follow-up data collection point as well as at ongoing contacts during the 12-week intervention phase, by peer coaches. During these contacts, symptoms of low blood sugar and low blood pressure will be assessed and reported to the investigators and to the participant's physician. If symptoms are present, the peer coach will refer participants to their primary care provider for evaluation immediately, assisting with the telephone call if needed.

Data on safety endpoints will be reviewed by a board convened for this purpose. Quarterly reports will be presented to the board over the course of the trial. The board will be constituted by 3 individuals experienced in the conduct of clinical trials and the safety of human subjects. Adverse events will be reported to the UAB IRB, and the NIH Office of Biotechnology Activities (OBA) in accordance with regulations, by the PI.

Dr. Safford and project investigators, including our community team members, will have an initial organizational meeting or conference call to discuss the protocol development, review of scientific, safety and ethical issues

related to the study design and approve plans for data integrity. After the initial planning meeting project investigators will be convened monthly in a meeting or conference call throughout the project period.

Dr. Safford will be responsible for monitoring the safety and efficacy of the study, executing the data and safety monitoring plan, and complying with the reporting requirements. She will provide a summary of the DSM report to PCORI on an annual basis as part of the progress report. The report will include participant's sociodemographic characteristics, expected versus actual recruitment rates, any quality assurance or regulatory issues that occurred during the past year, summary of adverse events, and any actions or changes with respect to the protocol. The DSM report to PCORI will also include, when available, the results of any efficacy data analysis conducted.

Project investigators will be primarily responsible for protecting the safety of the study participants and the scientific credibility of the project, and the validity of the assessment of the efficacy of the interventions used in the projects. The project investigators will also formulate recommendations relating to the selection, recruitment and retention of participants, their management, improving adherence to protocol-specified regimens, and the procedures for data management and quality control.

The entire project team will monitor success of recruitment, assess data integrity, and most importantly monitor for adverse events. Risks to study participants relate mostly to misinterpretation of what is research and what is usual care and loss of confidentiality. Project investigators will carefully evaluate how the study is described and assure that study subjects are informed not to report urgent symptoms (chest pain) through email communications. Any hospitalizations or deaths discovered by the research team will be promptly reported to the DSMB with an assessment of whether any study procedures may have contributed to these outcomes.

The risks of the study are low, and thus the safety monitoring plan has been matched to the risk to subjects in this study. Risks to physician study participants relate mostly to misinterpretation of what is research and what is usual care and loss of confidentiality. We are encouraging physicians and their staff to increase their provision of care related to diabetes, osteoarthritis and chronic pain to be consistent with current guidelines. However, we are not asking the physicians or their staff to provide services beyond those in standard, high-quality medical practices.

For this study, we plan interim data analysis twice annually to assess probability of statistically significant group differences. We will first compare baseline data to assure adequacy of randomization. We will then conduct interim analyses that will coincide with practice data intervals, and set intervals for patient data collection for outcomes data. Prior to interim analyses, investigators will assign stopping rules. Safety data to be included in these reports include hospitalization rates as well as Emergency Room utilization.

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Appendices

Appendix A

General Health Education Video Handout

General Health Education Program Videos

- **Video 1: Alzheimer's and Dementia**
- **Video 2: Breast Cancer**
- **Video 3: Colorectal Cancer**
- **Video 4: Osteoporosis and Fall Prevention**
- **Video 5: Eye Care**
- **Video 6: Oral Health**
- **Video 7: Foot Care**
- **Video 8: Driving Safety**

We are so glad to have you in our program!

Here is a list of the videos that are included on this DVD.

Living Well with Diabetes

For questions, please call the UAB Study Team at (205) 934-7163

Appendix B

Peer Advisor Candidate Screening Form

Peer Advisor Interest
Talking Points / Screening Form

Date of Discussion: _____

Name of Potential Peer: _____

Peer's Community: _____

Phone Number: _____

Phone Number: _____

What is Living Well with Diabetes?
Diabetes is a big problem in rural Alabama, especially in the Black Belt. The Black Belt has among the highest rates for diabetes and diabetes complications such as heart attack, stroke, kidney disease, amputation, and eye problems. Many people who have diabetes do not take their medications every day. Taking your diabetes medications every day as directed by your doctor is one of the ways that can help you live as well as you can, as long as you can.

The goal of the study is to help people take care of their diabetes by taking their medications every day as directed by their doctor, eating healthy foods, exercising, having effective interactions with their healthcare team, reducing stress, and getting positive support from family and friends. We think that this program will help people with diabetes live as well as they can, as long as they can.

What is a Peer Advisor?
Peer Advisors are people who live in the Black Belt and want to help their communities. We are looking for people with diabetes, or people who care for someone who has diabetes. The essentials: you care about your community, you want to help, and you have familiarity with what it is like to live with diabetes day in and day out.

How long would I be involved?
The Living Well with Diabetes study will last approximately 1 to 1.5 years.

Do I have to participate until the program ends?
We are looking for people who would be willing to work with us for at least one year.

What would I need to do?

Getting Trained and Certified as a Peer Advisor

- Attend 2 days of in-person training, followed by a10-week telephone training.
  - Costs you nothing
  - Learn about diabetes basics, motivational interviewing, talking to the doctor, medications for diabetes, blood pressure, and cholesterol
  - Practice your new skills. **NOTE: It is easier for some people to develop these skills than it is for others. There will be a test at the end of the 2 days of in-person training to see how much you have mastered. Unfortunately, some people may not move on to become Peer Advisors.**

- Time Commitment for Training:
    - 2 In-person trainings: 6 hours each day, lunch will be provided
    - 10-Week Telephone Training: 2 to 4 hours each week, depending on the week
        - 30-60 minutes listening to audio recording of the session and watching session video
        - 30-60 minute telephone call with the other peer advisor candidates
        - 30 minutes roleplaying as a client
        - 30 minutes roleplaying as peer
        - 30-60 minutes talking with UAB staff, providing feedback on the program, and completing certifications
        - *(as needed)* additional practice time with the community coordinator in order to complete certification

Working as a Peer Advisor

- Work with someone with diabetes on the phone for 5 months, one-on-one, over the phone.
- Time Commitment as a Peer Advisor:
    - First 2 months: talk with client on the telephone weekly (30-45 minutes per call)
    - Last 3 months: bi-weekly or monthly (10-20 minutes per call)
    - Special call before and after a doctor visit (10-15 minutes each call)
- Attend a weekly group call with other peer advisors (30-45 minutes)
- Speak with a UAB staff member every 1-2 weeks (15-30 minutes)

What's in it for me?
Peer advisors will be UAB employees.

- $50 Gift card for completing the 1st in person training, whether or not you pass the test (1 day)
- $50 Gift card for completing the 2nd in person training, whether or not you pass the test (1 day)
- $250 Gift card for completing the 10 week telephone training, whether or not you pass the test
- $150 for completing the program with each study participant.

When does it start?
The first in-person training will be July.

The second in-person training and 10-week telephone training will start late summer/early fall.

I have trouble with transportation. Does that matter?
Most of the Living Well with Diabetes program is done over the phone. We can arrange transportation for training.

I only have a cell phone. Is this OK?
You will receive an UAB cell phone for use for the study.

How much travel will I need to do?
You will need to attend the 2-day training in person.

You will have to meet with your community coordinator regularly to receive / turn in study materials.

Thank you for your interest in this study. It is our hope that by working together we can design innovative and effective ways to manage the burden of diabetes in Alabama's Black Belt.

If not interested, please find out reasons for not wanting to participate: *(check all that apply)*

- ☐ Transportation Difficulties
- ☐ Do not want to become a UAB employee
- ☐ Don't have enough time
- ☐ Other: *(specify)*

If not interested, please find out if there is anyone else the person would like to refer to become a peer advisor:

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

INCLUSION CRITERIA: Who are we looking for to become peer advisors?

To be invited to participate in the study, peer candidates must answer "Yes" to all questions in the gray squares. Questions in the white squares are "informational" and are other important characteristics/information to consider when interviewing Peer Advisor Candidates.

If you have any questions or concerns about someone, please reach out to the other community coordinators, Dr. Safford, Lynn, and/or Susan.

1. Do you have a desire to help others?	☐ Yes ☐ No
2. Are you willing to become an UAB employee?	☐ Yes ☐ No
3. Do you have diabetes or do you help a close friend or family member take care of their diabetes?	☐ Yes, I have diabetes ☐ Yes, I have diabetes and I care for someone with diabetes ☐ No, I do not have diabetes, but I care for someone with diabetes ☐ No, I do not have diabetes and I do not care for someone with diabetes
4. Do you have a doctor that you see regularly for your medical care?	☐ Yes ☐ No if yes, who/city_____
5. Do you have a doctor that you see for your diabetes or other medical care?	☐ Yes ☐ No if yes, who/city_____
6. Do you take pills every day that were prescribed by a doctor? Do you help a close friend or family member with their pills that were prescribed by a doctor? *(For example: pills for diabetes, high blood pressure, high cholesterol)*	☐ Yes, I take pills. ☐ Yes, I take pills and I help someone with their pills ☐ No, I don't take pills, but I help someone else with their pills ☐ No, I don't take pills and I do not help someone else with their pills.
7. Are you willing to attend and complete the Peer Advisor training? Training will consist of 2 in-person training days, and 10 weeks of training over the telephone.	☐ Yes ☐ No
8. Are you willing to work with 5-7 clients over 5 months, by telephone, at first weekly, and then biweekly and monthly?	☐ Yes ☐ No
9. Are you willing to attend weekly group phone calls with other peer advisors and study doctors?	☐ Yes ☐ No
10. For every client you take on, you will need to spend about 1 hour a week scheduling calls, completing the program, and completing paperwork. This will be weekly for the first 2 months and then biweekly and monthly for the last 3 months. Most peer advisors choose to take 3-5 clients at a time. In addition to your client calls, you will generally have 2 meetings every week or every 2 weeks. Both meetings together will last 30 minutes. You will meet with UAB staff one-on-one for about 30 minutes per week. **On a scale from 1 to 10, 1 being not confident at all to 10 being very confident, how confident are you that you will have enough time for the project?**	not confident very confident **1 2 3 4 5 6 7 8 9 10**
11. On a scale from 1 to 10, 1 being not easy and 10 being very easy, how easy is it for you to listen to other people?	not easy very easy **1 2 3 4 5 6 7 8 9 10**
12. Have you volunteered on other research projects as a peer advisor (sometimes referred to as community health advisor, community health worker, etc.)?	☐ Yes ☐ No
12.1. If yes, please provide the name of those projects, describe your role, length of time of your participation, and whether you are still volunteering on that project:	If yes, please provide, Project name: Length of time of participation: Whether you are still volunteering:

13. What other community volunteer activities do you currently do?	
14. How long have you lived in the present community in which you reside?	Community: Time:

- We would like to ask you about your personal views about medicines in general.
- These are statements other people have made about medicines in general.
- Please indicate the extent to which you agree or disagree by saying if you strongly agree, agree, are uncertain, disagree, or strongly disagree.
- There are no right or wrong answers. We are interested in your personal views.

15. Doctors use too many medicines	☐ Strongly agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree
16. People who take medicines should stop their treatment for a while every now and again	☐ Strongly agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree
17. Most medicines are addictive	☐ Strongly agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree
18. Natural remedies are safer than medicines	☐ Strongly agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree
19. Medicines do more harm than good	☐ Strongly agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree
20. All medicines are poisons	☐ Strongly agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree
21. Doctors place too much trust on medicines	☐ Strongly agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree
22. If doctors had more time with patients they would prescribe fewer medicines	☐ Strongly agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree

23. *Give page 4 of the screening form to the peer advisor candidate.* **Being a peer advisor for this study will require a lot of writing and reading. I would like for you to complete the following page.**	How long did the peer candidate take to complete the task? Did the peer candidate have any trouble completing the task? If yes, please provide details.

Now that we have shared our expectations for the project, we want to give you a chance to tell us why you decided to participate. Take a minute and write down the top 3 reasons why you are interested in becoming a Peer Advisor.

I am interested in becoming a Peer Advisor because:

1. _____

2. _____

3. _____

Appendix C

Peer Advisor's Program Tools
(Peer Advisor Manual)

Peer Advisor Manual

Client Information

UPDATE AS NEEDED

- *You will receive the name and study cell phone number of your client from your community coordinator or one of the research team members form UAB.*
- *Write them into the areas below. You'll get additional information during the first session call.*
- *You will call the client to set up the appointment for the first session.*
- ***Try to have the first session within 7 days of receiving the client's name.***

Client name:	**Study cell phone number:**
Notes:	**Home number:**
	Work number:

Additional people that would know how to get in touch with the client:

1. Phone number and the person at this number and how she/he is related to client:

2. Phone number and the person at this number and how she/he is related to client:

- *You should have this information filled out based on information that the Living Well with Diabetes research assistants have already collected.*
- *During the first call, fill in any missing information, especially additional phone numbers of people that might know how to get in touch with the client.*
- ***You will continue to update this information during the next 12 weeks.***

Scheduling Session 1

REMEMBER! *Session 1 should be within 7 days of receiving the client's name.* ***If unable to reach the client, note your attempt(s) in the log below.***

Call Log

	Dates	Times	Notes
Attempt 1			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 2			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 3			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 4			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 5			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 6			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 7			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 8			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**

All phone numbers provided are disconnected or 8 call attempts made*	
1. Community coordinator notified (note date / time): _____ *date* _____ *time*	*2. Community coordinator calls back with Next Steps:*

- ***If you do reach the client, follow the script below.***

- ☐ Hello, Ms. / Mr. (_____), I'm (_____), your peer advisor from the Living Well with Diabetes Program.
- ☐ I'll be working with you during the next six months to help you with the program. Is this a good time for a five-minute call? *If not, schedule a time to call the client back.*
- ☐ Great! When you met the research assistant for this program, she asked you a lot of questions and checked your blood pressure and other things.
- ☐ She also left with you an Activity Book, DVDs and a DVD player, and your study phone. You watched the first session on the DVD at that time.
- ☐ Now, I'd like to set up an appointment to talk with you on the phone sometime this week for about 45 minutes. When would be a good time for that?

Date of Session 1:	*Time:*

- ☐ Let me give you my contact information in case you need to reschedule. If you don't mind grabbing your Activity Book, there is a place in the front where you can write my name and my phone number. *Let the client fetch the Activity Book and write your information.*
- ☐ OK, my name is (_____), and my phone number is (_____). If something comes up and you can't talk at the time we just scheduled, just give me a call and let me know, and we'll reschedule.
- ☐ Now, when we talk again, I'd like to go over the materials that the research assistant left with you. So, please have your Activity Book handy when I call. Also, you may want to re-watch the first session on the DVD.
- ☐ We're also going to talk briefly about your diabetes medications, so please have with you your diabetes medications in their pill bottles when we talk again.
- ☐ OK, I look forward to speaking with you then!

Week 1, Session 1: "Introduction to Living Well with Diabetes"

Session Goals:

- *Introduction to the program, review of schedule, commitment to the program*
- *Diabetes basics*
- *Setting a goal for diabetes medication taking*
- *Assign homework*

Before Calling the Client ----------

- *From the in-person training, review the experiences that you, a family member, or someone you know have had while living with diabetes. Review client's diabetes medications and medication barriers in client plan book.*

Reminder!!

- *Cover and check off all of the session content.*
- *Any text in GRAY BOXES is instructions for you: don't read those sections aloud to the client.*

Call Log

	Dates	Times	Notes
Attempt 1			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 2			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 3			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 4			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 5			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 6			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 7			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 8			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**

All phone numbers provided are disconnected or 8 call attempts made*	*2. Community coordinator calls back with Next Steps:*
1. Community coordinator notified (note date / time): _____ *date* _____ *time*	

Getting to Know Your Client ----------☐

☐ Hello, Ms. / Mr. (_____), this is (_____) from the Living Well with Diabetes Program. How are you doing today?

☐ We had scheduled this time to talk for about 45 minutes. Is this still a good time?

☐ Great! Do you have your Activity Book and your diabetes medications in front of you? *If needed, let client fetch the Activity Book and medications.*

☐ OK, let's get started. First, let me make sure I have your contact information. I already have your study phone number, but in case it runs out of battery, would you give me the number of two people who would know how to reach you? *Verify that the information on page 1 of your manual is correct, and fill in any spaces that are empty.*

☐ Now, you may have questions between our sessions, so I want to make sure that you can call me. Do you still have my telephone number written on the front page of your Activity Book?

☐ If you do call me between our sessions, I might not be able to take your call all the time, but I'll call you back as soon as I can. Is that okay? *Make sure the client has your number written on the front page of the Activity Book.*

☐ Great. We will be talking today for about 45 minutes. Do you feel okay with that today?

☐ Wonderful. I would like to begin by getting to know each other better. Let me tell you a little about myself.

Potential Talking Points

- *Where you are from and where you live*
- *How long you and your family have lived in your area*
- *What you do for a living, or what you used to do if you are now retired*
- *How many children or grandchildren you have*
- *Whether you are married and for how long*
- *Your hobbies*
- *Your previous experience with the Encourage and Living Healthy programs and/or how you have been helping people with diabetes take care of their health*

☐ Can you tell me a little bit about yourself?

- *If needed, ask questions to get the client to open up.*
- *Write down some notes about things like their spouse's name, children's names, hobbies, etc.*
- *You will refer back to this section throughout the program.*

☐ Thank you for sharing that with me! I'm glad that we're getting to know each other better.

☐ An important part of this program is looking ahead positively. As part of that, would you mind sharing with me some things that you are looking forward to in the future, maybe a few years from now?

- *If needed, suggest events such as the wedding of a grandchild, the birth of a great grandchild, travel, or a special reunion.*
- *Try to get at least 2 to 3 long-term, meaningful events or goals that motivate them.*
- *Write goals on page 3 of the Client Plan Book.*

☐ Those are wonderful things to look forward to! This is the reason why I enjoy being a part of this program, because its goal is to help people like you and me live a full and healthy life.

☐ During this program, we'll discuss diabetes, healthy eating, exercise, and other health topics, providing information that can let you live longer, better.

☐ Now, it's very important that you understand that I am not a doctor or a nurse.

☐ I am a health coach, and I've been trained to work with you to complete this program. If you have a question that I can't answer, I will get the correct answer from the study doctors. How does that sound? *Let client answer.*

Introducing the Living Well with Diabetes Program ----------☐

☐ Great, now that we know a little bit about each other, let's talk about the program, which is called, "Living Well with Diabetes."

☐ We know that diabetes is very common and has a big effect on how you live. You will be taking care of your diabetes for the rest of your life.

☐ There are a lot of things you need to do every day to take care of yourself when you have diabetes, but people with diabetes can still live a full and active life.

☐ So, this program will help you learn what to do to take care of yourself the best you can, every single day. You will learn these things through our discussions and watching videos.

☐ Speaking of the videos, when you first met the research assistant for this program, she left with you a DVD player and program DVDs, and you watched a video on this program.

☐ You will watch a video each week between our telephone sessions, so I want to make sure you're comfortable with the DVD player and the DVDs. Do you have any questions about the DVDs or how to use the DVD player?

Refer to the FAQs for answers, or write down the question and let the client know that you will find out the answer and let them know next week.

☐ OK, another item that you will use during the program is the Activity Book, which you have in front of you right now. During our sessions, we will learn about ways to live well with diabetes, and between sessions, we'll ask you to practice what you've learned.

☐ The Activity Book will help you practice, so let's turn to page 2. Here you can see some of the points made on the DVD. *Let your client get to the page.*

Reviewing the DVD: Introduction to Living Well with Diabetes----------☐

☐ What did you think about the video for this week? *Listen supportively.*

☐ Let's review. We learned that diabetes is a problem with the body's ability to handle blood sugar. When the blood sugar stays too high, it can cause all sorts of problems.

☐ The video also talked about why some people get diabetes and others don't, and how long it takes for most people to develop diabetes. What did you think about that? *Let the client answer.*

☐ Another thing the video talked about was the health problems that people with diabetes may experience. This is shown with the figure in the middle at the bottom of page 2. Do you see all the arrows pointing to different parts of the body that diabetes can affect? Can you remember some of those problems that diabetes can cause?

> *If needed, remind your client that diabetes can cause blindness, stroke, heart attack, kidney failure, amputation, impotence, and nerve damage.*

☐ Was any of this information new to you? *Let the client answer and listen supportively.*

☐ There is a lot to take in, isn't there? For many people, learning that they have diabetes can be overwhelming at first.

☐ Do you remember the person in the video and what she went through when she first found out she had diabetes? What did you think about that? How did <u>*you*</u> feel when you first learned you had diabetes?

Notes:

☐ Thanks for sharing your experience with me! Different people react differently when they're first diagnosed, but most people find that living with diabetes has a big impact on their life.

☐ For most people, diabetes will never go away, so you'll need to manage your diabetes for the rest of your life. The good news is that there's a lot that you can do to keep your diabetes under control.

☐ An important point to remember is that much of what you should do to take care of your diabetes is good for everyone, not just people with diabetes. So, *your* healthy choices will not only help *you*, but it will also help the people that you care about.

☐ You will see that even small changes can have a big impact on your health and the health of the people around you. How do you feel about that? *Listen supportively.*

☐ You are making a wonderful start by joining this program! We have some easy ways to help you remember the important parts of taking care of your diabetes.

☐ OK, now find the box with "ABCDE" in it on page 2. The video also talked about the ABCDEs of diabetes. Do you remember what the ABCDEs stood for? *If needed, remind client the ABCDEs: A1c, or blood sugar; blood pressure; cholesterol; diet; and exercise.*

☐ Do you see the 3-legged stool, on the left-hand side of page 2, that the video talked about? Can you remind me what those 3 parts were? *If needed, remind client the 3 parts: healthy eating, being physically active, and taking medications as prescribed by the doctor.*

Activity 1a: Checking for Side Effect or Cost Issues for Diabetes Medications ----------☐

☐ As we just talked about, taking medications is an important part of living well with diabetes. However, many people have trouble taking their medications, and there are a lot of reasons why this may be.

☐ I'd like to begin by focusing on the medications that you take for your diabetes and see if you have any questions. You told the research assistant what medicine you're taking, and I'm looking at this list right now.

> ***Step 1.*** *Go to page 4 of the Client Plan Book, where UAB staff will have provided the names of all the diabetes medications your client is taking. Read out loud the name of the first diabetes medication.*

☐ One medicine that you're taking for your diabetes is [*read off first diabetes medication if there is more than one*].

> ***Step 2.*** *Ask how the client is taking the medication.*

☐ Tell me how you take this medicine. How many times a day do you take it? How many pills each time? What are the times you take it?
Compare what the client tells you to what is written in the Client Plan Book for dose and frequency (and other directions, if any). For that medication, mark down whether the client is taking the medicine as directed by checking "Yes" or "No" in the column headed "Taking as Prescribed." If they are not taking it correctly, explain how to take it. Then, have the client repeat back to you, at least once, how to take it correctly. Write notes in the space as needed so you can remember what the problem is. You'll go over this in future sessions.

- *Remember, once daily is usually in the morning at breakfast.*
- *Twice daily is about 12 hours apart, morning and evening (for example, 8 a.m. and 8 p.m.*
- *Three times daily is about 8 hours apart (8 a.m., 4 p.m., midnight, or bedtime).*

Step 3. *Now ask about side effects for the first diabetes medication.*

☐ Are you having any side effects from this medicine?
Check off "Yes" or "No" next to "Side Effects."
If they say, "No" (they are not having a side effect), move on to Step 4.
If they say, "Yes" (they <u>are</u> having a side effect), then ask: What's the side effect?

- *Note down any side effects in the space provided in the client plan book. Then ask:*

☐ Do you ever miss any doses of the medicine because of side effects?

- *Check off "Yes" or "No" next to "Is the side effect causing missed doses?"*
- *Often people can live with minor side effects, so having a side effect doesn't mean they aren't able to take the medicine. If they say, "No" (they are taking the medicine even though they are having a side effect), praise them and move on to Step 4.*
- *If they say "Yes" (they are missing doses due to the side effect), tell them:*

☐ Having side effects can make it hard for us to take our medicines! But, we are going to make a plan to see what we can do about that.

Step 4. *Now ask about cost for the first diabetes medication.*

☐ Are you having any trouble affording this medicine?
Check off "Yes" or "No" next to "Is medicine affordable?"
If they say, "No" (they are not having trouble affording the medicine), move on to Step 5.
If they say, "Yes" (they <u>are</u> having trouble affording the medicine), then say:

☐ OK, can you tell me more about this? *In the client plan book, write down details about what makes it hard to afford this medication.*

☐ Many people find it hard to afford their medicines! But, you and I are going to make a plan to see what we can do about that.

Step 5. *Repeat Steps 1, 2, 3 and 4 for each diabetes medication.*

Step 6. *This step depends on what the client has told you during Steps 1-5 for each diabetes medication:*

- *If the client <u>has trouble</u> with side effects and/or cost,*
  1. *Complete Activity 1b, "Making a Plan for Side Effects and/or Cost Issues."*
  2. *Then, go to Activity 2 and continue with the rest of the session.*
- *If the client <u>does **not** have trouble</u> with side effects and/or cost,*
  1. *Skip Activity 1b, "Making a Plan for Side Effects and/or Cost Issues."*
  2. *Go to Activity 2 and continue with the rest of the session.*

Activity 1b: Making a Plan for Side Effects and/or Cost Issues ----------☐

☐ OK, you are having trouble taking your medicine because of… *[repeat the side effect and/or cost issue from page 4 of the Client Plan Book]*.

☐ Your medicine can't help you if you can't take it. Let's make a plan today to reach out to your doctor this week to see what can be done. The doctor can switch you to a different medicine, cut back the dose, or both. *Go to page 5 of the Client Plan Book. Write today's month, day, and year under "Date of plan."*

☐ First, let's decide who is going to call the doctor. Will you be comfortable calling by yourself? If you'd like to have somebody else on the phone with you, who will it be? *Write down who will be calling the doctor.*

☐ OK, now, when will you make this call? *Write down the day and time for the call.*

☐ Finally, let's rehearse what you'll say to the doctor. *Write down what the client will say to the doctor. Have the client repeat what they will say if they hesitate the first time.*

☐ OK, that sounds like we are beginning to get a plan. Let's think about how hard this may be for you to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ What do you think you can do to overcome these things? *Help clients think of possible ways to overcome these barriers, and write down those solutions.*

☐ This is great. I look forward to hearing how it went when we talk next week.

Activity 2: Checking for Other Diabetes Medication Issues and Making a Plan ----------☐

☐ OK, let's move on.

☐ I'd like to go over some other issues that you mentioned to the research assistant about your diabetes medicines.

☐ Let's see. I see that you told the research assistant... *Follow the directions below*.

Go to page 8 of the Client Plan Book to review other barriers to taking diabetes medications.

- *Read aloud each issue marked "Very Often."*
- *If there are no issues marked "Very Often," then read aloud each issue marked "Often."*
- *If there are no issues marked "Often," then read aloud each issue marked "Sometimes."*

For example, you might say: "I see that you told the research assistant that you very often just forget to take your diabetes medication. Is that still true?"

☐ OK, it sounds like you've got some issues that prevent the medicine from working for you. So what should we work on first? *If client hesitates, ask:* How about… *[pick the first on the list]*? What do you think about working on this issue?

> *Listen supportively. Assess how receptive they are to tackling this issue. If they are not very receptive, move on to the next issue until you find one they want to work on. Once the client decides on the issue they want to work on, go to page 9 in the Client Plan Book and write down today's date and the issue.*

☐ OK, let's talk about this a bit. I'd like to understand this issue better. Can you tell me more about this issue? *Let them tell you why they have this issue, or why they feel this way. Listen supportively. If the issue is one that was mentioned by someone on the DVD, mention that. Or, if one of your clients has had a similar issue, mention that also. Let your client know that others have this issue also – they are not alone.*

☐ Can you think of some things that you can do to overcome this issue? *Brainstorm with them. Offer suggestions only after you first make sure they want suggestions. Refer to the table of potential solutions to each problem starting on page 27 in the Client Plan Book.*

☐ OK, so what would you like to try to do this week to work on this problem? *If they listed more than one strategy, ask them to pick one. Make sure to help client come up with a plan that is SMART (specific, measurable, achievable, relevant, and time-bound). Write down the strategy in the Client Plan Book in the space provided.*

☐ OK, that sounds like we are beginning to get a plan. Let's think about how hard this may be for you to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ What do you think you can do to overcome these things? *Help clients think of possible ways to overcome these barriers, and write down those solutions.*

☐ This sound great! I look forward to hearing how it went when we talk next week.

Tracking Your Progress ----------☐

☐ Now, let's look at the chart on page 4 in your Activity Book. On the left side of the page, do you see the column with a picture of a pill bottle at the top?

☐ Your homework is to check "Yes" for every day that you take your diabetes medications exactly the way they are prescribed. If you weren't able to take your diabetes medications that day, then mark "No" for that day.

☐ It's important that you are honest when you fill out this chart every day. The goal of the program is to help you take charge of your diabetes, and I can't help you if we can't track your progress together.

	 *Took my diabetes medications?*	
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Many people have a lot of problems with their medicines, so I need to understand when things are not going as planned. Do you understand? *Make sure they are committed to letting you know if the answers are "no" on the chart.*

☐ Do you have any questions about what to do? *Make sure client understands what to do.*

☐ Great! This homework is an important part of the program. Research has shown that tracking our progress by monitoring how we're doing can help us achieve our goals.

☐ You'll monitor something every day during the program, but what you'll monitor will vary. Honesty is really important here, otherwise I can't help you. We'll talk a lot more about monitoring in each session.

☐ Do you have any questions? *Give client a few seconds.*

Rules and Responsibilities ----------☐

☐ OK. Now, for this program to help you, you have to commit to it. So, please go back to page 3 in your Activity Book. There, you'll see rules for both of us to follow during the program.

☐ **Here is what *I* will need to do:**

☐ I will call you every week in the beginning, then less often to go over our sessions.

☐ We will schedule our phone appointments together. If I can't make an appointment, I'll let you know, and we'll reschedule.

☐ When I call you, I'll be on time.

☐ I will help you learn, and I will listen to you.

☐ **Here is what *you* will need to do:**

☐ Be on time. If you can't make it, call me, and we'll reschedule.

☐ Use the phone provided by the study for our calls. Please don't use the phone for personal calls. Also, please be careful with it, because we'll need it back at the end of the study.

☐ Tell me if you're not feeling well or if you don't feel up to having a session. We can reschedule.

☐ Participate actively. Try your best. This is a training program to help you help yourself, so if you don't try, the program won't help you.

☐ Between our phone sessions, practice and monitor your progress and watch the videos.

☐ Finally, tell me if you have any concerns.

☐ **Remember, this program does *not* include:**

☐ Financial support, medical advice, or medication management.

☐ As I said before, I am not a doctor or a nurse. I am a person from the community who has been trained to help you with this program.

☐ **This program is six months long.**

☐ Please stay on page 3 and look at the chart on the left side of the page. As you can see, I'll be calling you every week for the first six weeks. After that, I'll be calling you every other week for the next six weeks. Then, for the last three months, I'll be calling you once a month. Each phone session will last about a half hour to forty-five minutes.

☐ Since this is a research study, the researchers for this program will use the information you provide to see how well the program worked. They may also record some of the sessions to make sure everything is going on as planned.

☐ However, our discussions will be kept between you, the research team, and me.

☐ When the program is over, you don't get to keep the phone, but you do get to keep the DVD player and the DVDs.

☐ Do you have any questions about how this program works? *Let client ask questions.*

Signing the Contract ----------☐

☐ OK. Research has shown that making a commitment to the program really helps people.

☐ Are you ready to make this commitment? *Give client a few seconds.* Wonderful! Then, please stay on page 3 in your Activity Book and look at the bottom right-hand corner. *Let client get to the box.*

☐ Take a moment to sign on the line showing that you are making a commitment to the program. *Let client take a moment to sign on the line.*

Storing the Program Materials ----------☐

☐ OK, we're almost through! Let's take a second to figure out where you'll keep your study materials between our phone sessions.

☐ Remember, you'll use your Activity Book to track your progress between our sessions.

☐ So, can you think of a place to keep it where you'll see it every day and where you can easily get to it to do your homework and to bring to our phone calls?

Write down where client will store the Activity Book:

☐ Now, where do you think you can keep your DVD player? It would be good to keep it close to your Activity Book and in a place away from children until you're done with the program.

Write down where client will store the DVD player:

This Week's Homework ----------☐

☐ Great! Let's make sure we're clear on this week's homework and then schedule our next phone session.

☐ For your homework this week, you'll use the chart on page 4 to keep track of how you're doing with taking your diabetes medicine exactly as prescribed. Check "Yes" for every day that you took your diabetes medicine like the doctor prescribed. On the other hand, you'll check "No" if you weren't able to take your diabetes medicine as prescribed that day.

☐ You'll tackle the issue with your diabetes medicine that we talked about earlier. I want to hear all about how that went when we talk next week.

☐ Finally, you'll watch the Healthy Eating video and we'll be talking about that at our next phone session, too. Do you have any questions? *Let the client answer.*

Scheduling Next Session ----------☐

☐ OK, when would you like to talk next week?

- *Try to make this date as close to 7 days from now as possible.*
- *Allow at least 7 days between sessions, but no more than 10 days.*

Next appointment date and time:

☐ OK, please write down the date and time in the box at the bottom of page 4.

☐ I look forward to speaking next week and hearing how things went!

✓ Session 1 completed	____/____/____ *month / day / year*	____/____ *start time / end time*	____ *peer initials*

Week 2, Session 2: "Healthy Eating Strategies"

Session Goals:

- *Brief review of last week's session*
- *Review DVD: Healthy eating*
- *Apply the 3 rules of eating healthy to our diet*
- *Review homework*
- *Homework – SMART Goal for healthy eating*

Learn more content: *Tips for Shopping Healthy at the Dollar Store/Convenience Store*

Before Calling the Client ----------

- *Review last week's assignment and the medication barriers and strategies to overcome them.*
- *Once you've reviewed this, place the call.*

Reminder!!

- *Cover and check off all of the session content.*
- *Any text in GRAY BOXES is instructions for you: don't read those texts aloud to the client.*

Call Log

	Dates	Times	Notes
Attempt 1			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 2			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 3			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 4			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 5			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 6			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 7			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 8			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**

All phone numbers provided are disconnected or 8 call attempts made*	*2. Community coordinator calls back with Next Steps:*
1. Community coordinator notified (note date / time): _____ *date* _____ *time*	

Greeting ----------☐

☐ Great, do you have your Activity Book handy?
If not, let them get the Activity Book before going on.

Say hello and make sure the client is still okay with speaking for about a half hour to forty minutes today.

☐ OK, please turn to page 5 in the Activity Book.
Today, we'll review what we learned last week and talk about how your homework went.

☐ We'll also learn about healthy eating and diabetes. To do this, we'll review the video on Healthy Eating and talk about some simple rules that you can follow to help you eat healthy.

☐ Finally, we'll talk about your homework for this week.

☐ Can I ask if you've watched the DVD?

☐ *If they did not watch the DVD, tell them to watch it now, and you'll call back in a half hour.*

Review Last Week's Session ----------☐

☐ OK, let's review what we learned last time. Please turn to page 5 in your Activity Book.

☐ Please look at the review section of the page. We talked about diabetes, which means the body can't handle blood sugar.

☐ When the body can't use blood sugar normally, there's too much sugar in the blood stream. That's uncontrolled diabetes, and it makes you tired, thirsty, and run to the bathroom a lot.

☐ Over many years, diabetes can cause complications like heart attack, stroke, kidney problems like dialysis, blindness, nerve damage, and amputations. Uncontrolled diabetes increases your chances of getting these things, sometimes called "diabetes complications."

☐ You can see all the organs that diabetes affects in the cartoon in the middle of the page.

☐ We also learned that for most people, diabetes is an illness that develops over many years. That's the picture in the middle of the right side of the page, where diabetes didn't happen until after many years of eating unhealthy and being too inactive.

☐ For most people, even if they eat right, exercise, and take their medicines, diabetes won't go away. But there's a lot you can do to control diabetes and decrease your chances of getting the problems listed in the review section of the page.

☐ That means that you'll probably need to take care of your diabetes for the rest of your life.

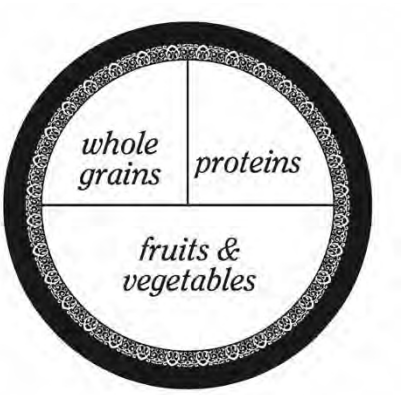
☐ Taking care of your diabetes means eating healthy, getting enough exercise, taking medications, and going to the doctor regularly for check-ups to keep the ABCDEs of diabetes in check. Do you remember what that stands for? *Point out the box on the bottom of page 5.*

☐ You can remember what you need to do every day at home to take care of your diabetes by thinking of the 3-legged stool on the bottom right of page 5. Can you remind me what the 3-legged stool is? *Let client answer. If needed, tell client the 3 legs: eating healthy, being physically active, and taking your medications as prescribed.*

☐ We learned that we need to do all 3 things in order for us to live better, longer, with diabetes.

☐ Does that sound right? *Let client answer.* Did you have any questions? *Let client answer.*

Review DVD: Healthy Eating ----------☐



☐ Great! Let's move on and talk about the DVD you watched this week. How did you like it? *Let the client answer and listen supportively.*

☐ OK, please turn to page 6 in your Activity Book. Let's review some of the things we saw on the DVD. *Let the client get to the page.*

☐ So, we learned why eating healthy is so important. First, eating healthy provides your body with the nutrients you need to be active and healthy.

☐ Eating healthy also helps you to better manage your weight and to control diabetes.

☐ A healthy diet can make us feel good now *and* in the future, because eating healthy helps keep the blood sugar down to keep you feeling well, and it also decreases the chances of diabetes complications, like heart attack, stroke, dialysis, and amputations.

☐ In the video, several people spoke about how eating healthy makes them feel, like how it affects their mood and their ability to do the things they need to do and to enjoy life. Have you noticed this yourself? Do you think healthy eating makes a difference in how you feel day-to-day? How about what you are able to do on a daily basis?

Notes:

☐ Now, the DVD shared three simple rules to help you eat healthy every day. Do you remember any of the three rules? *Let them tell you any or all of the 3 rules.*

☐ OK, let's review. **Rule Number One was to avoid second helpings.** We can remember this rule by thinking, **"One and done."**

☐ **Rule Number Two was to use the healthy eating plate as a guide to eating the right balance of foods, and to not overload the plate.** You can remember this rule by thinking, **"Respect the border,"** so that you can see the pretty border of the plate and not overload.

☐ Can you remember how we should divide up the plate?

Let client answer. If needed, remind client that
- *Half of the plate should be fruits and vegetables.*
- *A quarter of the plate should be protein, like red meat, pork, fish, chicken, and beans.*
- *The last quarter of the plate should be starchy foods, like brown rice, pasta, potatoes, corn, and peas.*

☐ An important part of this rule is not to overload your healthy plate, right? You want to be able to see the border of the plate – respect that border.

- ☐ Last but not least, **Rule Number Three was to eat less fried foods and fats, and drink fewer sugar-sweetened beverages.** You can remember this rule by thinking, **"Be sweet on yourself."** Avoiding unhealthy foods is definitely being sweet on yourself.
- ☐ How do these three rules sound? *Let the client answer and listen supportively.*
- ☐ These rules can not only help *you* eat healthy and live well, but they also can help *your family and friends*, too! If they don't already have diabetes, eating healthy can help prevent diabetes.
- ☐ As the DVD said, people with diabetes don't need to fix themselves "special" meals while having to fix something different for the rest of the family.
- ☐ Do you remember the person in the video that talked about how she felt when she thought she had to cook differently for herself, while the rest of the family ate what they wanted? Have you experienced that yourself or known anybody that has gone through that?

Notes:

- ☐ That person also talked about how her cooking and eating healthy ended up helping her whole family, like how her husband's blood pressure went down from eating healthier. What about you? Have you known anyone that has gotten healthier because their family or friends changed how they ate?

Notes:

- ☐ Thanks for sharing your thoughts about this! Like the video said, these three rules—one and done, respect the border, and be sweet on yourself—will help the *entire* family eat healthy and live well. How do you feel about that? *Let the client answer and listen supportively.*
- ☐ Great! Now that we know the three rules are good for the *whole* family, we can use these three rules to guide us as we shop and prepare foods for healthy meals and snacks.
- ☐ As you know, it can be challenging to shop and prepare healthy foods, because we have to drive far to get to the grocery store, and fresh fruits and vegetables can cost a lot and spoil quickly.
- ☐ Plus, we are often very busy taking care of our families and friends, working, and volunteering. This can make it hard to find the time to take care of our diabetes.

- ☐ We are going to work together to figure out what works best for you and your family so that you can eat healthy and live as well as you can, as long as you can.
- ☐ Also, you might enjoy reading the information on page 8 of your activity book, which shares some tips about how you can shop at your local Dollar Store or other convenience store and make healthier choices.
- ☐ Great! Do you have any questions so far? *Let client answer.*

Activity 1: Assess Your Healthy Eating: What did I eat in the past day? ----------☐

- ☐ OK, let's check out what you're eating and talk about what you could do to eat a little healthier.
- ☐ It's hard to make a change if we don't know what we're doing well and where we could use a little help.
- ☐ So, please think about what you ate yesterday. *Go to page 12 in the Client Plan Book and fill in the chart by following the script on the next page.*

☐ **Let's begin with breakfast.**

- ☐ Did you have more than one helping of a meat or a starch? *Remember: starches are "white foods" like potatoes, bread, bagels, rice, grits, pasta, cereal. If yes, then ask:* How many helpings in all? *Write down the number over 1; for example, if they had 2 helpings of grits, that's one second helping and you would write down 1 under breakfast.*
- ☐ Did you have any fruit? *If yes, then ask:* How many servings? *Write down the number of fruits under breakfast.*
- ☐ Did you have any vegetables? *If yes, then ask:* How many servings?
- ☐ Did you drink any sugar-sweetened drinks? *If they sweeten coffee with sugar, that's a sugar-sweetened drink. Soda pop is sugar-sweetened. Fruit juice counts as sugar-sweetened. If yes, then ask:* How many?
- ☐ Did you have any dessert? *If yes, then ask:* How many servings?
- ☐ Did you have any fried food? *If yes, then ask:* How many servings?

☐ **Now, let's talk about lunch.**

- ☐ Did you have more than one helping of a meat or a starch? *Note: a sandwich is usually two pieces of bread; the second piece counts as a second helping!*
- ☐ Did you have any fruit? *If yes, then ask:* How many servings?
- ☐ Did you have any vegetables? *If yes, then ask:* How many servings?
- ☐ Did you drink any sugar-sweetened drinks? *If yes, then ask:* How many?
- ☐ Did you have any dessert? *If yes, then ask:* How many?
- ☐ Did you have any fried food? *If yes, then ask:* How many servings?

☐ **OK, let's now talk about dinner.**

- ☐ Did you have more than one helping of a meat or a starch?
- ☐ Did you have any fruit? *If yes, then ask:* How many servings?
- ☐ Did you have any vegetables? *If yes, then ask:* How many servings?
- ☐ Did you drink any sugar-sweetened drinks? *If yes, then ask:* How many?
- ☐ Did you have any dessert? *If yes, then ask:* How many?
- ☐ Did you have any fried food? *If yes, then ask:* How many servings?

☐ **Finally, think about your snacks.**

- ☐ Did you have more than one helping of a meat or a starch?
- ☐ Did you have any fruit? *If yes, then ask:* How many servings?
- ☐ Did you have any vegetables? *If yes, then ask:* How many servings?
- ☐ Did you drink any sugar-sweetened drinks? *If yes, then ask:* How many?
- ☐ Did you have any dessert? *If yes, then ask:* How many?
- ☐ Did you have any fried food? *If yes, then ask:* How many servings?

☐ OK, that's great. Now, give me a minute to total this up.

- *Add across in each row and enter the total in the "Total" column.*
  - *For example, if they had 1 second helping of starch at breakfast, no second helpings at lunch, 1 second helping at dinner, and no second helpings at snack, that's 1 + 1 = 2.*
  - *You would enter a "2" in the "Total" box for "Second helpings of meat or starch."*
- *Repeat for each line (number of fruits, number of vegetables, number of sugar-sweetened drinks, number of desserts, number of fried foods).*

☐ OK, now let's see how healthy your eating was. Please turn to page 6 in your Activity Book, and write down these numbers in the chart under where it says "Me". Do you see that?

☐ OK, under "Me" in the line that says "Number of second helpings of meat or starch", please write down … *say the number in the Total box for "Number of second helpings of meat or starch" from the chart on page 12 in the Client Plan Book.*

- *Repeat for each line (number of fruits, number of vegetables, number of sugar-sweetened drinks, number of desserts, number of fried foods).*
- *Keep your voice neutral and don't make the client feel bad.*

This is what they see in their Activity Book:

	ME	***Goal***
Number of second helpings of meat or starch		0
Number of fruits		3-4
Number of vegetables		3-4
Number of sugar-sweetened drinks		0
Number of desserts		0-1
Number of servings of fried foods		0

Activity 2: Set a SMART Goal to Improve Healthy Eating ----------☐

☐ OK, did you write down those numbers? Why don't you read them back to me? *Let the client confirm.* What are your thoughts as you look at this?

> *Listen supportively. Use "OARS" (open-ended questions, affirmations, reflective listening, summaries) to help them recognize areas in need of improvement.*

☐ OK, so what would you like to do over the next week to make a change?

> - *Go to page 13 of the Client Plan Book and write today's date next to "Date of plan."*
> - *Help the client set a specific, measurable, achievable, relevant, and time-bound goal.*
> - *Once a plan has been made, summarize it. For example, a summary could go like this:*
>
> *"OK, let me make sure I got this right. So, you noticed that you aren't eating enough fruits and vegetables, you're taking too many second helpings of starches, eating too much fried food, and you drink a lot of sugar-sweetened drinks. This week, you would like to make a change by cutting back on your sugar-sweetened drinks. Rather than drinking sweet tea at dinner, you're going to switch to water. You feel that you're going to be able to do this during weeknights to start with, so you are going to follow your goal Monday through Friday, starting tonight. Did I get that right"?*
> - *Once the client confirms the plan, write it down in the space provided in the Client Plan Book. Be sure to write down specific meal(s) and days during which client will follow the goal.*
> - *You will encourage the client to also write down their goal in the box to the right of the chart on page 6 of their Activity Book.*

☐ OK, so that you remember, why don't you jot down this plan in the space on page 6 in the box marked "My Goal Is". Do you see that?

☐ Ok, let's think about how hard this may be for you to do. It's pretty challenging to change what we eat. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers in the space in the Client Plan Book.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions in the space in the Client Plan Book.*

☐ This is great! You'll monitor your progress every day this week, and I can't wait to hear how this went for you. Please turn to page 7 and look at the column marked "Eat Healthy?". Each day that you keep to your plan, you'll mark off "yes". If you were not able to keep your plan, you'll mark off "no." Is that clear? *Make sure they understand what to do.*

Review of Last Week's Homework ----------☐

☐ OK, let's now go over your homework from last week. Can you turn to page 4? *Let the client get to the page.*

☐ For homework, you monitored whether you took all your diabetes medication each day. I'd like to go over it, day by day, and see how it went.

☐ Let's start with Day 1. Did you take all of your diabetes medication just like the doctor prescribed on Day 1?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Now, last week, we talked about… *[go to Client Plan Book on page 5 and check if the plan focused on side effects or cost; if not, go to page 9 and check if the plan focused on Other Barriers. Read out loud the diabetes medication issue that they chose to work on last week.* We made a plan together to overcome this so you can get the most out of your medicines. Let's review how things went.

☐ To overcome this issue, you decided to… *[read out loud the medication-taking plan from last week]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ So, how did this go? *Listen supportively and take notes in the box below. If things did not go well, discuss what to do differently this week. If the problem is solved, praise them!*

Notes:

- ***If their plan worked and last week's issue is resolved, encourage them to tackle a <u>new issue</u> this week.*** *If you try hard and they don't want to tackle another issue and they took their medicine each day, praise them again for their success and tell them you'd like to discuss tackling a new issue next time.*
  - *If they are ready to tackle a new issue, go back to page 4 of the Client Plan Book to the diabetes medication list.*
  - *If there are remaining issues related to side effects or cost, then help the client make a plan to address them this week.*
  - *If there are no remaining issues related to side effects or cost, go to page 8 to the chart on Other Barriers. Look at the list of statements that are marked "Very Often," or "Often" if there are no "Very Often" statements to address, and "Sometimes" if there are no "Often" statements to address.*
  - *Help them decide which new goal they would like to tackle for the coming week.*
  - *Summarize to confirm their new goal. For example, you could say:*
    "OK, let me see if I got this straight. Last week, you … [repeat <u>last</u> week's goal]. You did well with that, so this week, you'll … [repeat <u>this</u> week's goal]. Did I get that right?"

- ***If they were <u>not</u> able to meet their medication goal, then let them stick to the same goal.***
  - *Be supportive, and let them know you'll revisit the goal next week to see how it went this time.*
  - *Strategize what they will do differently this week to succeed. Make it a SMART goal.*

- ***Record this week's strategy in the Client Plan Book.***
  - *If the strategy addresses side effects/and or cost, record this week's strategy on page 5, "Plan for Diabetes Medication Side Effects and/or Cost".*
  - *If the strategy addresses other barriers besides side effects or cost, then record this week's strategy on page 9, "Plan for Other Diabetes Medication Barriers".*

☐ OK, so let's talk about what you'd like to do for the next week.

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down barriers in the Client Plan Book.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions in the Client Plan Book.*

☐ OK, let's review that. It looks like you'll… *repeat the medication goal. Then, review potential barriers and how client will go around those barriers. Let client confirm.*

☐ I look forward to hearing how this plan worked when we talk next time!

This Week's Homework ----------☐

☐ Now, let's go over your homework for the coming week. Please turn to page 7 in your Activity Book. There, you'll see the chart where you'll monitor your progress until our next session.

	 Took all my medications?		 Eat healthy?	
Day 1 (today)	☐ Yes	☐ No	☐ Yes	☐ No
Day 2	☐ Yes	☐ No	☐ Yes	☐ No
Day 3	☐ Yes	☐ No	☐ Yes	☐ No
Day 4	☐ Yes	☐ No	☐ Yes	☐ No
Day 5	☐ Yes	☐ No	☐ Yes	☐ No
Day 6	☐ Yes	☐ No	☐ Yes	☐ No
Day 7	☐ Yes	☐ No	☐ Yes	☐ No

☐ First, you're going to continue tracking how you're doing with your diabetes medication.

☐ Every day, under the column with the picture of a pill bottle, you're going to mark "Yes" if you took all of your diabetes medication that day. If you weren't able to take all of your diabetes medication, then you'll mark "No" for that day.

☐ Remember to be honest. I can't help you if I don't know where you need help.

☐ You'll carry out the plan we discussed that will help you get the most out of your medicines.

☐ You're also going to mark down whether you succeeded with your healthy eating plan. Remember, you were going to…*Repeat the healthy eating goal you developed today and recorded on page 13 of the Client Plan Book.*

☐ So, under the column with a picture of apples, you're going to mark "Yes" if you were able to follow your healthy eating plan as we discussed.

☐ Finally, you'll watch the DVD on Getting Exercise, which we'll talk about next time.

☐ Do you have any questions about what to do? *Make sure client knows what to do.*

Scheduling the next session----------☐

☐ OK, when would you like to talk next week?

- *Try to make this date as close to 7 days from now as possible.*
- *Allow at least 7 days between sessions, but no more than 10 days.*

Next appointment date and time:

☐ OK, please write down the date and time in your Activity Book at the bottom of page 7.

☐ I look forward to speaking next week and hearing how things went!

✓ Session 2 completed	____/____/____ *month / day / year*	____/____ *start time / end time*	____ *peer initials*

Week 3, Session 3: "Physical Activity and Your Health"

Session Goals:

- *Brief review of last week's session*
- *Review DVD: Physical Activity and Your Health*
- *Review last week's homework*
- *Homework – SMART Goal for physical activity*

Learn more content: *Chair Exercises, Walking in Place*

Before Calling the Client ----------

- *Review last week's assignment and the barriers and strategies to overcome them.*
- *Once you've reviewed this, place the call.*

Reminder!!

- *Cover and check off all of the session content.*
- *Any text in GRAY BOXES is instructions for you: don't read the text aloud to the client.*

Call Log

	Dates	Times	Notes
Attempt 1			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 2			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 3			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 4			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 5			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 6			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 7			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 8			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**

All phone numbers provided are disconnected or 8 call attempts made*	*2. Community coordinator calls back with Next Steps:*
1. Community coordinator notified (note date / time): _____ *date* _____ *time*	

Greeting ----------☐

☐ Great, do you have your Activity Book handy?
If not, let them get the Activity Book before going on.

Say hello and make sure the client is still okay with speaking for about a half hour to forty minutes today.

☐ OK, please turn to page 9. Today, we'll review what we learned last week and talk about how your homework went.

☐ We'll also learn about physical activity. To do this, we'll review the DVD on physical activity and talk about some simple rules that you can follow to help you add physical activity to your life. Finally, we'll talk about your homework for this week.

☐ Can I ask if you've watched the DVD?

☐ *If they did not watch the DVD, tell them to watch it now, and you'll call back in a half hour.*

Review Last Week's Session ----------☐

☐ OK, let's review what we learned last time. Please stay on page 9 in your Activity Book.

☐ We talked about healthy eating, which is one of the legs of the three-legged stool.

☐ Eating healthy will not only help you get the nutrients you need to be active and healthy, but it also will help you better manage your weight and your diabetes.

☐ We learned 3 rules to help us eat healthy – can you name them? *Let the client answer. If needed, remind the client that the 3 rules of healthy eating are "One and Done," "Respect the Border," and "Be Sweet on Yourself." Be sure to review what each of these rules means.*

☐ We also went over how things were going taking your medicines, and made a plan for how you'll try to get the most out of your medicines to Live Well with Diabetes.

☐ Does that sound right? *Let the client answer.* Did you have any questions? *Let the client answer.*

Review DVD: Physical Activity ----------☐

☐ Great! Let's move on and talk about the DVD you watched this week. How did you like it? *Let the client answer and listen supportively.*

☐ OK, let's turn to page 10 in your Activity Book and review some of the things we saw on the DVD.

☐ Now, just as there were 3 rules for healthy eating, the DVD talked about 3 rules for physical activity.

☐ **The first rule is, "Be Smart, Exercise Your Heart."** This rule will help you to remember the many benefits of physical activity.

☐ Physical activity can help us feel less tired and more energetic; improve our mood and reduce stress and anxiety; help us think better as we age; and help us live better longer by reducing chronic aches and pains and lowering our risk of future health problems.

- ☐ In the video for the past week, there were several people that talked about how exercise helps them in a variety of ways. Can you remember some of those things? *(If needed, remind client of some of the benefits that people mentioned: exercise lifts their spirits, exercise helps them sleep better, and exercise helps get stiffness and pain out of their joints.)* What did you think about that? Have you or anyone you know benefited from exercise like this?

Notes:

- ☐ Exercise has lots of benefits beyond helping you lose weight, which is what many people think exercise is only good for. The video mentioned that it's actually not common for people to lose weight when they begin an exercise program.
- ☐ Now, the combination of diet and exercise can lead to weight loss, but remember that exercise has many other benefits! It's a critical part of living a long and healthy life.
- ☐ For instance, do you remember the pastor from the video talking about how he thinks about his body like a car? Can you remember how he described the heart? How did that strike you?

Notes:

- ☐ **Now, the second rule is, "Walk Down Your Blood Sugar."** This rule will help you to remember that walking and other kinds of physical activity can help lower your blood sugar.
- ☐ The DVD told you that adults should try to get at least 30 minutes of moderate-level exercise on 5 or more days per week. If you're exercising at a moderate level, you can talk but you can't sing.
- ☐ If you are not used to getting any exercise, work up to the 30 minutes gradually. It's fine to start small, for example, just 10 minutes a day, and add 5 or 10 minutes every couple of weeks.
- ☐ Since exercise lowers your blood sugar, a great time to take a brisk walk is after a meal, when your blood sugar goes up. If you monitor your blood sugar, try testing your blood sugar before and after you exercise to see the difference.
- ☐ OK, last but not least, **our third rule is, "Sitting is the New Smoking."** This rule will help you remember that it is very unhealthy to sit too long.
- ☐ So, try to incorporate 2 minutes of light activity every hour. The DVD discussed several strategies for doing this. For example, if you're watching TV, you can get up during the commercials and walk briskly around the house until your show comes back on.
- ☐ How do these three rules sound? *Let the client answer and listen supportively.*

☐ What's nice about these rules is that they can not only help *you* exercise and live well, but they also can help *your family and friends*, too!

☐ As the DVD said, getting at least 30 minutes of moderate-intensity exercise, 5 days per week, is recommended for *all* adults, so you can improve the health of your family and friends by having them exercise with you.

☐ You also don't need to get fancy equipment or go anywhere special to exercise. Our goal is to help you be physically active in a way that is *manageable* for you.

☐ So if walking around your neighborhood works best for you, your schedule, and your budget, that's fine! Walking is a great way to reach your physical activity goal.

☐ Also, you might enjoy the chair exercises video and the walk in place video. These videos show how we can do chair exercises if we are in too much pain to walk very much, or how we can walk in place indoors if we're not able to go outside.

☐ Great! Do you have any questions so far? *Let the client answer.*

Activity 1: Set a SMART Goal for Exercise ----------☐

☐ Great! Now that we've discussed how important exercise is, let's come up with a plan that will help you get enough exercise.

☐ Some people with diabetes find it hard to walk because of painful joints, amputations, or other limitations. However, that doesn't mean that you can't exercise. One option is to exercise in a chair. Like walking, chair exercises can improve your health. Also, if your joints are hurting, chair exercises can improve your pain.

☐ There is a "Learn More" video that shows you how to do chair exercises when you are unable to be on your feet for a long time. You can do the chair exercises with the DVD running, so you might want to give it a try.

☐ Now, let's think about your own exercise program. Remember, we want to work toward a total of 30 minutes of brisk walking or other similar exercise at least 5 days of the week.

☐ Let's start with what you do right now to get exercise. Can you tell me what kind of activity you are doing now? Many people do no exercise at all, so, if that's you, don't be shy.

- *Go to page 16 in the Client Plan Book and write today's date next to "Date of plan."*
- *Next to "Current exercise," write down what they are doing currently for exercise and how much.*
  - *Include minutes per day and level of activity.*
  - *For example, if they are doing 5 minutes of slow walking, write that down.*
- *Be reassuring and supportive if they don't do any exercise now, or if they do very little.*

☐ OK, thanks for sharing that with me! Now, look at the the top right-hand corner of page 10, and you will see a clock and a small calendar.

☐ This will help you remember that that the recommended amount of exercise is 30 minutes of brisk walking on at least 5 days per week. So what do you think?

☐ What would you like to do to improve? What kind of activity do you want to do this coming week?

- *In the Client Plan Book on page 16, help client set a SMART goal that includes these details:*
  - *Next to "What client will do this week," write down what they'll do, for example, walking, or chair exercises.*
  - *Next to "Where client will do it," write down where the client will exercise.*
  - *Next to "When during the day," write down at what time in the day the client will exercise, for example, after dinner or 7pm.*
  - *Next to "How many minutes each time," write down how many minutes of exercise they will do.*
  - *Next to "Which days of the week," write down specific days the client will exercise.*
- *For clients that don't exercise at all right now, start with 5-10 minutes per day at a slow pace. If they do well with that, then add another 5 minutes after 2 weeks, and then have them try to pick up the pace. Build slowly toward the 30 minutes, 5 days a week goal!*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ OK, let's review that. It looks like you'll… *repeat the type of exercise, how many minutes on which days, when and where they'll do it, and with whom, if they plan to exercise with another person. Then, review potential barriers and how client will go around those barriers. Let the client confirm.*

☐ Great, I look forward to hearing how this went when we talk next week!

Review of Last Week's Homework ----------☐

☐ OK, now let's go over your homework from last week.

☐ Can you turn to page 7 in your Activity Book? *Let the client get to the page.*

Note: if the client has not done some of the homework 2 sessions in a row, talk about what is making it hard to monitor. Let them know that since this is a research project, the investigators may want to help the person to succeed. Let them know that someone from the research team will be in touch.

- *Call the research team within 24 hours and let them know what is happening.*
- *UAB staff will brief you on the conversation and the plan so that you can reinforce it next week.*

Client has not done homework for 2 sessions in row	*2. Community coordinator calls back with next steps:*
1. Community coordinator notified (note date / time): _____ _____ *date* *time*	

Homework #1: Medications

☐ OK, let's review how things went with your diabetes medication. Let's start with Day 1. Did you take all of your diabetes medication on Day 1? *Don't review healthy eating at this point.*

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

Notes:

☐ Now, I'd like to follow up on the plan that we made last week to help you get the most out of your medications by taking them every day.

☐ Let me see, last week, the issue you wanted to work on was… *[go to Client Plan Book on page 5 and check if the plan focused on side effects or cost; if not, go to page 9 and check if the plan focused on Other Barriers. Read out loud the diabetes medication issue that they chose to work on last week]*.

☐ To overcome this issue, you decided to… *[read out loud the medication-taking plan from last week]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, how did it go? *Listen supportively and take notes in the box below. Assess how well this worked. If it did not work well, talk about why not. If it did go well, praise them.*

Notes:

☐ OK, so what would you like to do over the next week to help you get the most out of your medications?

- ***If their plan worked and last week's issue is resolved, encourage them to tackle a new issue this week.*** *If you try hard and they don't want to tackle another issue and they took their medicine each day, praise them and let them know you'll be talking again about this next time.*
  - *If they are willing to work on something new, go back to the Client Plan Book on page 4, the diabetes medication list.*
  - *If there are remaining issues related to side effects or cost, then help the client make a plan to address them this week.*
  - *If there are no remaining issues related to side effects or cost, turn to page 8 to the Other Barriers list and look at the list of statements that are marked "Very Often," or "Often" if there are no "Very Often" statements to address, or "Sometimes" if there are no "Often" statements to address.*
  - *Help them decide which new goal they would like to add for the coming week.*
  - *Summarize to confirm their new goal. For example, you could say:*
    "OK, let me see if I got this straight. Last week, you … [repeat <u>last</u> week's goal]. You did well with that, so this week, you'll … [repeat <u>this</u> week's goal]. Did I get that right?"

- ***If they were <u>not</u> able to meet their medication goal, then let them stick to the same goal.***
  - *Be supportive, and let them know you'll revisit the goal next week to see how it went this time.*
  - *Strategize what they will do differently this week to succeed. Make it a SMART goal.*

- ***Record this week's strategy in the Client Plan Book.***
  - *If the strategy addresses side effects/and or cost, record this week's strategy on the page, "Plan for Diabetes Medication Side Effects and/or Cost," in the Client Plan Book.*
  - *If the strategy addresses other barriers besides side effects or cost, then record this week's strategy on the page, "Plan for Other Diabetes Medication Barriers," in the Client Plan Book.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ OK, let's review that. It looks like you'll… *repeat the medication goal. Then, review potential barriers and how the client will go around those barriers. Let the client confirm.*

☐ I look forward to hearing how this plan worked when we talk next time!

Homework #2: Healthy Eating

☐ OK, great! Let's talk about your plans for healthier eating. How did things go with your diet? *Listen supportively.*

☐ Let's review what you wanted to do to eat healthier. Last week, you decided to… *[go to Client Plan Book page 13 and read the healthy eating goal that they chose to work on last week].*

☐ How did that go on Day 1? *For each day, check "yes" or "no" for the Healthy Eating column.*

		***Ate healthy?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ OK, so let's talk about this.

- *If they met their healthy eating goal,*
  - *Explore if they are ready to add another goal this week. Ask them to turn to page 6 in their Activity Book and look at the chart. Help them decide which new goal they would like to add for the coming week.*
  - *Go to page 13 in the Client Plan Book and write down details in the space provided. Be sure to include all the information necessary for the goal.*
  - *Summarize to confirm their new goal. For example, you could say:*

    "OK, let me see if I got this straight. Last week, you … [repeat last week's goal]. You did well with that, so now you'd like to add another healthy eating goal. So, this week, you'll … [repeat this week's goal]. Did I get that right?"
- *If they were not able to meet their healthy eating goal,*
  - *Let client stick to the same eating goal, but be sure to modify the plan if needed.*
  - *Go to page 13 in the Client Plan Book and write down details in the space provided. Be sure to include all the information necessary for the goal.*
  - *Be supportive, but do remind your client that you'll revisit the goal next week to see how it went this time.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ OK, let's review that. It looks like you'll… *repeat the healthy eating goal. Then, review potential barriers and how client will go around those barriers. Let the client confirm.*

☐ Great, I look forward to hearing how this plan worked when we talk next time!

This Week's Homework ----------☐

- ☐ Now, let's go over your homework for the coming week. Please turn to page 11 in your Activity Book.
- ☐ This week, you're going to have 3 types of homework, one for each leg of the 3-legged stool.
- ☐ First, you're going to continue keeping track of how you're doing with your diabetes medication. Every day, under the column with the picture of a pill bottle, you're going to mark "Yes" if you took all of your diabetes medication that day. If you weren't able to take all of your diabetes medication, then you're going to mark "No" for that day.
- ☐ Remember to be honest. I can't help you if I don't know where you need help.
- ☐ You'll carry out the plan we discussed that will help you get the most out of your medicines.
- ☐ Second, you're going to mark down whether you kept to your heathy eating goal on the days that we discussed. Your plan is to *...Repeat the healthy eating goal from today on page 13 of the Client Plan Book.*
- ☐ So, under the column with a picture of apples, you're going to mark "Yes" if you were able to follow your healthy eating goal on the days we discussed.
- ☐ The goal is to eat healthy every day, so if you are able to follow your healthy eating goal on the other days, mark "Yes" on those days, too.
- ☐ Third, you're going to monitor the number of minutes of exercise every day. You decided that you would try *...Repeat the exercise goal from page 16 of the Client Plan Book.*
- ☐ So, under the column with a picture of a person walking, you're going to write down the number of minutes of exercise you were able to do on the days we discussed.
- ☐ If you are doing well with your goal and were able to exercise on the other days, write down the number of minutes of exercise on those days, too.
- ☐ Finally, you'll watch the DVD on Diabetes Medications, which we'll talk about next time.
- ☐ Do you have any questions about what to do? *Make sure client knows what to do.*
- ☐ OK, when would you like to talk next week?

• *Try to make this date as close to 7 days from now as possible.* • *Allow at least 7 days between sessions, but no more than 10 days.*	***Next appointment date and time:***

- ☐ OK, please write down the date and time in your Activity Book at the bottom of page 11.
- ☐ I look forward to speaking next week and hearing how things went!

✓ Session 3 completed	____ / ____ / ____ *month / day / year*	____ / ____ *start time / end time*	____ *peer initials*

Week 4, Session 4: "Diabetes Medications"

Session Goals:

- *Brief review of last week's session*
- *Review DVD: Diabetes Medications*
- *Review homework*
- *Learn to connect medicines to future goals*
- *Your A1c number*

Before Calling the Client ----------

- *Review last week's assignment and the barriers and strategies to overcome them.*
- *Once you've reviewed this, place the call.*

Reminder!!

- *Cover and check off all of the session content.*
- *Any text in GRAY BOXES is instructions for you: don't read the text aloud to the client.*

Call Log

	Dates	Times	Notes
Attempt 1			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 2			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
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Attempt 7			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 8			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**

All phone numbers provided are disconnected or 8 call attempts made*	*2. Community coordinator calls back with Next Steps:*
1. Community coordinator notified (note date / time): _____ *date* _____ *time*	

Greeting ----------☐

☐ Great, do you have your Activity Book handy? *If not, let them get the Activity Book before going on.*

Say hello and make sure the client is still okay with speaking for about a half hour to forty minutes today.

☐ Please turn to page 12. Today, we'll review what we learned last week, review your homework, and learn about diabetes medications.

☐ We'll review what you learned on the DVD, and we'll get new homework for this week.

☐ OK, let's get started. Can I ask if you've watched the DVD?

☐ *If they did not watch the DVD, tell them to watch it now, and you'll call back in a half hour.*

Review Last Week's Session ----------☐

☐ OK, let's review what we learned last time. Please stay on page 12.

☐ We talked about the importance of physical activity, which is one of the legs of the three-legged stool. Remember – if you ignore any one of the three legs, it all comes tumbling down!

☐ We learned 3 rules to help us be physically active – can you name them? *Let client answer. If needed, remind client that the 3 rules of physical activity are "Be Smart, Exercise Your Heart," "Walk Down Your Blood Sugar," and "Sitting is the New Smoking."*

☐ We also checked on how you were doing with your medicines, and with healthy eating. You are now actively working on all 3 legs of that stool.

☐ Does that sound right? *Let client answer.* Did you have any questions? *Let client answer.*

Review DVD: Diabetes Medications ----------☐

☐ Great! Let's move on and talk about the DVD you watched this week. How did you like it? *Let the client answer and listen supportively.*

☐ Let's review some of the things we saw on the DVD. Please stay on page 12. *Let the client get to the page.*

☐ During this week's video and the first video you watched for this program, you heard some people talk about diabetes medications and how they felt when they were first given medications for their diabetes. What did you think about that? *Listen to their response. Bring out that many people feel reluctant to take medications after finding out that they have diabetes. Emphasize how common it is that people in your communities feel this way at first and don't realize how important medicines are for keeping them well. However, it's never too late to get the benefits of medicines.*

Notes:

- ☐ One of the important points made on the video is that the medications are really important for keeping down your blood sugar, but they aren't perfect.
- ☐ We learned that diabetes progresses even on medications. This is why you may eventually need a second or third medication even if you're doing everything right.
- ☐ Also, we learned that diabetes progresses much more quickly off medications, shortening your life and increasing risks for disabling conditions like stroke, dialysis, heart attack, and amputations.
- ☐ These complications can be prevented or delayed with medications, diet, and exercise.
- ☐ There are many types of diabetes medications available, so you should be able to get on a medication that both controls your sugar and lets you feel well.
- ☐ Side effects can be a problem, but you should discuss with your doctor before stopping. In the video, do you remember what happened with the person that had trouble with her medications at first? *If needed, remind client that she had trouble with her sugar going too low and experiencing stomach upset. However, instead of stopping her medications on her own, she worked with her doctor to find the right medicine for her.*

Notes:

- ☐ Finally, the video mentioned how generic medications work as well as brand name drugs, but generics can be more affordable.
- ☐ Did you have any questions about what you learned? *If the client has questions that weren't covered in the video, write down the questions and ask the research team. Tell the client you'll ask the doctors in the study and let them know the answer next time. Or, coach the client to ask their doctor their questions. Write down questions in the box below.*

Notes:

Activity 1: How Medications Can Help Me Live Better, Longer----------☐

- ☐ Now, let's review some of the things we talked about at our first session. Please turn to page 13. *Go to page 3 in the Client Plan Book and look at what the client told you were some of their hopes for the future.*

☐ You told me that you wanted to... *read one of their long term goals from page 3.* Is that still important to you? *Listen supportively.*

- *If the client didn't share anything during the first session, encourage them to share something now. Future plans could include something they want to do in retirement, watching a grandchild grow up, attending a family reunion, etc.*
- *If needed, ask them about their loved ones, especially grandchildren or great grandchildren. Suggest something they may want to look forward to in the future, for example, see their great grandchild get married. Add what client shares with you to what you already wrote on page 3 in the Client Plan Book.*

☐ After watching the video, now you know how diabetes medications are supposed to work for you. How do you think taking the medicines will let you… *[restate their long-term goal]?*

☐ So, taking your diabetes medication will help you live well now *and* live well in the future, so that you can do the things we just talked about.

☐ Your diabetes medication will help you have less symptoms of high blood sugar. If you stop your medicine, within a few days, you may feel very tired and thirsty, and you may run to the bathroom all the time.

☐ On top of you feeling better, day to day, your diabetes medication will help you reach your long-term, future plans so that you're well enough to do what you want to do and to enjoy it.

☐ If you stop your diabetes medication, in the long run, you'll have higher risks for stroke, heart attack, dialysis, and amputation.

☐ Many people who have these complications can't live alone anymore.

☐ Independence is so important for us as we get older. It's great to know there are so many things we can do to improve our chances for remaining independent as long as possible.

☐ Do you know anyone who lost their independence because of diabetes, or because of a diabetes complication like stroke, amputation, or dialysis? *Encourage them to tell you about a family member or acquaintance who lost their independence. If they don't know anyone, share a personal story of someone you know who lost their independence. Relate this person's story to the client's own future plans. Ask them how they would feel if this happened to them. Ask them whether they'd like to avoid this if possible.*

☐ If you make sure you are on medicines that you can afford and that agree with you, and you take them every day, you'll feel better now and you'll increase your chances of being well for… *restate the long-term goal again.* How does that sound? *Listen supportively.*

1. *If they are skeptical about the value of the medicines, talk about others like them who you have helped. You may also want to discuss the video clips of Black Belt residents talking about their diabetes and medicines.*
2. *Be supportive and don't criticize. Encourage them to see the value of medicine.*
3. *If they don't want to, be supportive and move on. There will be more opportunities to talk about this later in the program.*

Activity 2: Are My Diabetes Medications Working for Me? ----------☐

☐ OK, let's be sure that your medicines are working for you.

☐ The way we tell whether they're working is your A1c number. From your report card that you got at the start of the study, I see that your A1c number was… *read out loud the A1c number on page 2 in the Client Plan Book.*

☐ On page 13, write in your A1c number into the box.

☐ Can you tell me what that number means? *Encourage them to tell you how to interpret the number and reinforce what it means. Use the chart below. This is also in their Activity Book.*

☐ OK, so your number is… *read the category of A1c number*, which means it's… *read "what it means".*

☐ Let's talk about what this means in terms of what you should do.

A1c number	***What it means***	***What you should do***
Less than 7	*Great control*	*Praise, encourage to keep taking medicine, emphasize if they stop it, A1c will go up*
7-8	*OK, not perfect*	*Review diet, exercise, and whether they are taking medicines right. Reinforce importance of taking medicine.*
8-9	*Cause for concern*	*Review diet, exercise, how they are taking the medicines. Coach them to talk to their doctor if there has not been a change in the medicines since the A1c was taken. Coach them to call the doctor and ask for more medicine if they are taking it correctly.*
9 or higher	*Bigger cause for concern*	*Review diet, exercise, how they are taking medicines. If they are taking medicines correctly, coach them to call the doctor and request more medicine.*

☐ If the number is less than 7, you want to do whatever you can to keep it there. Can you tell me what that is? *Discuss that this is healthy eating, exercise, and taking the medicines as the doctor prescribed.*

☐ When it's over 7, it's time for action. That's a sign that you may need to make more efforts to eat healthier, exercise more, or get better at taking the medicines.

☐ Sometimes you are doing all of those things well, but the number is still high. Do you know what that means? *Explain that this happens as diabetes progresses, and some people may have uncontrolled diabetes even if they are doing everything right. It may be time to increase a dose or get another medicine added – both requiring a talk with the doctor.*

If you decided together that they should reach out to the doctor, discuss in detail how the client will do that.

- *Many people won't want to call the doctor themselves and may need help. Discuss who in their family can make the call if they don't feel comfortable.*
- *Write down the date of the call and what they'll say when the client calls the doctor in the box below.*

If you make a plan to reach out to the doctor, call back the day after the planned call by the client/family member to check how things went. If needed, plan together what to do next if things did not go well (for example, if the client never called, or if they never got to talk to the doctor). They may need to make an appointment, and may need help figuring out how to get there. Help them with this.

Review of Last Week's Homework ----------☐

☐ OK, now let's go over your homework from last week.

☐ Can you turn back to page 11 in your Activity Book? *Let client get to the page.*

☐ Were you able to complete the homework?

Note: if the client has not done some of the homework 2 sessions in a row, talk about what is making it hard to monitor. Let them know that since this is a research project, the investigators may want to help the person to succeed. Let them know that someone from the research team will be in touch.

- *Call the research team within 24 hours and let them know what is happening.*
- *UAB staff will brief you on the conversation and the plan so that you can reinforce it next week.*

Client has not done homework for 2 sessions in row	*2. Community coordinator calls back with next steps:*
1. Community coordinator notified (note date / time): _____ _____ *date* *time*	

Homework #1: Medications

☐ OK, let's review your 3 kinds of homework, starting with your medicines.

☐ How did things go with your diabetes medication? Let's start with Day 1. Did you take all of your diabetes medication on Day 1?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Now, I'd like to follow up on the plan that we made last week to help you get the most out of your medications by taking them every day.

☐ Last week, the issue you wanted to work on was… *[go to Client Plan Book and read out loud the diabetes medication issue that they chose to work on last week]*.

☐ To overcome this issue, you decided to… *[read out loud the medication-taking plan from last week]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, how did it go? *Listen supportively and take notes in the box below. Assess how well this worked. If it did not work well, talk about why not. If it did go well, praise them.*

Notes:

☐ OK, so what would you like to do over the next week to help you get the most out of your medications?

- ***If their plan worked and last week's issue is resolved, encourage them to tackle a new issue this week.*** *If you try hard and they don't want to tackle another issue and they took their medicine each day:*
  - *Go back to the Client Plan Book.*
  - *If there are remaining issues related to side effects or cost, then help the client make a plan to address them this week.*
  - *If there are no remaining issues related to side effects or cost, look at the list of statements on Page 8 that are marked "Very Often" (or "Often" if there are no "Very Often" statements to address, or "Sometimes" if there are no "Often" statements to address).*
    - *Help them decide which new goal they would like to add for the coming week.*
  - *Summarize to confirm their new goal. For example, you could say:*
    "OK, let me see if I got this straight. Last week, you … [repeat last week's goal]. You did well with that, so this week, you'll … [repeat this week's goal]. Did I get that right?"

- ***If they were not able to meet their medication goal, then let them stick to the same goal.***
  - *Be supportive, and let them know you'll revisit the goal next week to see how it went this time.*
  - *Strategize what they will do differently this week to succeed. Make it a SMART goal.*

- ***Record this week's strategy in the Client Plan Book.***
  - *If the strategy addresses side effects/and or cost, record this week's strategy on the page, "Client Plan for Diabetes Medication Side Effects and/or Cost," in the Client Plan Book.*
  - *If the strategy addresses other barriers besides side effects or cost, then record this week's strategy on the page, "Client Plan for Other Diabetes Medication Barriers," in the Client Plan Book.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ OK, let's review that. It looks like you'll… *repeat the medications goal. Then, review potential barriers and how client will go around those barriers. Let client confirm.*

☐ I look forward to hearing how this plan worked when we talk next time!

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

Homework #2: Healthy Eating

☐ OK, now, let's talk about your healthy eating.

☐ Were you able to eat healthy on Day 1? *For each day, check*

"yes" or "no" for the Healthy Eating column.

☐ Great! Now, I'd like to talk about the plan that we made last week to help you eat healthy every day. Last week, you planned to… *[go to Client Plan Book and read out loud the healthy eating goal the client chose to work on last week]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, how did it go? *If they were able to meet their goal, praise them profusely! However, if things did not go as planned, provide encouragement and tell them that you'll come up with new strategies together, if new plans are needed.*

- *If they met their healthy eating goal,*
  - *Explore if they are ready to add another goal this week. Ask them to turn to page 9 in their Activity Book and look at the chart. Help them decide which new goal they would like to add for the coming week.*
  - *Go to "Plan for Healthy Eating" in the Client Plan Book and write down details in the space provided. Be sure to include all the information necessary for the goal.*
  - *Summarize to confirm their new goal. For example, you could say:*

    "OK, let me see if I got this straight. Last week, you … [repeat last week's goal]. You did well with that, so now you'd like to add another healthy eating goal. So, this week, you'll … [repeat this week's goal]. Did I get that right?"
- *If they were not able to meet their healthy eating goal,*
  - *Let client stick to the same eating goal, but be sure to modify the plan if needed.*
  - *Go to page "Plan for Healthy Eating" in the Client Plan Book and write down details in the space provided. Be sure to include all the information necessary for the goal.*
  - *Be supportive, but do remind your client that you'll revisit the goal next week to see how it went this time.*

☐ OK, what would you like to do this week in terms of healthy eating?

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ OK, let's review that. It looks like you'll… *repeat healthy eating goal. Then, review potential barriers and how client will go around those barriers. Let the client confirm.*

☐ Great, I look forward to hearing how this plan worked when we talk next time!

Homework #3: Physical Activity

		Exercise minutes
Day 1 (today)		*minutes*
Day 2		*minutes*
Day 3		*minutes*
Day 4		*minutes*
Day 5		*minutes*
Day 6		*minutes*
Day 7		*minutes*

☐ OK, now, let's talk about your exercise.

☐ How many minutes of exercise were you able to get on Day 1? *For each day, write number of minutes under the exercise column.*

☐ OK, now, I'd like to talk about the plan that we made last week to help you eat be more physically active. Last week, you planned to… *[go to Client Plan Book and read out loud the exercise goal the client chose to work on last week]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, how did it go? *If they were able to meet their goal, praise them profusely! However, if things did not go as planned, provide encouragement and tell them that you'll come up with new strategies together, if new plans are needed.*

☐ Thanks for sharing that with me! We know that the recommendation is to get 30 minutes or more exercise at least 5 days each week, but we need to build up to that gradually.

☐ OK, what would you like to do this week in terms of physical activity?

- *If they met their goal and were doing less than 30 minutes per day, 5 days per week, then explore if they are ready to add another 5 minutes.*
  - *If they are not comfortable advancing the goal, let them stick to the same goal, but supportively warn that you'll be discussing this again next week and remind them that the eventual goal is 30 minutes per day.*
  - *Go to "Plan for Physical Activity" in the Client Plan Book and write the goal for this week.*
- *If they were not able to meet their goal,*
  - *Let client stick to the same goal, but be sure to modify the plan if needed.*
- *Summarize. For example, say: OK, let me see if I got this straight. Last week, you [repeat last week's goal], and you did pretty well with that, so now you'd like to add another 5 minutes each day. That means that, this week, you'd like to [repeat this week's goal]. Did I get that right?*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ Great, I look forward to hearing how this plan worked when we talk next time!

This Week's Homework ----------☐

- ☐ Now, let's go over your homework for the coming week. Please turn to page 13 in your Activity Book.
- ☐ This week, we'll again have homework for each leg of the 3-legged stool.
- ☐ You're going to continue keeping track of how you're doing with your diabetes medication. So, every day, under the column with the picture of a pill bottle, you're going to mark "Yes" if you took all of your diabetes medication that day. If you weren't able to take all of your diabetes medication, then you're going to mark "No" for that day.
- ☐ Remember to be honest. I can't help you if I don't know where you need help.
- ☐ You'll carry out the plan we discussed that will help you get the most out of your medicines.
- ☐ You're also going to mark down whether you kept to your heathy eating goal on the days that we discussed. Your plan is to… *repeat the healthy eating goal from today written down in the Client Plan Book.*
- ☐ So, under the column with a picture of apples, you're going to mark "Yes" if you were able to follow your healthy eating goal on the days we discussed.
- ☐ The goal is to eat healthy every day, so if you are able to follow your healthy eating goal on the other days, mark "Yes" on those days, too.
- ☐ You're going to monitor the number of minutes of exercise every day. You decided that you would try *...Repeat the exercise goal from today written down in the Client Plan Book.*
- ☐ So, under the column with a picture of someone walking, you're going to write down the number of minutes of exercise you were able to do on the days we discussed.
- ☐ If you are doing well with your goal and were able to exercise on the other days, mark "Yes" on those days, too.
- ☐ Finally, you'll watch the DVD on Blood Pressure and Cholesterol Medications, which we'll talk about next time.
- ☐ Do you have any questions about what to do? *Make sure client knows what to do.*
- ☐ OK, when would you like to talk next week?

• *Try to make this date as close to 7 days from now as possible.* • *Allow at least 7 days between sessions, but no more than 10 days.*	***Next appointment date and time:***

- ☐ OK, please write down the date and time in your Activity Book at the bottom of page 13.
- ☐ I look forward to speaking next week and hearing how things went!

✓ Session 4 completed	____ / ____ / ____ *month* *day* *year*	____ / ____ *start time* *end time*	____ *peer initials*

Week 5, Session 5: "Blood Pressure and Cholesterol Medications"

Session Goals:

- *Brief review of last week's session*
- *Review DVD: Blood Pressure and Cholesterol Medications*
- *Review homework*
- *Learn to connect medicines to future goals*
- *Your blood pressure and cholesterol numbers*

Before Calling the Client ----------

- *Review last week's assignment and the barriers and strategies to overcome them.*
- *Once you've reviewed this, place the call.*

Reminder!!

- *Cover and check off all of the session content.*
- *Any text in GRAY BOXES is instructions for you: don't read that text aloud to the client.*

Call Log

	Dates	Times	Notes
Attempt 1			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 2			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 3			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 4			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 5			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 6			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 7			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 8			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**

All phone numbers provided are disconnected or 8 call attempts made*	*2. Community coordinator calls back with Next Steps:*
1. Community coordinator notified (note date / time): _____ *date* _____ *time*	

Greeting ----------☐

☐ Great, do you have your Activity Book handy?
If not, let them get the Activity Book before going on.

Say hello and make sure the client is still okay with speaking for about a half hour to forty minutes today.

☐ Please turn to page 14. Today, we'll review what we learned last week, learn about blood pressure and cholesterol medications, and review what you learned on the DVD.

☐ We'll also review your homework, and we'll get new homework for this week.

☐ OK, let's get started. Can I ask if you've watched the DVD?

☐ *If they did not watch the DVD, tell them to watch it now, and you'll call back in a half hour.*

Review Last Week's Session ----------☐

☐ OK, let's review what we learned last time. Please stay on page 14.

☐ We talked about the importance of taking our diabetes medications, which is one of the legs of the three-legged stool.

☐ Can you remember some of the ways diabetes medications can help you? *Let client answer. If needed, remind client that diabetes medications work to keep down their blood sugar; high blood sugar will make them feel bad - tired, going to the bathroom too often, and feeling thirsty all the time. Along with diet and exercise, medications also prevent or delay complications of diabetes like stroke, dialysis, heart attack, and amputations.*

☐ OK, we learned that medications aren't perfect, and that your diabetes may continue to progress, even when you're on medications. If you don't take the medicine, your diabetes will progress faster. That's why you may need a second or third medication, even if you're doing everything right.

☐ Diabetes medications may give you side effects, but many people won't get any side effects.

☐ There are many types of medications available, so you and your doctor should be able to find a medication that controls your sugar and lets you feel well.

☐ We also checked on how you were doing with your diabetes medicines and with healthy eating and exercise. In the past two weeks, you have been working on all 3 legs of the stool! That's great!

☐ Does that sound right? *Let client answer.* Did you have any questions? *Let client answer.*

Review DVD: Blood Pressure and Cholesterol Medications ----------☐

☐ OK. Let's move on and talk about the DVD you watched this week. How did you like it? *Let the client answer and listen supportively.*

☐ Let's review some of the things we saw on the DVD. Please turn to page 15. *Let the client get to the page.*

☐ You heard someone on the video talk about blood pressure medications. What did you think about that? *Listen to their response. Bring out that she didn't really understand how*

important blood pressure medicines were until well after she experienced a complication. Emphasize that high blood pressure is very common in your communities, and that the consequences of not taking care of high blood pressure can be very serious.

- ☐ There are some important numbers to remember. Do you remember the numbers that mean you have high blood pressure? *140 over 90 or higher is high blood pressure.*
- ☐ If you don't get it under control, meaning lower than 140 over 90, high blood pressure can lead to serious complications. Do you remember any of these complications? *Complications include stroke, heart attack, dialysis, blindness.*
- ☐ One of the important points made on the video is that because it has no symptoms, high blood pressure can be especially dangerous. You may feel OK right up until you have a stroke. It's the "silent killer."
- ☐ Sometimes it can feel like the doctor is experimenting because they often switch the medications and change the dose. But this isn't experimenting, right? Many blood pressure medicines work better in some people than others, so it may take a while to get it right.
- ☐ Just like for diabetes, there are many different medications available to treat high blood pressure, so you should be able to get on a medication that both controls your blood pressure and lets you feel well.
- ☐ Some people do get side effects. Do you remember what the advice was if you get a side effect? *Let them tell you. It should be "talk to the doctor." You shouldn't just stop.*
- ☐ Now, the video also talked about high cholesterol. We learned that high cholesterol causes health problems. Do you remember what those were? *Answer: stroke and heart attack.*
- ☐ OK, here's a trick question. Do you remember what symptoms high cholesterol causes? *Answer: no symptoms with high cholesterol.*
- ☐ What about the "bad cholesterol", do you remember what that was? *Answer: LDL cholesterol.* OK, do you remember the good number you want to be below? *Answer: 100.*
- ☐ The main medicine for high cholesterol is a statin. Do you remember how many people feel well and have no side effects on statins? *Answer: 3 of 4.*
- ☐ Finally, the video mentioned that, for both blood pressure and cholesterol medications, the generic versions work as well as the brand name drugs, but generics can be more affordable.
- ☐ Did you have any questions about what you learned? *If the client has questions that weren't covered in the video, write down the questions and ask the research team. Tell the client you'll ask the doctors in the study and let them know the answer next time. Or, coach the client to ask their doctor their questions. Write down questions in the box below.*

Notes:

Activity 1: How Medications Can Help Me Live Better, Longer----------☐

☐ Now, let's review some of the things we talked about at our first session as well as last time. Please turn to page 16. Here you see some events or occasions that many people look forward to. Can you tell me what you see? *There are pictures of a 50th anniversary, a wedding, graduation, a baby, and a family reunion.*

☐ *Go to page 3 in the Client Plan Book and look at what the client told you were some of their hopes for the future.* Last time we talked, you told me that it was important for you to… *read their long term goals from page 3.* Since we talked, did you think of any other things that you're looking forward to doing in the future? *Listen supportively.*

- *Encourage clients to think of other things they'd like to do in the future. Plans could include something they want to do in retirement, watching a grandchild grow up, attending a family reunion, etc.*
- *If needed, ask them about their loved ones, especially grandchildren or great grandchildren. Suggest something they may want to look forward to in the future, for example, see their great grandchild get married. If client mentions anything new, add to what you already wrote on page 3.*

☐ You learned a lot about how high blood pressure and high cholesterol affect the body, and how the medicines help to slow these changes down.

☐ Now that you've watched the videos on medicines for diabetes, blood pressure, and cholesterol, you know how these medicines are supposed to work for you. How do you think taking the medicines will let you… *[repeat their long-term goals]? Listen supportively.*

☐ If you stop your medication, in the long run, you'll have higher risks for complications like stroke, heart attack, dialysis, and amputation. Do you know anyone with any of these conditions? *Listen supportively.*

☐ Many people who have these complications can't live alone anymore. During our last session, we talked a little about people we know that lost their independence because of these complications.

☐ Since we talked, did you think of anyone else you know who can't live alone anymore because of stroke, heart problems, dialysis or amputation? *Encourage client to talk about another family member or acquaintance who lost their independence. If they don't know anyone else, repeat or share another personal story of someone you know who lost their independence. Relate this person's story to the client's own future plans. Ask how they would feel if this happened to them. Ask whether they'd like to avoid this if possible.*

☐ Independence is so important for us as we get older. A lot of people don't realize that taking these medicines for diabetes, high blood pressure, or cholesterol let us stay independent longer. Did you know that's what the medicines are for? *Listen supportively.*

☐ If you make sure you are on medicines that you can afford and that agree with you, and you take them every day, you'll increase your chances of being well for… *repeat their future goal.* You'll also be able to live independently for longer. What do you think about that?

- *If they are skeptical about the value of the medicines, talk about others like them whom you have helped. You may also want to discuss video clips of Black Belt residents talking about their medicines.*
- *Be supportive and don't criticize. Encourage them to see the value of medicine.*
- *If they don't want to, be supportive and move on.*

Activity 2: How is My Blood Pressure? ----------☐

☐ OK, let's talk about your blood pressure. From your report card that you got at the start of the study, I see that your blood pressure was… *read out loud the blood pressure number from the client report card on page 2 in the Client Plan Book.*

☐ OK, if you don't mind, on page 16 of your Activity Book, write in your blood pressure numbers into the box. Do you see the box in the middle of the left-hand side of the page? First, write...*read out the first number.* Then, write...*read out the second number.*

☐ Can you tell me what these numbers mean? Is your blood pressure normal? Is it high? *Let the client answer. If needed, remind client that 120/80 is normal, less than 140/90 is the goal, and 140/90 or higher is high.*

If the blood pressure is lower than 140/90, say:

☐ Your blood pressure is in a great range. You'll want to keep an eye on it because it may go up at some point in the future as you get older. Now, let's stay on page 16 and talk about your cholesterol. ***Go to ACTIVITY 3 on page 54 of your manual.***

If the blood pressure is 140/90 or higher:

☐ OK, so your blood pressure is high. Did you know that over half of people with high blood pressure don't have it under control? So you are not alone.

☐ If you and your doctor can get it under control, under 140/90, it will help you meet your goals and stay independent.

☐ Let's go over your blood pressure medicines and make sure you are not having problems. *Go to page 19 in the Client Plan Book to see if they're taking any medications for blood pressure.*

If there are <u>no</u> blood pressure medicines listed, ***go to #1 on page 53 in your manual.***

If there are blood pressure medicines listed, go over each medicine: how they're taking their medicine, whether they're experiencing side effects that are causing them to miss doses, and whether they're able to afford their medicine.

1) *If they are making mistakes in how they are taking it, or they are missing doses because of side effects or cost,* ***go to #2 on page 53 in your manual.***
2) *If they are taking it correctly and aren't missing doses because of side effects or cost,* ***go to #3 on page 54 in your manual****.*

1) IF NOT TAKING ANY BLOOD PRESSURE MEDICINES:

☐ It looks like you are not taking any medicines for blood pressure, and it's high. As you learned from the video, it's very common to get high blood pressure as we get older.

☐ Have you ever been told your pressure is high before? *If this is the first time the pressure is high, suggest they get it rechecked at the pharmacy over the next week. Check back at the next session.*

If they have been told the pressure was high in the past, suggest they talk to the doctor about it. Go to page 20 in the Client Plan Book and help client come up with a plan on how to reach out to the doctor: who is calling the doctor, when they are calling, what the client will say, potential barrier for carrying out the plan, and how they will get around the barrier. Write down plan in the Client Plan Book and check back at the next session.

When finished, ***go to ACTIVITY 3 on page 54 of your manual****.*

2) IF ON MEDICINES BUT <u>NOT</u> TAKING CORRECTLY:

If they are missing doses because of side effects or cost, be supportive and tell them this happens to a lot of people.

Go to page 20 in the Client Plan Book and help client come up with plan on how to reach out to the doctor: who is calling the doctor, when they are calling, what they will say, potential barrier to the plan, and how to get around the barrier. Write down the plan in the Client Plan Book and check back at the next session.

If they are not having issues with side effects or cost but still not taking it correctly, supportively correct any mistakes. Tell them a lot of people find this confusing.

Go to page 21 in the Client Plan Book and help client make a plan for how to take correctly. Ask client to get their blood pressure rechecked after about a week, possibly at the pharmacist or at the doctor's office with the nurse. Write down the plan in the Client Plan Book and check back at the next session.

☐ OK, let's see how that goes. I look forward to hearing about whether the blood pressure is better now that you are taking it like the doctor prescribed.

Note: here are some common mistakes:

- ✓ *Twice daily means morning and evening (not 2 doses in the morning)*
- ✓ *Many people skip doses of water pills if they are going out. If they do this, make sure they take it when they come back – don't skip a whole day.*
- ✓ *Some people only take them every other day.*

When finished, ***go to ACTIVITY 3 on page 54 of your manual****.*

3) IF ON MEDICINES AND THEY ARE TAKING CORRECTLY:

☐ It looks like you are taking the medicines just like the doctor prescribed, but the medicine may not be enough. What would you like to do about your blood pressure to get it under control? *Listen to what they would like to do. If they don't know what to do, suggest they talk to the doctor. If they agree to talk to the doctor, go to page 22 in the Client Plan Book and help client come up with plan on how to reach out to the doctor. Decide:*

1. *Who is calling the doctor, and when*
2. *What the client will say to the doctor*
3. *Whether the client needs a friend or family member with them to make sure their questions get answered; if yes, then who*
4. *Possible barriers to the plan, and what client will do to go around barriers*

Check back at the next session.

Note: About 1 in 5 people may need 4 or even 5 blood pressure medicines to get the blood pressure below 140/90, and some can't get it down below 140/90. However, if the blood pressure is a lot lower than it used to be, that means the medicine is helping a lot and they are lowering risks, so you can praise them for getting it down, even if it's not below 140/90.

When finished, ***go to ACTIVITY 3 on page 54 of your manual.***

Activity 3: How is My Cholesterol? ----------☐

☐ OK, let's make sure that your cholesterol is where it needs to be.

☐ From your report card that you got at the start of the study, I see that your LDL cholesterol, or the "bad" cholesterol, was… *read out loud the LDL cholesterol number from page 2 in the Client Plan Book.*

☐ OK, if you don't mind, on page 16 of your Activity Book, write in your cholesterol number into the box at the bottom left-hand corner of the page.

☐ Can you tell me what this number means? Is it OK or is it high? *Let the client answer. If needed, remind client that less than 100 is the goal, whereas 100 or higher is high.*

If the LDL cholesterol is less than 100, say:

☐ Your cholesterol is in a great range. Congratulations! Now, we can review your homework from last week. Please turn to page 13 in your Activity Book.

Go to Review of Last Week's Homework on page 57 of your manual.

If the LDL cholesterol is 100 or higher:

- ☐ OK, so your cholesterol is high. Did you know that most people with diabetes have high cholesterol? So, you are not alone.
- ☐ If you and your doctor can get it under control, which is under 100, it will help you meet your goals and stay independent as long as possible.
- ☐ Let's go over your cholesterol medicines and make sure you are not having any problems. *Go to page 23 in the Client Plan Book to see if they're taking any medications for cholesterol.*

  If there are no cholesterol medicines listed, ***go to #1 on page 55 in your manual.***

  If there are cholesterol medicines listed, go over each medicine: how they're taking their medicine, whether they're experiencing side effects that are causing them to miss doses, and whether they're able to afford their medicine.

  1) *If they are making mistakes in how they are taking it, or they are missing doses because of side effects or cost,* ***go to #2 on page 56 in your manual.***
  2) *If they are taking it correctly and aren't missing doses because of side effects or cost,* ***go to #3 on page 56 in your manual.***

1) IF NOT TAKING ANY CHOLESTEROL MEDICINES:

- ☐ It looks like you are not taking any medicines for cholesterol and it's high. As I already told you, it's very common for people with diabetes to have high cholesterol. The two sort of go hand in hand.
- ☐ Have you ever been told your cholesterol is high before? *Listen supportively.*

  Note: Some people may have tried a medicine and it didn't agree with them, or they could not afford it, or they just didn't feel like taking it.

  If your client mentions any of these things, discuss what they learned about cholesterol on the video.

  Tell them about others in the community just like them who used to feel the way they do, but who now take cholesterol medicine.

  Remind them that most people feel normal when on cholesterol medicine.

  If they seem open to it, suggest making a plan to reach out to their doctor. Go to page 24 in the Client Plan Book and help client client come up with a plan: who is calling the doctor, when they are calling, what the client will say, potential barrier for carrying out the plan, and how they will get around the barrier. Write down the plan in the Client Plan Book and check back at the next session.

When finished, ***go to Review of Last Week's Homework on page 57 of your manual.***

2) IF ON MEDICINE BUT <u>NOT</u> TAKING CORRECTLY:

If they are missing doses because of side effects or cost, be supportive and tell them this happens to a lot of people.

Go to page 24 in the Client Plan Book and help client come up with plan on how to reach out to the doctor: who is calling the doctor, when they are calling, what they will say, potential barrier to the plan, and how to get around the barrier. Write down the plan in the Client Plan Book and check back at the next session.

If they are not having issues with side effects or cost but still not taking it correctly, supportively correct any mistakes. Tell them a lot of people find this confusing.

Go to page 25 in the Client Plan Book and help client make a plan for taking it correctly. Ask client to get cholesterol rechecked at the doctor's office after about a month. They can wait until their next regularly scheduled visit, which may not be for several months. Write down the plan and check back at the next session.

☐ OK, let's see how that goes. I look forward to hearing about how it went and whether you got any side effects now that you will be taking the medicine every day like the doctor prescribed. If you do, we'll make a plan for how to handle that. How does that sound? *Let the client answer.*

When finished, ***go to Review of Last Week's Homework on page 57 of your manual.***

3) IF ON MEDICINES AND THEY ARE TAKING CORRECTLY:

☐ It looks like you are taking the medicines just like the doctor prescribed, but the medicine may not be enough. What would you like to do about your cholesterol to get it under control? *Listen to what they would like to do. If they don't know what to do, suggest they talk to the doctor. If they agree, go to page 26 in the Client Plan Book and help client come up with plan on how to reach out to the doctor. Decide:*

1. *Who is calling the doctor, and when*
2. *What the client will say to the doctor*
3. *Whether the client needs a friend or family member with them to make sure their questions get answered; if yes, then decide who will call with them.*
4. *Possible barriers to the plan, and what client will do to go around barriers*

Check back at the next session.

Note: About 1 in 5 people may get muscle cramps on statin medicines. This can be controlled by reducing the dose, or taking it every other day. The doctor may suggest one of these strategies.

When finished, ***go to Review of Last Week's Homework on page 57 of your manual.***

Review of Last Week's Homework ----------☐

☐ OK, now let's go over your homework from last week.

☐ Can you turn to page 13 in your Activity Book? *Let client get to the page.*

☐ Were you able to complete the homework?

Note: if the client has not done some of the homework 2 sessions in a row, talk about what is making it hard to monitor. Let them know that since this is a research project, the investigators may want to help the person to succeed. Let them know that someone from the research team will be in touch.

- *Call the research team within 24 hours and let them know what is happening.*
- *UAB staff will brief you on the conversation and the plan so that you can reinforce it next week.*

Client has not done homework for 2 sessions in row	*2. Community coordinator calls back with next steps:*
1. Community coordinator notified (note date / time): _____ _____ *date* *time*	

Homework #1: Medications

☐ OK, let's start with your medicines, beginning with Day 1.

☐ Did you take all of your diabetes medication on Day 1?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes."*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Now, I'd like to follow up on the plan that we made last week to help you get the most out of your diabetes medications by taking them every day.

☐ Last week, the issue you wanted to work on was… *[go to Client Plan Book and read out loud the diabetes medication issue that they chose to work on last week]*.

☐ To overcome this issue, you decided to… *[read out loud the medication-taking plan from last week]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, how did it go? *Listen supportively and take notes in the box below. Assess how well this worked. If it did not work well, talk about why not. If it did go well, praise them.*

Notes:

☐ OK, so what would you like to do over the next week to help you get the most out of your medications?

- ***If their plan worked and last week's issue is resolved, encourage them to tackle a new issue this week.*** *If you try hard and they don't want to tackle another issue and they took their medicine each day, try this:*
  - *Go back to the Client Plan Book.*
  - *If there are remaining issues related to side effects or cost, then help the client make a plan to address them this week.*
  - *If there are no remaining issues related to side effects or cost, look at the list of statements that are marked "Very Often" (or "Often" if there are no "Very Often" statements to address, and "Sometimes" if there are no "Often" statements to address).*
    - *Help them decide which new goal they would like to add for the coming week.*
  - *Summarize to confirm their new goal. For example, you could say:*
    "OK, let me see if I got this straight. Last week, you … [repeat <u>last</u> week's goal]. You did well with that, so this week, you'll … [repeat <u>this</u> week's goal]. Did I get that right?"

- ***If they were <u>not</u> able to meet their medication goal, then let them stick to the same goal.***
  - *Be supportive, and let them know you'll revisit the goal next week to see how it went this time.*
  - *Strategize what they will do differently this week to succeed. Make it a SMART goal.*

- ***Record this week's strategy in the Client Plan Book.***
  - *If the strategy addresses side effects/and or cost, record this week's strategy on the page, "Plan for Diabetes Medication Side Effects and/or Cost," in the Client Plan Book.*
  - *If the strategy addresses other barriers besides side effects or cost, then record this week's strategy on the page, "Plan for Other Diabetes Medication Barriers," in the Client Plan Book.*

- ☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down barriers.*
- ☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*
- ☐ OK, let's review that. It looks like you'll… *repeat the medications goal. Then, review potential barriers and how client will go around those barriers. Let client confirm.*
- ☐ I look forward to hearing how this plan worked when we talk next time!

Homework #2: Healthy Eating

- ☐ OK, now, let's go over what happened with your healthy eating.
- ☐ So, were you able to eat healthy on Day 1? *For each day, check "yes" or "no" for the Healthy Eating column.*

		***Ate healthy?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

- ☐ Let's review what you wanted to do to eat healthier. Last week, you decided to… *[go to Client Plan Book and read the healthy eating goal that they chose to work on last week].*
- ☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers].*
- ☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers].*
- ☐ Now, how did it go? *If they were able to meet their goal, praise them profusely! However, if things did not go as planned, provide encouragement and tell them that you'll come up with new strategies together, if new plans are needed.*

☐ OK, what would you like to do this week in terms of healthy eating?

- *If they met their healthy eating goal,*
  - *Explore if they are ready to add another goal this week. Ask them to turn to page 9 in their Activity Book and look at the chart. Help them decide which new goal they would like to add for the coming week.*
  - *Go to the Client Plan Book and write down details in the space provided. Be sure to include all the information necessary for the goal.*
  - *Summarize to confirm their new goal. For example, you could say:*

    "OK, let me see if I got this straight. Last week, you … [repeat last week's goal]. You did well with that, so now you'd like to add another healthy eating goal. So, this week, you'll … [repeat this week's goal]. Did I get that right?"
- *If they were not able to meet their healthy eating goal,*
  - *Let client stick to the same eating goal, but be sure to modify the plan if needed.*
  - *Go to the Client Plan Book and write down details in the space provided. Be sure to include all the information necessary for the goal.*
  - *Be supportive, but do remind your client that you'll revisit the goal next week to see how it went this time.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ Great, I look forward to hearing how this plan worked when we talk next time!

Homework #3: Physical Activity

☐ OK, now, let's go over how you did with exercise.

☐ How much exercise were you able to get on Day 1? *For each day, write number of minutes under the exercise column.*

		***Exercise minutes***
Day 1 (today)		*minutes*
Day 2		*minutes*
Day 3		*minutes*
Day 4		*minutes*
Day 5		*minutes*
Day 6		*minutes*
Day 7		*minutes*

☐ Great! Now, Let's review what you wanted to do to get more exercise. Last week, you decided to… *[go to Client Plan Book and read the exercise goal that they chose to work on last week]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, how did it go? *If they were able to meet their goal, praise them profusely! However, if things did not go as planned, provide encouragement and tell them that you'll come up with new strategies together, if new plans are needed.*

☐ Thanks for sharing that with me! We know that the recommendation is to get 30 minutes or more exercise at least 5 days each week, but we need to build up to that gradually.

☐ OK, what would you like to do this week in terms of physical activity?

- *If they met their goal and were doing less than 30 minutes per day, 5 days per week, then explore if they are ready to add another 5 minutes.*
  - *If they are not comfortable advancing the goal, let them stick to the same goal, but supportively warn that you'll be discussing this again next week and remind them that the eventual goal is 30 minutes per day.*
  - *Write the goal for this week in the space provided in the Client Plan Book.*
- *If they were not able to meet their goal,*
  - *Let client stick to the same goal, but be sure to modify the plan if needed.*
- *Summarize. For example, say: OK, let me see if I got this straight. Last week, you [repeat last week's goal], and you did pretty well with that, so now you'd like to add another 5 minutes each day. That means that, this week, you'd like to [repeat this week's goal]. Did I get that right?*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ OK, let's review that. It looks like you'll… *repeat the type of exercise, how many minutes on which days, when and where they'll do it, and with whom, if they plan to exercise with another person. Then, review potential barriers and how client will go around those barriers. Let the client confirm.*

☐ Great, I look forward to hearing how this plan worked when we talk next time!

This Week's Homework ----------☐

☐ You are doing so much to maintain your health – it's really great!

☐ Now, let's keep up the momentum and let's go over your homework for the coming week. Please turn to page 16 in your Activity Book.

☐ This week, we'll again have homework for each leg of the 3-legged stool.

☐ You're going to continue keeping track of how you're doing with your diabetes medication. So, every day, under the column with the picture of a pill bottle, you're going to mark "Yes" if you took all of your diabetes medication that day. If you weren't able to take all of your diabetes medication, then you're going to mark "No" for that day.

☐ Remember to be honest. I can't help you if I don't know where you need help.

☐ You'll carry out the plan we discussed that will help you get the most out of your medicines.

☐ You're also going to mark down whether you kept to your healthy eating goal on the days that we discussed. Your plan is to… *repeat the healthy eating goal from today written in the Client Plan Book.*

☐ So, under the column with a picture of apples, you're going to mark "Yes" if you were able to follow your healthy eating goal as we discussed.

☐ The goal is to eat healthy every day, so if you are able to follow your healthy eating goal every day, mark "Yes" on each day.

☐ You're going to monitor the number of minutes of exercise every day. You decided that you would try *...Repeat the exercise goal from today written in the Client Plan Book.*

☐ So, under the column with a picture of a person walking, you're going to write down the number of minutes of exercise you were able to do on the days we discussed.

☐ If you are doing well with your goal and were able to exercise on the other days, mark "Yes" on those days, too.

☐ Finally, you'll watch the DVD on Stress and Your Health, which we'll talk about next time.

☐ Do you have any questions about what to do? *Make sure client knows what to do.*

☐ Remember, although it's not homework, we'll also talk about your blood pressure and cholesterol to make sure you're doing everything you can to keep those numbers in control.

☐ OK, when would you like to talk next week?

• *Try to make this date as close to 7 days from now as possible.* • *Allow at least 7 days between sessions, but no more than 10 days.*	***Next appointment date and time:***

☐ OK, please write down the date and time in your Activity Book at the bottom of page 16.

☐ I look forward to speaking next week and hearing how things went!

✓ Session 5 completed	____/____/____	____/____	____
	month day year	*start time end time*	*peer initials*

Week 6, Session 6: "Stress and Your Health"

Session Goals:

- *Brief review of last week's session*
- *Review DVD: Stress and Your Health*
- *Learn stress reduction techniques*
- *Review homework*

Before Calling the Client ----------

- *Review last week's assignment and the barriers and strategies to overcome them.*
- *Once you've reviewed this, place the call.*

Reminder!!

- *Cover and check off all of the session content.*
- *Any text in GRAY BOXES is instructions for you: don't read that text aloud to the client.*

Call Log

	Dates	Times	Notes
Attempt 1			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 2			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 3			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 4			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 5			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 6			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 7			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 8			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**

All phone numbers provided are disconnected or 8 call attempts made*	*2. Community coordinator calls back with Next Steps:*
1. Community coordinator notified (note date / time): _____ *date* _____ *time*	

Greeting ----------☐

☐ Great, do you have your Activity Book handy? *If not, let them get the Activity Book before going on.*

Say hello and make sure the client is still okay with speaking for about a half hour to forty minutes today.

☐ Please turn to page 17. Today, we'll review what we learned last week, review the DVD, and learn more about stress and your health, including some specific strategies you can take to reduce stress.

☐ We'll also review your homework and what you learned on the DVD, and we'll get new homework for two weeks.

☐ I will give you a quick call next week, just to check in and see how you're doing, but it won't be a full session. We will talk more in two weeks.

☐ OK, let's get started. Can I ask if you've watched the DVD?

☐ *If they did not watch the DVD, tell them to watch it now, and you'll call back in a half hour.*

Review Last Week's Session ----------☐

☐ OK, let's review what we learned last time. Please stay on page 17.

☐ We talked about the importance of keeping our blood pressure and cholesterol under control. Can you remember some complications that can happen from having high blood pressure? *Let client answer. If needed, remind client that high blood pressure can cause complications like stroke, heart attack, dialysis, and blindness.*

☐ And can you remember some complications of high cholesterol? *Let client answer. If needed, remind client that high cholesterol can cause heart attacks and strokes.*

☐ This is why it's so important for us to keep both of these things under control. Can you remind me what is our goal for blood pressure? *Let client answer. If needed, remind client that our goal is to be below 140/90.* What about a normal blood pressure, do you remember what that number was? *120/80 is a normal blood pressure.*

☐ And can you remind me what is our goal for LDL, or "bad," cholesterol? *Let client answer. If needed, remind client that our goal is to be below 100.*

☐ Now, for blood pressure, we learned that there are many different medications available to treat high blood pressure. This is why it can take some time to find the right one for you.

☐ For cholesterol, on the other hand, there is one main type of medication, the "statins."

☐ As with diabetes medicines, there may be some side effects with blood pressure and cholesterol medicines. However, you and your doctor should be able to find a medication that works to control your blood pressure and cholesterol and that lets you feel well. Remember, don't just stop – talk to your doc!

☐ We also checked on how you were doing with your diabetes medicines and with healthy eating and exercise. In the past few weeks, you have been working on all 3 legs of the stool.

☐ Does that sound right? *Let client answer.* Did you have any questions? *Let client answer.*

Review DVD: Stress and Your Health ----------☐

☐ Great! Let's move on and talk about the DVD you watched this week. How did you like it? *Let the client answer and listen supportively.*

☐ Let's review some of the things we saw on the DVD. Please turn to page 18. *Let the client get to the page.*

☐ The video talked about how being stressed over long periods of time, or having chronic stress, can cause problems for our health.

☐ People experiencing chronic stress can experience upset stomach, irritability, bad mood, or fatigue. Chronic stress can worsen arthritis symptoms, cause weight gain or loss, or cause you to have trouble sleeping or concentrating.

☐ It can even increase your chances of getting some health conditions. Do you remember what those were? *Answer: high blood pressure and heart disease.*

☐ We learned several tips for managing stress in a healthy way. Please stay on page 18.

☐ First, it's important to recognize when we're stressed. Becoming aware of how stress makes us feel physically and emotionally is an important step towards dealing with stress in a healthy way. How does stress make you feel? *Listen supportively.*

☐ Second, it's important to identify the sources of stress in our lives. If we're aware of the things and situations that cause us to feel stressed, then we can prepare ourselves ahead of time to deal with the stressful situation. What are some of the things in your life that make you feel stressed? *Listen supportively.*

☐ Third, know what helps you relax. Some things that relax you are not so healthy, like smoking, or overeating. These things cause even more health problems in the long run.

☐ So it's important to have healthy ways of dealing with stress so that you can live as well as you can, as long as you can.

☐ The video mentioned some healthy strategies to relax. Can you remember any of the strategies? *Let client answer. If needed, remind client that being physically active and practicing deep breathing are two great ways to relax. Other talking points:*

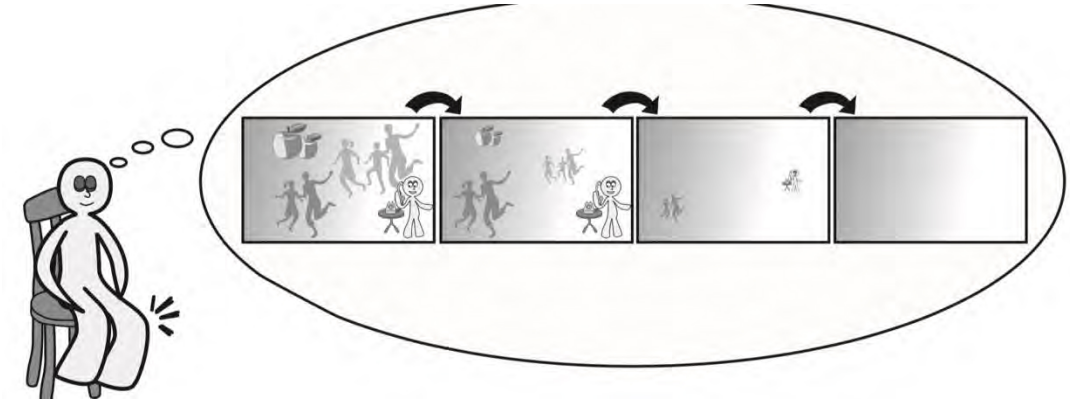
- *Exercising decreases the level of stress hormones in your body so that you feel less stressed and anxious, improving your mood and allowing you to sleep better.*
- *In addition to exercise and deep breathing, other helpful things might include: calling a friend or a loved one; taking a long, relaxing bath; working in your garden; reading a good book; listening to music; or prayer.*

☐ We're going to practice one of these strategies together next. Before we do that, did you have any questions so far? *Let client answer.*

Activity 1: Deep Breathing Stress Reduction Technique ----------☐

- ☐ OK, please stay on page 18 in your Activity Book. Let's practice together the deep breathing exercise that you saw on the DVD.
- ☐ This exercise can remove a lot of the stress from our bodies, and you can do it just about anywhere.
- ☐ OK, the first step is to get comfortable. Are you comfortable?
- ☐ OK, take some deep and very slow breaths. In…and out…and in…and out.
- ☐ Now, let's start from the top and work our way down. We're going to relax every muscle in our bodies. Remember to breathe deeply and slowly throughout.
- ☐ Let's focus on the neck muscles, which are often very tense when we are stressed, and we don't even know it. Focus on relaxing them.
- ☐ Now the upper back…the shoulders…the arms…the chest and stomach.
- ☐ Concentrate on relaxing your back…your thighs…your legs.
- ☐ We're continuing to breathe deeply…and slowly.
- ☐ Now, we're going to relax our brain.
- ☐ Our brain is part of our body, and it is working all the time, especially when we are stressed.
- ☐ Now, we're going to relax our brain, breathing deeply…and slowly.
- ☐ Many people have never relaxed their brains. Let's begin by focusing on our senses.
- ☐ First, let's relax and not have any thoughts in response to what I'm saying.
- ☐ Breathing in…and out…deeply…and slowly.
- ☐ Now, do not let your brain respond to anything that I'm saying. Don't have any thoughts in response to what I'm saying.
- ☐ Try to let the sound and the words flow right over you. You hear them, but don't react to them. Just breathe deeply…and slowly.
- ☐ Now, concentrate on your thoughts. Become aware of your thoughts, and then just let them flow up…and out…and away. Just like a water fountain…a beautiful water fountain in the sunshine.
- ☐ Every new thought that comes, think of it like a sparkling drop of water, floating up…and out…and away from you.
- ☐ Don't react to it…don't respond to it…it is a new thought that flows away.
- ☐ Breathe in…and out…deeply…and slowly.

☐ Think of a big movie screen that's blank and white.



☐ Think of your thoughts being images on the movie screen, and as soon as the image is there, you let it flow away, disappearing and leaving the screen blank again.

☐ Let your mind become blank and white as fewer and fewer new thoughts come, letting each of them barely come onto the movie screen before they begin to disappear again.

☐ All the time breathing in…and out…deeply…and slowly.

☐ OK, that was great! I feel really relaxed! How do you feel?

- *Share that you feel great when you do this exercise.*
- *Emphasize how good it feels to be rid of stress.*
- *Talk about how often we have a lot of stress, and we don't even know it.*

☐ The great thing about this breathing exercise is that you can do it anywhere. If you feel stressed at work, you can do this at your desk, or go to the restroom if you really need to get away. If the grandkids are really getting to you, go in the kitchen away from them and practice deep breathing.

Review of Last Week's Homework ----------☐

☐ OK, now let's go over your homework from last week and talk about your homework for the next two weeks. Like I mentioned earlier, we won't be having a full session for two weeks, but you'll continue working on your homework, just like you've been doing.

☐ Over these two weeks, it will be a great time to start thinking about how you will carry on after this program is finished.

☐ You've been focusing on your health and living in a way that will keep you healthy.

☐ You've learned about the importance of the three-legged stool: eating healthy, being physically active, and taking your medications as prescribed by the doctor.

☐ You've also been setting goals for yourself so that you can tend to all three legs of the stool, and you've been keeping track of your progress between our sessions.

☐ You also took small steps forward, week to week, so that you can continue to live even more healthy and do the things that are important to you.

☐ Now, we won't be talking for two weeks. So, if you've been able to carry out your plan successfully during the upcoming week, you can consider taking another small step forward on your own during the second week.

☐ For example, you could add another 5 minutes to your exercise plan.

☐ You also could add another step towards healthy eating on top of those steps that you've already taken. You can go back to page 6 in your Activity Book to see your healthy eating goals that we discussed a few weeks back.

☐ Now, let's discuss how you did on your homework last week. Can you turn to page 16 in your Activity Book? *Let client get to the page.*

☐ Were you able to complete the homework?

Note: if the client has not done some of the homework 2 sessions in a row, talk about what is making it hard to monitor. Let them know that since this is a research project, the investigators may want to help the person to succeed. Let them know that someone from the research team will be in touch.

- *Call the research team within 24 hours and let them know what is happening.*
- *UAB staff will brief you on the conversation and the plan so that you can reinforce it next week.*

Client has not done homework for 2 sessions in row	*2. Community coordinator calls back with next steps:*
1. Community coordinator notified (note date / time): _____ _____ *date* *time*	

Homework #1: Medications

☐ OK, let's start with your medicines, beginning with Day 1.

☐ Did you take all of your diabetes medication on Day 1?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Now, I'd like to follow up on the plan that we made last week to help you get the most out of your diabetes medications by taking them every day.

☐ Last week, the issue you wanted to work on was… *[go to Client Plan Book and read out loud the diabetes medication issue that they chose to work on last week]*.

☐ To overcome this issue, you decided to… *[read out loud the medication-taking plan from last week]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, how did it go? *Listen supportively and take notes in the box below. Assess how well this worked. If it did not work well, talk about why not. If it did go well, praise them.*

Notes:

☐ OK, so what would you like to do over the next week to help you get the most out of your medications?

- ***If their plan worked and last week's issue is resolved, encourage them to tackle a new issue this week.*** *If you try hard and they don't want to tackle another issue and they took their medicine each day, try this:*
  - *Go back to the Client Plan Book.*
  - *If there are remaining issues related to side effects or cost, then help the client make a plan to address them this week.*
  - *If there are no remaining issues related to side effects or cost, look at the list of statements that are marked "Very Often" (or "Often" if there are no "Very Often" statements to address, and "Sometimes" if there are no "Often" statements to address).*
    - *Help them decide which new goal they would like to add for the coming week.*
  - *Summarize to confirm their new goal. For example, you could say:*
    "OK, let me see if I got this straight. Last week, you … [repeat last week's goal]. You did well with that, so this week, you'll … [repeat this week's goal]. Did I get that right?"

- ***If they were not able to meet their medication goal, then let them stick to the same goal.***
  - *Be supportive, and let them know you'll revisit the goal next week to see how it went this time.*
  - *Strategize what they will do differently this week to succeed. Make it a SMART goal.*

- ***Record this week's strategy in the Client Plan Book.***
  - *If the strategy addresses side effects and/or cost, record this week's strategy on the page, "Plan for Diabetes Medication Side Effects and/or Cost," in the Client Plan Book.*
  - *If the strategy addresses other barriers besides side effects or cost, then record this week's strategy on the page, "Plan for Other Diabetes Medication Barriers," in the Client Plan Book.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ OK, let's review that. It looks like you'll… *repeat the medications goal. Then, review potential barriers and how client will go around those barriers. Let client confirm.*

☐ I look forward to hearing how this plan worked when we talk next time!

Homework #2: Healthy Eating

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ OK, now, let's go over what happened with your healthy eating.

☐ So, were you able to eat healthy on Day 1? *For each day, check "yes" or "no" in the Healthy Eating column.*

☐ Great! Now, I'd like to talk about the plan that we made last week to help you eat healthy every day. Last week, you planned to… *[go to Client Plan Book and read out loud the healthy eating goal the client chose to work on last week]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, how did it go? *If they were able to meet their goal, praise them profusely! However, if things did not go as planned, provide encouragement and tell them that you'll come up with new strategies together, if new plans are needed.*

☐ OK, what would you like to do this week in terms of healthy eating?

- *If they met their healthy eating goal,*
  - *Explore if they are ready to add another goal this week. Ask them to turn to page 6 in their Activity Book and look at the chart. Help them decide which new goal they would like to add for the coming week.*
  - *Go to the Client Plan Book and write down details in the space provided. Be sure to include all the information necessary for the goal.*
  - *Summarize to confirm their new goal. For example, you could say:*

    "OK, let me see if I got this straight. Last week, you … [repeat <u>last</u> week's goal]. You did well with that, so now you'd like to add another healthy eating goal. So, this week, you'll … [repeat <u>this</u> week's goal]. Did I get that right?"
- *If they were not able to meet their healthy eating goal,*
  - *Let client stick to the same eating goal, but be sure to modify the plan if needed.*
  - *Go to the Client Plan Book and write down details in the space provided. Be sure to include all the information necessary for the goal.*
  - *Be supportive, but do remind your client that you'll revisit the goal next week to see how it went this time.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ Great, I look forward to hearing how this plan worked when we talk next time!

Homework #3: Physical Activity

		***Exercise minutes***
Day 1 (today)		*minutes*
Day 2		*minutes*
Day 3		*minutes*
Day 4		*minutes*
Day 5		*minutes*
Day 6		*minutes*
Day 7		*minutes*

- ☐ OK, now, let's go over how you did with exercise.
- ☐ How much exercise were you able to get on Day 1? *For each day, write number of minutes under the exercise column.*
- ☐ OK, now, let's review the plan that we made last week to help you eat be more physically active. Last week, you planned to… *[go to Client Plan Book and read out loud the exercise goal the client chose to work on last week]*.
- ☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.
- ☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.
- ☐ Now, how did it go? *If they were able to meet their goal, praise them profusely! However, if things did not go as planned, provide encouragement and tell them that you'll come up with new strategies together, if new plans are needed.*
- ☐ Thanks for sharing that with me! We know that the recommendation is to get 30 minutes or more exercise at least 5 days each week, but we need to build up to that gradually.
- ☐ OK, what would you like to do this week in terms of healthy eating?

- *If they met their goal and were doing less than 30 minutes per day, 5 days per week, then explore if they are ready to add another 5 minutes.*
  - *If they are not comfortable advancing the goal, let them stick to the same goal, but supportively warn that you'll be discussing this again next week and remind them that the eventual goal is 30 minutes per day.*
  - *Write the goal for this week in the space provided in the Client Plan Book.*
- *If they were not able to meet their goal,*
  - *Let client stick to the same goal, but be sure to modify the plan if needed.*
- *Summarize. For example, say: OK, let me see if I got this straight. Last week, you [repeat last week's goal], and you did pretty well with that, so now you'd like to add another 5 minutes each day. That means that, this week, you'd like to [repeat this week's goal]. Did I get that right?*

- ☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*
- ☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*
- ☐ Great, I look forward to hearing how this plan worked when we talk next time!

If your client had high blood pressure and you set a goal last week:

- *Go to **Homework #4: High Blood Pressure Plan** on page 74 in your manual and follow the script for your client's situation.*
- *Once you're finished, go to **This Week's Homework** on page 78.*

If your client had high cholesterol and you set a goal last week:

- *Go to **Homework #5: High Cholesterol Plan** on page 76 in your manual and follow the script for your client's situation.*
- *Once you're finished, go to **This Week's Homework** on page 78.*

If your client had high blood pressure and high cholesterol and you set goals last week:

- *Go to **Homework #4: High Blood Pressure Plan** on page 74 in your manual and follow the script for your client's situation.*
- *Then, go to **Homework #5: High Cholesterol Plan** on page 76 in your manual and follow the script for your client's situation.*
- *Once you're finished, go to **This Week's Homework** on page 78.*

*If your client's blood pressure and cholesterol were under control and you didn't set goals last week, then go to **This Week's Homework** on page 78 in your manual.*

Homework #4: High Blood Pressure Plan (only if client is on medicine for high blood pressure or should talk to doctor about starting treatment)

☐ OK, let's discuss the plan we made last week for your high blood pressure.

☐ Last week, you wanted to… *[go to Client Plan Book and read out loud the blood pressure plan that they chose to work on last week]*.

☐ Now, how did it go?

- ***If they were not on blood pressure medication and were <u>not able</u> to talk with doctor about starting medication:***
  - *Be encouraging and help them set a new plan for reaching out to the doctor. Write the new plan in the Client Plan Book and let client know you'll check back with them.*
- ***If they were not on blood pressure medication and were <u>able</u> to talk with doctor about starting medication:***
  - *Ask how it went and what the client and the doctor decided to do.*
  - *If client has decided to take blood pressure medication, be supportive and ask them if they have any questions about their new medication. Tell client you'll check back to see how they're doing.*
  - *If client has decided not to take blood pressure medication, be supportive, but encourage them to talk again with their doctor if their blood pressure is still high at their next appointment. Remind them that medications for high blood pressure can help them live longer and stay independent by helping to lower risk for serious health problems like stroke, heart attack, dialysis, or blindness.*

Notes:

- ***If there were issues with side effects or cost, but <u>not able</u> to talk with the doctor:***
  - *Be encouraging and help them set a new plan for reaching out to the doctor. Write the new plan in the Client Plan Book and let client know you'll check back with them.*
- ***If there were issues with side effects or cost and were <u>able</u> to talk with the doctor:***
  - *Praise them! Ask how it went and what the client and the doctor decided to do. Tell client you'll check back to see how they're doing with this the next time you talk.*

Notes:

Homework #4: High Blood Pressure Plan (Continued – page 2)

- ***If there were issues other than side effects or cost, and their plan to overcome the problem did not work:***
  - *Be encouraging and help them set a new plan for overcoming the problem. Write the new plan in the Client Plan Book and let client know you'll check back with them.*
- ***If there were issues other than side effects or cost, and their plan to overcome the problem worked:***
  - *Praise them! Ask them if they got their blood pressure rechecked. If not, encourage them to do so.*
  - *Make sure they aren't having any other problems with taking their blood pressure medication, and tell client you'll check back with them to see how they're doing.*

Notes:

- ***If they were not able to talk with the doctor about having high blood pressure even though they were taking their medication correctly:***
  - *Be encouraging and help them set a new plan for reaching out to the doctor. Write the new plan in the Client Plan Book and let client know you'll check back with them.*
- ***If they were able to talk with the doctor about having high blood pressure even though they were taking their medication correctly:***
  - *Praise them! Ask how it went and what the client and the doctor decided to do. Tell client you'll check back to see how they're doing with this the next time you talk.*

Notes:

Homework #5: High Cholesterol Plan (only if client is on cholesterol medicine or should talk to doctor about starting treatment)

☐ OK, let's discuss the plan we made last week for your high cholesterol.

☐ Last week, you wanted to… *[go to Client Plan Book and read out loud the cholesterol plan that they chose to work on last week]*.

☐ Now, how did it go?

- ***If they were not on cholesterol medication and were <u>not able</u> to talk with doctor about starting medication:***
  - *Be encouraging and help them set a new plan for reaching out to the doctor. Write the new plan in the Client Plan Book and let client know you'll check back with them.*
- ***If they were not on cholesterol medication and were <u>able</u> to talk with doctor about starting medication:***
  - *Ask how it went and what the client and the doctor decided to do.*
  - *If client has decided to take cholesterol medication, be supportive and ask them if they have any questions about their new medication. Tell client you'll check back to see how they're doing.*
  - *If client has decided not to take cholesterol medication, be supportive, but encourage them to talk again with their doctor if their LDL cholesterol is still high at their next appointment. Remind them that medications for high cholesterol can help them live longer and stay independent by helping to lower risk for serious health problems like stroke and heart attack.*

Notes:

- ***If there were issues with side effects or cost, but <u>not able</u> to talk with the doctor:***
  - *Be encouraging and help them set a new plan for reaching out to the doctor. Write the new plan in the Client Plan Book and let client know you'll check back with them.*
- ***If there were issues with side effects or cost and were <u>able</u> to talk with the doctor:***
  - *Praise them! Ask how it went and what the client and the doctor decided to do. Tell client you'll check back to see how they're doing with this the next time you talk.*

Notes:

Homework #4: High Cholesterol Plan (Continued – page 2)

- ***If there were issues other than side effects or cost, and their plan to overcome the problem did not work:***
  - *Be encouraging and help them set a new plan for overcoming the problem. Write the new plan in the Client Plan Book and let client know you'll check back with them.*
- ***If there were issues other than side effects or cost, and their plan to overcome the problem worked:***
  - *Praise them! Ask them to get their LDL cholesterol rechecked after a month, if possible. They can wait until their next regularly scheduled appointment.*
  - *Make sure they aren't having any other problems with taking their cholesterol medication, and tell client you'll check back with them to see how they're doing.*

Notes:

- ***If they were not able to talk with the doctor about having high cholesterol even though they were taking their medication correctly:***
  - *Be encouraging and help them set a new plan for reaching out to the doctor. Write the new plan in the Client Plan Book and let client know you'll check back with them.*
- ***If they were able to talk with the doctor about having high cholesterol even though they were taking their medication correctly:***
  - *Praise them! Ask how it went and what the client and the doctor decided to do. Tell client you'll check back to see how they're doing with this the next time you talk.*

Notes:

This Week's Homework ----------☐

- ☐ Now, let's go over your homework for the next two weeks. Please turn to page 19 in your Activity Book.
- ☐ For the next two weeks, you'll continue our homework for each leg of the 3-legged stool.
- ☐ You're going to continue keeping track of how you're doing with your diabetes medication. So, every day, under the column with the picture of a pill bottle, you're going to mark "Yes" if you took all of your diabetes medication that day. If you weren't able to take all of your diabetes medication, then you're going to mark "No" for that day.
- ☐ Remember to be honest. I can't help you if I don't know where you need help.
- ☐ You'll carry out the plan we discussed that will help you get the most out of your medicines.
- ☐ You're also going to mark down whether you kept to your heathy eating goal on the days that we discussed. Your plan is to… *repeat the healthy eating goal from today written in the Client Plan Book.*
- ☐ So, under the column with a picture of apples, you're going to mark "Yes" if you were able to follow your healthy eating goal on the days we discussed.
- ☐ The goal is to eat healthy every day, so if you are able to follow your healthy eating goal on the other days, mark "Yes" on those days, too.
- ☐ Remember, if you do well with your goal this week, you could add another step towards healthy eating. You can go back to page 6 in your Activity Book to see your healthy eating goals and see if you would like to work on another goal for the second week.
- ☐ You're going to monitor the number of minutes of exercise every day. You decided that you would try *...Repeat the exercise goal from today written in the Client Plan Book.*
- ☐ So, under the column with a picture of a person walking, you're going to write down the number of minutes of exercise you were able to do on the days we discussed.
- ☐ If you are doing well with your goal and were able to exercise on the other days, mark "Yes" on those days, too.
- ☐ Remember, if you do well with your goal this week, you could also add another step towards being physically active. For example, you could add another 5 minutes to your exercise plan during the second week.
- ☐ Do you have any questions about what to do? *Make sure client knows what to do.*
- ☐ Now, remember, we're not going to have a full session for two weeks, but I am going to give you a quick call next week, just to check in and see how you're doing.

☐ OK, when would you like to talk next week? How about in 2 weeks?

- *Try to make the dates as close to 7 and 14 days from now as possible.*
- *Allow at least 7 days between sessions, but no more than 10 days.*

Next appointment date and time in 1 week:

Next appointment date and time in 2 weeks:

☐ OK, please write down the dates and times in your Activity Book at the bottom of page 19.

☐ I look forward to speaking next week briefly, and then longer in 2 weeks. I look forward to hearing how things went!

✓ Session 6 completed	____ / ____ / ____ *month day year*	____ / ____ *start time end time*	____ *peer initials*

Week 7, Check-In Session 1 (One Week After Session 6)

Session Goals:

- *Brief encouragement to client*
- *Brief troubleshooting if client is having difficulty with any of the homework*
- *Brief reminder to client about upcoming Session 7 in one week*

Before Calling the Client ----------

- *Review last session's assignment and the barriers and strategies to overcome them.*
- *Once you've reviewed this, place the call.*

Reminder!!

- *Cover and check off all of the session content.*
- *Any text in GRAY BOXES is instructions for you: don't read that text aloud to the client.*

Call Log

	Dates	Times	Notes
Attempt 1			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 2			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 3			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 4			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 5			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 6			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 7			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 8			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**

All phone numbers provided are disconnected or 8 call attempts made*	*2. Community coordinator calls back with Next Steps:*
1. Community coordinator notified (note date / time): _____ *date* _____ *time*	

Check In ----------☐

☐ So, it's been about a week since we talked.
☐ I know that we're not supposed to have a full session until next week, but I just wanted to give you a quick call to see how you were doing.

Say hello and make sure the client is still okay with speaking for about ten minutes today.

☐ How are you? Has everything been going okay with you since we talked? *Listen supportively.*

☐ And how has it been going with your homework?

- *If client has been doing well:*
  - *Provide lots of praise, and encourage them to keep it up during the upcoming week.*
- *If client has been struggling:*
  - *Quickly review their goal from last session*
  - *Encourage client to think about what they can do to troubleshoot. Try to encourage client to come up with a solution themselves (we are working to build their confidence to overcome difficulties and set goals for themselves).*

Notes:

Remind Client of Next Session ----------☐

☐ Now, we'll have a full session *[repeat the date and time for Session 7 from page 79 in your manual]*.

☐ Between now and when we talk again, you are going to continue doing your homework, just like you did in the past week.

☐ You'll keep track of your progress on page 19 of your Activity Book, just like you've been doing. Do you have any questions? *Make sure client understands what to do.*

☐ All right, then! I look forward to hearing how things went when we talk next week!

✓ Check In completed	____/____/____ *month / day / year*	____/____ *start time / end time*	____ *peer initials*

Week 8, Session 7: "Practice and Planning for the Future – Part 1"

Session Goals:

- *Brief review of previous session*
- *Review homework*
- *Discuss what client has learned and how activities have helped*
- *Help client identify a Health Buddy*

Before Calling the Client ----------

- *Review last session's assignment and the barriers and strategies to overcome them.*
- *Once you've reviewed this, place the call.*

Reminder!!

- *Cover and check off all of the session content.*
- *Any text in GRAY BOXES is instructions for you: don't read that text aloud to the client.*

Call Log

	Dates	Times	Notes
Attempt 1			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 2			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 3			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 4			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 5			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 6			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 7			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 8			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**

All phone numbers provided are disconnected or 8 call attempts made*	*2. Community coordinator calls back with Next Steps:*
1. Community coordinator notified (note date / time): _____ *date* _____ *time*	

Greeting ----------☐

Say hello and make sure the client is still okay with speaking for about a half hour to forty minutes today.

☐ Great, do you have your Activity Book handy? *If not, let them get the Activity Book before going on.*

☐ Please turn to page 20. Today, we'll review what we learned during our last session, and then we'll talk about how your homework went.

☐ After today's session, our next full session will be in four weeks.

☐ So, today, we'll talk about what you'll be doing for homework for the next four weeks.

☐ Now, I will give you a quick call in two weeks, just to check in and see how you're doing, but it won't be a full session. Like I said, we'll talk more in four weeks.

☐ Do you have any questions? *Let client ask questions.* Great, let's get started!

Review Last Session ----------☐

☐ First, let's review what we learned last time. Please stay on page 20.

☐ We talked about the importance of managing stress. Can you remember some of the things that people feel if they are stressed over long periods of time? *Let client answer. If needed, remind client that people with chronic stress can have upset stomach, irritability, bad mood, or fatigue. Chronic stress can worsen arthritis symptoms, cause weight gain or loss, or cause people to have trouble sleeping or concentrating.*

☐ And having chronic stress can even increase your chances of getting some health conditions. Can you remember what they were? *Let client answer. If needed, remind client that chronic stress can increase your chances of developing high blood pressure and heart disease.*

☐ Because it's so important for us to manage our stress in a healthy way, the video gave us several tips for doing this. Can you remember what some of those tips were? *Let client answer. If needed, remind client of these tips: 1) recognize when we're stressed and how we feel, physically and emotionally, when we're stressed; 2) identify the sources of stress in our lives so that we can prepare ourselves ahead of time; and 3) know what healthy things we can do to help us relax and reduce our stress.*

☐ We talked about some healthy things that people can do to relax, such as being physically active, practicing deep breathing, and calling a friend. We also practiced deep breathing together over the telephone.

☐ Were you able to try any of these things the last two weeks to help manage your stress? *Let client answer. If yes, praise client and ask them how it went. If no, share with client how these things have helped you, and encourage client to give them a try before the next call.*

☐ We also checked on how you were doing with your diabetes medicines and with healthy eating and exercise. In the past few weeks, you have been working on all 3 legs of the stool.

☐ Does that sound right? *Let client answer.* Did you have any questions? *Let client answer.*

Review Homework For Last Two Weeks ----------☐

☐ OK, now let's go over your homework from the past two weeks and talk about your homework for the next four weeks.

☐ Like I mentioned earlier, we won't be having a full session for four weeks, but you'll continue working on your homework, just like you've been doing.

☐ These four weeks will be a great way to see how you are able to do your homework on your own and make a plan for how you can carry on after the program is finished.

☐ In a few minutes, we'll talk about some things that will help you continue doing the great work you've been doing to take care of yourself.

☐ But first, let's discuss how you did on your homework during the past two weeks. Can you turn to page 19 in your Activity Book? *Let client get to the page.*

☐ Were you able to complete the homework?

Note: if the client has not done some of the homework 2 sessions in a row, talk about what is making it hard to monitor. Let them know that since this is a research project, the investigators may want to help the person to succeed. Let them know that someone from the research team will be in touch.

- *Call the research team within 24 hours and let them know what is happening.*
- *UAB staff will brief you on the conversation and the plan so that you can reinforce it next week.*

Client has not done homework for 2 sessions in row	*2. Community coordinator calls back with next steps:*
1. Community coordinator notified (note date / time): _____ _____ *date* *time*	

Homework #1: Medications

☐ OK, let's start with your medicines and how you did with them that first week.

☐ Let's start with Day 1. Did you take all of your diabetes medication on Day 1?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Now, let's talk about how you did with your medicines during the second week. On Day 1 of the second week, did you take all of your diabetes medication?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

If your client 1) took their diabetes medication every day as directed in the past two weeks and 2) has successfully overcome all of the diabetes medication barriers identified at the beginning of the program:

- *Praise profusely! Tell them to keep up the great work by continuing to take their medications every day as directed.*
- *Then, **go to page 88** and continue with **Homework #2, Healthy Eating**.*

If your client was not able to take their diabetes medication every day as directed in the past two weeks:

- *Stay on **page 86** in your manual and continue with setting a diabetes medication goal.*
- *Then, go on with the rest of the session.*

If your client took their diabetes medication every day as directed in the past two weeks, but still has diabetes medication barriers that haven't been addressed:

- *Check page 8 in the Client Plan Book and see what issues are remaining. Then, remind client about these remaining issues and ask which one they would like to work on next.*
- *Go to **page 87** in your manual and continue with setting a diabetes medication goal.*
- *Then, go on with the rest of the session.*

☐ Now, I'd like to follow up on the plan that we made at our last session to help you get the most out of your diabetes medications by taking them every day.

☐ Last time we talked, the issue you wanted to work on was… *[go to Client Plan Book and read out loud the diabetes medication issue that they chose to work on last time]*.

☐ To overcome this issue, you decided to… *[read out loud the medication-taking plan from last time]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, how did it go? *Listen supportively and take notes in the box below. Assess how well this worked. If it did not work well, talk about why not. If it did go well, praise them.*

Notes:

☐ OK, so what would you like to do over the next four weeks to help you get the most out of your medications?

- ***If their plan worked and last session's issue is resolved, encourage them to tackle a new issue this week.*** *If you try hard and they don't want to tackle another issue and they took their medicine each day, try this:*
  - *Go back to the Client Plan Book.*
  - *If there are remaining issues related to side effects or cost, then help the client make a plan to address them this week.*
  - *If there are no remaining issues related to side effects or cost, look at the list of statements that are marked "Very Often" (or "Often" if there are no "Very Often" statements to address, and "Sometimes" if there are no "Often" statements to address).*
    - *Help them decide which new goal they would like to add for the coming week.*
  - *Summarize to confirm their new goal. For example, you could say:*
    "OK, let me see if I got this straight. Last week, you … [repeat <u>last</u> week's goal]. You did well with that, so this week, you'll … [repeat <u>this</u> week's goal]. Did I get that right?"

- ***If they were <u>not</u> able to meet their medication goal, then let them stick to the same goal.***
  - *Be supportive, and let them know you'll revisit the goal next week to see how it went this time.*
  - *Strategize what they will do differently this week to succeed. Make sure it is a SMART goal.*

- ***Record this week's strategy in the Client Plan Book.***
  - *If the strategy addresses side effects/and or cost, record this week's strategy on the page, "Plan for Diabetes Medication Side Effects and/or Cost," in the Client Plan Book.*
  - *If the strategy addresses other barriers besides side effects or cost, then record this week's strategy on the page, "Client Plan for Other Diabetes Medication Barriers," in the Plan Book.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ OK, let's review that. It looks like you'll… *repeat the new medication goal. Then, review potential barriers and how client will go around those barriers. Let client confirm.*

☐ This is a great plan! I look forward to hearing how this plan worked when we talk next time!

Homework #2: Healthy Eating

☐ OK, let's talk about how your healthy eating went during the first week. How did it go on Day 1? *For each day, check "yes" or "no" for the Healthy Eating column.*

Week 1

	Ate healthy?	
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Now, during the second week, were you able to take another step to eat healthier?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - ☐ *Did not evaluate goal after 1st week*
  - ☐ *Evaluated goal after 1st week, did not increase goal for 2nd week*
  - ☐ *Evaluated goal after 1st week, increased goal for 2nd week*

Notes and new healthy eating goal for 2nd week, if client increased goal:

☐ OK, let's take a look at how you did with healthy eating during the second week. How did it go on Day 1 of the second week? *For each day, check "yes" or "no" for the Healthy Eating column.*

☐ Great! Now, the last time we made a plan to help you eat healthy every day, you planned to… *[go to Client Plan Book and read out loud the healthy eating goal the client chose to work on last time]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, during the first week, you were able to… *[based on what client told you about Week 1, describe what happened]*.

☐ During the second week, you were able to… *[based on what client told you about Week 2, describe what happened]*.

Week 2

	Ate healthy?	
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ OK, what would you like to do this week in terms of healthy eating?

- *If they met their healthy eating goal,*
  - *Explore if they are ready to add another goal this week. Ask them to turn to page 6 in their Activity Book and look at the chart. Help them decide which new goal they would like to add for the coming week.*
  - *Go to the Client Plan Book and write down details in the space provided. Be sure to include all the information necessary for the goal.*
  - *Summarize to confirm their new goal. For example, you could say:*

    "OK, let me see if I got this straight. Last week, you … [repeat last week's goal]. You did well with that, so now you'd like to add another healthy eating goal. So, this week, you'll … [repeat this week's goal]. Did I get that right?"
- *If they were not able to meet their healthy eating goal,*
  - *Let client stick to the same eating goal, but be sure to modify the plan if needed.*
  - *Go to the Client Plan Book and write down details in the space provided. Be sure to include all the information necessary for the goal.*
  - *Be supportive, but do remind your client that you'll revisit the goal next week to see how it went this time.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ Great, I look forward to hearing how this plan worked when we talk next time!

Homework #3: Physical Activity

☐ OK, now, let's talk about how your exercise went during the first week. How did it go on Day 1? *For each day, write number of minutes under the exercise column.*

Week 1

	 *Exercise minutes*
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, during the second week, were you able to take another step to become more physically active?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - *Did not evaluate goal after 1st week*
  - *Evaluated goal after 1st week, did not increase goal for 2nd week*
  - *Evaluated goal after 1st week, increased goal for 2nd week*

Notes and new exercise goal for 2nd week, if client increased goal:

☐ OK, let's take a look at how you did with exercise during the second week. How did it go on Day 1 of the second week? *For each day, write number of minutes under the Exercise column.*

Week 2

	Exercise minutes
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, the last time we made a plan to help you exercise every day, you planned to… *[go to Client Plan Book and read out loud the exercise goal the client chose to work on last time]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, during the first week, you were able to… *[based on what client told you about Week 1, describe what happened]*.

☐ During the second week, you were able to… *[based on what client told you about Week 2, describe what happened]*.

☐ OK, what would you like to do this week in terms of exercise?

- *If they met their goal and were doing less than 30 minutes per day, 5 days per week, then explore if they are ready to add another 5 minutes.*
  - *If they are not comfortable advancing the goal, let them stick to the same goal, but supportively warn that you'll be discussing this again next week and remind them that the eventual goal is 30 minutes per day.*
  - *Write the goal for this week in the space provided in the Client Plan Book.*
- *If they were not able to meet their goal,*
  - *Let client stick to the same goal, but be sure to modify the plan if needed.*
- *Summarize. For example, say: OK, let me see if I got this straight. Last week, you [repeat last week's goal], and you did pretty well with that, so now you'd like to add another 5 minutes each day. That means that, this week, you'd like to [repeat this week's goal]. Did I get that right?*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ Great, I look forward to hearing how this plan worked when we talk next time!

If your client had high blood pressure and you set a goal during Session 6:
- *Go to **Homework #4: High Blood Pressure Plan** on page 92 in your manual.*
- *Once you're finished, continue with the session on page 93.*

If your client had high cholesterol and you set a goal last week:
- *Go to **Homework #5: High Cholesterol Plan** on page 92 in your manual.*
- *Once you're finished, continue with the session on page 93.*

If your client had high blood pressure and high cholesterol and you set goals last week:
- *Go to **Homework #4: High Blood Pressure Plan** on page 92 in your manual.*
- *Then, continue on to **Homework #5: High Cholesterol Plan** on the same page.*
- *Once you're finished, continue with the session on page 93.*

*If your client's blood pressure and cholesterol were under control and you didn't set goals last week, then go to **Activity 1 on page 93** in your manual.*

Homework #4: High Blood Pressure Plan (only if client is on medicine for high blood pressure or should have talked to doctor about starting treatment)

☐ OK, let's discuss the plan we made last time for your high blood pressure.

☐ Last time, you wanted to… *[go to Client Plan Book and read out loud the blood pressure plan that they chose to work on last session]*.

☐ Now, how did it go?

- *Listen supportively and praise client's effort in the past week.*
- *Encourage client to continue working with their doctor to control their blood pressure.*
- *If they are taking medication for their blood pressure, tell them that the strategies they have used to take their diabetes medication can also help them take their blood pressure medication.*
- *If needed, remind client that controlling blood pressure is important for reducing their chances of developing serious illnesses such as heart attack, stroke, dialysis, and blindness. Medications can help them live longer and stay independent by lowering their risk for such health problems.*

Notes:

Homework #5: High Cholesterol Plan (only if client is on medicine for high cholesterol or should have talked to doctor about starting treatment)

☐ OK, let's discuss the plan we made last time for your high cholesterol.

☐ Last time, you wanted to… *[go to Client Plan Book and read out loud the cholesterol plan that they chose to work on last session]*.

☐ Now, how did it go?

- *Listen supportively and praise client's effort in the past week.*
- *Encourage client to continue working with their doctor to control their cholesterol.*
- *If they are taking medication for their cholesterol, tell them that the strategies they have used to take their diabetes medication can also help them take their cholesterol medication.*
- *If needed, remind client that controlling cholesterol is important for reducing their chances of developing serious illnesses such as heart attack and stroke. Medications can help them live longer and stay independent by lowering their risk for such health problems.*

Notes:

Activity 1. What Have I Learned, and How Are the Activities Helping? ----------☐

☐ You have been doing great to take care of yourself for the past month and a half! Now that you've been tending to all three legs of the three-legged stool, how do you feel? *Listen supportively, and provide praise and encouragement.*

☐ Can you tell me some things that you have learned about how to eat healthy?

If needed, you can talk with client about the three rules of eating healthy:

1. *One and Done – this rule reminds us to avoid second helpings*
2. *Respect the Border – this rule reminds us to not overload our plate, and divide up the plate so that half of the plate is fruit and vegetables, a quarter of the plate is protein, and a quarter of the plate is starchy foods*
3. *Be Sweet On Yourself – this rule reminds us to eat less fried foods and fats, and drink fewer sugar-sweetened drinks*

☐ How about exercise? What have you learned about living a physically active life?

If needed, you can talk about the client about the three rules of physical activity:

1. *Be Smart, Exercise Your Heart – this rule reminds us that exercise has many benefits*
2. *Walk Down Your Blood Sugar – this rule reminds us that walking and other kinds of physical activity can help lower our blood sugar*
3. *Sitting is the New Smoking – this rule reminds us that it is unhealthy to sit too long, and we should try to be active throughout the day, even if it's just 2 minutes of light activity every hour*

☐ And what have you learned about your diabetes medications and what they can do for you?

If needed, you can talk about some of the basics of diabetes medications:

- *Medications are important for diabetes, but they aren't perfect – diabetes progresses, even on medications. So, even if you're doing everything right, you may eventually need a second or third medication.*
- *However, diabetes progresses much more quickly without medications. Medications, together with diet and exercise, can prevent or delay complications like stroke, dialysis, heart attack, and amputations.*
- *Side effects can be a problem, but you should discuss with your doctor before stopping. Remember that there are many types of diabetes medications available, so you should be able to get on a medication that controls your sugar and lets you feel well.*
- *Another problem with medications can be how much they cost. However, there are generic medications for diabetes that work as well as brand-name drugs and cost much less.*

☐ And can you recall what medications can do for you if you have high blood pressure or high cholesterol?

If needed, you can remind them these things about medications for blood pressure and cholesterol:

- *Like with diabetes, there are many different medications available to treat high blood pressure.*
- *So, if you have high blood pressure, you should be able to get on a medication that controls your blood pressure and lets you feel well.*
- *For high cholesterol, there is one main type of medicine, called statins. Most people taking a statin to treat their high cholesterol feel well and have no side effects.*
- *However, if you ever feel side effects with either blood pressure or cholesterol medicine, don't just stop: always reach out to your doctor first.*
- *Finally, if you are worried about the cost of these medications, there are generic medications for blood pressure and cholesterol that work as well as brand-name drugs and cost much less.*

☐ Great! It's good to keep in mind that paying attention to all three legs of the stool – eating healthy, being physically active, and taking your medications – can make a big difference in how you are able to live now as well as your life many years down the road.

☐ Now that you've been working on the three-legged stool for the past month and a half, let's think about how it's helping you. Please turn to page 21 in your Activity Book.

☐ On that page, you can see some of the ways that people have been helped by eating healthy, exercising, and taking their medications.

☐ How about you? Have you been helped in these ways? Let's go down the list together and check the boxes that apply to you.

- ☐ How about your blood sugar? Has your blood sugar gotten better?
- ☐ How about your weight?
- ☐ How about your energy?
- ☐ How about your mood?
- ☐ How about your ability to take care of your family?
- ☐ How about your ability to do your job?
- ☐ How about going out?

☐ Now, the things that we've been talking about are some of the ways that eating healthy, exercising, and taking your medications are helping you live well *now*. Take a minute and think about how taking care of the three-legged stool can help you a bit further down the line

- ☐ How about your chances of experiencing complications from your diabetes? Do you think taking care of the three-legged stool is helping you achieve that?
- ☐ How about your chances of being there for important events down the road, like *[repeat long-term goals from page 3 in the Client Plan Book]*? Do you think taking care of the three-legged stool is helping you achieve that?

Activity 2: How Can I Keep Going in the Future? Health Buddy ----------☐

☐ Thanks so much for sharing with me what you have learned about eating healthy, exercising, and taking your medications. You have done such a great job, and made a lot of progress.

☐ Now, we have one more full session, in four weeks' time. I'll be calling you in two weeks, but it'll be just a brief call to check in and see how you're doing.

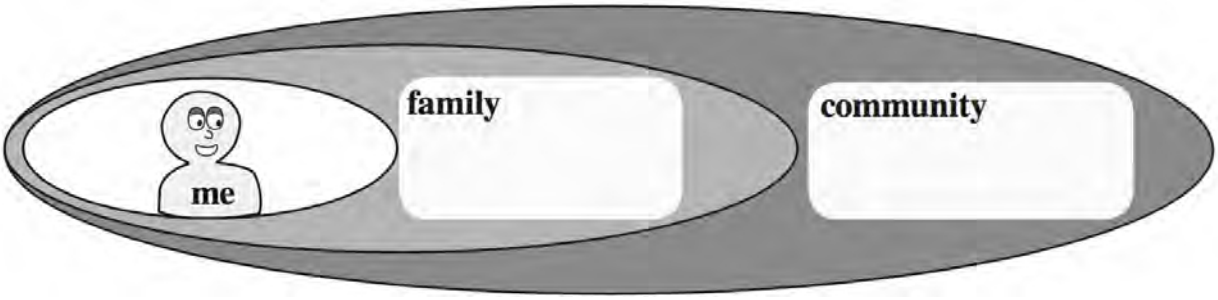
☐ So, in the next month, you'll practice setting goals and taking care of the three-legged stool, mostly on your own.

☐ I mention this, because research has shown that, once a program like this comes to an end, people may stop doing the good things that helped them during the program.

☐ This is understandable! It can be hard to keep going all on your own.

☐ One thing that may help is to have a Health Buddy, or a person in your life that can support you as you continue practicing those things to live well with diabetes.

☐ So, let's turn to page 22 in your Activity Book and look at the image.



☐ Now, think about the main person in your family that supports you. Can you tell me who this is? *Let client answer.* OK, let's write their name in the blank box labeled, "family."

☐ Now, who is the main person in your community that supports you? *Let client answer.* OK, let's write their name in the blank box labeled, "community."

☐ OK, can you tell me a little bit about them and how they support you? *Let client answer. If needed, share your experience with the main people that support you and how they help you live a full, healthy life.*

Notes:

☐ Now, who do you think could be your Health Buddy, or a person that can help you keep living well once the program ends?

- *Write down the name of potential health buddy in the box below.*

Name of potential health buddy:

- *If client has a hard time thinking of a support person in their family or their community,*
  - *Ask them to think of a person in the community that they reach out to when they need support for their diabetes. Explore if the client can find a Health Buddy with the help of this person.*
  - *If they can't think of anyone from the community who could help, offer to help the client find a person in the Living Well with Diabetes Program that could be their Health Buddy.*
    - *If the client asks for this option, call the UAB team TODAY after your session to discuss how to find a Health Buddy for this client.*

☐ Do you see the smaller box in the middle of the left-hand side? In that box, write down the name of your Health Buddy.

☐ OK, when would you like to approach them and see if they would be willing to help you out like this? It may be a good idea to do this soon, perhaps this week or next week.

When they will reach out to health buddy:

☐ Now, do you see the larger box on the bottom left-hand corner of the page? Write down when you're going to ask this person to be your Health Buddy.

☐ Wonderful! I'll ask you about how that went when we talk next time.

Homework for Next Four Weeks ----------☐

☐ Now, let's go over your homework for the next four weeks. Please turn to page 23 in your Activity Book.

☐ For the next four weeks, you'll continue your homework for each leg of the 3-legged stool.

☐ You'll carry out the plan we discussed that will help you get the most out of your medicines.

☐ You're also going to mark down whether you kept to your heathy eating goal on the days that we discussed. Your plan is to… *repeat the healthy eating goal from today written in the Client Plan Book.*

☐ So, under the column with a picture of apples, you're going to mark "Yes" if you were able to follow your healthy eating goal on the days we discussed.

☐ The goal is to eat healthy every day, so if you are able to follow your healthy eating goal on the other days, mark "Yes" on those days, too.

☐ If you do well with your goal this week, you could add another step towards healthy eating the following week. You can go back to page 6 in your Activity Book to see your healthy eating goals and see if you would like to work on another goal for the following week.

☐ You're going to monitor the number of minutes of exercise every day. You decided that you would try… *repeat the exercise goal from today written in the Client Plan Book.*

☐ So, under the column with a picture of a person walking, you're going to write down the number of minutes of exercise you were able to do on the days we discussed.

☐ If you are doing well with your goal and were able to exercise on the other days, write down the number of minutes of exercise you did on those days, too.

☐ Also, if you do well with your goal this week, you could add another step towards being physically active, like adding 5 more minutes to your plan during the following week.

☐ Do you have any questions about what to do? *Make sure client knows what to do.*

☐ Now, remember, we're not going to have a full session for four weeks, but I am going to give you a quick call in two weeks, just to check in and see how you're doing.

☐ OK, when would you like to talk in two weeks? How about in four weeks?

- *Try to make the dates as close to 14 and 28 days from now as possible.*
- *For the quick check-in call in 2 weeks, schedule it at least 14 days from today, but no more than 17 days.*
- *For the full session in 4 weeks, schedule it at least 28 days from today, but no more than 31 days.*

Next appointment date and time in 2 weeks:

Next appointment date and time in 4 weeks:

☐ Great! Please go ahead and write down both dates and times in your Activity Book on page 24. So, our appointment in two weeks is *[read aloud the date and time in 2 weeks]*, and our appointment in four weeks is *[read aloud the date and time in four weeks]*.

☐ All right, then. I will be speaking briefly with you in two weeks, and then longer in four weeks. I look forward to hearing how things went!

✓ Session 7 completed	____/____/____ *month / day / year*	____/____ *start time / end time*	____ *peer initials*

Week 10, Check-In Session 2 (Two Weeks After Session 7)

Session Goals:

- *Brief encouragement to client*
- *Brief troubleshooting if client is having difficulty with any of the homework*
- *Brief reminder to client about upcoming Session 8 in two weeks*

Before Calling the Client ----------

- *Review last session's assignment and the barriers and strategies to overcome them.*
- *Once you've reviewed this, place the call.*

Reminder!!

- *Cover and check off all of the session content.*
- *Any text in GRAY BOXES in instructions for you: don't read that text aloud to the client.*

Call Log

	Dates	Times	Notes
Attempt 1			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 2			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 3			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 4			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 5			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 6			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 7			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 8			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**

All phone numbers provided are disconnected or 8 call attempts made*	*2. Community coordinator calls back with Next Steps:*
1. Community coordinator notified (note date / time): _____ *date* _____ *time*	

Check In ----------☐

Say hello and make sure the client is still okay with speaking for about ten minutes today.

☐ So, it's been about two weeks since we talked.

☐ I know that we're not supposed to have a full session for another two weeks, but I just wanted to give you a quick call to see how you were doing.

☐ How are you? Has everything been going okay with you since we talked? *Listen supportively.*

☐ And how has it been going with your homework?

- *If client has been doing well:*
  - *Provide lots of praise, and encourage them to keep it up for the next two weeks.*
- *If client has been struggling:*
  - *Quickly review their goal from last session*
  - *Encourage client to think about what they can do to troubleshoot. Try to encourage client to come up with a solution themselves (we are working to build their confidence to overcome difficulties and set goals for themselves).*

Notes:

Remind Client of Next Session ----------☐

☐ Now, we'll have a full session *[repeat the date and time for Session 8 from page 97 in your manual]*.

☐ Between now and when we talk again, you are going to continue doing your homework, just like you did in the past two weeks.

☐ You'll keep track of your progress on page 24 of your Activity Book, just like you've been doing. Do you have any questions? *Make sure client understands what to do.*

☐ All right, then! I look forward to hearing how things went when we talk in two weeks!

✓ Check In completed	____ / ____ / ____ *month / day / year*	____ / ____ *start time / end time*	____ *peer initials*

Week 12, Session 8: "Practice and Planning for the Future – Part 2"

Session Goals:

- *Brief review of last week's session*
- *Review homework*
- *Discuss how the Health Buddy can help the client keep going when the program ends*

Before Calling the Client ----------

- *Review last session's assignment and the barriers and strategies to overcome them.*
- *Once you've reviewed this, place the call.*

Reminder!!

- *Cover and check off all of the session content.*
- *Any text in GRAY BOXES is instructions for you: don't read that text aloud to the client.*

Call Log

	Dates	Times	Notes
Attempt 1			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 2			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 3			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 4			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 5			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 6			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 7			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 8			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**

All phone numbers provided are disconnected or 8 call attempts made*	*2. Community coordinator calls back with Next Steps:*
1. Community coordinator notified (note date / time): _____ *date* _____ *time*	

Greeting ----------☐

Say hello and make sure the client is still okay with speaking for about a half hour to forty minutes today.

☐ Great, do you have your Activity Book handy?
If not, let them get the Activity Book before going on.

☐ Please turn to page 25. Today, we'll talk about how your homework went, and then we'll talk about some things that you can do to help you keep going when the program ends.

☐ After today's session, we're going to have three more scheduled calls.

☐ Those will be calls lasting about thirty minutes, where I will check in on you and see how you're doing with the three-legged stool. Our next call will be in four weeks.

☐ Do you have any questions about that? *Let client ask questions.* Great, let's get started!

Review Last Session ----------☐

☐ First, let's review what we talked about last time. Please stay on page 25 in your Activity Book.

☐ We talked about what we have learned from this program to take care of the three-legged stool so that we can live well with diabetes.

☐ We also talked about how healthy eating, exercising, and taking our medications are helping us live well now and live longer so that we can reach our long-term goals, like *[repeat long-term goals on page 3 in the Client Plan Book]*.

☐ Does that sound right? *Let client answer.* Did you have any questions? *Let client answer.*

Review Homework For Last Four Weeks ----------☐

☐ OK, now, I'd like to go over your homework from the past four weeks and then talk about your homework for the next four weeks.

☐ First, let's discuss how you did on your homework during the past four weeks. Can you turn to page 23 in your Activity Book? *Let client get to the page.*

☐ Were you able to complete the homework?

Note: if the client has not done some of the homework 2 sessions in a row, talk about what is making it hard to monitor. Let them know that since this is a research project, the investigators may want to help the person to succeed. Let them know that someone from the research team will be in touch.

- *Call the research team within 24 hours and let them know what is happening.*
- *UAB staff will brief you on the conversation and the plan so that you can reinforce it next week.*

Client has not done homework for 2 sessions in row	*2. Community coordinator calls back with next steps:*
1. Community coordinator notified (note date / time): _____ _____ *date* *time*	

Homework #1: Medications

☐ OK, let's start with your medicines and how you did with them that first week.

☐ Let's start with Day 1. Did you take all of your diabetes medication on Day 1?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Now, let's talk about how you did with your medicines during the second week. On Day 1 of the second week, did you take all of your diabetes medication?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Let's continue with the third week. On Day 1 of the third week, did you take all of your diabetes medication?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Finally, let's talk about how you did with your diabetes medication during the fourth week. On Day 1 of the fourth week, did you take all of your diabetes medication?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

If your client 1) took their diabetes medication every day as directed in the past four weeks and 2) has successfully overcome all of the diabetes medication barriers identified at the beginning of the program:

- *Praise profusely! Tell them to keep up the great work by continuing to take their medications every day as directed.*
- *Then, **go to page 106** and continue with **Homework #2, Healthy Eating**.*

If your client was not able to take their diabetes medication every day as directed in the past four weeks:

- *Stay on **page 104** in your manual and continue with setting a diabetes medication goal.*
- *Then, go on with the rest of the session.*

If your client took their diabetes medication every day as directed in the past four weeks, but still has diabetes medication barriers that haven't been addressed:

- *Check page 8 in the Client Plan Book and see what issues are remaining. Then, remind client about these remaining issues and ask which one they would like to work on next.*
- *Go to **page 105** in your manual and continue with setting a diabetes medication goal.*
- *Then, go on with the rest of the session.*

☐ Now, I'd like to follow up on the plan that we made at our last session to help you get the most out of your diabetes medications by taking them every day.

☐ Last time we talked, the issue you wanted to work on was… *[go to Client Plan Book and read out loud the diabetes medication issue that they chose to work on last time]*.

☐ To overcome this issue, you decided to… *[read out loud the medication-taking plan from last time]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

Now, how did it go? *Listen supportively and take notes in the box below. Assess how well this worked. If it did not work well, talk about why not. If it did go well, praise them.*

Notes:

☐ OK, so what would you like to do over the next four weeks to help you get the most out of your medications?

- ***If their plan worked and last session's issue is resolved, encourage them to tackle a new issue this week.*** *If you try hard and they don't want to tackle another issue and they took their medicine each day, try this:*
  - *Go back to the Client Plan Book.*
  - *If there are remaining issues related to side effects or cost, then help the client make a plan to address them this week.*
  - *If there are no remaining issues related to side effects or cost, look at the list of statements that are marked "Very Often" (or "Often" if there are no "Very Often" statements to address, and "Sometimes" if there are no "Often" statements to address).*
    - *Help them decide which new goal they would like to add for the coming week.*
  - *Summarize to confirm their new goal. For example, you could say:*
    "OK, let me see if I got this straight. Last week, you … [repeat <u>last</u> week's goal]. You did well with that, so this week, you'll … [repeat <u>this</u> week's goal]. Did I get that right?"

- ***If they were <u>not</u> able to meet their medication goal, then let them stick to the same goal.***
  - *Be supportive, and let them know you'll revisit the goal next week to see how it went this time.*
  - *Strategize what they will do differently this week to succeed. Make sure it is a SMART goal.*

- ***Record this week's strategy in the Client Plan Book.***
  - *If the strategy addresses side effects/and or cost, record this week's strategy on the page, "Plan for Diabetes Medication Side Effects and/or Cost," in the Client Plan Book.*
  - *If the strategy addresses other barriers besides side effects or cost, then record this week's strategy on the page, "Plan for Other Diabetes Medication Barriers," in the Client Plan Book.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ OK, let's review that. It looks like you'll… *repeat the new medication goal. Then, review potential barriers and how client will go around those barriers. Let client confirm.*

☐ This is a great plan! I look forward to hearing how this plan worked when we talk next time!

Homework #2: Healthy Eating

☐ OK, let's talk about how your healthy eating went during the first week. How did it go on Day 1? *For each day, check "yes" or "no" for the Healthy Eating column.*

Week 1

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Now, during the second week, were you able to take another step to eat healthier?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - ☐ *Did not evaluate goal after 1st week*
  - ☐ *Evaluated goal after 1st week, did not increase goal for 2nd week*
  - ☐ *Evaluated goal after 1st week, increased goal for 2nd week*

New healthy eating goal for 2nd week, if client increased goal:

☐ OK, let's take a look at how you did with healthy eating during the second week. How did it go on Day 1 of the second week? *For each day, check "yes" or "no" for the Healthy Eating column.*

Week 2

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Now, during the third week, were you able to take another step to eat healthier?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - ☐ *Did not evaluate goal after 2nd week*
  - ☐ *Evaluated goal after 2nd week, did not increase goal for 3rd week*
  - ☐ *Evaluated goal after 2nd week, increased goal for 3rd week*

New healthy eating goal for 3rd week, if client increased goal:

☐ OK, let's talk about how your healthy eating went during the third week. How did it go on Day 1? *For each day, check "yes" or "no" for the Healthy Eating column.*

Week 3

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Now, during the fourth week, were you able to take another step to eat healthier?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - ☐ *Did not evaluate goal after 3rd week*
  - ☐ *Evaluated goal after 3rd week, did not increase goal for 4th week*
  - ☐ *Evaluated goal after 3rd week, increased goal for 4th week*

New healthy eating goal for 4th week, if client increased goal:

☐ OK, let's take a look at how you did with healthy eating during the fourth week. How did it go on Day 1? *For each day, check "yes" or "no" for the Healthy Eating column.*

Week 4

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Now, the last time we made a plan to help you eat healthy every day, you planned to… *[go to Client Plan Book and read out loud the healthy eating goal the client chose to work on last time]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, during the first week, you were able to… *[based on what client told you about Week 1, describe what happened]*.

☐ During the second week, you were able to… *[based on what client told you about Week 2, describe what happened]*.

☐ During the third week, you were able to… *[based on what client told you about Week 3, describe what happened]*.

☐ During the fourth week, you were able to… *[based on what client told you about Week 4, describe what happened]*.

☐ OK, what would you like to do this week in terms of healthy eating?

- *If they met their healthy eating goal,*
  - *Explore if they are ready to add another goal this week. Ask them to turn to page 6 in their Activity Book and look at the chart. Help them decide which new goal they would like to add for the coming week.*
  - *Go to the Client Plan Book and write down details in the space provided. Be sure to include all the information necessary for the goal.*
  - *Summarize to confirm their new goal. For example, you could say:*

    "OK, let me see if I got this straight. Last week, you … [repeat last week's goal]. You did well with that, so now you'd like to add another healthy eating goal. So, this week, you'll … [repeat this week's goal]. Did I get that right?"
- *If they were not able to meet their healthy eating goal,*
  - *Let client stick to the same eating goal, but be sure to modify the plan if needed.*
  - *Go to the Client Plan Book and write down details in the space provided. Be sure to include all the information necessary for the goal.*
  - *Be supportive, but remind client that you'll revisit the goal next week to see how it went this time.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ Great, I look forward to hearing how this plan worked when we talk next time!

Homework #3: Physical Activity

☐ Now, let's talk about how your exercise went during the first week. How much exercise were you able to do on Day 1? *For each day, write down number of minutes.*

Week 1

	Exercise minutes
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, during the second week, were you able to take another step to become more physically active?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - *Did not evaluate goal after 1st week*
  - *Evaluated goal after 1st week, did not increase goal for 2nd week*
  - *Evaluated goal after 1st week, increased goal for 2nd week*

Notes and new exercise goal for 2nd week, if client increased goal:

☐ OK, let's take a look at how you did with exercise during the second week. How did it go on Day 1 of the second week? *For each day, write down number of minutes.*

Week 2

	Exercise minutes
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, during the third week, were you able to take another step to become more physically active?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - *Did not evaluate goal after 2nd week*
  - *Evaluated goal after 2nd week, did not increase goal for 3rd week*
  - *Evaluated goal after 2nd week, increased goal for 3rd week*

Notes and new exercise goal for 3rd week, if client increased goal:

☐ OK, let's take a look at how you did with exercise during the third week. How did it go on Day 1 of the third week? *For each day, write down number of minutes.*

Week 3

	Exercise minutes
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, during the fourth week, were you able to take another step to become more physically active

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - *Did not evaluate goal after 3rd week*
  - *Evaluated goal after 3rd week, did not increase goal for 4th week*
  - *Evaluated goal after 3rd week, increased goal for 4th week*

Notes and new exercise goal for 4th week, if client increased goal:

☐ OK, let's take a look at how you did with exercise during the fourth week. How did it go on Day 1 of the fourth week? *For each day, write down number of minutes.*

Week 4

	 ***Exercise minutes***
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, the last time we made a plan to help you exercise every day, you planned to… *[go to Client Plan Book and read out loud the exercise goal the client chose to work on last time]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, during the first week, you were able to… *[based on what client told you about Week 1, describe what happened]*.

☐ During the second week, you were able to… *[based on what client told you about Week 2, describe what happened]*.

☐ During the third week, you were able to… *[based on what client told you about Week 3, describe what happened]*.

☐ During the fourth week, you were able to… *[based on what client told you about Week 4, describe what happened]*.

☐ OK, what would you like to do this week in terms of exercise?

- *If they met their goal and were doing less than 30 minutes per day, 5 days per week, then explore if they are ready to add another 5 minutes.*
  - *If they are not comfortable advancing the goal, let them stick to the same goal, but supportively warn that you'll be discussing this again next week and remind them that the eventual goal is 30 minutes per day.*
  - *Write the goal for this week in the space provided in the Client Plan Book.*
- *If they were not able to meet their goal,*
  - *Let client stick to the same goal, but be sure to modify the plan if needed.*
- *Summarize. For example, say: OK, let me see if I got this straight. Last week, you [repeat last week's goal], and you did pretty well with that, so now you'd like to add another 5 minutes each day. That means that, this week, you'd like to [repeat this week's goal]. Did I get that right?*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ Great, I look forward to hearing how this plan worked when we talk next time!

If you and your client talked about high blood pressure during Session 7:
- *Go to **Homework #4: High Blood Pressure** on page 112 in your manual.*
- *Once you're finished, continue with the session on page 113.*

If you and your client talked about high cholesterol during Session 7:
- *Go to **Homework #5: High Cholesterol** on page 112 in your manual.*
- *Once you're finished, continue with the session on page 113.*

If you and your client talked about high blood pressure and high cholesterol during Session 7:
- *Go to **Homework #4: High Blood Pressure** on page 112 in your manual.*
- *Then, continue on to **Homework #5: High Cholesterol** on the same page.*
- *Once you're finished, continue with the session on page 113.*

*If your client's blood pressure and cholesterol were under control and you didn't set goals last week, then go to **Activity 1 on page 113** in your manual.*

Homework #4: High Blood Pressure (only if client is on medicine for high blood pressure or should have talked to doctor about starting treatment)

☐ Now, I'd like to follow up on the talk we had last time about your high blood pressure.

☐ Last time, you wanted to… *[review your notes from page 92 in your manual]*.

☐ Now, how did it go?

- *Listen supportively and praise client's effort in the past week.*
- *Encourage client to continue working with their doctor to control their blood pressure.*
- *If they are taking medication for their blood pressure, tell them that the strategies they have used to take their diabetes medication can also help them take their blood pressure medication.*
- *If needed, remind client that controlling blood pressure is important for reducing their chances of developing serious illnesses such as heart attack, stroke, dialysis, and blindness. Medications can help them live longer and stay independent by lowering their risk for such health problems.*

Notes:

Homework #5: High Cholesterol Plan (only if client is on medicine for high cholesterol or should have talked to doctor about starting treatment)

☐ Now, I'd like to follow up on the talk we had last time about your high cholesterol.

☐ Last time, you wanted to… *[review your notes from page 92 in your manual]*.

☐ Now, how did it go?

- *Listen supportively and praise client's effort in the past week.*
- *Encourage client to continue working with their doctor to control their cholesterol.*
- *If they are taking medication for their cholesterol, tell them that the strategies they have used to take their diabetes medication can also help them take their cholesterol medication.*
- *If needed, remind client that controlling cholesterol is important for reducing their chances of developing serious illnesses such as heart attack and stroke. Medications can help them live longer and stay independent by lowering their risk for such health problems.*

Notes:

Activity 1. Planning for the Future with Your Health Buddy ----------☐

☐ You've spent another month doing a great job to take care of yourself! As you continue to work on eating healthy, being physically active, and taking your medications, how do you feel? *Listen supportively, and provide praise and encouragement.*

☐ Over the past three months, you have learned about the importance of the three-legged stool for living well with diabetes. Healthy eating, exercise, and medications will help you live well *now* so that you can do what you need to do, day to day.

☐ Doing these things also will help you *stay* well so that you can accomplish your long-term goals and be there for important events in the future.

☐ You learned how to eat healthy, get exercise, and take medications in ways that work for you and your life, and you kept track of how you're able to do these things so that you can see the progress that you're making.

☐ Now, our hope is that you can keep going once the program ends. But, research has shown that, once a program like this ends, it can be hard for people to keep doing the good things that helped them during the program.

☐ This is understandable! It can be hard to keep going all on your own.

☐ Now, during our last session, we talked about a Health Buddy, or a person in your life that can help you to keep living well once the program ends.

☐ Let's talk about how things went with your Health Buddy. So the last time we talked, you were going to contact [*name of Health Buddy on page 96 in your manual*] and talk to them about being your Health Buddy. How did that go?

- *If they succeeded in getting a Health Buddy, discuss how that went.*
- *If they did not succeed in getting a Health Buddy, ask them if they want to try the same person again or if they want to try another person. Write down what they decide in the box below:*

Notes:

- *If they cannot think of a person to be their Health Buddy, contact UAB staff or your community coordinator at the end of today's session.*
- *Note:*
  - *Sometimes a client may want to have more than one Health Buddy (for example, one Health Buddy to help them be physically active, another Health Buddy to go shopping for healthy foods and preparing healthy meals, or another Health Buddy to remind each other to refill medications or accompany each other to their doctor's appointment).*
  - *Encourage your client to have one main Health Buddy.*
  - *However, if they feel like they would be helped more by having more than one Health Buddy, that is fine. Be sure to write that down in the box above.*

☐ As I mentioned before, it can be very helpful to have a Health Buddy to help you continue living well after the program ends.

☐ Now, can you think of some things you could do with your Health Buddy to help you keep taking care of the three-legged stool?

- *If needed, use your motivational interviewing skills to help them figure out how they can engage the Health Buddy to help them with eating healthy, being physically active, and taking medications.*

- *Here are some suggestions for how the Health Buddy can help:*
  - *Someone to talk to when feeling stressed, or feeling down or blue.*
  - *Someone to exercise with.*
  - *Someone to help you eat healthy (for example, go shopping for healthy foods, swapping healthy recipes, preparing healthy meals, making healthy choices when you go out to eat or when you're attending a party)*
  - *Someone to help you to take your medications (for example, getting refills on time, accompanying you to doctor's visits, talking to the pharmacist with you)*

- *It's also good to remind your client that they will be helping their Health Buddy live well, too!*
  - *Your client will help their Health Buddy live well now, so that they can do what they need to do, day to day.*
  - *Your client also will help their Health Buddy to stay well so that they can accomplish their long-term goals and be there for important events in the future.*

Homework for Next Four Weeks ----------☐

☐ Great! We're almost done. The only thing left to do is go over your homework for the next four weeks. Please turn to page 26 in your Activity Book.

☐ For the next four weeks, you'll continue your homework for each leg of the 3-legged stool.

☐ You'll carry out the plan we discussed that will help you get the most out of your medicines.

☐ You're also going to mark down whether you kept to your heathy eating goal on the days that we discussed. Your plan is to… *repeat the healthy eating goal from today written in the Client Plan Book.*

☐ So, under the column with a picture of apples, you're going to mark "Yes" if you were able to follow your healthy eating goal on the days we discussed.

☐ The goal is to eat healthy every day, so if you are able to follow your healthy eating goal on the other days, mark "Yes" on those days, too.

☐ If you do well with your goal this week, you could add another step towards healthy eating the following week. You can go back to page 6 in your Activity Book to see your healthy eating goals and see if you would like to work on another goal for the following week.

☐ You're going to monitor the number of minutes of exercise every day. You decided that you would try… *repeat the exercise goal from today written in the Client Plan Book.*

☐ So, under the column with a picture of a person walking, you're going to write down the number of minutes of exercise you were able to do on the days we discussed.

☐ If you are doing well with your goal and were able to exercise on the other days, write down the number of minutes of exercise you did on those days, too.

☐ Also, if you do well with your goal this week, you could add another step towards being physically active, like adding 5 more minutes to your plan during the following week.

☐ Do you have any questions about what to do? *Make sure client knows what to do.*

☐ OK, remember that we're not going to talk again for four weeks. When we do talk, we'll be talking for thirty minutes or so to make sure everything is going well with your homework.

☐ Now, if you are having trouble with your homework, we'll talk until we figure out what we can do to help you get back on track. Do you have any questions? *Let client answer.*

☐ OK, when would you like to talk in four weeks?

• *Try to make the dates as close to 28 days from now as possible.* • *Schedule it at least 28 days from today, but no more than 31 days.*	***Next appointment date and time in 4 weeks:***

☐ Great! Please go ahead and write down the date and time in your Activity Book on page 27.

☐ I will be speaking with you in four weeks. I look forward to hearing how things went!

✓ Session 8 completed	_____ / _____ / _____ *month* *day* *year*	_____ / _____ *start time* *end time*	_____ *peer initials*

Week 16, Session 9 (Checking In, Four Weeks After Session 8)

Session Goals:

- *Review homework from past four weeks*
- *Brief troubleshooting if client is having difficulty with any of the homework*
- *Schedule next session in four weeks*

Before Calling the Client ----------

- *Review last session's assignment and the barriers and strategies to overcome them.*
- *Once you've reviewed this, place the call.*

Reminder!!

- *Cover and check off all of the session content.*
- *Any text in GRAY BOXES is instructions for you: don't read that text aloud to the client.*

Call Log

	Dates	Times	Notes
Attempt 1			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 2			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 3			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 4			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 5			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 6			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 7			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 8			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**

All phone numbers provided are disconnected or 8 call attempts made*	*2. Community coordinator calls back with Next Steps:*
1. Community coordinator notified (note date / time): _____ *date* _____ *time*	

Check In ----------☐

☐ So, it's been about four weeks since we talked, and I just wanted to give you a call to see how you were doing and how it was going with your homework.

Say hello and make sure the client is still okay with speaking for about thirty minutes today.

☐ Great, do you have your Activity Book handy? *If not, let them get the Activity Book before going on.*

☐ Today, we'll go over your homework for the past four weeks to see how you've been doing with that.

☐ Then, we'll schedule our next call, which will be a check-in call, just like the one we're having today. Our next call will be in four weeks.

☐ Do you have any questions about that? *Let client ask questions.* Great, let's get started!

Review Homework For Last Four Weeks ----------☐

☐ OK, now, I'd like to go over your homework from the past four weeks and then talk about your homework for the next four weeks.

☐ First, let's discuss how you did on your homework during the past four weeks. Can you turn to page 26 in your Activity Book? *Let client get to the page.*

☐ Were you able to complete the homework?

Note: if the client has not done some of the homework 2 sessions in a row, talk about what is making it hard to monitor. Let them know that since this is a research project, the investigators may want to help the person to succeed. Let them know that someone from the research team will be in touch.

- *Call the research team within 24 hours and let them know what is happening.*
- *UAB staff will brief you on the conversation and the plan so that you can reinforce it next week.*

Client has not done homework for 2 sessions in row	*2. Community coordinator calls back with next steps:*
1. Community coordinator notified (note date / time): _____ _____ *date* *time*	

Homework #1: Medications

☐ OK, let's start with your medicines and how you did with them that first week.

☐ Let's start with Day 1. Did you take all of your diabetes medication on Day 1?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Now, let's talk about how you did with your medicines during the second week. On Day 1 of the second week, did you take all of your diabetes medication?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Let's continue with the third week. On Day 1 of the third week, did you take all of your diabetes medication?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Finally, let's talk about how you did with your diabetes medication during the fourth week. On Day 1 of the fourth week, did you take all of your diabetes medication?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

If your client 1) took their diabetes medication every day as directed in the past four weeks and 2) has successfully overcome all of the diabetes medication barriers identified at the beginning of the program:

- *Praise profusely! Tell them to keep up the great work by continuing to take their medications every day as directed.*
- *Then, **go to page 122** and continue with **Homework #2, Healthy Eating**.*

If your client was not able to take their diabetes medication every day as directed in the past four weeks:

- *Stay on to **page 120** in your manual and continue with setting a diabetes medication goal.*
- *Then, go on with the rest of the session.*

If your client took their diabetes medication every day as directed in the past four weeks, but still has diabetes medication barriers that haven't been addressed:

- *Go to **page 121** in your manual and continue with setting a diabetes medication goal.*
- *Then, go on with the rest of the session.*

☐ Now, I'd like to follow up on the plan that we made at our last session to help you get the most out of your diabetes medications by taking them every day.

☐ Last time we talked, the issue you wanted to work on was… *[go to Client Plan Book and read out loud the diabetes medication issue that they chose to work on last time]*.

☐ To overcome this issue, you decided to… *[read out loud the medication-taking plan from last time]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, how did it go? *Listen supportively and take notes in the box below. Assess how well this worked. If it did not work well, talk about why not. If it did go well, praise them.*

Notes:

☐ OK, so what would you like to do over the next four weeks to help you get the most out of your medications?

- ***If their plan worked and last session's issue is resolved, encourage them to tackle a new issue this week.*** *If you try hard and they don't want to tackle another issue and they took their medicine each day, try this:*
  - *Go back to the Client Plan Book.*
  - *If there are remaining issues related to side effects or cost, then help the client make a plan to address them this week.*
  - *If there are no remaining issues related to side effects or cost, look at the list of statements that are marked "Very Often" (or "Often" if there are no "Very Often" statements to address, and "Sometimes" if there are no "Often" statements to address).*
    - *Help them decide which new goal they would like to add for the coming week.*
  - *Summarize to confirm their new goal. For example, you could say:*
    "OK, let me see if I got this straight. Last week, you … [repeat <u>last</u> week's goal]. You did well with that, so this week, you'll … [repeat <u>this</u> week's goal]. Did I get that right?"

- ***If they were <u>not</u> able to meet their medication goal, then let them stick to the same goal.***
  - *Be supportive, and let them know you'll revisit the goal next week to see how it went this time.*
  - *Strategize what they will do differently this week to succeed. Make sure it is a SMART goal.*

- ***Record this week's strategy in the Client Plan Book.***
  - *If the strategy addresses side effects/and or cost, record this week's strategy on the page, "Plan for Diabetes Medication Side Effects and/or Cost," in the Client Plan Book.*
  - *If the strategy addresses other barriers besides side effects or cost, then record this week's strategy on the page, "Client Plan for Other Diabetes Medication Barriers," in the Plan Book.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ OK, let's review that. It looks like you'll… *repeat the new medication goal. Then, review potential barriers and how client will go around those barriers. Let client confirm.*

☐ This is a great plan! I look forward to hearing how this plan worked when we talk next time!

Homework #2: Healthy Eating

☐ OK, let's talk about how your healthy eating went during the first week. How did it go on Day 1? *For each day, check "yes" or "no" for the Healthy Eating column.*

Week 1

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Now, during the second week, were you able to take another step to eat healthier?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - ☐ *Did not evaluate goal after 1st week*
  - ☐ *Evaluated goal after 1st week, did not increase goal for 2nd week*
  - ☐ *Evaluated goal after 1st week, increased goal for 2nd week*

New healthy eating goal for 2nd week, if client increased goal:

☐ OK, let's take a look at how you did with healthy eating during the second week. How did it go on Day 1 of the second week? *For each day, check "yes" or "no" for the Healthy Eating column.*

Week 2

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Now, during the third week, were you able to take another step to eat healthier?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - ☐ *Did not evaluate goal after 2nd week*
  - ☐ *Evaluated goal after 2nd week, did not increase goal for 3rd week*
  - ☐ *Evaluated goal after 2nd week, increased goal for 3rd week*

New healthy eating goal for 3rd week, if client increased goal:

☐ OK, let's talk about how your healthy eating went during the third week. How did it go on Day 1? *For each day, check "yes" or "no" for the Healthy Eating column.*

Week 3

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Now, during the fourth week, were you able to take another step to eat healthier?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - ☐ *Did not evaluate goal after 3rd week*
  - ☐ *Evaluated goal after 3rd week, did not increase goal for 4th week*
  - ☐ *Evaluated goal after 3rd week, increased goal for 4th week*

New healthy eating goal for 4th week, if client increased goal:

☐ OK, let's take a look at how you did with healthy eating during the fourth week. How did it go on Day 1? *For each day, check "yes" or "no" for the Healthy Eating column.*

Week 4

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Now, the last time we made a plan to help you eat healthy every day, you planned to… *[go to Client Plan Book and read out loud the healthy eating goal the client chose to work on last time]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, during the first week, you were able to… *[based on what client told you about Week 1, describe what happened]*.

☐ During the second week, you were able to… *[based on what client told you about Week 2, describe what happened]*.

☐ During the third week, you were able to… *[based on what client told you about Week 3, describe what happened]*.

☐ During the fourth week, you were able to… *[based on what client told you about Week 4, describe what happened]*.

☐ OK, what would you like to do this week in terms of healthy eating?

- *If they met their healthy eating goal,*
  - *Explore if they are ready to add another goal this week. Ask them to turn to page 6 in their Activity Book and look at the chart. Help them decide which new goal they would like to add for the coming week.*
  - *Go to the Client Plan Book and write down details in the space provided. Be sure to include all the information necessary for the goal.*
  - *Summarize to confirm their new goal. For example, you could say:*

    "OK, let me see if I got this straight. Last week, you … [repeat last week's goal]. You did well with that, so now you'd like to add another healthy eating goal. So, this week, you'll … [repeat this week's goal]. Did I get that right?"
- *If they were not able to meet their healthy eating goal,*
  - *Let client stick to the same eating goal, but be sure to modify the plan if needed.*
  - *Go to the Client Plan Book and write down details in the space provided. Be sure to include all the information necessary for the goal.*
  - *Be supportive, but remind client that you'll revisit the goal next week to see how it went this time.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ Great, I look forward to hearing how this plan worked when we talk next time!

Homework #3: Physical Activity

☐ Now, let's talk about how your exercise went during the first week. How much exercise were you able to do on Day 1? *For each day, write down number of minutes.*

Week 1

	Exercise minutes
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, during the second week, were you able to take another step to become more physically active?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - *Did not evaluate goal after 1st week*
  - *Evaluated goal after 1st week, did not increase goal for 2nd week*
  - *Evaluated goal after 1st week, increased goal for 2nd week*

Notes and new exercise goal for 2nd week, if client increased goal:

☐ OK, let's take a look at how you did with exercise during the second week. How did it go on Day 1 of the second week? *For each day, write down number of minutes.*

Week 2

	Exercise minutes
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, during the third week, were you able to take another step to become more physically active?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - *Did not evaluate goal after 2nd week*
  - *Evaluated goal after 2nd week, did not increase goal for 3rd week*
  - *Evaluated goal after 2nd week, increased goal for 3rd week*

Notes and new exercise goal for 3rd week, if client increased goal:

☐ OK, let's take a look at how you did with exercise during the third week. How did it go on Day 1 of the third week? *For each day, write down number of minutes.*

Week 3

	Exercise minutes
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, during the fourth week, were you able to take another step to become more physically active

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - *Did not evaluate goal after 3rd week*
  - *Evaluated goal after 3rd week, did not increase goal for 4th week*
  - *Evaluated goal after 3rd week, increased goal for 4th week*

Notes and new exercise goal for 4th week, if client increased goal:

☐ OK, let's take a look at how you did with exercise during the fourth week. How did it go on Day 1 of the fourth week? *For each day, write down number of minutes.*

Week 4

	 ***Exercise minutes***
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, the last time we made a plan to help you exercise every day, you planned to… *[go to Client Plan Book and read out loud the exercise goal the client chose to work on last time]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, during the first week, you were able to… *[based on what client told you about Week 1, describe what happened]*.

☐ During the second week, you were able to… *[based on what client told you about Week 2, describe what happened]*.

☐ During the third week, you were able to… *[based on what client told you about Week 3, describe what happened]*.

☐ During the fourth week, you were able to… *[based on what client told you about Week 4, describe what happened]*.

☐ OK, what would you like to do this week in terms of exercise?

- *If they met their goal and were doing less than 30 minutes per day, 5 days per week, then explore if they are ready to add another 5 minutes.*
  - *If they are not comfortable advancing the goal, let them stick to the same goal, but supportively warn that you'll be discussing this again next week and remind them that the eventual goal is 30 minutes per day.*
  - *Write the goal for this week in the space provided in the Client Plan Book.*
- *If they were not able to meet their goal,*
  - *Let client stick to the same goal, but be sure to modify the plan if needed.*
- *Summarize. For example, say: OK, let me see if I got this straight. Last week, you [repeat last week's goal], and you did pretty well with that, so now you'd like to add another 5 minutes each day. That means that, this week, you'd like to [repeat this week's goal]. Did I get that right?*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ Great, I look forward to hearing how this plan worked when we talk next time!

If you and your client talked about high blood pressure during the previous session
- *Go to **Homework #4: High Blood Pressure** on page 128 in your manual.*
- *Once you're finished, continue with the session on page 129.*

If you and your client talked about high cholesterol during the previous session:
- *Go to **Homework #5: High Cholesterol** on page 128 in your manual.*
- *Once you're finished, continue with the session on page 129.*

If you and your client talked about high blood pressure and high cholesterol during the previous session:
- *Go to **Homework #4: High Blood Pressure** on page 128 in your manual.*
- *Then, continue on to **Homework #5: High Cholesterol** on the same page.*
- *Once you're finished, continue with the session on page 129.*

*If your client's blood pressure and cholesterol were under control and you didn't set goals during the previous session, then continue with the session on **page 129** in your manual.*

Homework #4: High Blood Pressure (only if client is on medicine for high blood pressure or should have talked to doctor about starting treatment)

☐ Now, I'd like to follow up on the talk we had last time about your high blood pressure.

☐ Last time, you wanted to… *[review your notes from page 112 in your manual]*.

☐ Now, how did it go?

- *Listen supportively and praise client's effort in the past week.*
- *Encourage client to continue working with their doctor to control their blood pressure.*
- *If they are taking medication for their blood pressure, tell them that the strategies they have used to take their diabetes medication can also help them take their blood pressure medication.*
- *If needed, remind client that controlling blood pressure is important for reducing their chances of developing serious illnesses such as heart attack, stroke, dialysis, and blindness. Medications can help them live longer and stay independent by lowering their risk for such health problems.*

Notes:

Homework #5: High Cholesterol Plan (only if client is on medicine for high cholesterol or should have talked to doctor about starting treatment)

☐ Now, I'd like to follow up on the talk we had last time about your high cholesterol.

☐ Last time, you wanted to… *[review your notes from page 112 in your manual]*.

☐ Now, how did it go?

- *Listen supportively and praise client's effort in the past week.*
- *Encourage client to continue working with their doctor to control their cholesterol.*
- *If they are taking medication for their cholesterol, tell them that the strategies they have used to take their diabetes medication can also help them take their cholesterol medication.*
- *If needed, remind client that controlling cholesterol is important for reducing their chances of developing serious illnesses such as heart attack and stroke. Medications can help them live longer and stay independent by lowering their risk for such health problems.*

Notes:

Schedule Next Check-In Session ----------☐

☐ You have been doing a wonderful job with the three-legged stool! And keeping track of your progress is very helpful for seeing how well you're doing with this.

☐ OK, our next session will be four weeks from now. It will be just like today's call, where we'll talk for about a half hour to see how you're doing with your homework.

☐ If you can turn to page 28 in your Activity Book, you'll see where you'll monitor your homework for the next four weeks. Do you have any questions about what to do?

☐ Great! Now, when would you like to talk in four weeks?

• *Try to make the dates as close to 28 days from now as possible.* • *Schedule it at least 28 days from today, but no more than 31 days.*	***Next appointment date and time in 4 weeks:***

☐ Great! Please go ahead and write down the date and time in your Activity Book on page 29.

☐ I will be speaking with you in four weeks. I look forward to hearing how things went!

✓ Check In completed	_____ / _____ / _____	_____ / _____	_____
	month *day* *year*	*start time* *end time*	*peer initials*

Week 20, Session 10 (Checking In, Four Weeks After Session 9)

Session Goals:

- *Review homework from past four weeks*
- *Brief troubleshooting if client is having difficulty with any of the homework*
- *Schedule next session in four weeks*

Before Calling the Client ----------

- *Review last session's assignment and the barriers and strategies to overcome them.*
- *Once you've reviewed this, place the call.*

Reminder!!

- *Cover and check off all of the session content.*
- *Any text in GRAY BOXES is instructions for you: don't read that text aloud to the client.*

Call Log

	Dates	Times	Notes
Attempt 1			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 2			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 3			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 4			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 5			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 6			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 7			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 8			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**

All phone numbers provided are disconnected or 8 call attempts made*	*2. Community coordinator calls back with Next Steps:*
1. Community coordinator notified (note date / time): _____ *date* _____ *time*	

Check In ----------☐

☐ So, it's been about four weeks since we talked, and I just wanted to give you a call to see how you were doing and how it was going with your homework.

Say hello and make sure the client is still okay with speaking for about thirty minutes today.

☐ Great, do you have your Activity Book handy? *If not, let them get the Activity Book before going on.*

☐ Today, we'll go over your homework for the past four weeks to see how you've been doing with that.

☐ Then, we'll schedule our next call, which will be a check-in call, just like the one we're having today. Our next call will be in four weeks.

☐ Do you have any questions about that? *Let client ask questions.* Great, let's get started!

Review Homework For Last Four Weeks ----------☐

☐ OK, now, I'd like to go over your homework from the past four weeks and then talk about your homework for the next four weeks.

☐ First, let's discuss how you did on your homework during the past four weeks. Can you turn to page 28 in your Activity Book? *Let client get to the page.*

☐ Were you able to complete the homework?

Note: if the client has not done some of the homework 2 sessions in a row, talk about what is making it hard to monitor. Let them know that since this is a research project, the investigators may want to help the person to succeed. Let them know that someone from the research team will be in touch.

- *Call the research team within 24 hours and let them know what is happening.*
- *UAB staff will brief you on the conversation and the plan so that you can reinforce it next week.*

Client has not done homework for 2 sessions in row	*2. Community coordinator calls back with next steps:*
1. Community coordinator notified (note date / time): _____ _____ *date* *time*	

Homework #1: Medications

☐ OK, let's start with your medicines and how you did with them that first week.

☐ Let's start with Day 1. Did you take all of your diabetes medication on Day 1?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Now, let's talk about how you did with your medicines during the second week. On Day 1 of the second week, did you take all of your diabetes medication?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Let's continue with the third week. On Day 1 of the third week, did you take all of your diabetes medication?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Finally, let's talk about how you did with your diabetes medication during the fourth week. On Day 1 of the fourth week, did you take all of your diabetes medication?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

If your client took 1) their diabetes medication every day as directed in the past four weeks and 2) has successfully overcome all of the diabetes medication barriers identified at the beginning of the program:

- *Praise profusely! Tell them to keep up the great work by continuing to take their medications every day as directed.*
- *Then, **go to page 136** and continue with **Homework #2, Healthy Eating**.*

If your client was not able to take their diabetes medication every day as directed in the past four weeks:

- *Stay on **page 134** in your manual and continue with setting a diabetes medication goal.*
- *Then, go on with the rest of the session.*

If your client took their diabetes medication every day as directed in the past four weeks, but still has diabetes medication barriers that haven't been addressed:

- *Go to **page 135** in your manual and continue with setting a diabetes medication goal.*
- *Then, go on with the rest of the session.*

☐ Now, I'd like to follow up on the plan that we made at our last session to help you get the most out of your diabetes medications by taking them every day.

☐ Last time we talked, the issue you wanted to work on was… *[go to Client Plan Book and read out loud the diabetes medication issue that they chose to work on last time]*.

☐ To overcome this issue, you decided to… *[read out loud the medication-taking plan from last time]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, how did it go? *Listen supportively and take notes in the box below. Assess how well this worked. If it did not work well, talk about why not. If it did go well, praise them.*

Notes:

☐ OK, so what would you like to do over the next four weeks to help you get the most out of your medications?

- ***If their plan worked and last session's issue is resolved, encourage them to tackle a new issue this week.*** *If you try hard and they don't want to tackle another issue and they took their medicine each day, try this:*
  - *Go back to the Client Plan Book.*
  - *If there are remaining issues related to side effects or cost, then help the client make a plan to address them this week.*
  - *If there are no remaining issues related to side effects or cost, look at the list of statements that are marked "Very Often" (or "Often" if there are no "Very Often" statements to address, and "Sometimes" if there are no "Often" statements to address).*
    - *Help them decide which new goal they would like to add for the coming week.*
  - *Summarize to confirm their new goal. For example, you could say:*
    "OK, let me see if I got this straight. Last week, you … [repeat <u>last</u> week's goal]. You did well with that, so this week, you'll … [repeat <u>this</u> week's goal]. Did I get that right?"

- ***If they were <u>not</u> able to meet their medication goal, then let them stick to the same goal.***
  - *Be supportive, and let them know you'll revisit the goal next week to see how it went this time.*
  - *Strategize what they will do differently this week to succeed. Make sure it is a SMART goal.*

- ***Record this week's strategy in the Client Plan Book.***
  - *If the strategy addresses side effects/and or cost, record this week's strategy on the page, "Client Plan for Diabetes Medication Side Effects and/or Cost," in the Client Plan Book.*
  - *If the strategy addresses other barriers besides side effects or cost, then record this week's strategy on the page, "Client Plan for Other Diabetes Medication Barriers," in the Client Plan Book.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ OK, let's review that. It looks like you'll… *repeat the new medication goal. Then, review potential barriers and how client will go around those barriers. Let client confirm.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down barriers in the left column in the box below.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write those solutions in the right column in the box below.*

☐ This is a great plan! I look forward to hearing how this plan worked when we talk next time!

Homework #2: Healthy Eating

☐ OK, let's talk about how your healthy eating went during the first week. How did it go on Day 1? *For each day, check "yes" or "no" for the Healthy Eating column.*

Week 1

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Now, during the second week, were you able to take another step to eat more healthy?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - ☐ *Did not evaluate goal after 1st week*
  - ☐ *Evaluated goal after 1st week, did not increase goal for 2nd week*
  - ☐ *Evaluated goal after 1st week, increased goal for 2nd week*

New healthy eating goal for 2nd week, if client increased goal:

☐ OK, let's take a look at how you did with healthy eating during the second week. How did it go on Day 1 of the second week? *For each day, check "yes" or "no" for the Healthy Eating column.*

Week 2

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Now, during the third week, were you able to take another step to eat more healthy?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - ☐ *Did not evaluate goal after 2nd week*
  - ☐ *Evaluated goal after 2nd week, did not increase goal for 3rd week*
  - ☐ *Evaluated goal after 2nd week, increased goal for 3rd week*

New healthy eating goal for 3rd week, if client increased goal:

☐ OK, let's talk about how your healthy eating went during the third week. How did it go on Day 1? *For each day, check "yes" or "no" for the Healthy Eating column.*

Week 3

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Now, during the fourth week, were you able to take another step to eat more healthy?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - ☐ *Did not evaluate goal after 3rd week*
  - ☐ *Evaluated goal after 3rd week, did not increase goal for 4th week*
  - ☐ *Evaluated goal after 3rd week, increased goal for 4th week*

New healthy eating goal for 4th week, if client increased goal:

☐ OK, let's take a look at how you did with healthy eating during the fourth week. How did it go on Day 1? *For each day, check "yes" or "no" for the Healthy Eating column.*

Week 4

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Now, the last time we made a plan to help you eat healthy every day, you planned to… *[go to Client Plan Book and read out loud the healthy eating goal the client chose to work on last time]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, during the first week, you were able to… *[based on what client told you about Week 1, describe what happened]*.

☐ During the second week, you were able to… *[based on what client told you about Week 2, describe what happened]*.

☐ During the third week, you were able to… *[based on what client told you about Week 3, describe what happened]*.

☐ During the fourth week, you were able to… *[based on what client told you about Week 4, describe what happened]*.

☐ OK, what would you like to do this week in terms of healthy eating?

- *If they met their healthy eating goal,*
  - *Explore if they are ready to add another goal this week. Ask them to turn to page 6 in their Activity Book and look at the chart. Help them decide which new goal they would like to add for the coming week.*
  - *Go to the Client Plan Book and write down details in the space provided. Be sure to include all the information necessary for the goal.*
  - *Summarize to confirm their new goal. For example, you could say:*

    "OK, let me see if I got this straight. Last week, you … [repeat last week's goal]. You did well with that, so now you'd like to add another healthy eating goal. So, this week, you'll … [repeat this week's goal]. Did I get that right?"
- *If they were not able to meet their healthy eating goal,*
  - *Let client stick to the same eating goal, but be sure to modify the plan if needed.*
  - *Go to the Client Plan Book and write down details in the space provided. Be sure to include all the information necessary for the goal.*
  - *Be supportive, but remind client that you'll revisit the goal next week to see how it went this time.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ Great, I look forward to hearing how this plan worked when we talk next time!

Homework #3: Physical Activity

☐ Now, let's talk about how your exercise went during the first week. How much exercise were you able to do on Day 1? *For each day, write down number of minutes.*

Week 1

	Exercise minutes
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, during the second week, were you able to take another step to become more physically active?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - *Did not evaluate goal after 1st week*
  - *Evaluated goal after 1st week, did not increase goal for 2nd week*
  - *Evaluated goal after 1st week, increased goal for 2nd week*

Notes and new exercise goal for 2nd week, if client increased goal:

☐ OK, let's take a look at how you did with exercise during the second week. How did it go on Day 1 of the second week? *For each day, write down number of minutes.*

Week 2

	Exercise minutes
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, during the third week, were you able to take another step to become more physically active?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - *Did not evaluate goal after 2nd week*
  - *Evaluated goal after 2nd week, did not increase goal for 3rd week*
  - *Evaluated goal after 2nd week, increased goal for 3rd week*

Notes and new exercise goal for 2nd week, if client increased goal:

☐ OK, let's take a look at how you did with exercise during the third week. How did it go on Day 1 of the third week? *For each day, write down number of minutes.*

Week 3

	Exercise minutes
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, during the fourth week, were you able to take another step to become more physically active

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - *Did not evaluate goal after 3rd week*
  - *Evaluated goal after 3rd week, did not increase goal for 4th week*
  - *Evaluated goal after 3rd week, increased goal for 4th week*

Notes and new exercise goal for 2nd week, if client increased goal:

☐ OK, let's take a look at how you did with exercise during the fourth week. How did it go on Day 1 of the fourth week? *For each day, write down number of minutes.*

Week 4

	 ***Exercise minutes***
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, the last time we made a plan to help you exercise every day, you planned to… *[go to Client Plan Book and read out loud the exercise goal the client chose to work on last time]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, during the first week, you were able to… *[based on what client told you about Week 1, describe what happened]*.

☐ During the second week, you were able to… *[based on what client told you about Week 2, describe what happened]*.

☐ During the third week, you were able to… *[based on what client told you about Week 3, describe what happened]*.

☐ During the fourth week, you were able to… *[based on what client told you about Week 4, describe what happened]*.

☐ OK, what would you like to do this week in terms of exercise?

- *If they met their goal and were doing less than 30 minutes per day, 5 days per week, then explore if they are ready to add another 5 minutes.*
  - *If they are not comfortable advancing the goal, let them stick to the same goal, but supportively warn that you'll be discussing this again next week and remind them that the eventual goal is 30 minutes per day.*
  - *Write the goal for this week in the space provided in the Client Plan Book.*
- *If they were not able to meet their goal,*
  - *Let client stick to the same goal, but be sure to modify the plan if needed.*
- *Summarize. For example, say: OK, let me see if I got this straight. Last week, you [repeat last week's goal], and you did pretty well with that, so now you'd like to add another 5 minutes each day. That means that, this week, you'd like to [repeat this week's goal]. Did I get that right?*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ Great, I look forward to hearing how this plan worked when we talk next time!

If you and your client talked about high blood pressure during the previous session:
- *Go to **Homework #4: High Blood Pressure** on page 142 in your manual.*
- *Once you're finished, continue with the session on page 143.*

If you and your client talked about high cholesterol during the previous session:
- *Go to **Homework #5: High Cholesterol** on page 142 in your manual.*
- *Once you're finished, continue with the session on page 143.*

If you and your client talked about high blood pressure and high cholesterol during the previous session:
- *Go to **Homework #4: High Blood Pressure** on page 142 in your manual.*
- *Then, continue on to **Homework #5: High Cholesterol** on the same page.*
- *Once you're finished, continue with the session on page 143.*

*If your client's blood pressure and cholesterol were under control and you didn't set goals during the previous session, then continue with the session on **page 143** in your manual.*

Homework #4: High Blood Pressure (only if client is on medicine for high blood pressure or should have talked to doctor about starting treatment)

☐ Now, I'd like to follow up on the talk we had last time about your high blood pressure.

☐ Last time, you wanted to… *[review your notes from page 128 in your manual]*.

☐ Now, how did it go?

- *Listen supportively and praise client's effort in the past week.*
- *Encourage client to continue working with their doctor to control their blood pressure.*
- *If they are taking medication for their blood pressure, tell them that the strategies they have used to take their diabetes medication can also help them take their blood pressure medication.*
- *If needed, remind client that controlling blood pressure is important for reducing their chances of developing serious illnesses such as heart attack, stroke, dialysis, and blindness. Medications can help them live longer and stay independent by lowering their risk for such health problems.*

Notes:

Homework #5: High Cholesterol Plan (only if client is on medicine for high cholesterol or should have talked to doctor about starting treatment)

☐ Now, I'd like to follow up on the talk we had last time about your high cholesterol.

☐ Last time, you wanted to… *[review your notes from page 128 in your manual]*.

☐ Now, how did it go?

- *Listen supportively and praise client's effort in the past week.*
- *Encourage client to continue working with their doctor to control their cholesterol.*
- *If they are taking medication for their cholesterol, tell them that the strategies they have used to take their diabetes medication can also help them take their cholesterol medication.*
- *If needed, remind client that controlling cholesterol is important for reducing their chances of developing serious illnesses such as heart attack and stroke. Medications can help them live longer and stay independent by lowering their risk for such health problems.*

Notes:

Schedule Next Check-In Session ----------☐

☐ You have been doing a wonderful job with the three-legged stool! And keeping track of your progress is very helpful for seeing how well you're doing with this.

☐ OK, our next session will be four weeks from now. It will be just like today's call, where we'll talk about thirty minutes to see how you're doing with your homework.

☐ If you can turn to page 30 in your Activity Book, you'll see where you'll monitor your homework for the next four weeks. Do you have any questions about what to do?

☐ Great! Now, when would you like to talk in four weeks?

• *Try to make the dates as close to 28 days from now as possible.* • *Schedule it at least 28 days from today, but no more than 31 days.*	***Next appointment date and time in 4 weeks:***

☐ Great! Please go ahead and write down the date and time in your Activity Book at the bottom of page 31.

☐ I will be speaking with you in four weeks. I look forward to hearing how things went!

✓ Check In completed	_____ / _____ / _____	_____ / _____	_____
	month *day* *year*	*start time* *end time*	*peer initials*

Week 24, Session 11 (Final Session, 4 Weeks After Session 10)

Session Goals:

- *Brief encouragement to client*
- *Brief troubleshooting if client is having difficulty with any of the homework*
- *Reinforcement of benefits of taking care of the three-legged stool*
- *Help for client in creating plan to keep going*

Before Calling the Client ----------

- *Review last week's assignment and the barriers and strategies to overcome them.*
- *Once you've reviewed this, place the call.*

Reminder!!

- *Cover and check off all of the session content.*
- *Any text in GRAY BOXES is instructions for you: don't read that text aloud to the client.*

Call Log

	Dates	Times	Notes
Attempt 1			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 2			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 3			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 4			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 5			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 6			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 7			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**
Attempt 8			☐ no answer / phone busy ☐ left message / voicemail ☐ rescheduled ☐ bad phone number**

All phone numbers provided are disconnected or 8 call attempts made*	*2. Community coordinator calls back with Next Steps:*
1. Community coordinator notified (note date / time): _____ *date* _____ *time*	

Check In ----------☐

☐ Today is our last session! We'll talk about how it's been going with your homework since the last time we talked, which was about four weeks ago.

Say hello and make sure the client is still okay with speaking for about thirty minutes today.

☐ Now, do you have your Activity Book handy?
If not, let them get the Activity Book before going on.

☐ Great, let's get started!

Review Homework For Last Four Weeks ----------☐

☐ OK, now, I'd like to go over your homework from the past four weeks and then talk about your homework for the next four weeks.

☐ First, let's discuss how you did on your homework during the past four weeks. Can you turn to page 30 in your Activity Book? *Let client get to the page.*

Homework #1: Medications

☐ OK, let's start with your medicines and how you did with them that first week.

☐ Let's start with Day 1. Did you take all of your diabetes medication on Day 1?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Now, let's talk about how you did with your medicines during the second week. On Day 1 of the second week, did you take all of your diabetes medication?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Let's continue with the third week. On Day 1 of the third week, did you take all of your diabetes medication?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Finally, let's talk about how you did with your diabetes medication during the fourth week. On Day 1 of the fourth week, did you take all of your diabetes medication?

Continue with Days 2 through 7 before stopping to discuss.

- *For each day, check "Yes" or "No."*
- *For each day, ask client if they took their diabetes medicine, even if their blood sugar was normal. Praise them for every "yes"*
- *If they didn't take their diabetes medicine every day, discuss what happened. Avoid being judgmental.*
  - *Reassure client that taking medicine every day the way the doctor prescribed is hard for a lot of people. Tell them that you will work together to develop a plan for this week to help them take the medicine every day.*
  - *Write down what happened in the box below.*

Notes:

		***Took all my medications?***
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

If your client took 1) their diabetes medication every day as directed in the past four weeks and 2) has successfully overcome all of the diabetes medication barriers identified at the beginning of the program:

- *Praise profusely! Tell them to keep up the great work by continuing to take their medications every day as directed.*
- *Then, **go to page 150** and continue with **Homework #2, Healthy Eating**.*

If your client was not able to take their diabetes medication every day as directed in the past four weeks:

- *Stay on **page 148** in your manual and continue with setting a diabetes medication goal. Since this is the last session, you will not record their goal in the Client Plan Book.*
- *Then, go on with the rest of the session.*

If your client took their diabetes medication every day as directed in the past four weeks, but still has diabetes medication barriers that haven't been addressed:

- *Go to **page 149** in your manual and continue with setting a diabetes medication goal. Since this is the last session, you will not record their goal in the Client Plan Book.*
- *Then, go on with the rest of the session.*

☐ Now, I'd like to follow up on the plan that we made at our last session to help you get the most out of your diabetes medications by taking them every day.

☐ Last time we talked, the issue you wanted to work on was… *[go to Client Plan Book and read out loud the diabetes medication issue that they chose to work on last time]*.

☐ To overcome this issue, you decided to… *[read out loud the medication-taking plan from last time]*.

- ☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.
- ☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, how did it go? *Listen supportively and take notes in the box below. Assess how well this worked. If it did not work well, talk about why not. If it did go well, praise them.*

Notes:

☐ OK, even though the program is over today, you can continue setting goals for yourself to continue taking your medications every day. So, what would you like to do next to help you get the most out of your medications?

- ***If their plan worked and last session's issue is resolved, encourage them to tackle a new issue this week.*** *If you try hard and they don't want to tackle another issue and they took their medicine each day, try this:*
  - *Go back to the Client Plan Book.*
  - *If there are remaining issues related to side effects or cost, then help the client make a plan to address them this week.*
  - *If there are no remaining issues related to side effects or cost, look at the list of statements that are marked "Very Often" (or "Often" if there are no "Very Often" statements to address, and "Sometimes" if there are no "Often" statements to address).*
    - *Help them decide which new goal they would like to add for the coming week.*
  - *Summarize to confirm their new goal. For example, you could say:*
    "OK, let me see if I got this straight. Last week, you … [repeat <u>last</u> week's goal]. You did well with that, so this week, you'll … [repeat <u>this</u> week's goal]. Did I get that right?"

- ***If they were <u>not</u> able to meet their medication goal, then let them stick to the same goal.***
  - *Be supportive, and let them know you'll revisit the goal next week to see how it went this time.*
  - *Strategize what they will do differently this week to succeed. Make sure it is a SMART goal.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ OK, let's review that. It looks like you'll… *repeat the new medication goal. Then, review potential barriers and how client will go around those barriers. Let client confirm.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down barriers in the left column in the box below.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write those solutions in the right column in the box below.*

☐ This is a great plan!

Homework #2: Healthy Eating

☐ OK, let's talk about how your healthy eating went during the first week. How did it go on Day 1? *For each day, check "yes" or "no" for the Healthy Eating column.*

Week 1

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Now, during the second week, were you able to take another step to eat more healthy?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - ☐ *Did not evaluate goal after 1st week*
  - ☐ *Evaluated goal after 1st week, did not increase goal for 2nd week*
  - ☐ *Evaluated goal after 1st week, increased goal for 2nd week*

New healthy eating goal for 2nd week, if client increased goal:

☐ OK, let's take a look at how you did with healthy eating during the second week. How did it go on Day 1 of the second week? *For each day, check "yes" or "no" for the Healthy Eating column.*

Week 2

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Now, during the third week, were you able to take another step to eat more healthy?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - ☐ *Did not evaluate goal after 2nd week*
  - ☐ *Evaluated goal after 2nd week, did not increase goal for 3rd week*
  - ☐ *Evaluated goal after 2nd week, increased goal for 3rd week*

New healthy eating goal for 3rd week, if client increased goal:

☐ OK, let's talk about how your healthy eating went during the third week. How did it go on Day 1? *For each day, check "yes" or "no" for the Healthy Eating column.*

Week 3

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Now, during the fourth week, were you able to take another step to eat more healthy?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - ☐ *Did not evaluate goal after 3rd week*
  - ☐ *Evaluated goal after 3rd week, did not increase goal for 4th week*
  - ☐ *Evaluated goal after 3rd week, increased goal for 4th week*

New healthy eating goal for 4th week, if client increased goal:

☐ OK, let's take a look at how you did with healthy eating during the fourth week. How did it go on Day 1? *For each day, check "yes" or "no" for the Healthy Eating column.*

Week 4

		*Ate healthy?*
Day 1 (today)	☐ Yes	☐ No
Day 2	☐ Yes	☐ No
Day 3	☐ Yes	☐ No
Day 4	☐ Yes	☐ No
Day 5	☐ Yes	☐ No
Day 6	☐ Yes	☐ No
Day 7	☐ Yes	☐ No

☐ Great! Now, the last time we made a plan to help you eat healthy every day, you planned to… *[go to Client Plan Book and read out loud the healthy eating goal the client chose to work on last time]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, during the first week, you were able to… *[based on what client told you about Week 1, describe what happened]*.

☐ During the second week, you were able to… *[based on what client told you about Week 2, describe what happened]*.

☐ During the third week, you were able to… *[based on what client told you about Week 3, describe what happened]*.

☐ During the fourth week, you were able to… *[based on what client told you about Week 4, describe what happened]*.

☐ OK, even though the program is over today, you can continue setting goals for yourself to continue eating healthy every day. So, what would you like to do next to eat healthy?

- *If they met their healthy eating goal,*
  - *Explore if they are ready to add another goal this week. Ask them to turn to page 6 in their Activity Book and look at the chart. Help them decide which new goal they would like to add for the coming week.*
  - *Summarize to confirm their new goal. For example, you could say:*

    "OK, let me see if I got this straight. Last week, you … [repeat <u>last</u> week's goal]. You did well with that, so now you'd like to add another healthy eating goal. So, this week, you'll … [repeat <u>this</u> week's goal]. Did I get that right?"
- *If they were not able to meet their healthy eating goal,*
  - *Let client stick to the same eating goal, but be sure to modify the plan if needed.*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ This is a great plan!

Homework #3: Physical Activity

☐ Now, let's talk about how your exercise went during the first week. How much exercise were you able to do on Day 1? *For each day, write down number of minutes.*

Week 1

	Exercise minutes
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, during the second week, were you able to take another step to become more physically active?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - *Did not evaluate goal after 1st week*
  - *Evaluated goal after 1st week, did not increase goal for 2nd week*
  - *Evaluated goal after 1st week, increased goal for 2nd week*

Notes and new exercise goal for 2nd week, if client increased goal:

☐ OK, let's take a look at how you did with exercise during the second week. How did it go on Day 1 of the second week? *For each day, write down number of minutes.*

Week 2

	 Exercise minutes
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, during the third week, were you able to take another step to become more physically active?

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - *Did not evaluate goal after 2nd week*
  - *Evaluated goal after 2nd week, did not increase goal for 3rd week*
  - *Evaluated goal after 2nd week, increased goal for 3rd week*

Notes and new exercise goal for 2nd week, if client increased goal:

☐ OK, let's take a look at how you did with exercise during the third week. How did it go on Day 1 of the third week? *For each day, write down number of minutes.*

Week 3

	 Exercise minutes
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, during the fourth week, were you able to take another step to become more physically active

- *Discuss how this went and provide encouragement and praise. If client was not able to take another step, discuss together what happened. Check the correct box below:*
  - *Did not evaluate goal after 3rd week*
  - *Evaluated goal after 3rd week, did not increase goal for 4th week*
  - *Evaluated goal after 3rd week, increased goal for 4th week*

Notes and new exercise goal for 2nd week, if client increased goal:

☐ OK, let's take a look at how you did with exercise during the fourth week. How did it go on Day 1 of the fourth week? *For each day, write down number of minutes.*

Week 4

	 ***Exercise minutes***
Day 1 (today)	*minutes*
Day 2	*minutes*
Day 3	*minutes*
Day 4	*minutes*
Day 5	*minutes*
Day 6	*minutes*
Day 7	*minutes*

☐ Great! Now, the last time we made a plan to help you exercise every day, you planned to… *[go to Client Plan Book and read out loud the exercise goal the client chose to work on last time]*.

☐ You thought that it might be hard for you to carry out this plan, because… *[read potential barriers]*.

☐ To go around the problem, you decided to… *[read how client decided to go around potential barriers]*.

☐ Now, during the first week, you were able to… *[based on what client told you about Week 1, describe what happened]*.

☐ During the second week, you were able to… *[based on what client told you about Week 2, describe what happened]*.

☐ During the third week, you were able to… *[based on what client told you about Week 3, describe what happened]*.

☐ During the fourth week, you were able to… *[based on what client told you about Week 4, describe what happened]*.

☐ OK, even though the program is over today, you can continue setting goals for yourself to continue being physically active. So, what would you like to do next for exercise?

- *If they met their goal and were doing less than 30 minutes per day, 5 days per week, then explore if they are ready to add another 5 minutes.*
  - *If they are not comfortable with immediately advancing the goal, let them stick to the same goal. Remind them that the eventual goal is 30 minutes per day.*
- *If they were not able to meet their goal,*
  - *Let client stick to the same goal, but be sure to modify the plan if needed.*
- *Summarize. For example, say: OK, let me see if I got this straight. Last week, you [repeat last week's goal], and you did pretty well with that, so now you'd like to add another 5 minutes each day. That means that, this week, you'd like to [repeat this week's goal]. Did I get that right?*

☐ OK, let's think about how hard this may be to do. What are some things that might make it hard for you to carry out this plan? *Write down potential barriers.*

☐ OK, what do you think you can do to overcome these things? *Help clients think of possible solutions to these barriers, and write down those solutions.*

☐ This is a great plan!

If you and your client talked about high blood pressure during the previous session:
- *Go to **Homework #4: High Blood Pressure** on page 156 in your manual.*
- *Once you're finished, continue with the session on page 157.*

If you and your client talked about high cholesterol during the previous session:
- *Go to **Homework #5: High Cholesterol** on page 156 in your manual.*
- *Once you're finished, continue with the session on page 157.*

If you and your client talked about high blood pressure and high cholesterol during the previous session:
- *Go to **Homework #4: High Blood Pressure** on page 156 in your manual.*
- *Then, continue on to **Homework #5: High Cholesterol** on the same page.*
- *Once you're finished, continue with the session on page 157.*

*If your client's blood pressure and cholesterol were under control and you didn't set goals during the previous session, then continue with the session on **page 157** in your manual.*

Homework #4: High Blood Pressure (only if client is on medicine for high blood pressure or should have talked to doctor about starting treatment)

☐ Now, I'd like to follow up on the talk we had last time about your high blood pressure.

☐ Last week, you wanted to… *[review your notes from page 142 in your manual]*.

☐ Now, how did it go?

- *Listen supportively and praise client's effort in the past week.*
- *Encourage client to continue working with their doctor to control their blood pressure.*
- *If they are taking medication for their blood pressure, tell them that the strategies they have used to take their diabetes medication can also help them take their blood pressure medication.*
- *If needed, remind client that controlling blood pressure is important for reducing their chances of developing serious illnesses such as heart attack, stroke, dialysis, and blindness. Medications can help them live longer and stay independent by lowering their risk for such health problems.*

Notes:

Homework #5: High Cholesterol Plan (only if client is on medicine for high cholesterol or should have talked to doctor about starting treatment)

☐ Now, I'd like to follow up on the talk we had last time about your high cholesterol.

☐ Last week, you wanted to… *[review your notes from page 142 in your manual]*.

☐ Now, how did it go?

- *Listen supportively and praise client's effort in the past week.*
- *Encourage client to continue working with their doctor to control their cholesterol.*
- *If they are taking medication for their cholesterol, tell them that the strategies they have used to take their diabetes medication can also help them take their cholesterol medication.*
- *If needed, remind client that controlling cholesterol is important for reducing their chances of developing serious illnesses such as heart attack and stroke. Medications can help them live longer and stay independent by lowering their risk for such health problems.*

Notes:

Homework and Wrapping Up ----------☐

- ☐ You have been doing a wonderful job with the three-legged stool! And keeping track of your progress is very helpful for seeing how well you're doing with this.
- ☐ I know that we talked a few sessions ago about how eating healthy, being physically active, and taking your medications are helping you right now *and* helping you stay well so that you can achieve your goals down the line. Have you thought any more about that since we talked? *If needed, share with client your own day-to-day efforts to live a healthy, active life and how that effort is paying off now, because you are able to do the things that you need to do right now, and paying off later, because you will be able to accomplish things that matter to you and be there for important events in the future.*
- ☐ I just want to tell you I'm so proud of the great work you have done in this program.
- ☐ Now that you have completed the program, you'll be in charge of your own homework from here on out!
- ☐ You can continue to use the Activity Book if you find it helpful.
- ☐ Also, research has shown that monitoring yourself, like the way you've been keeping track of your homework, can help you improve more than if you don't monitor yourself.
- ☐ If you turn to page 32 in your Activity Book, you can see that there are a lot more pages for you to use if you want to keep track of your homework.
- ☐ Now that you know what to do, you can monitor on your own.
- ☐ Also, your Health Buddy can help you with this, much like I did.
- ☐ Now, you may stop keeping track of your homework and find yourself not taking care of your three-legged stool.
- ☐ If that happens, then it may be helpful to keep track of your healthy eating, physical activity, and medications every day, just like you did during the program.
- ☐ Don't forget to reach out to your doctor if you have trouble taking care of any part of the three-legged stool, especially if you have trouble with your medications.
- ☐ Just remember that taking care of the three-legged stool will help you live well *now* and live well *in the future*, so that you can accomplish things that are important to you, like *[repeat long-term goals from page 3 in the Client Plan Book]*.
- ☐ Now, the study staff will be in touch to talk with you again within the next month.
- ☐ Do you have any questions? *Give client chance to ask questions.*
- ☐ I hope this program has helped you. It's been a pleasure to work with you!

✓ Check In completed	____/____/____ *month / day / year*	____/____ *start time / end time*	____ *peer initials*

Peer Advisor's Program Tools
(Client Plan Book)

Living Well with Diabetes – Client Plan Book

Client Name:	**Peer Advisor Name:**
Notes:	

Table of Contents

Client A1c, Blood Pressure, and Cholesterol

-------A1C *(average blood sugar over three months)* ----------

Today's A1c	☐ **7 or Less**	**Great Control**
	☐ **7 – 7.9**	**Okay, not perfect**
	☐ **8 – 8.9**	**Cause for concern**
	☐ **9 or higher**	**Bigger cause for concern**

-------Blood Pressure----------

Today's Blood Pressure	☐ **Less than 120/80**	**Normal**	**Take medication for blood pressure?**
	☐ **Less than 140/90**	**Our goal**	☐ **Yes-Listed on page 19** ☐ **No**
	☐ **140/90 or higher**	**High-talk to doctor**	

-------Cholesterol *LDL Cholesterol (Bad cholesterol)*----------

Today's LDL Cholesterol	☐ **Less than 100**	**Okay**	**Take medication for cholesterol?**
	☐ **100 or higher**	**High talk to doctor**	☐ **Yes-Listed on page 23** ☐ **No**

-------Long-Term Goals----------

Diabetes Medication Name	Dose, Frequency , and Other Instructions	Taking as Prescribed?
1.		Yes ☐ No ☐
Side effects? Yes ☐ No ☐ If yes, what's the side effect? Is the side effect causing missed doses? Yes ☐ No ☐	Is medicine affordable? Yes ☐ No ☐ Notes:	Notes:
2.		Yes ☐ No ☐
Side effects? Yes ☐ No ☐ If yes, what's the side effect? Is the side effect causing missed doses? Yes ☐ No ☐	Is medicine affordable? Yes ☐ No ☐ Notes:	Notes:
3.		Yes ☐ No ☐
Side effects? Yes ☐ No ☐ If yes, what's the side effect? Is the side effect causing missed doses? Yes ☐ No ☐	Is medicine affordable? Yes ☐ No ☐ Notes:	Notes:
4.		Yes ☐ No ☐
Side effects? Yes ☐ No ☐ If yes, what's the side effect? Is the side effect causing missed doses? Yes ☐ No ☐	Is medicine affordable? Yes ☐ No ☐ Notes:	Notes:

Plan for Diabetes Medication Side Effects and/or Cost		
Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Plan for Diabetes Medication Side Effects and/or Cost (Continued – page 2)		
Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Plan for Diabetes Medication Side Effects and/or Cost (Continued – page 3)		
Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Diabetes Medications – Other Barriers

	Never	Rarely	Sometimes	Often	Very often
I just forget to take my diabetes medicine.	1	2	3	4	5
I forgot to fill my diabetes prescription in time.	1	2	3	4	5
I don't know what dose of my diabetes medicine to take.	1	2	3	4	5
I'm not sure exactly what each medicine is for.	1	2	3	4	5
There are too many doses of my diabetes medicine to take each day	1	2	3	4	5
It's too hard to keep track of what I am supposed to take when.	1	2	3	4	5
My diabetes medicine are unpleasant to take.	1	2	3	4	5
I have heard about side effects from diabetes medicines that I am afraid I might get.	1	2	3	4	5
Getting to the pharmacy to pick up my diabetes medicine is difficult.	1	2	3	4	5
The pharmacy could not fill my diabetes prescription.	1	2	3	4	5
My doctor or nurse forgot to write a new diabetes prescription.	1	2	3	4	5
I ran out of diabetes medication before I could call or visit my doctor or nurse.	1	2	3	4	5
I don't have enough time to talk with my doctor or nurse about problems I am having with my diabetes medicines.	1	2	3	4	5
I sometimes forget to ask my doctor or nurse about problems that I am having with my diabetes medicines.	1	2	3	4	5
I don't feel my diabetes medicines are helping me.	1	2	3	4	5
I just don't like taking medicines in general.	1	2	3	4	5
Taking diabetes medicines makes my health worse.	1	2	3	4	5
I sometimes find it hard to ask my doctor or nurse questions about my diabetes medications.	1	2	3	4	5
If my blood sugar is normal in the morning, I don't take my diabetes medications.	1	2	3	4	5

Plan for Other Diabetes Medication Barriers	
Date of plan (mm/dd/yy):	Issue:
Write down the strategy that the client wants to try to overcome the issue. Make sure it's a SMART plan (specific, measurable, achievable, relevant, and time-bound):	
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):

Date of plan (mm/dd/yy):	Issue:
Write down the strategy that the client wants to try to overcome the issue. Make sure it's a SMART plan (specific, measurable, achievable, relevant, and time-bound):	
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):

Date of plan (mm/dd/yy):	Issue:
Write down the strategy that the client wants to try to overcome the issue. Make sure it's a SMART plan (specific, measurable, achievable, relevant, and time-bound):	
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):

Plan for Other Diabetes Medication Barriers (Continued – page 2)	
Date of plan (mm/dd/yy):	Issue:
Write down the strategy that the client wants to try to overcome the issue. Make sure it's a SMART plan (specific, measurable, achievable, relevant, and time-bound):	
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):

Date of plan (mm/dd/yy):	Issue:
Write down the strategy that the client wants to try to overcome the issue. Make sure it's a SMART plan (specific, measurable, achievable, relevant, and time-bound):	
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):

Date of plan (mm/dd/yy):	Issue:
Write down the strategy that the client wants to try to overcome the issue. Make sure it's a SMART plan (specific, measurable, achievable, relevant, and time-bound):	
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):

Plan for Other Diabetes Medication Barriers (Continued – page 3)	
Date of plan (mm/dd/yy):	Issue:
Write down the strategy that the client wants to try to overcome the issue. Make sure it's a SMART plan (specific, measurable, achievable, relevant, and time-bound):	
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):

Date of plan (mm/dd/yy):	Issue:
Write down the strategy that the client wants to try to overcome the issue. Make sure it's a SMART plan (specific, measurable, achievable, relevant, and time-bound):	
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):

Date of plan (mm/dd/yy):	Issue:
Write down the strategy that the client wants to try to overcome the issue. Make sure it's a SMART plan (specific, measurable, achievable, relevant, and time-bound):	
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):

Client Healthy Eating Assessment

[redacted]

	Breakfast	*Lunch*	*Dinner*	*Snack*	*Total*	*Goal*
Number of second helpings of meat or starch						0
Number of fruits						3-4
Number of vegetables						3-4
Number of sugar-sweetened drinks						0
Number of desserts						0-1
Number of servings of fried foods						0

Plan for Healthy Eating

Date of plan (mm/dd/yy):	
Write down the strategy that the client wants to try to improve their healthy eating. Make sure it's a SMART goal (specific, measurable, achievable, relevant, and time-bound):	
Meal(s) of the day:	Days of the week:
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):

Date of plan (mm/dd/yy):	
Write down the strategy that the client wants to try to improve their healthy eating. Make sure it's a SMART goal (specific, measurable, achievable, relevant, and time-bound):	
Meal(s) of the day:	Days of the week:
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):

Date of plan (mm/dd/yy):	
Write down the strategy that the client wants to try to improve their healthy eating. Make sure it's a SMART goal (specific, measurable, achievable, relevant, and time-bound):	
Meal(s) of the day:	Days of the week:
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):

Plan for Healthy Eating (Continued – page 2)

Date of plan (mm/dd/yy):

Write down the strategy that the client wants to try to improve their healthy eating. Make sure it's a SMART goal (specific, measurable, achievable, relevant, and time-bound):

Meal(s) of the day: Days of the week:

Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):

Date of plan (mm/dd/yy):

Write down the strategy that the client wants to try to improve their healthy eating. Make sure it's a SMART goal (specific, measurable, achievable, relevant, and time-bound):

Meal(s) of the day: Days of the week:

Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):

Date of plan (mm/dd/yy):

Write down the strategy that the client wants to try to improve their healthy eating. Make sure it's a SMART goal (specific, measurable, achievable, relevant, and time-bound):

Meal(s) of the day: Days of the week:

Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):

Plan for Healthy Eating (Continued – page 3)

Date of plan (mm/dd/yy):

Write down the strategy that the client wants to try to improve their healthy eating. Make sure it's a SMART goal (specific, measurable, achievable, relevant, and time-bound):

Meal(s) of the day: Days of the week:

Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):

Date of plan (mm/dd/yy):

Write down the strategy that the client wants to try to improve their healthy eating. Make sure it's a SMART goal (specific, measurable, achievable, relevant, and time-bound):

Meal(s) of the day: Days of the week:

Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):

Date of plan (mm/dd/yy):

Write down the strategy that the client wants to try to improve their healthy eating. Make sure it's a SMART goal (specific, measurable, achievable, relevant, and time-bound):

Meal(s) of the day: Days of the week:

Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):

Plan for Physical Activity		
Date of plan (mm/dd/yy):	Current exercise (what is it and how much):	
What client will do this week:	Where client will do it:	
When during the day:	How many minutes each time:	Which days of the week:
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Date of plan (mm/dd/yy):		
What client will do this week:	Where client will do it:	
When during the day:	How many minutes each time:	Which days of the week:
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Date of plan (mm/dd/yy):		
What client will do this week:	Where client will do it:	
When during the day:	How many minutes each time:	Which days of the week:
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Plan for Physical Activity (Continued – page 2)

Date of plan (mm/dd/yy):		
What client will do this week:	Where client will do it:	
When during the day:	How many minutes each time:	Which days of the week:
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Date of plan (mm/dd/yy):		
What client will do this week:	Where client will do it:	
When during the day:	How many minutes each time:	Which days of the week:
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Date of plan (mm/dd/yy):		
What client will do this week:	Where client will do it:	
When during the day:	How many minutes each time:	Which days of the week:
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Plan for Physical Activity (Continued – page 3)		
Date of plan (mm/dd/yy):		
What client will do this week:	Where client will do it:	
When during the day:	How many minutes each time:	Which days of the week:
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Date of plan (mm/dd/yy):		
What client will do this week:	Where client will do it:	
When during the day:	How many minutes each time:	Which days of the week:
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Date of plan (mm/dd/yy):		
What client will do this week:	Where client will do it:	
When during the day:	How many minutes each time:	Which days of the week:
Potential barrier(s) to carrying out this plan:	What client will do instead to get around barrier(s):	

Blood Pressure Medication Name	Dose, Frequency , and Other Instructions	Taking as Prescribed?
1.		Yes ☐ No ☐
Side effects? Yes ☐ No ☐ If yes, what's the side effect? Is the side effect causing missed doses? Yes ☐ No ☐	Is medicine affordable? Yes ☐ No ☐ Notes:	Notes:
2.		Yes ☐ No ☐
Side effects? Yes ☐ No ☐ If yes, what's the side effect? Is the side effect causing missed doses? Yes ☐ No ☐	Is medicine affordable? Yes ☐ No ☐ Notes:	Notes:
3.		Yes ☐ No ☐
Side effects? Yes ☐ No ☐ If yes, what's the side effect? Is the side effect causing missed doses? Yes ☐ No ☐	Is medicine affordable? Yes ☐ No ☐ Notes:	Notes:
4.		Yes ☐ No ☐
Side effects? Yes ☐ No ☐ If yes, what's the side effect? Is the side effect causing missed doses? Yes ☐ No ☐	Is medicine affordable? Yes ☐ No ☐ Notes:	Notes:

Plan for Blood Pressure – Not taking any, or Missing doses due to side effects or cost		
Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):	

Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):	

Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):	

Plan for Blood Pressure Medications – No Issues with Side Effects or Cost, but Not Taking Medicine Correctly	
Date of plan (mm/dd/yy):	Issue:
Write down the strategy that the client wants to try to overcome the issue. Make sure it's a SMART plan (specific, measurable, achievable, relevant, and time-bound):	
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):

Date of plan (mm/dd/yy):	Issue:
Write down the strategy that the client wants to try to overcome the issue. Make sure it's a SMART plan (specific, measurable, achievable, relevant, and time-bound):	
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):

Date of plan (mm/dd/yy):	Issue:
Write down the strategy that the client wants to try to overcome the issue. Make sure it's a SMART plan (specific, measurable, achievable, relevant, and time-bound):	
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):

Plan for Blood Pressure – Taking Correctly, but Blood Pressure Still High		
Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):	

Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):	

Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):	

Cholesterol Medication Name	Dose, Frequency , and Other Instructions	Taking as Prescribed?
1.		Yes ☐ No ☐
Side effects? Yes ☐ No ☐ If yes, what's the side effect? Is the side effect causing missed doses? Yes ☐ No ☐	Is medicine affordable? Yes ☐ No ☐ Notes:	Notes:
2.		Yes ☐ No ☐
Side effects? Yes ☐ No ☐ If yes, what's the side effect? Is the side effect causing missed doses? Yes ☐ No ☐	Is medicine affordable? Yes ☐ No ☐ Notes:	Notes:
3.		Yes ☐ No ☐
Side effects? Yes ☐ No ☐ If yes, what's the side effect? Is the side effect causing missed doses? Yes ☐ No ☐	Is medicine affordable? Yes ☐ No ☐ Notes:	Notes:
4.		Yes ☐ No ☐
Side effects? Yes ☐ No ☐ If yes, what's the side effect? Is the side effect causing missed doses? Yes ☐ No ☐	Is medicine affordable? Yes ☐ No ☐ Notes:	Notes:

Plan for Cholesterol – Not taking any, or Missing doses due to side effects or cost		
Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):	

Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):	

Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):	

Plan for Cholesterol Medications – No Issues with Side Effects or Cost, but Not Taking Medicine Correctly	
Date of plan (mm/dd/yy):	Issue:
Write down the strategy that the client wants to try to overcome the issue. Make sure it's a SMART plan (specific, measurable, achievable, relevant, and time-bound):	
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):

Date of plan (mm/dd/yy):	Issue:
Write down the strategy that the client wants to try to overcome the issue. Make sure it's a SMART plan (specific, measurable, achievable, relevant, and time-bound):	
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):

Date of plan (mm/dd/yy):	Issue:
Write down the strategy that the client wants to try to overcome the issue. Make sure it's a SMART plan (specific, measurable, achievable, relevant, and time-bound):	
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):

Plan for Cholesterol Medicine – Taking Correctly, but Cholesterol Still High		
Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):	

Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):	

Date of plan (mm/dd/yy):	Who is calling the doctor:	When (day and time):
What the client will say to the doctor:		
Potential barrier(s) to carrying out this plan:	What client will do instead, or get around barrier(s):	

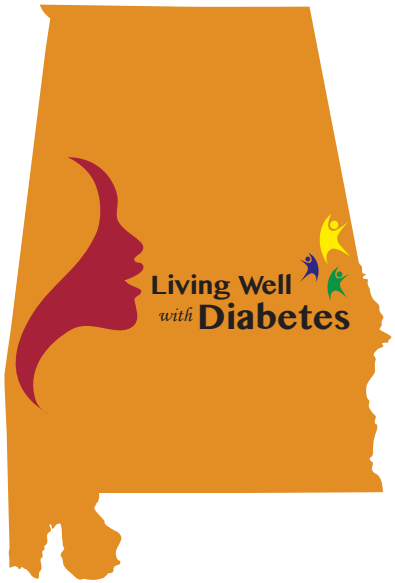
Examples of strategies to overcome each medication barrier:

1. I just forget to take them:	weekly pill box, take them at the same time each day (breakfast, brushing teeth, etc.), put a reminder on the fridge; if traveling the next day, place pills in a pouch or zip lock bag in your purse or your jacket the night before
2. I forgot to fill my prescription in time:	ask the pharmacist if they can call you when it's time, ask for a 90-day supply, ask pharmacy if they have an automatic reminder program that can call you or send you a text, ask a family member to keep track of your refill date with you; ask family member to pick the medicine up for you if you can't
3. I don't know what dose to take:	have the client read the label to you and go over how to take it; if needed, call the doctor together to clarify
4. I'm not sure exactly what each medicine is for:	go over the medicine together with the client; using the list of medicines in the back of your manual, let them know what the medicine is for
5. There are too many doses to take each day:	go over the dosing schedule (see below box of common misunderstandings); if needed, call the doctor to see if there is another option that has fewer doses per day; if there are no other options, consider pill boxes that have multiple doses per day and tie the medicine to a routine (meals, brushing teeth, etc.)
6. It's too hard to keep track of what I am supposed to take when:	pill box that you fill once per week; go over the list with the client and make sure they understand how to take each one; use color-coding to know which medications to take (example: put a red sticker on all medicines you're supposed to take in the morning, put a blue sticker on all the medicines you're supposed to take in the evening; put both red and blue stickers on the pill bottle if you're supposed to take it both AM and PM)
7. They are unpleasant to take:	take with a strongly flavored drink, drink a lot of water; if having trouble swallowing a pill, check with doctor to see if it's okay to crush it up in Jell-O or applesauce; think of a future goal right before you take the medicine
8. I can't afford them	Ask the pharmacist for generics or what may be cheaper and then ask him to call the doctor, apply for free medications from the drug company
9. My medicines make me feel bad or have side effects I don't like.	Talk to the doctor about cutting back the dose, or switching to a cheaper medicine
10. I have heard about side effects that I am afraid I might get	Talk to the pharmacist about how often people get the side effect you are afraid of, not everyone gets side effects, it's possible the side effects you heard about are not true – there are a lot of rumors and misinformation -Reassured client that everyone is different and not everyone has side effects; always useful to provide a real world example -All medicines have side effects/ make sure client is correctly taking the

	medication (ex: eating food with medications) -Reassure the client. Talk through the symptoms of the side effect with the client. Tell the client to talk to their pharmacist and doctor if they experience any of the side effects
11. Getting to the pharmacy to pick them up is difficult	Ask for a 90 day supply, ask a friend or family member for help, plan ahead, use a mail-order pharmacy
12. The pharmacy could not fill my prescription	Call the pharmacy and find out why – could be they were temporarily out of stock, prescription expired and doctor has to renew (by law, prescriptions are only filled for 1 year no matter how many refills are ordered)
13. My doctor or nurse forgot to write a new prescription	Call the doctor and ask them to phone it in to the pharmacy
14. I ran out of medication before I could call or visit my doctor or nurse	Plan ahead, ask the pharmacy to set up regular calls before you run out, you can call the doctor the same day and they will call the pharmacy that day, use a calendar
15. I don't have enough time to talk with my doctor or nurse about problems I am having with my medicines.	Tell the doctor anyway, start with this problem at your next visit (they always ask how you are), write things down and show the list to the nurse, bring a younger friend or family member who can help you to get your problems heard -Leave a note with the receptionist and nurse to have a doctor call you -The night before, write down your questions -prioritize items on the list / questions so that the most important ones are covered during visit.
16. I sometimes forget to ask my doctor or nurse about problems that I am having with my medicines.	Write it down ahead of the visit, bring the list, bring a friend or family member
17. I don't feel my medicines are helping me	Learn what the medicine is and is not supposed to do (this program), realize that even if the medicine is not controlling your sugar it would be even worse off the medicine, the medicines mostly prevent long-term complications so it can be hard to know if they are helping without talking to the doctor -Talk to the doctor or nurse or pharmacy, this depends on the client -Get the pharmacist's opinion -Talk to them and see if they feel better now than before they started, (may have felt bad before the doctor started on the medication and after they started the meds they felt better).
18. I just don't like taking	Most people don't like taking medicine so you're not alone, years ago

medicine in general.	people didn't have these options and complications were a lot more common, want to avoid complications, think positive thoughts about you long-term goal and that the medicine will help you get there alive and well -Talk about what the client wants to accomplish? Talk about why they want to accomplish this - emphasis the positive benefits – such as living as long as you can, as well as you can - provide your personal story as an example – say if you didn't like taking medications and why; and what lead you to believe that medications were needed.
19. Taking medicines makes my health worse	Ask the doctor for a different medicine to minimize side effects, there are a lot of different options available nowadays, although you may have side effects the medicine is lowering your risks of bad things like stroke or dialysis -Cost-benefit comparison -Discussing your numbers with your doctor and relationship with medicines -Talk to your doctor about alternating medications -How and what way does the medicine make health worse, severity of the side effects -Finding a medicine that works for you → work with you -Have a notebook to keep all of your documents
20. I sometimes find it hard to ask my doctor or nurse questions about my medications	Write it down, practice at home, take a friend/family member with you

Participant Material (Activity Book)



Participant
Activity Book

Welcome to the Living Well Research Study!

Please keep this Activity Book with your DVD player in a safe place!

My Peer Advisor's Name Is:

My Peer Advisor's Phone Numbers Are:

Do you have questions? Call…

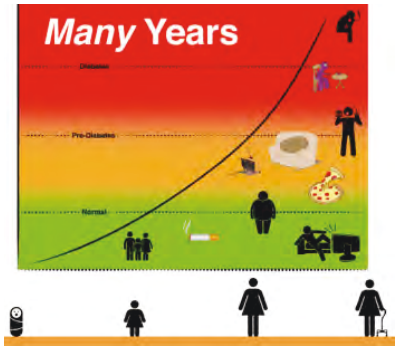
Living Well Study's Birmingham Contact:

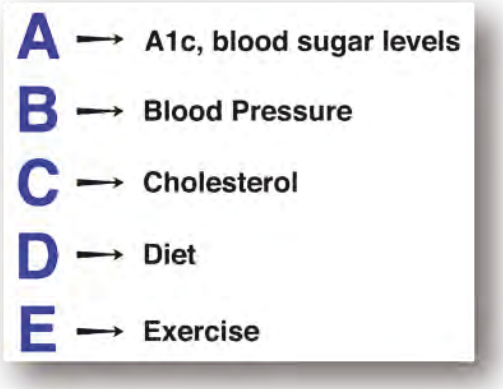
Living Well Study's Local Contact:

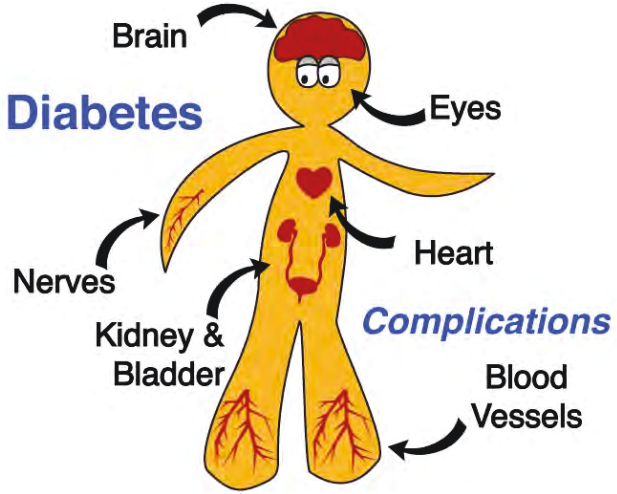
In Today's Session

- Learn about the Living Well with Diabetes Program
- Review Video 1, "Introduction to Living Well with Diabetes Program"
- Learn about diabetes basics

DVD Review







Sheree's Story

Program Schedule

Month 1	Session 1: Introduction to Living Well with Diabetes (Today!)
	Session 2: Healthy Eating Strategies
	Session 3: Physical Activity and Your Health
	Session 4: Diabetes Medications
Month 2	Session 5: Blood Pressure & Cholesterol Medications
	Session 6: Stress and Living Well with Diabetes
	Check-in
	Session 7: Planning for the Future – Part 1
Month 3	No session this week
	Check-in
	No session this week
	Session 8: Planning for the Future – Part 2
Month 4	No session this week
	No session this week
	No session this week
	Session 9: Monitoring Our Progress
Month 5	No session this week
	No session this week
	No session this week
	Session 10: Monitoring Our Progress
Month 6	No session this week
	No session this week
	No session this week
	Session 11: Final Session

Rules & Responsibilities

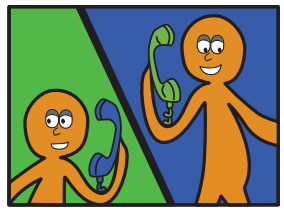
My Rules

- Be on time!
- Tell me if you are not feeling well.
- Participate actively.
- Practice everyday.
- Watch the videos.
- Tell me if you have concerns.

My Peer Advisors Rules

- Be on time!
- Call you regularly during the program.
- Help you learn.
- Listen.

Before every call,
Watch the Video



After every call,
Homework & Practice

I **commit** to the

Living Well with Diabetes Program!

_____

Sign Here

Living Well with Diabetes

This Week's Homework

	Took My **Diabetes Medications**?	
Day 1 *(today)*	☐ **Yes**	☐ **No**
Day 2	☐ **Yes**	☐ **No**
Day 3	☐ **Yes**	☐ **No**
Day 4	☐ **Yes**	☐ **No**
Day 5	☐ **Yes**	☐ **No**
Day 6	☐ **Yes**	☐ **No**
Day 7	☐ **Yes**	☐ **No**

☐ **I carried out my diabetes medication plan**

☐ **I watched the Session 2 Video on Healthy Eating**

My next session is:

Remember!

Session 2

Healthy Eating Strategies

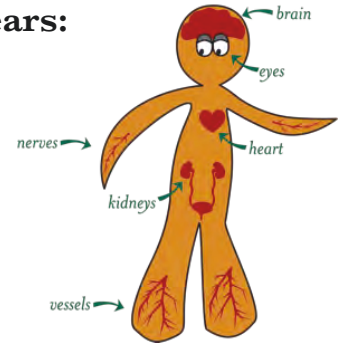
In Today's Session

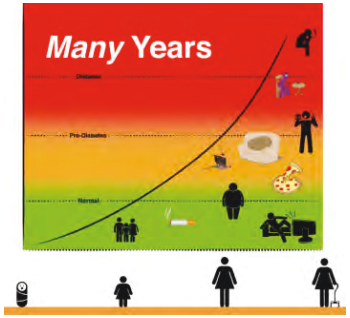
- Review last week's session
- Learn more about healthy eating strategies to live well with diabetes
- Review Video 2 "Healthy Eating Strategies"
- Review what you ate in a day
- Make a plan to eat healthier
- Review your homework
- Work more on taking your medicines

30 - 45

Last Session Review

- **Diabetes: body can't handle blood sugar**
- **Uncontrolled diabetes causes high blood sugar**
- **Uncontrolled diabetes over many years:**
  - *heart attack, heart failure*
  - *stroke*
  - *kidney problems, dialysis*
  - *eye problems, blindness*
  - *nerve damage, numbness, impotence*
  - *amputation*

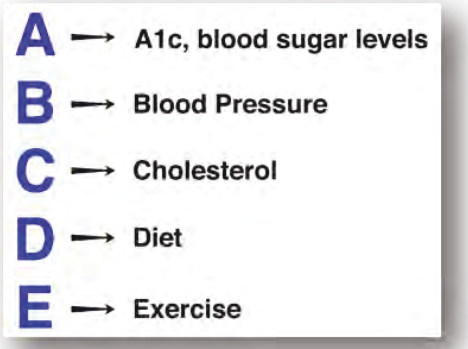




In Most People:

Diabetes develops over *many years.*

Diabetes won't go away.



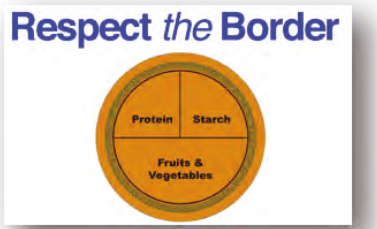
Taking care of diabetes – lots we can do to reduce our chances of getting health problems from diabetes ("diabetes complications")

- *Eat healthy*
- *Get enough exercise*
- *Take medications as prescribed*
- *Go to the doctor regularly for check-ups*

DVD Review

Remember the 3 Rules for Healthy Eating:

One and Done.
Avoid 2nd Helpings



Respect the Border
Eat Healthy
Portions of Food

Be Sweet on Yourself
Eat less fried foods
and drink fewer sugar-
sweetend beverages

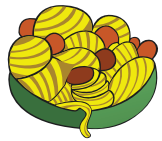
What did I eat in the past day?

	ME	Goal
Number of 2nd Helpings of Meat or Starch		**0**
Number of Fruits		**3 - 4**
Number of Vegetables		**3 - 4**
Number of Sugar-Sweetened Drinks		**0**
Number of Desserts		**0 -1**
Number of Servings of Fried Foods		**0**

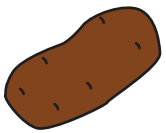
My Goal Is

Some examples of starchy foods are…


Rice


Pasta


Bread


Potato


Corn

This Week's Homework

	Took My **Diabetes Medications**?		**Eat Healthy**?	
Day 1 *(today)*	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
Day 2	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
Day 3	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
Day 4	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
Day 5	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
Day 6	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
Day 7	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**

☐ **I carried out my diabetes medication plan**

☐ **I carried out my healthy eating plan**

☐ **I watched the Session 3 Video**

My next session is:

Healthy Grocery Shopping at the Dollar Store

1/4 = Protein

- Canned tuna *(canned in water, not oil)*
- Milk *(choose skim or non-fat milk)*
- Eggs *(try scrambling, poaching, boiling)*
- Cheese
- Beans
- Spam
- Low-salt nuts

1/4 = Starch

- Whole-wheat bread *(even white bread is okay if you eat the correct portion!)*
- Starchy vegetables *(like potatos, corn, peas, yams)*
- Grits
- Rice
- Noodles and Pasta
- Oatmeal *(Instant oatmeal is often sweetened with sugar, so look for regular oatmeal: it's cheaper & lasts longer!)*
- Cereal

1/2 = Fruits & Veggies

- Dried fruits
- Canned vegetables *(look for low salt options, rinse salt off)*
- Canned fruit *(look for fruit canned in water, rinse with water fruit canned in sugary syrups)*

Fresh Fruits & Veggies

During the summer, check outside for a produce stand. **Fresh fruits and vegetables are much tastier than canned!**

Before You Go Shopping!

- **Make a plan.** Think about what you need to buy so you can make healthy choices for breakfast, lunch, dinner, and snacks.
- The stock at the Dollar Store can change often, so **make a list of the categories of food** you need, not specific foods. *(For example, list "dried fruit", not "dried apricots")*
- **Don't go shopping when you are hungry!**

Snack Options

- Dried fruits and nuts *(Look for low salt options. Try to wipe off as much salt as possible if you can't find low salt options.)*
- Baked chips, not fried *(remember to eat the correct portion!)*
- Water is the best drink option! *(If you want soda, get the bottles with a cap. Drink half a cup and save the rest for later.)*

Physical Activity *and* Your Health

In Today's Session

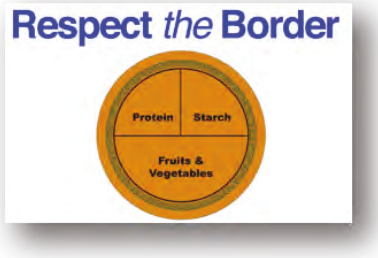
- Review last week's session
- Learn more about getting physical activity to live well with diabetes
- Review Video 3, "Physical Activity and Your Health"
- Develop a plan to get more exercise
- Review progress on healthy eating
- Review homework
- Work more on taking your medicines

30 - 45

Last Session Review

Remember the 3 Rules for Healthy Eating:

One and Done.
Avoid 2nd Helpings



Respect the Border
Eat Healthy
Portions of Food

Be Sweet on Yourself
Eat less fried foods and drink fewer sugar-sweetend beverages

DVD Review

Remember the 3 Rules for Physical Activity

Rule 1

→ **Feel** Better
Think Better
Live Better

Rule 2

Walk down your blood sugar →

Cardiovascular Exercise
(Brisk Walk)

Rule 3

Sitting is the New Smoking

Move 2 Minutes
Every Hour

Recommended:
30 minutes of brisk walking on 5 or more days per week

My Exercise Goal Is:

Small *Changes*
Big Benefits!

This Week's Homework

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1 *(today)*	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

☐ **I carried out my diabetes medication plan**

☐ **I carried out my healthy eating plan**

☐ **I carried out my exercise plan**

☐ **I watched the Session 4 Video**

My next session is:

In Today's Session

- Review last week's session
- Learn more about diabetes medicines and how they can help you live a full, active life
- Review video 4, "Diabetes Medications"
- Review homework
- Continue working on healthy eating, exercise, and taking your diabetes medicines as the doctor prescribed

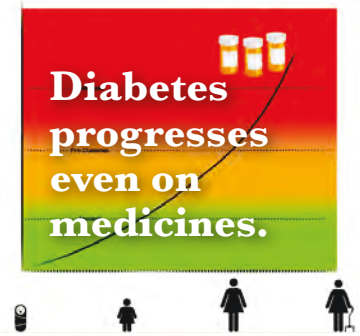
Last Session Review

Remember the 3 Rules for Physical Activity

Recommended:
30 minutes of brisk walking on 5 or more days per week

DVD Review

Medications are **important**, ***but*** they are **not perfect**.



You may need a 2nd or 3rd medication,
even if you're doing everything right.

Diabetes progresses *much more quickly* off medications

Shortening your life

+

Increasing risks for conditions like


stroke


heart attack

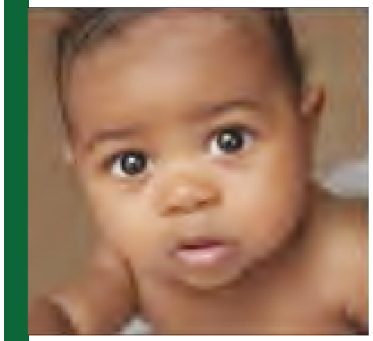

dialysis


amputations

These complications can be prevented or delayed with medications, diet, and exercise.

- **Many types of diabetes medications!** You should be able to get on a medication that both controls your sugar and lets you feel well.
- **Side effects can be problem**, but you should discuss with your doctor before stopping.
- **Generic drugs** work as well as brand name drugs, but generics can be more affordable.

My Future



We all have plans for our future,
or occasions we'd like to be part of.

Are my diabetes medicines working for me?

A1C *(Average Sugar Control over the last 3 months)*

☐ Great control	Less than 7
☐ Ok, not perfect	7.0 ⟷ 7.9
☐ Cause for concern	8.0 ⟷ 8.9
☐ Bigger cause for concern	> 9.0

This Week's Homework

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1 *(today)*	☐ Yes ☐ No	☐ Yes ☐ No	*minutes*
Day 2	☐ Yes ☐ No	☐ Yes ☐ No	*minutes*
Day 3	☐ Yes ☐ No	☐ Yes ☐ No	*minutes*
Day 4	☐ Yes ☐ No	☐ Yes ☐ No	*minutes*
Day 5	☐ Yes ☐ No	☐ Yes ☐ No	*minutes*
Day 6	☐ Yes ☐ No	☐ Yes ☐ No	*minutes*
Day 7	☐ Yes ☐ No	☐ Yes ☐ No	*minutes*

☐ I carried out my **diabetes medication plan**

☐ I carried out my **healthy eating plan**

☐ I carried out my **exercise plan**

☐ I watched the **Session 5 Video**

My next session is:

Session 5

Blood Pressure *and* Cholesterol Medicines

In Today's Session

- Review last week's session
- Learn more about blood pressure and cholesterol medicines and how they can help you live a full, active life
- Review Video 5, "Cholesterol and Blood Pressure Medications"
- Review homework
- Continue working on healthy eating, exercise, and taking your diabetes medicines as the doctor prescribed

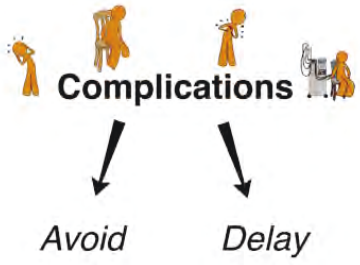
30 - 45

Last Session Review

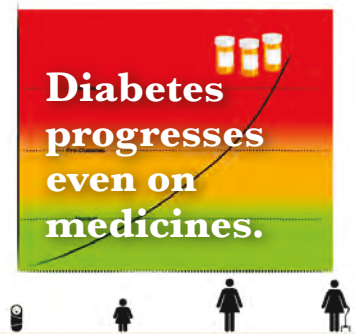
Diabetes Medications

- **Control your blood sugar**
- **Keep you from feeling bad from high sugar**

- **Prevent or delay diabetes complications**

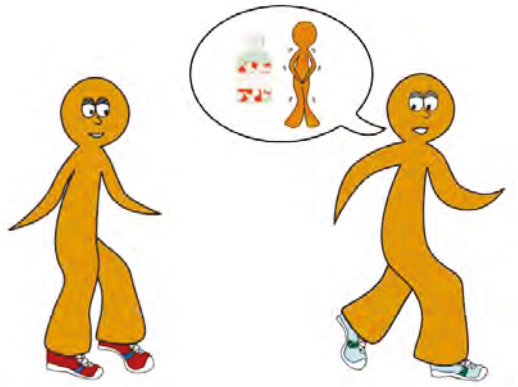


Medications are **not perfect**.



You may need a 2nd or 3rd pill, **even if you're doing everything right.**

Diabetes progresses *much more quickly* off medications



Not Everyone Gets Side Effects!

Many types of diabetes medications are available.

Work with your doctor to find a medicine that...

- *controls your sugar*
- *and lets you feel well*

DVD Review

140 / 90

High blood pressure is a chronic disease that develops over years.

High blood pressure causes

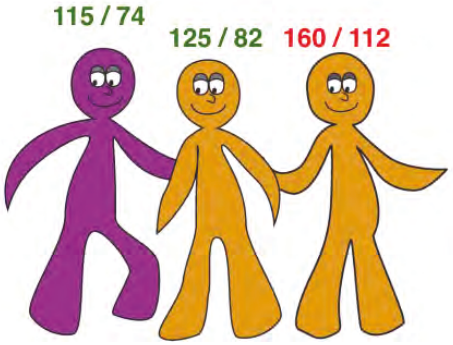
Stroke

Heart Attack

Dialysis

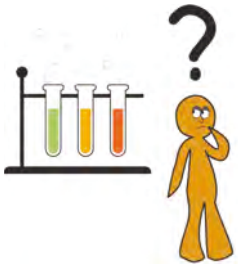
Blindness

"The Silent Killer"



High blood pressure often has **no symptoms.**

- Sometimes it can feel like the doctor is experimenting on you because of the many changes in dose and pills!



- One blood pressure pill may not work as well in you as in someone else, so it may take a while for you to get on the best pill for you

Many types of blood pressure medications are available.

Work with your doctor to find a medicine that...

- *controls your blood pressure*
- *and lets you feel well*

High Cholesterol

LDL Cholesterol → *over 100*

High cholesterol has **no symptoms.**

High cholesterol causes

Stroke

Heart Attack

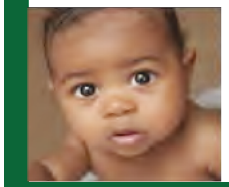
Statins

most common medicine for high cholesterol

- **Side effects can be problem**, but you should discuss with your doctor before stopping.
- **Generic medications** work as well as brand name drugs, but generics can be more affordable.

My Future






We all have plans for our future, or occasions we'd like to be part of.

How is my blood pressure?

Blood Pressure

☐ Normal	Less than 120/80
☐ Our Goal	Less than 140/90
☐ High-*talk to doctor*	140/90 or higher

How is my cholesterol?

Cholesterol *(LDL cholesterol or your "bad cholesterol")*

☐ Okay	Less than 100
☐ High-*talk to doctor*	100 or higher

This Week's Homework

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1 *(today)*	☐ Yes ☐ No	☐ Yes ☐ No	*minutes*
Day 2	☐ Yes ☐ No	☐ Yes ☐ No	*minutes*
Day 3	☐ Yes ☐ No	☐ Yes ☐ No	*minutes*
Day 4	☐ Yes ☐ No	☐ Yes ☐ No	*minutes*
Day 5	☐ Yes ☐ No	☐ Yes ☐ No	*minutes*
Day 6	☐ Yes ☐ No	☐ Yes ☐ No	*minutes*
Day 7	☐ Yes ☐ No	☐ Yes ☐ No	*minutes*

☐ I carried out my **diabetes medication plan**

☐ I carried out my **healthy eating plan**

☐ I carried out my **exercise plan**

☐ I watched the **Session 6 Video**

My next session is:

Session 6

Stress *and* Your Health

In Today's Session

- Review last week's session
- Review Video 5, "Stress and Your Health"
- Learn about stress, diabetes, and your health
- Learn how to reduce your stress
- Review homework
- Continue working on healthy eating, exercise, and taking your medicines as the doctor prescribed

30 - 45

Last Session Review

Important to keep blood pressure and cholesterol under control.

High blood pressure causes


Stroke


Heart Attack


Dialysis


Blindness

High cholesterol causes


Stroke


Heart Attack

Blood pressure goal is to be ***under* 140 / 90**

- Normal blood pressure is 120/80
- There are many blood pressure medicines available to get your blood pressure under control, but it might take a while to get there

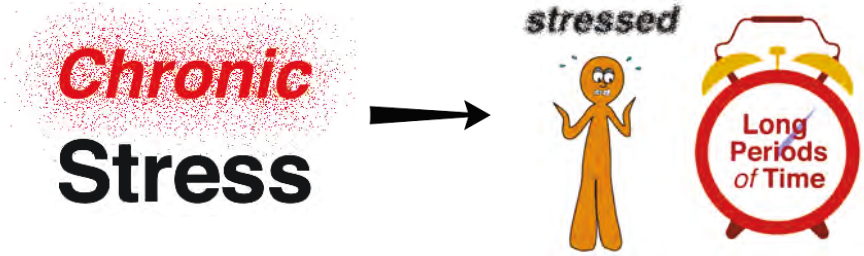
LDL cholesterol goal is to be ***under* 100**

- Most people take statins to lower cholesterol
- Most people with diabetes have high cholesterol

Side Effects are possible with blood pressure and cholesterol medicatons

- Work with your doctor to find a pill that works for you!
- **Don't Just Stop: talk to your doctor!**

DVD Review



Upset stomach

Irritability

Fatigue

Worse arthritis

Trouble sleeping

No concentration

160/100
145/90
120/80

Higher blood pressure

Heart disease

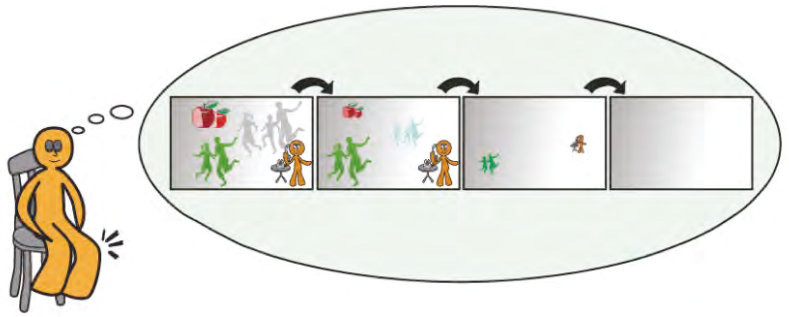
How to manage stress:

1. **Recognize** when you are stressed

2. **Identify** the sources of stress

3. **Do healthy things** to reduce stress

Deep Breathing Technique



This Week's Homework

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1 *(today)*	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

Homework for the following week

Try to add more healthy eating and exercise!

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

☐ **I carried out my diabetes medication plan**

☐ **I carried out my healthy eating plan**

☐ **I carried out my exercise plan**

My call next week is:

Call in 2 weeks:

Session 7

Practice and Planning for the Future - Part 1

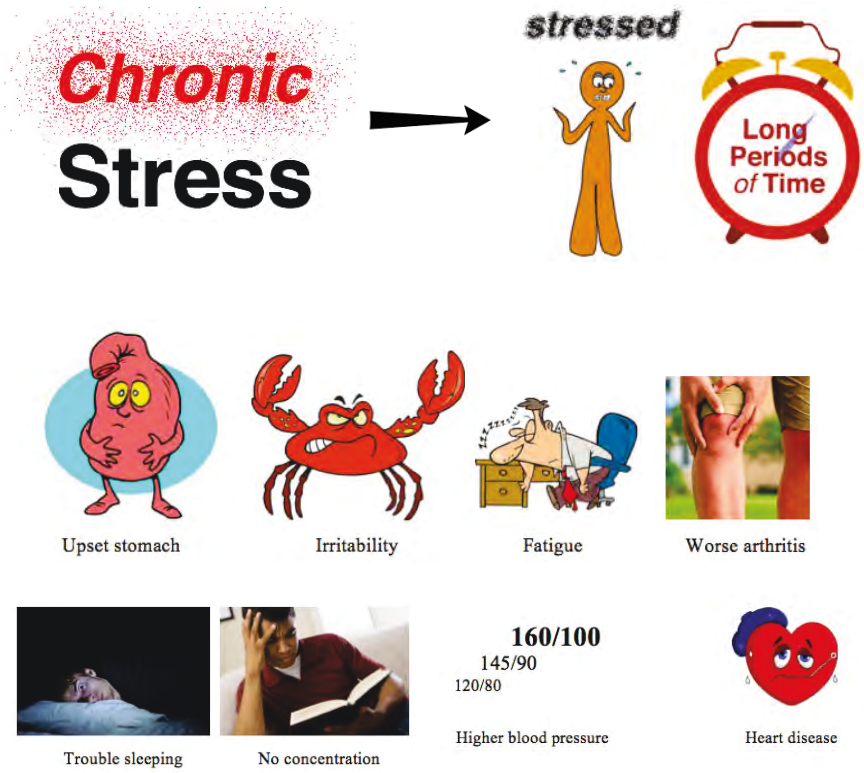
Small
Changes
Big Benefits!

In Today's Session

- Review last session and homework
- Discuss what you have learned from this program and how activities have helped
- Think about a Health Buddy that can help you keep going when the program ends
- Continue working on healthy eating, exercise, and taking your medicines as the doctor prescribed

30 - 45

Last Session Review



Important to manage stress in healthy ways!

1. **Recognize** when you are stressed

2. **Identify** the sources of stress

3. **Do healthy things** to reduce stress

Exercise

Deep breathing

How is eating healthy, exercising, and taking my medications helping me?

☐ My **blood sugar** is better

☐ I have **lost weight**

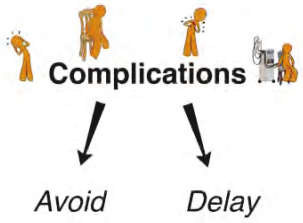
☐ I have **more energy**

☐ My **mood** is better

☐ I can **take care** of my **family** better

☐ I can do **my job** better

☐ I can **go out** more

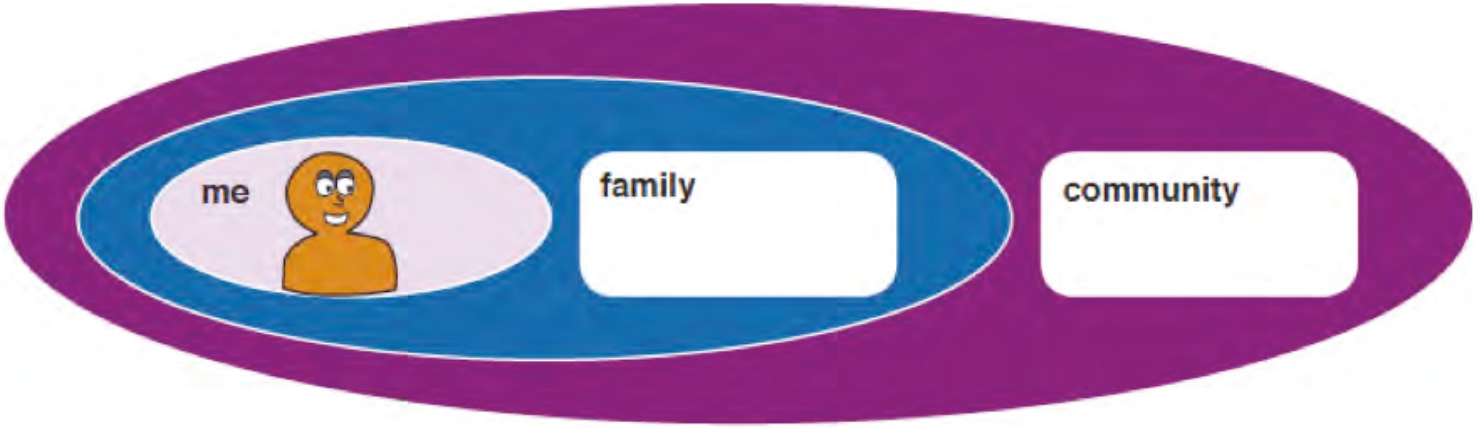


☐ It is **decreasing my chances** of experiencing complications from my diabetes.

☐ It is **increasing my chances** of being there for **important events down the road.**

How Can I Keep Going in the Future? My Health Buddy

Who Supports Me?



Name of the person that I would like to be my health buddy:

When I will ask them to be my health buddy:

Week 1

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1 *(today)*	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

Week 2

Try to add more healthy eating and exercise!

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

Week 3

Try to add more healthy eating and exercise!

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

Week 4

Try to add more healthy eating and exercise!

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

☐ **I carried out my diabetes medication plan**

☐ **I carried out my healthy eating plan**

☐ **I carried out my exercise plan**

Call in 2 weeks is:

Call in 4 weeks:

Session 8

Practice and Planning for the Future - Part 2

In Today's Session

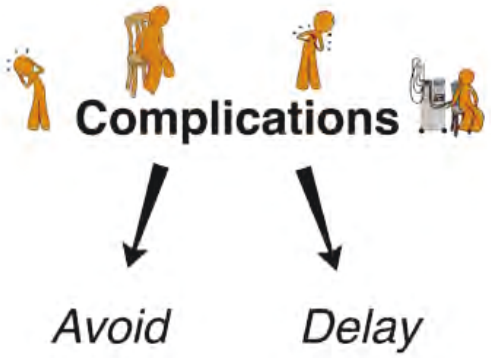
- Review last session and homework
- Discuss what you have learned from this program and how activities have helped
- Continue working on healthy eating, exercise, and taking your medicines as the doctor prescribed

30 - 45

Last Session Review

Medications aren't perfect

- Control your blood sugar, blood pressure, and cholesterol
- Medications help prevent or delay complications



- **Side effects can be problem**, but you should discuss with your doctor before stopping.
- **Generic medications** work as well as brand name drugs, but generics can be more affordable.
- **Work with your doctor** to find a pill that works for you!

How Can I Keep Going in the Future? My Health Buddy

I want to keep going with the three-legged stool on my own!

What activities can I do with my Health Buddy to help me…

Eat Healthy?

Take medications?

Exercise?

Homework

Week 1

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1 *(today)*	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

Week 2

Try to add more healthy eating and exercise!

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

Week 3

Try to add more healthy eating and exercise!

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

Week 4

Try to add more healthy eating and exercise!

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

☐ **I carried out my diabetes medication plan**

☐ **I carried out my healthy eating plan**

☐ **I carried out my exercise plan**

Call in 4 week is:

Session 9

Monitoring My Progress

In Today's Session

- Review homework
- Continue working on healthy eating, exercise, and taking your medicines as the doctor prescribed

10 - 15

Homework

Week 1

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1 *(today)*	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

Week 2

Try to add more healthy eating and exercise!

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

Week 3

Try to add more healthy eating and exercise!

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

Week 4

Try to add more healthy eating and exercise!

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

☐ **I carried out my diabetes medication plan**

☐ **I carried out my healthy eating plan**

☐ **I carried out my exercise plan**

Call in 4 week is:

Session 10 | Monitoring My Progress

In Today's Session

- Review homework
- Continue working on healthy eating, exercise, and taking your medicines as the doctor prescribed

10 - 15

Homework

Week 1

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1 *(today)*	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

Week 2

Try to add more healthy eating and exercise!

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

Week 3

Try to add more healthy eating and exercise!

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

Week 4

Try to add more healthy eating and exercise!

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

☐ **I carried out my diabetes medication plan**

☐ **I carried out my healthy eating plan**

☐ **I carried out my exercise plan**

Call in 4 week is:

Session 11 | Final Session

In Today's Session

- Review homework
- Continue working on healthy eating, exercise, and taking your medicines as the doctor prescribed

10 - 15

Keep Going On Your Own!

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1 *(today)*	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1 *(today)*	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1 *(today)*	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1 *(today)*	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1 *(today)*	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1 *(today)*	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1 *(today)*	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1 *(today)*	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1 *(today)*	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

	Took My **Diabetes Medications**?	**Eat Healthy**?	**Exercise Minutes**?
Day 1	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 2	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 3	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 4	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 5	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 6	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***
Day 7	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	***minutes***

Appendix D

Recruitment Flyer

Participant Interest Card

Need Help Managing Your Diabetes?

As a participant in the Living Well Study, you will receive:

- Health Education Videos
- A personalized “Diabetes Report Card
- A portable DVD player and a $20 gift card

and

- You may also be partnered with a trained peer advisor to provide you with one-on-one advice to help improve your diabetes care

Call 205-934-7163 for more information!

Living Well *with* Diabetes

Living Well (X160301010) is a research study being conducted in the UAB Division of Preventive Medicine.
Dr. Andrea Cherrington, Principal Investigator

Participant Interest Card

Today's Date: _____

I am interested in learning more about the Living Well with Diabetes Study. I authorize the Living Well Study Team to contact me about this.

_____
Signature

_____ _____
First Name *Last Name*

( ) -
_____
Telephone Number 1

( ) -
_____
Telephone Number 2

Best Times to Call

- ☐ Morning
- ☐ Afternoons
- ☐ Evenings

- ☐ Mon
- ☐ Tues
- ☐ Weds
- ☐ Thurs
- ☐ Fri
- ☐ Sat
- ☐ Sun

Referred By

First Name *Last Name*

city / telephone number

For UAB Staff

Date received:	*notes*
Logged:	

Participant Eligibility Screening Script

Living Well Research Study: **Telephone Eligibility Script**

This is the first telephone call with UAB staff. Potential participant may have been referred by 1) signing an interest card that gave us permission to contact them or 2) calling the study's phone number.

Goals of this call are:

- Provide community member with study information and answer any questions
- Determine community member's study eligibility
- Schedule 45-60 minutes telephone interview

VOICEMAIL: Hello, my name is (_____) and I am calling from the University of Alabama at Birmingham about the Living Well research study. If you are interested in learning more about this research study, please call 1.205.934.7163 and one of our study team members will call you back. Thank you and have a great day!

Hello, my name is (_____) and I am calling from the University of Alabama at Birmingham about the Living Well Research Study.

S1.	**May I please speak with Mr/Ms (_____)?**
	[If not speaking] Is Mr./Ms. (_____) available? *[If no]* When may I call back to speak with Mr./Ms. (_____) *[If yes]* Continue with S2 when he/she comes on the line.
S2.	**Before we continue, let me make sure I have the correct spelling of your name.** Correct spelling? ☐ Yes ☐ No**:** *Note correct spelling here:*_____

☐ Community member called UAB **Complete S3a.**	☐ Community member signed and submitted a study interest card **Complete S3b.**

S3a. *[Called UAB]* You recently called the UAB Living Well research study's phone number and requested someone from the study to contact you. Living Well is a research study that could help improve your diabetes. Is this a good time to talk about this? It will take between 5-10 minutes.

☐ **Not interested in study** → Would you mind telling me the reason you are not interested in the program?
[Note reason not interested here] _____

☐ **Not a good time to talk**→ When would be a better time to call you?
[schedule date/time to call back] _____

☐ **Yes, can talk now → Great! First, how did you hear about this program?**

- ☐ Flyer/advertisement
- ☐ Referred by friend or family member
- ☐ At a community event (e.g. health fair)
- ☐ Other

*[Add specific details for all methods]*_____

Go to question S4.

S3b. *[Signed interest card. Interest card from:*_____*]*

I received your name from (Ms/Mr/Event)_____, and (she/he) thought that you might be interested in a program that could help improve your diabetes. Is this a good time to talk about this? It will take between 5-10 minutes.

☐ **Not interested in study** → Would you mind telling me the reason you are not interested in the program?
[Note reason not interested here] _____

☐ **Not a good time to talk**→ When would be a better time to call you?
[schedule date/time to call back] _____

☐ **Yes, can talk now → go to S4.**

S4.	Let me tell you a little about the program. - This study is trying to improve the quality of life of people with diabetes. - If you are eligible and decide to participate in the study, you may be paired with a Peer Advisor who is very familiar with diabetes. - Your peer advisor: o Is someone who lives in your community o Was trained by study investigators to help people take care of their diabetes o Will call you on the telephone 13-16 times over 6 months. - During these calls, you will talk to your peer advisor about your diabetes care. Are you interested in working with a peer advisor as I just described for 6 months over the telephone? ☐ No → Thank you so much for your time. You are not eligible for this study since we are looking for people who are interested in working with a peer advisor over the telephone. Have a nice day! ☐ Yes → *continue to next section*
In order to find out if you might be eligible to participate in this study, I would like to ask you some questions. Your answers to these questions will help us know if you are eligible to be in this study. If there are any questions you don't want to answer, you can tell me, and we will skip to the next question.	
S5.	Have you ever been told by a doctor or nurse that you have diabetes? ☐ No → Thank you so much for your time. You are not eligible for this study since we are looking for people who have diabetes. Have a nice day! ☐ Yes → *continue to next section*
S6.	Do you have a doctor that you see regularly for your diabetes and other medical care (at least once in the past 12 months? If yes = What is your doctor's name?_____ What city is your doctor located in?_____ If yes = Have you seen Dr. _____ in the past 12 months? ☐ No → Thank you so much for your time. You are not eligible for this study since we are looking for people who have been to a doctor in the past 12 months. Have a nice day! ☐ Yes → *continue to next section*
S7.	Do you take pills for your diabetes or blood sugar? ☐ No → Thank you so much for your time. You are not eligible for this study since we are looking for people who are taking pills for their blood sugar. Have a nice day! ☐ Yes → *continue to next section*
S8.	• Do you ever forget to take your diabetes (or sugar) medicines? ☐ Yes ☐ No • People sometimes miss taking their medications for reasons other than forgetting. Thinking over the past two weeks, were there any days when you did not take your medicine? ☐ Yes ☐ No • When you feel better, do you sometimes stop taking your diabetes (or sugar) medicines? ☐ Yes ☐ No • Sometimes, if you feel worse when you take the diabetes (or sugar) medicines, do you stop taking it? ☐ Yes ☐ No • Would you like help with taking your diabetes or sugar medicines? ☐ Yes ☐ No ☐ No to all 5 questions→ Thank you so much for your time. You are not eligible for this study since we are looking for people who sometimes do not take their diabetes medications. Have a nice day! ☐ Yes to at least 1 question → *continue to next section*

S9.	Are you participating in any other study or studies about diabetes? ☐ Yes → Thank you so much for your time. You are not eligible for this study since we are looking for people who are not participating in any other study or studies about diabetes. Have a nice day! ☐ No → *continue to next section*	
S10.	Are you on chemotherapy or have been on chemotherapy in the past 12 months? Are you on dialysis?	☐ Yes ☐ No ☐ Yes ☐ No
	☐ Yes → Thank you so much for your time. You are not eligible for this study since we are looking for people who have not been on chemotherapy in the past 12 months / on dialysis. Have a nice day! ☐ No → *continue to next section*	
S11.	Are you planning on moving out of the county in the next 6 months? ☐ Yes → Thank you so much for your time. You are not eligible for this study since we are looking for people who are not planning on moving out of the county in the next 6 months. Have a nice day! ☐ No → *continue to next section*	
S12.	What is your age today? ☐ <18 years old → Thank you so much for your time. You are not eligible for this study since we are looking for people 18 years old or older. ☐ > 18 → *continue to next section*	
S13.	What is your gender? If female: are you pregnant or planning on becoming pregnant in the next 6 months? ☐ Female, pregnant → Thank you so much for your time. You are not eligible for this study since we are looking for people who are not pregnant. ☐ Female, not pregnant → *continue to next section* ☐ Male → *continue to next section*	
S14.	An important part of enrolling in this study involves completing several data collection visits. Let me tell you a about these data collection visits. - The first part of this study involves completing an interview over the telephone that will take around 45 to 60 minutes. - During this telephone interview, we will ask you some questions about you and your diabetes. - This call will happen after you decide that you want to participate in the study. - After this phone interview is complete, we will schedule an in-person data collection visit. During this visit, we will measure your blood pressure, weight, and height. Our team will also do a finger stick test to check your "A1c" and "LDL cholesterol" numbers. - The phone interview and in-person visits will be done again after the end of the program. - The in-person data collection visits will be held at a community location. If you are unable to come to a community location, with your permission, a study research assistant will visit you at your home to complete this data collection visit. Would you be willing to participate in 2 telephone interviews and 2 in-person data collection visits? ☐ No → Thank you so much for your time. You are not eligible for this study since we are looking for people who are willing to participate in telephone interviews and in person data collection visits before and after the program (this is a total of 2 telephone interviews and 2 in person data collection visits.). Have a nice day! ☐ Yes → Continue to next section.	

Great! We are almost through. Thank you so much for answering these questions. Let me tell you a little more about the study.

- Living Well program is a research study that partners a team at the University of Alabama at Birmingham with Peer Advisors in several Alabama Black Belt communities.
- We want to find ways to improve health outcomes in people who have diabetes.
- There is no cost for you to be part of this program.

- This is a 6 month project. During the 6 months, you will meet with the UAB study team 2 times in person and complete a telephone interview 2 times.
- If you are assigned a peer advisor, you will speak with your peer advisor 13-16 times over a period of 6 months.
- If you do qualify and enroll in the study, you will receive a portable DVD player, educational materials, and a $20 VISA giftcard for participating in the study.
- At each in-person data collection visit with the UAB study team, the staff will do a finger stick test to check your A1c number, which is your average blood sugar level, and your blood cholesterol. They will also measure your height, weight, blood pressure, and make a list of your medications.
- Do you have any questions about this program?

S15. Are you interested in enrolling in the study?

☐ **Not interested in study** → Would you mind telling me the reason you are not interested in the program?
[Note reason not interested here] _____

☐ **Interested in study** → Continue to next section

Great! Let me tell you the next steps for enrolling in the program.

- I will need to schedule a time for a study research assistant to call you to complete a telephone interview with you. The telephone interview will take about 45-60 minutes to complete.
- After the interview is complete, we will schedule a time for your first in-person data collection visit.
- We ask that you do not drink any caffeine (from coffee, tea, or soda), eat, do any heavy physical activity, smoke, or ingest alcohol for 30 minutes prior to the in-person data collection visit.
- Since this is a research study, we will ask you to sign an informed consent form during the in-person visit. Even though the program does not involve any experimental medicines or procedures, we still need your consent.
- After the in person visit, you will receive the health education materials and if you are in the program with a Peer Advisor, your peer advisor will begin calling you on the telephone once a week.
- May I answer any questions you have at this point?

Schedule Telephone Interview:

Okay, let's schedule your telephone interview. The telephone interview will take about 45-60 minutes to complete. A study research assistant will call you on the phone to complete the telephone interview. When is a good time and day for a study research assistant to call you to complete the telephone interview? Remember, the interview will take around 45-60 minutes.

I will mail a study informed consent to your home. You will receive it in the mail in about a 2 to 3 days.

Great! Thank you so much for your time today. A study research team member will call you on _____(date/time) at this number _____(telephone number) to complete your telephone interview.

Have a wonderful day!

COMPLETE Contact information

Phone (home): _____ *Phone (work):* _____
Phone (cell): _____ *Phone (other):* _____

We would also like the name and telephone number of a friend or family member who would know your whereabouts in case we have trouble contacting you. Please think of someone you know who would not mind if we called them for this information.
Alternative phone 1: _____ *Alternative phone 2:* _____
Mailing Address:

Appendix E

Telephone Interview

Participant ID:	
Interviewer ID:	
Scheduled Date:	
Scheduled Time:	

Living Well with Diabetes Program
Baseline Interview

Interviewer Notes

VOICEMAIL: Hello, my name is (_____) and I am calling from the University of Alabama at Birmingham about the Living Well Research Study. Please call 1.205.934.7163 and one of our study team members will call you back. Thank you and have a great day!

C1. **Hello, this is (_____) from the University of Alabama at Birmingham's Living Well Program.**
May I please speak with _____
[Not available - reschedule date / time for call]
Okay, when is a better time for me to call back to speak with Mr./Ms. (_____)?
[Note date/time to call back].

[Continue when participant comes to the phone].
Hi, (Mr. / Ms._____), I am calling so that we can complete your telephone interview. Is this still an okay time to talk? Our call will take between 45 - 60 minutes?
Yes → *continue to C2*
No → [do not have time - reschedule date / time]

No → [decline participation] Would you mind telling me why you are not interested in the study?

[document reason_____]
Thank you so much for your time.

C2. **You should have received a package that contained the informed consent. Have you received this packet?**

No → [arrange to mail another packet / reschedule date time____ _____]

Yes → Great! Let's get started.

C3. **First, I would like to go over the Informed Consent with you.**

[Review each section of the consent form, stop and ask if the participant has questions after each section. Does the participant give verbal consent to the interview?] **- Does the participant give verbal consent to the interview?**

Yes → *continue to C4 to begin the interview.*
No → [decline participation] Would you mind telling me why you are not interested in the study?

[document reason_____]
Thank you so much for your time.

C4. **Today, we are going to talk about different topics to help us better understand your experience with diabetes and your experience with medical care in general.**
- Please let me know if you need me to repeat any of the questions.
- If there is a question you do not want to answer, please let me know and we can skip it.
- Also, if at any point in time you need to take a break please let me know.
- Okay, let's begin.

Interview started date: _____/_____/_____

Interview started time: _____ am / pm

First, I have a few questions about what you may have heard about diabetes.
1. What are the signs and symptoms of high blood sugar? *[if no response after 10-15 seconds, prompt]* How do you feel when your blood sugar is high or when you were diagnosed?
2. What are the signs and symptoms of low blood sugar? *[prompt]* How do you feel when your blood sugar is too low?
3. How do you treat low blood sugar? *[prompt]* What should you do if your sugar is too low? How can you bring your blood sugar up if it's too low?
4. What is a normal HB A1C (Hemoglobin A1c) or "average blood sugar test"? *[prompt]* When your doctor draws blood from your arm and gets an average blood sugar reading, what should it be?
5. How many times a week should someone with diabetes exercise and for how long? *[prompt]* How many times a week? How long or how much per day?
6. What are some long-term complications of uncontrolled diabetes? *[prompt]* Do you know anyone that has diabetes and had "bad things" happen to them? What are some of those "bad things"?

Managing diabetes on your own can be challenging. We would like to learn a little more about what kinds of help and support you might like to get from friends and family.		
7. How much support do you get from family and friends dealing with your diabetes? *Do you receive...*	☐ A great deal of support ☐ Neutral ☐ No support	■ DK ■ NA ■ Ref
8. How satisfied are you with the support you get from family and friends for dealing with your diabetes? *Are you...*	☐ Extremely satisfied ☐ Neutral ☐ Not at all satisfied	■ DK ■ NA ■ Ref
9. How much support do you get from your health care team for dealing with your diabetes problems? *Do you receive...*	☐ A great deal of support ☐ Neutral ☐ No support	■ DK ■ NA ■ Ref
10. How satisfied are you with the support you get from your health care team for dealing with your diabetes problems? *Are you...*	☐ Extremely satisfied ☐ Neutral ☐ Not at all satisfied	■ DK ■ NA ■ Ref

Notes

The next set of questions asks for your views about your health.					
11. In general, would you say your health is excellent, very good, good, fair, or poor?	excellent	very good	good	fair	poor

12. Have you smoked at least 100 cigarettes in your entire life? *Note: **5 packs** = 100 cigarettes, **do not include**: electronic cigarettes (e-cigarettes, NJOY, Bluetip), herbal cigarettes, cigars, cigarillos, little cigars, pipes, bidis, kreteks, water pipes (hookahs), or marijuana."*	☐ Yes ☐ No ■ don't know ■ refused

13. Do you smoke cigarettes every day, some days, or not at all?	☐ Everyday ☐ Somedays ☐ Not at all ■ don't know ■ refused	

The following questions are about activities you might do during a typical day.		
14. During a typical day, does your health limit you in **moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf. *Does your health limit you a lot, a little, or not at all?*	☐ Yes, a lot ☐ Yes, a little ☐ No, not at all	DK NA Ref
15. During a typical day, does your health limit you in climbing **several** flights of stairs? *Does your health limit you a lot, a little, or not at all?*	☐ Yes, a lot ☐ Yes, a little ☐ No, not at all	DK NA Ref

16. During the past 4 weeks, as a result of your **physical health**, have you **accomplished less** than you would like? *Yes or no?*	☐ Yes ☐ No	DK NA Ref
17. During the past 4 weeks, as a result of your **physical health,** you were **limited in any kind of work or other activities**? *Yes or no?*	☐ Yes ☐ No	DK NA Ref
18. During the past 4 weeks, as a result of any **emotional problems**, such as feeling depressed or anxious, have you **accomplished less** than you would like? *Yes or no?*	☐ Yes ☐ No	DK NA Ref
19. During the past 4 weeks, as a results of any **emotional problems**, such as feeling depressed or anxious, did you work **less carefully than usual**? *Yes or no?*	☐ Yes ☐ No	DK NA Ref

20. During the past 4 weeks, how much did **pain** interfere with your normal work including both work outside the home and housework? *Not at all, a little bit, moderately, quite a bit, or extremely?*	not at all	a little bit	moderately	quite a bit	extremely	DK NA Ref

	<u>All</u> of the time	<u>Most</u> of the time	a <u>good bit</u> of the tiime	<u>Some</u> of the time	<u>a little</u> of the time	<u>none</u> of the time	
21. During the past 4 weeks, how much of the time have you felt calm and peaceful?	All	Most	Good bit	Some	Little	None	DK NA Ref
22. During the past 4 weeks, how much of the time did you have a lot of energy?	All	Most	Good bit	Some	Little	None	DK NA Ref
23. During the past 4 weeks, how much of the time have you felt downhearted and blue?	All	Most	Good bit	Some	Little	None	DK NA Ref
24. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends or relatives)?	All	Most	Good bit	Some	Little	None	DK NA Ref

Notes

Now I am going to read statements of people with diabetes. Please tell me if you agree with the statements. For each statement, please tell me if you agree not at all, somewhat, to a large extent, or completely.

		Not at all	*Somewhat*	*To a large extent*	*Completely*	
25.	Because of my diabetes, I miss the things I like to do most. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
26.	I can handle the problems related to my diabetes. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
27.	I have learned to live with my diabetes. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
28.	Dealing with my diabetes has made me a stronger person. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
29.	My diabetes controls my life. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
30.	I have learned a great deal from my diabetes. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
31.	My diabetes makes me feel useless at times. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
32.	My diabetes has made life more precious to me. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
33.	My diabetes prevents me from doing what I would really like to do. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
34.	I have learned to accept the limitations imposed by my diabetes. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
35.	Looking back, I can see that my diabetes has brought about some positive changes in my life. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
36.	My diabetes limits me in everything that is important to me. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
37.	I can accept my diabetes well. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
38.	I think I can handle the problems related to my diabetes, even if the diabetes gets worse. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
39.	My diabetes frequently makes me feel helpless. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
40.	My diabetes has helped me realize what's important in life. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
41.	I can cope effectively with my diabetes. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
42.	My diabetes has taught me to enjoy the moment more. *Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?*	N	S	T	C	DK Ref
		Not at all	*Somewhat*	*To a large extent*	*Completely*	

Notes

The next few questions are about prescription medications you take for your diabetes or sugar.			
43. Do you ever forget to take your diabetes (or sugar) medicines?	Yes	No	DK Ref
44. People sometimes miss taking their medications for reasons other than forgetting. Thinking over the past 2 weeks, were there any days when you did not take your diabetes medicine for reasons other than forgetting?	Yes	No	DK Ref
45. When you feel better, do you sometimes stop taking your diabetes medicines?	Yes	No	DK Ref
46. Sometimes, if you feel worse when you take the diabetes medicines, do you stop taking it?	Yes	No	DK Ref

These questions are about beliefs about medication. For each statement, please tell me if you strongly agree, agree, are neutral, disagree, or strongly disagree.

	strongly agree	*agree*	*not sure*	*disagree*	*strongly disagree*	
47. My medicine protects me from becoming worse. *Do you strongly agree, agree, are not sure, disagree, or strongly disagree?*	SA	A	NS	D	SD	DK Ref
48. My health, right now, depends on my medicines. *Do you strongly agree, agree, are not sure, disagree, or strongly disagree?*	SA	A	NS	D	SD	DK Ref
49. My health in the future depends on my medicine. *Do you...*	SA	A	NS	D	SD	DK Ref
50. Without my medicine, I would be very ill. *Do you...*	SA	A	NS	D	SD	DK Ref
51. My life would be impossible without my medicine. *Do you...*	SA	A	NS	D	SD	DK Ref
52. I sometimes worry about the long-term effects of my medicine. *Do you...*	SA	A	NS	D	SD	DK Ref
53. My medicine is a mystery to me. *Do you...*	SA	A	NS	D	SD	DK Ref
54. I sometimes worry about becoming too dependent on my medicine. *Do you...*	SA	A	NS	D	SD	DK Ref
55. Having to take medicines worries me. *Do you...*	SA	A	NS	D	SD	DK Ref
56. My medicine disrupts my life. *Do you...*	SA	A	NS	D	SD	DK Ref
57. Doctors use too many medicines. *Do you...*	SA	A	NS	D	SD	DK Ref
58. If doctors had more time with patients, they would prescribe fewer medicines. *Do you...*	SA	A	NS	D	SD	DK Ref
59. Doctors place too much trust in medicines. *Do you...*	SA	A	NS	D	SD	DK Ref
60. Natural remedies are safer than medicines. *Do you...*	SA	A	NS	D	SD	DK Ref
61. Most medicines are addictive. *Do you...*	SA	A	NS	D	SD	DK Ref
62. People who take medicines should stop their treatment for a while every now and again. *Do you...*	SA	A	NS	D	SD	DK Ref
63. Medicines do more harm than good. *Do you...*	SA	A	NS	D	SD	DK Ref
64. All medicines are poisons. *Do you...*	SA	A	NS	D	SD	DK Ref
	strongly agree	*agree*	*not sure*	*disagree*	*strongly disagree*	

Notes

These next questions are some reasons why people may have trouble taking their diabetes medicines. Please tell us **how often** these reasons apply to YOU.

		Very often	*often*	*some-times*	*rarely*	*never*	
65.	I just forget to take my diabetes medications. *Does this statement apply to you very often, often, sometimes, rarely, or never?*	VO	O	S	R	N	DK Ref
66.	I forgot to fill my prescription for diabetes medicines in time. *Does this statement apply to you very often, often, sometimes, rarely, or never?*	VO	O	S	R	N	DK Ref
67.	I don't know what dose to take. *Does this statement apply to you very often, often, sometimes, rarely, or never?*	VO	O	S	R	N	DK Ref
68.	I'm not sure exactly what each diabetes medicine is for. *Does this apply to you...*	VO	O	S	R	N	DK Ref
69.	There are too many doses to take each day. *Does this apply to you...*	VO	O	S	R	N	DK Ref
70.	It's too hard to keep track of what I am supposed to take when. *Does this apply to you...*	VO	O	S	R	N	DK Ref
71.	My diabetes medicines are unpleasant to take. *Does this apply to you...*	VO	O	S	R	N	DK Ref
72.	I can't afford my diabetes medicines. *Does this apply to you...*	VO	O	S	R	N	DK Ref
73.	My diabetes medicines make me feel bad or have side effects I don't like. *Does this apply to you...*	VO	O	S	R	N	DK Ref
74.	I have heard about side effects that I am afraid I might get. *Does this apply to you...*	VO	O	S	R	N	DK Ref
75.	Getting to the pharmacy to pick up my diabetes medicines is difficult. *Does this apply to you...*	VO	O	S	R	N	DK Ref
76.	The pharmacy could not fill my prescription for my diabetes medicines. *Does this apply to you...*	VO	O	S	R	N	DK Ref
77.	My doctor or nurse forgot to write a new prescription for my diabetes medicine. *Does this apply to you...*	VO	O	S	R	N	DK Ref
78.	I ran out of diabetes medication before I could call or visit my doctor or nurse. *Does this apply to you...*	VO	O	S	R	N	DK Ref
79.	I don't have enough time to talk with my doctor or nurse about problems I am having with my diabetes medicines. *Does this apply to you...*	VO	O	S	R	N	DK Ref
80.	I sometimes forget to ask my doctor or nurse about problems that I am having with my diabetes medicines. *Does this apply to you...*	VO	O	S	R	N	DK Ref
81.	I don't feel my diabetes medicines are helping me. *Does this apply to you...*	VO	O	S	R	N	DK Ref
82.	I just don't like taking diabetes medicine in general. *Does this apply to you...*	VO	O	S	R	N	DK Ref
83.	Taking diabetes medicines makes my health worse. *Does this apply to you...*	VO	O	S	R	N	DK Ref
84.	I sometimes find it hard to ask my doctor or nurse questions about my diabetes medications. *Does this apply to you...*	VO	O	S	R	N	DK Ref
85.	If my blood sugar is normal in the morning, I don't take my diabetes medications. *Does this apply to you...*	VO	O	S	R	N	DK Ref
		Very often	*often*	*some-times*	*rarely*	*never*	

Notes

The next few questions are about all your prescription medications.

		not at all confident	*Somewhat confident*	*very confident*	
86.	How confident are you that you can take your medicines correctly **when you take several different medicines each day?** *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
87.	How confident are you that you can take your medicines correctly **when you take medicines more than once a day?** *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
88.	How confident are you that you can take your medicines correctly **when you are away from home?** *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
89.	How confident are you that you can take your medicines correctly **when you have a busy day planned?** *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
90.	How confident are you that you can take your medicines correctly **when they cause some side effects?** *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
91.	How confident are you that you can take your medicines correctly **when no one reminds you to take the medicine?** *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
92.	How confident are you that you can take your medicines correctly **when the schedule to take the medicine is not convenient?** *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
93.	How confident are you that you can take your medicines correctly **when your normal routine gets messed up?** *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
94.	How confident are you that you can take your medicines correctly **when you are not sure how to take the medicine?** *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
95.	How confident are you that you can take your medicines correctly **when you are not sure what time of the day to take your medicine?** *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
96.	How confident are you that you can take your medicines correctly **when you are feeling sick (like having a cold or the flu)?** *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
97.	How confident are you that you can take your medicines correctly **when you get a refill of your old medicines and some of the pills look different than usual?** *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
98.	How confident are you that you can take your medicines correctly **when a doctor changes your medicines?** *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
		not at all confident	*Somewhat confident*	*very confident*	

Notes

Now, I am going to ask you some questions about your diet.

99. How many days during the PAST 7 DAYS did you eat high fat foods?

High-fat foods include: fried foods such as fried fish, fried chicken and french fries; snack foods such as chips or pork skins; fatty meats such as bologna, sausage, ribs, hot dogs, burgers; breads such as biscuits and cornbread; dairy foods such as whole milk and regular cheese; desserts such as pie, ice cream, snack cakes, puddings.

number of days

0 1 2 3 4 5 6 7

100. How many days during the PAST 7 DAYS did you have a second serving at a meal?

number of days

0 1 2 3 4 5 6 7

101. How many days during the PAST 7 DAYS did you have 1 or more sugar-sweetened beverage?

Sugar-sweetened beverages include regular soda, sweet tea, fruit juice, energy drinks, sports drinks.

number of days

0 1 2 3 4 5 6 7

102. How many days during the PAST 7 DAYS did you eat 5 or more servings of fruits and vegetables?

number of days

0 1 2 3 4 5 6 7

Now, I will ask you some questions about your daily activities.

103. Over the PAST 7 DAYS, which of the following best describes your usual daily activities at home and work?

[read answer options listed on the right] →

- ☐ Usually sit during the day and don't walk around very much
- ☐ Stand or walk quite a lot during the day but don't have to carry or lift things very often
- ☐ Usually lift or carry light loads or have to climb stairs or hills often
- ☐ Do heavy work or carry very heavy loads

- ■ don't know
- ■ refused

104. How many days during the PAST 7 DAYS did you engage in intense physical activity, enough to work up a sweat?

number of days

0 1 2 3 4 5 6 7

105. How many days during the PAST 7 DAYS have you walked for exercise?

number of days

0 1 2 3 4 5 6 7

106. How many days during the PAST 7 DAYS did you do other forms of exercise besides walking?

number of days

0 1 2 3 4 5 6 7

107. How would you compare your activity level to others your age?
Would you say that you are less active, about the same, or more active?

- ☐ Less active
- ☐ Same as others your age
- ☐ More active

- ■ don't know
- ■ refused

Notes

We would like to know how confident you are in doing certain activities. For each of the following questions, tell me for each statement if you are not at all confident, somewhat confident, or very confident.

		Not at all confident	*Somewhat confident*	*Very confident*	
108.	How confident do you feel that you can eat your meals every 4 to 5 hours every day, including breakfast every day? *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
109.	How confident do you feel that you can follow your diet when you have to prepare or share food with other people who do not have diabetes? *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
110.	How confident do you feel that you can choose the appropriate foods to eat when you are hungry (for example, snacks)? *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
111.	How confident do you feel that you can exercise 15 to 30 minutes, 4 to 5 times a week? *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
112.	How confident do you feel that you can do something to prevent your blood sugar level from dropping when you exercise? *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
113.	How confident do you feel that you know what to do when your blood sugar level goes higher or lower than it should be? *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
114.	How confident do you feel that you can judge when the changes in your illness mean you should visit the doctor? *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
115.	How confident do you feel that you can control your diabetes so that it does not interfere with the things you want to do? *Are you not at all confident, somewhat confident, or very confident?*	Not	Somewhat	Very	DK Ref
		Not at all confident	*Somewhat confident*	*Very confident*	

Next, I am going to ask you a few questions, so we can learn a little bit more about living with diabetes. Living with diabetes can sometimes be tough. There may be many problems and hassles concerning diabetes and they can vary greatly in severity. Problems may range from minor hassles to major life difficulties. I have a list of 17 potential problem areas that people with diabetes may experience. Consider the degree to which each of the 17 items may have distressed or bothered you DURING THE PAST MONTH.

Please note that we are asking you to indicate the degree to which each item may be bothering you in your life, NOT whether the item is merely true for you. If you feel that a particular item is not a bother or a problem for you, you would say “Not a problem”. If it is very bothersome to you, you might say “a very serious problem”.

I will read the question to you as if you were reading them. For each question, please tell me if it is not a problem, a slight problem, a moderate problem, somewhat serious problem, a serious problem, or a very serious problem.

		Not a problem	*Slight problem*	*Moderate problem*	*Somewhat serious problem*	*Serious problem*	*Very serious problem*	
116.	Feeling overwhelmed by the demands of living with diabetes. *Is this...*	Not	Slight	Moderate	Somewhat serious	serious	very serious	DK Ref
117.	Feeling that I am often failing with my diabetes routine. *Is this...*	Not	Slight	Moderate	Somewhat serious	serious	very serious	DK Ref
118.	Not feeling motivated to keep up my diabetes self-management. *Is this...*	Not	Slight	Moderate	Somewhat serious	serious	very serious	DK Ref
119.	Feeling angry, scared, and/or depressed when I think about living with diabetes. *Is this...*	Not	Slight	Moderate	Somewhat serious	serious	very serious	DK Ref
		Not a problem	*Slight problem*	*Moderate problem*	*Somewhat serious problem*	*Serious problem*	*Very serious problem*	

Notes

Over the last 2 weeks, how often have you been bothered by any of the following problems?			
120.	Over the last 2 weeks, you were bothered by having **little interest or pleasure in doing things?** *Has this been a problem for you not at all, several days, more than half the days, or nearly every day?*	☐ Not at all (0-1 days) ☐ Several days (2-6 days) ☐ More than half the days (7-11 days) ☐ Nearly every day (12-14 days)	DK Ref
121.	Over the last 2 weeks, you were bothered by **feeling down, depressed, or hopeless?** *Has this been a problem for you not at all, several days, more than half the days, or nearly every day?*	☐ Not at all (0-1 days) ☐ Several days (2-6 days) ☐ More than half the days (7-11 days) ☐ Nearly every day (12-14 days)	DK Ref
122.	Over the last 2 weeks, you were bothered by having **trouble falling or staying asleep, or sleeping too much?** *Has this been a problem for you not at all, several days, more than half the days, or nearly every day?*	☐ Not at all (0-1 days) ☐ Several days (2-6 days) ☐ More than half the days (7-11 days) ☐ Nearly every day (12-14 days)	DK Ref
123.	Over the last 2 weeks, you were bothered by **feeling tired or having little energy?** *Has this been a problem for you not at all, several days, more than half the days, or nearly every day?*	☐ Not at all (0-1 days) ☐ Several days (2-6 days) ☐ More than half the days (7-11 days) ☐ Nearly every day (12-14 days)	DK Ref
124.	Over the last 2 weeks, you were bothered by **poor appetite or overeating?** *Has this been a problem for you not at all, several days, more than half the days, or nearly every day?*	☐ Not at all (0-1 days) ☐ Several days (2-6 days) ☐ More than half the days (7-11 days) ☐ Nearly every day (12-14 days)	DK Ref
125.	Over the last 2 weeks, you were bothered by **feeling bad about yourself, or that you are a failure, or have let yourself or your family down?** *Has this been a problem for you not at all, several days, more than half the days, or nearly every day?*	☐ Not at all (0-1 days) ☐ Several days (2-6 days) ☐ More than half the days (7-11 days) ☐ Nearly every day (12-14 days)	DK Ref
126.	Over the last 2 weeks, you were bothered by **trouble concentrating on things, such as reading the newspaper or watching television?** *Has this been a problem for you not at all, several days, more than half the days, or nearly every day?*	☐ Not at all (0-1 days) ☐ Several days (2-6 days) ☐ More than half the days (7-11 days) ☐ Nearly every day (12-14 days)	DK Ref
127.	Over the last 2 weeks, you were bothered by **moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?** *Has this been a problem for you not at all, several days, more than half the days, or nearly every day?*	☐ Not at all (0-1 days) ☐ Several days (2-6 days) ☐ More than half the days (7-11 days) ☐ Nearly every day (12-14 days)	DK Ref

Notes

We are now over half way done with the interview! How are you doing? We're almost finished so let's keep going!

Now I would like to ask you about your feelings and thoughts during THE LAST MONTH. In each case, please tell me which response represents HOW OFTEN you felt or thought a certain way. So, for these questions, your answer options are: never, almost never, sometimes, fairly often, or very often.

		Never	*Almost never*	*Some-times*	*Fairly often*	*Very often*	
128.	In the last month, **how often have you been upset because of something that happened unexpectedly?** *Have you felt this way never, almost never, sometimes, fairly often, or very often?*	Never	Almost never	Some-times	Fairly often	Very often	DK Ref
129.	In the last month, **how often have you felt that you were unable to control the important things in your life?** *Have you felt this way never, almost never, sometimes, fairly often, or very often?*	Never	Almost never	Some-times	Fairly often	Very often	DK Ref
130.	In the last month, **how often have you felt nervous and "stressed"?** *Have you felt this way never, almost never, sometimes, fairly often, or very often?*	Never	Almost never	Some-times	Fairly often	Very often	DK Ref
131.	In the last month, **how often have you felt confident about your ability to handle your personal problems?** *Have you felt this way never, almost never, sometimes, fairly often, or very often?*	Never	Almost never	Some-times	Fairly often	Very often	DK Ref
132.	In the last month, **how often have you felt that things were going your way?** *Have you felt this way never, almost never, sometimes, fairly often, or very often?*	Never	Almost never	Some-times	Fairly often	Very often	DK Ref
133.	In the last month, **how often have you found that you could not cope with all the things that you had to do?** *Have you felt this way never, almost never, sometimes, fairly often, or very often?*	Never	Almost never	Some-times	Fairly often	Very often	DK Ref
134.	In the last month, **how often have you been able to control irritations in your life?** *Have you felt this way never, almost never, sometimes, fairly often, or very often?*	Never	Almost never	Some-times	Fairly often	Very often	DK Ref
135.	In the last month, **how often have you felt that you were on top of things?** *Have you felt this way never, almost never, sometimes, fairly often, or very often?*	Never	Almost never	Some-times	Fairly often	Very often	DK Ref
136.	In the last month, **how often have you been angered because of things that were outside your control?** *Have you felt this way never, almost never, sometimes, fairly often, or very often?*	Never	Almost never	Some-times	Fairly often	Very often	DK Ref
137.	In the last month, **how often have you felt difficulties were piling up so high that you could not overcome them?** *Have you felt this way never, almost never, sometimes, fairly often, or very often?*	Never	Almost never	Some-times	Fairly often	Very often	DK Ref

Notes

The following questions ask about a variety of different resources that people may use to manage their illness. For each question, please tell me if the item applies to you not at all, a little, a moderate amount, quite a bit, or a great deal.

		Not at all	*Little*	*Moderate amount*	*Quite a bit*	*Great Deal*	
138.	Over the past 6 months, to what extent **has your doctor involved you as an equal partner in making decisions about diabetes management strategies and goals?** *Not at all, a little, a moderate amount, quite a bit, or a great deal?*	N	L	M	Q	G	DK NA Ref
139.	Over the past 6 months, to what extent **has your doctor or other health care advisor listened carefully to what you had to say about your diabetes?** *Not at all, a little, a moderate amount, quite a bit, or a great deal?*	N	L	M	Q	G	DK NA Ref
140.	Over the past 6 months, to what extent **has your doctor or other health care provider thoroughly explained the results of tests you had done (e.g. cholesterol, blood pressure or other laboratory tests)?** *Not at all, a little, a moderate amount, quite a bit, or a great deal?*	N	L	M	Q	G	DK NA Ref
141.	Over the past 6 months, to what extent **have you had a flexible work schedule that you could adjust to meet your needs?**	N	L	M	Q	G	DK NA Ref
142.	Over the past 6 months, to what extent **has your workplace had rules or policies that made it easier for you to manage your illness (such as no smoking rules or time off work to exercise)?**	N	L	M	Q	G	DK NA Ref
143.	Over the past 6 months, to what extent **have you had control over your job in terms of making decisions and setting priorities?**	N	L	M	Q	G	DK NA Ref
		Not at all	*Little*	*Moderate amount*	*Quite a bit*	*Great Deal*	

Great. Now I will ask you about your health care.

144.	Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, government plans such as Medicare, or Indian Health Service?	Yes No	DK NA Ref
145.	Do you have one person you think of as your personal doctor or health care provider? If "No," ask: "Is there more than one, or is there no person who you think of as your personal doctor or health care provider?"	☐ Yes, only 1 ☐ Yes, more than 1 ☐ No	DK NA Ref
146.	Was there a time in the past 6 months when you needed to see a doctor but could not because of cost?	Yes No	DK NA Ref

147.	About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.	☐ Within the past 1-3 months ☐ Within the past 4-6 months ☐ Within the past 7-9 months ☐ Within the past 10-12 months	DK NA Ref

The next questions are about the area where you live and travel. Your responses will help explain how easy or difficult it is for you to access health care services.

What is the distance (in miles) that you live from the health care service you would go to for each of the following, and in which town/city is it located:

148.	Routine diabetes care checkups:	***City:***	***Miles:***	DK NA Ref
149.	Emergency care:	***City:***	***Miles:***	DK NA Ref
150.	Overnight stays in a hospital:	***City:***	***Miles:***	DK NA Ref

Notes

For each of the following questions, please tell me on how good you are at doing the following things.

151.	How good are you at working with fractions? *Are you not good at all, a little good, somewhat good, very good, or extremely good?*	☐ Not good at all ☐ A little good ☐ Somewhat good ☐ Very good ☐ Extremely good	DK Ref
152.	How good are you at working with percentages? *Are you not good at all, a little good, somewhat good, very good, or extremely good?*	☐ Not good at all ☐ A little good ☐ Somewhat good ☐ Very good ☐ Extremely good	DK Ref
153.	How good are you at calculating a 15% tip? *Are you not good at all, a little good, somewhat good, very good, or extremely good?*	☐ Not good at all ☐ A little good ☐ Somewhat good ☐ Very good ☐ Extremely good	DK Ref
154.	How good are you at figuring out how much a shirt will cost if it is 25% off? *Are you not good at all, a little good, somewhat good, very good, or extremely good?*	☐ Not good at all ☐ A little good ☐ Somewhat good ☐ Very good ☐ Extremely good	DK Ref
155.	When reading the newspaper, how helpful do you find tables and graphs that are parts of a story? *Do you find tables and graphs helpful never, rarely, sometimes, often, or very often?*	☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very often	DK Ref
156.	When people tell you the chance of something happening, do you prefer that they use words ("it rarely happens") or numbers ("there's a 1% chance")? *Do you always prefer words, usually prefer words, have no preference, usually prefer numbers, or always prefer numbers?*	☐ Always prefer words ☐ Usually prefer words ☐ No preference ☐ Usually prefer numbers ☐ Always prefer numbers	DK Ref
157.	When you hear a weather forecast, do you prefer predictions using percentages (e.g., "there will be a 20% chance of rain today") or predictions using only words (e.g., "there is a small chance of rain today")? *Do you always prefer percentages, usually prefer percentages, have no preference, usually prefer words, or always prefer words?*	☐ Always prefer percentages ☐ Usually prefer percentages ☐ No preference ☐ Usually prefer words ☐ Always prefer words	DK Ref
158.	How often do you find numerical information to be useful? *Do you find numerical information useful never, rarely, sometimes, often, or very often?*	☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very often	DK Ref

		Strongly disagree	*Disagree*	*Neutral*	*Agree*	*Strongly agree*	
159.	Doctors who do medical research only care about what is best for each patient. *Do you strongly disagree, disagree, are neutral, agree, or strongly agree?*	SD	D	N	A	SA	DK Ref
160.	Doctors tell their patients everything they need to know about being in a research study. *Do you strongly disagree, disagree, are neutral, agree, or strongly agree?*	SD	D	N	A	SA	DK Ref
161.	Medical researchers treat people like "guinea pigs". *Do you strongly disagree, disagree, are neutral, agree, or strongly agree?*	SD	D	N	A	SA	DK Ref
162.	I completely trust doctors who do medical research. *Do you strongly disagree, disagree, are neutral, agree, or strongly agree?*	SD	D	N	A	SA	DK Ref
		Strongly disagree	*Disagree*	*Neutral*	*Agree*	*Strongly agree*	

Notes

The next questions are about your diabetes.				
163.	Hold old were you when you first found out you had diabetes?	***Age:***	***Year (if needed)***	DK NA Ref
164.	Hold old were you when you were first told you needed to take medications for your diabetes or sugar?	***Age:***	***Year (if needed)***	DK NA Ref
165.	Do you take insulin?		Yes No	DK NA Ref

Now I would like to ask you some questions about general health conditions. Has a doctor, nurse, or other health professional EVER told you that you had any of the following? For each, tell me "Yes," "No," or you're "Not sure."			
166.	Has a doctor, nurse, or other health professional EVER told you that you had **a heart attack?**	Yes No	DK NA Ref
167.	Has a doctor, nurse, or other health professional EVER told you that you had **angina or coronary heart disease?**	Yes No	DK NA Ref
168.	Has a doctor, nurse, or other health professional EVER told you that you had **a stroke?**	Yes No	DK NA Ref
169.	Has a doctor, nurse, or other health professional EVER told you that you had **some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?** *INTERVIEWER NOTE: Arthritis diagnoses include:* • rheumatism, polymyalgia rheumatica • osteoarthritis (not osteoporosis) • tendonitis, bursitis, bunion, tennis elbow • carpal tunnel syndrome, tarsal tunnel syndrome • joint infection, Reiter's syndrome • ankylosing spondylitis; spondylosis • rotator cuff syndrome • connective tissue disease, scleroderma, polymyositis, Raynaud's syndrome • vasculitis (giant cell arteritis, Henoch-Schonlein purpura, Wegener's granulomatosis, polyarteritis nodosa)	Yes No	DK NA Ref
170.	Has a doctor, nurse, or other health professional EVER told you that you had **a depressive disorder, including depression, major depression, dysthymia, or minor depression?**	Yes No	DK NA Ref
171.	Has a doctor, nurse, or other health professional EVER told you that you had **kidney disease? Do NOT include kidney stones, bladder infection or incontinence.** *INTERVIEWER NOTE: Incontinence is not being able to control urine flow.*	Yes No	DK NA Ref

The next question asks about difficulties in thinking or remembering that can make a big difference in everyday activities. This does not refer to occasionally forgetting your keys or the name of someone you recently met. This refers to things like confusion or memory loss that are happening more often or getting worse. We want to know how these difficulties impact you.			
172.	During the past 12 months, have you **experienced confusion or memory loss that is happening more often or is getting worse?**	Yes No	DK NA Ref

Notes

Thank you for hanging in there. Next, I have few more questions about your background.

173.	Do you have a doctor that you see regularly for you diabetes care? *[CLEARLY PRINT]*	☐ Yes	☐ No

First:	
Last:	
City:	

174.	Are you of a Hispanic, Latino/a, or Spanish origin? (Read if necessary: Puerto Rican, Cuban/Cuban American, Dominican (Republic), Mexican, Mexican American, Central or South American, Other Latin American, Other Hispanic/Latino)	☐ Yes ☐ No	DK Ref

175.	What race or races do you consider yourself to be? *(Select all that applies)*	☐ White ☐ Black / African American ☐ American Indian	☐ Asian or Pacific Islander ☐ other, specify:_____	DK Ref

176.	How old are you?	***Age today in years:***	DK Ref

177.	Are you married, divorced, widowed, separated, never married, or living with a partner?	☐ Married ☐ Divorced ☐ Widowed	☐ Separated ☐ Never married ☐ Living with a partner	DK Ref

178.	Are you currently employed for wages, self-employed, out of work for 1 year or more, out of work for less than 1 year, homemaker, a student, retired, unable to work. *(select all that applies)*	☐ Employed for wages ☐ Self-employed ☐ Out of work for 1 year or more ☐ Out of work for less than 1 year	☐ Homemaker ☐ A student ☐ Retired ☐ Unable to work	DK Ref

179.	Is your annual household income from all sources?	☐ Less than $10,000 ☐ $10,000 to less than $20,000 ☐ $20,000 to less than $30,000 ☐ $30,000 to less than $40,000 ☐ $40,000 to less than $50,000 ☐ $50,000 to less than $60,000 ☐ $60,000 to less than $70,000 ☐ $70,000 to less than $80,000 ☐ $80,000 to less than $90,000 ☐ $90,000 to less than $100,000 ☐ $100,000 or greater ■ don't know ■ refused

Notes

180.	What is the HIGHEST level of school completed or the highest degrees received?	☐ Never attended or only attended kindergarten ☐ Grades 1 through 8 (elementary) ☐ Grade 9 through 11 (elementary) ☐ Grade 12 or GED (High school graduate) ☐ College 1 year to 3 years (Some college or technical school) ☐ College 4 years or more (College graduate) ■ don't know ■ refused

181.	How often do you use text messaging?	☐ Never ☐ Rarely ☐ Frequently ☐ All the time	■ DK ■ Ref
182.	How often do you use the internet? [Prompt if needed] Go online.	☐ Never ☐ Rarely ☐ Frequently ☐ All the time	■ DK ■ Ref
183.	Where do you most often use the internet?	☐ At home ☐ A friend or family member's home ☐ Library ☐ On a cell phone ☐ Other *(specify)*: _____	■ DK ■ Ref

184.	Indicate sex of respondent. **Ask only if necessary**	☐ Male ☐ Female

Notes

F1. We are now finished with the interview. Thank you so much for taking time today to answer these questions. The next step is to schedule an in-person data collection. As we mentioned before, during this visit, Living Well Program research assistants will measure your blood pressure, blood sugar, cholesterol, weight, and height.

- Wearing a loose fitting shirt is recommended to the in-person data collection visit so that we are able to measure your blood pressure.
- We ask that you not to drink any caffeine (from coffee, tea, or soda), eat, do any heavy physical activity, smoke, or ingest alcohol for 30 minutes prior to the in person data collection visit.

There are 2 options for this visit, which will last from 45-60 minutes. Option 1 is Living Well research assistants to come to your home to do the measurements. Option 2 is for you to meet us a data collection visit that is scheduled at a community venue in your community.

Are you interested in the in-home data collection or would you like to meet us for a group data collection day?

☐ In home data collection perferred: (schedule date / time / location & directions)

☐ Group data collection at community venue preferred: (schedule for a data collection)
The next data collections in your area are scheduled for _____(DATE / TIME) at _____(LOCATION).
Which dates/times are convenient for you? [Schedule data collection]_____

F2. [Scheduled data collection] Great! I have your data collection date scheduled for [date / time / location].

You will receive a reminder card in the mail at this address 5 -7 days before this date. You will also receive a telephone call to remind you of the date the day before the visit.

F3. Verify telephone / contact information:

F4. Verify location / directions:

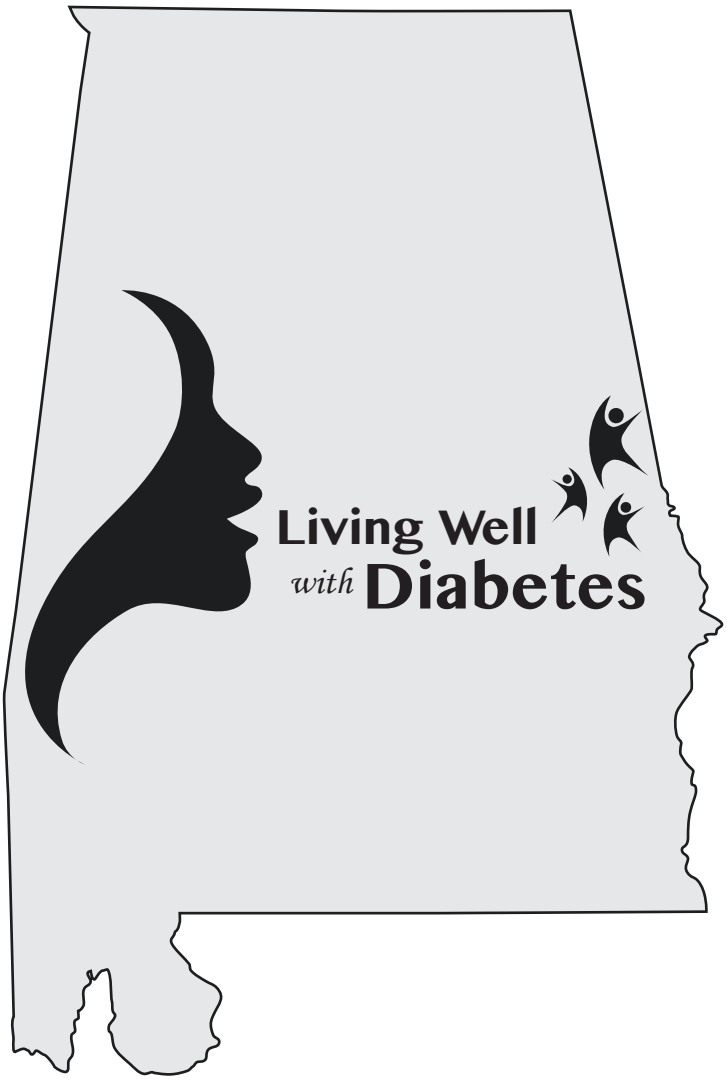
F5 Great! I have your data collection date scheduled for [date / time / location]. A research study assistant will meet you at (_____location) and at (_____time/date).

Thank you so much! Have a great day.

Appendix F

Biometric Protocol

Anthropopomorphic and Biometric Measurements Protocol



Protocol Version 2016-March

Table of Contents

Introduction

The Living Well with Diabetes Study is a randomized controlled trial enrolling 500 participants in rural Alabama.

Your role of as a data collector is very important to this study. The information that you collect will help us better understand the day-to-day experiences of individuals living with diabetes and pain. The information will also determine what effects the program has on the health and well-being of study participants.

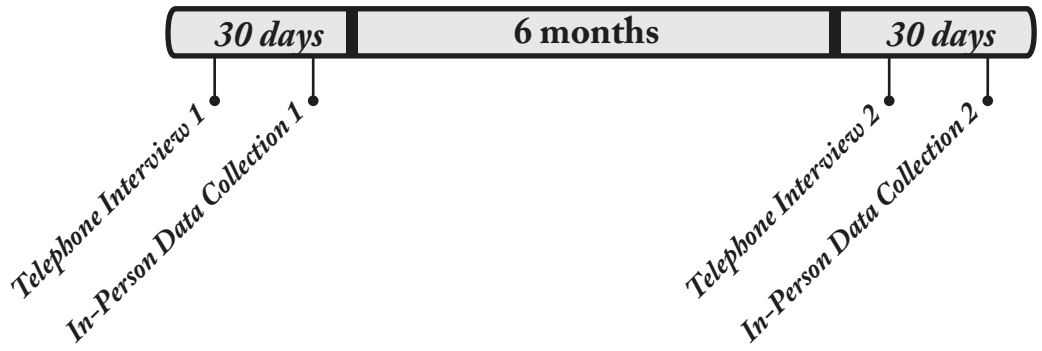
The information that you gather will help the study investigators make important decisions. The information that you gather will help us make important decisions. Therefore, we have to have confidence in the conclusions that we make. We get that confidence from knowing that the data was collected in a ***standard, reliable way***.

The in-person data collection will consist of 3 types of activitie:

- Gathering baseline measurements (blood pressure, A1c, LDL-Cholesterol, weight, height)
- Generating a participant medication list
- Providing the participant with their measurements in the form of a report card.

1. Baseline Measurements

Among the goals of the Living Well Study is to determine if the program improve HbA1c, blood pressure, weight, and physical function. These values will be measured at the beginning of the study and after the 12-week program.



Measurements on each participant will be made at a community venue or in the participant's home. Measurements will be made in a separate room or, at minimum, in an area properly screened from other participants. Participants should be wearing a loose fitting shirt that allows full access to the arm for blood pressure measurement.

If asked, the research assistant measuring and recording the values may tell the participant their values at the time of measurement. ***Remind the participant that they will receive a "report card" with the measurement values and an explanation of the values.***

2. Medication List

The investigators and Peer Advisors require an accurate list of all medications taken by the participants. The participants will be notified prior to the in-person data collection visit that you will making this list. You will be writing down the names, dosages, and frequencies of the participant's medications.

3. Report Card

Participants will receive a report card and an explanation of what the values mean in general terms.

This manual will provide details on how each of the activities should be completed. Since Living Well is a research study, we all all Biometric personnel to strictly follow these protocols so that we can be certain these measurements are accurate the precise.

Blood Pressure

It will take approximately 10-15 minutes to make two blood pressure measurements including the initial 5-minute rest. The BP measurements will be the first measurement taken during the in-person data collection visit.

1. Equipment and Supplies.

- LifeSource Blood Pressure Monitor (Model UA 789)
- Blood pressure cuffs (medium, large, extra large sizes)
- Tape measure
- Eyebrow pencil
- Chair with back support
- Table to rest arm

1.1. Maintenance of Equipment

With each use:

- Device is turned off at the completion of each participant's examination.
- Squeeze all air from the cuff
- Confirm that the connection of the cuff to the tubing is secure and tubing is not kinked.

Monhtly:

- Inspect cuff and tubing for cracks or tears. If a leak is suspeced, place the cuff around an unopened, full, 12-ounce can, start the monitor, and submerge the cuff in water. If there is a leak, air bubbles will start to rise from the area of the leak. Replace the cuff if a leak is detected.
- Wipe the exterior of the monitor with a clean cloth slightly dampened with mild detergents.
- Check the blood pressure cuffs to assure all sizes of cuffs are available.
- Inspect the measuring tape used to measure arm circumference for damage or wear.

2. Participant Preparation.

Participants should not drink any caffeine (from coffee, tea, or soda), should not eat or do any heavy physical activity, smoke, ingest alcohol for 30 minutes prior to recording the blood pressure.

2.1. Arm Circumference

The blood pressure is taken on the right arm. If the participant's right arm is injured or missing, or if the participant reports a compelling reason to avoid measurement in this arm, such as a mastectomy on the right side, use the left arm for the blood pressure measurement. Measure the participant's arm to determine the appropriate cuff size before allowing the participant to rest. Use the following procedures to measure the participant's arm and determine the appropriate cuff size:

- Proper measurement requires that the participant's arm is bare to the shoulder. The participant should be wearing a loose-fitting top.
- Request the participant to stand facing away from the examiner with the right elbow bent 90 degrees at the elbow with the hand on the stomach. The upper arm should be at a 90-degree angle to the lower arm.
- Measure arm length from the bony prominence of the shoulder girdle (acromion) to the tip of the elbow (olecranon process) using a tape measure.
- Mark the midpoint on the dorsal (back) surface of the arm with an eyebrow pencil.
- Ask the participant to relax their arm along the side of the body.
- Wrap the tape measure horizontally around the arm at the midpoint mark, but do not indent the skin. Make the measurement to the nearest 0.5 cm (round down).
- Use the measurement to determine the correct cuff size. Wipe pencil mark off participant's skin

Do not use the markings on the blood pressure cuff for reference. Instead, use the criteria in the chart below for determining the appropriate cuff size for the participant.

Arm Circumference		Cuff Size
24 - 35.5 cm	9.4 - 14.1 in	Medium Cuff
36 - 42 cm	14.2 - 16.5 in	Large Cuff
> 42 cm	> 16.5 in	Extra Large Cuff

3. Measurement Procedures.

The blood pressure can be measured after any period where the participant has been sitting quietly (no talking or completing forms) for 5 or more minutes, and at least 30 minutes after ingestion of caffeine. After applying the appropriate sized blood pressure cuff, the participant should sit for 5 minutes with his/her feet flat on the floor and legs and ankles uncrossed. Two blood pressure readings will be obtained.

3.1 Application of the cuff

- Ensure that the participant is seated comfortably in a chair with back supported and both feet are flat on the floor.
- Make sure that the participant's arm is resting on the table at a 90-degree angle with the palm facing up.
- Palpate the brachial artery.
- Mark the brachial artery with an eyebrow pencil.
- Attach the appropriate-sized cuff to the monitor by firmly inserting the Air Connector Plug of the blood pressure cuff into the Air Socket of the monitor.
- Place the cuff around the upper right arm, approximately at heart level, with the participant's palm facing upward (the participant may rest their forearm and elbow on a table or arm of the chair). Place the lower edge of the cuff with its tubing connections about one inch above the natural crease across the inner aspect of the elbow.
- Wrap the cuff snugly about the arm, with the inflatable inner bladder centered over the area of the brachial artery. The brachial artery is usually found at the crease of the arm, slightly toward the body. Secure the wrapped cuff firmly by applying pressure to the locking fabric fastener over the area that it overlaps the cuff. You should be able to insert the first joint of two fingers under the cuff.
- If it is not feasible to measure blood pressure using the right arm, the left arm will be used. Mark which arm is used for the measurement on the Biometric Data Collection Form.

3.2 Performing the blood pressure measurement

- After the 5 minute rest, press "Start" on the monitor
- On the Data Form under "1st Reading" record: time, armed used (L or R), systolic value, diastolic value, pulse
- Allow 1 minute rest.
- Press "Start"
- On the Data Collection Form under "2nd Reading" record: time, systolic value, diastolic value, pulse
- Wipe pencil mark off participant's skin

3.3 Interruptions

If the blood pressure measurement is interrupt and requires the participant to move from the seated position, the participant will be required to repeat the 5-minute rest and another 2 blood pressures must be performed. 4.1 Training requirements

4. Quality Assurance

Clinical experience with blood pressure measurement is required. In addition, training should include:

- Read and study manual and data collection packet
- Attend Living Well training session on techniques
- Practice on other staff or volunteers
- Discuss problems and questions with program coordinator

4.2 Certification requirements

- Complete training requirements
- Explain and demonstrate daily and monthly checks of blood pressure monitor
- Explain procedure if measurement is interrupted
- Performs exam according to protocol

4.3 Quality assurance checklist

- Explains procedure
- Measures for cuff size
- Wraps cuff snugly, centering bladder over brachial artery
- Five minute rest period before measurement
- Records the systolic and diastolic readings as they appear on the digital display
- Deflates bladder
- Reviews forms for completeness
- Completes Data Collection Form appropriately

Acknowledgments:

- Women's Health Initiative Operations Manual. Volume 2, Section 9.2: Blood Pressure. 8/30/95.
- WHAS Operations Manual. Section 3.5 Blood Pressure Measurements. 6/18/93.
- MOST Operations Manual Vol. IV Chapter 3E, Version 1.0. 4/3/09
- Mr.OS Visit 3 Operations Manual Version 1.5. 07/25/2007

Obtaining Blood Samples

For the A1c measurement, blood samples will be collected. Instructions for the fingerstick are given here while instructions on use of the A1c machine and recording the data are in the following section.

1. Equipment and Supplies.

- Lancet
- Alcohol wipes
- Gauze
- Bandaid
- Gloves
- Sharps Container

2. Participant Preparation and Sample Collection.

- Put on gloves.
- Clean the participant's finger, just lateral to the fingertip pad with an alcohol wipe, and allow it to dry.
- (Use the lancet as direct). Accu-check Safe-T-Pro Plus Lancet directions: Holding the lancet, twist off the blue protective lancet cap. Press the lancet lightly against the cleaned lateral side of the fingertip. Press the blue button.
- Dispose of lancet in sharps container
- "Milk" finger by gently applying pressure from the base to the tip of the finger.
- Wipe away first drop of blood with gauze and use subsequent blood drops for testing.
- After sample is collected, apply light pressure with gauze. If needed, apply bandage.

3. Quality Assurance.

3.1 Training requirements

The technician requires no special qualifications for performing this assessment. Training includes:

- Read and study manual and data collection packet
- Attend Living Well training session on techniques
- Practice on other staff or volunteers
- Discuss problems and questions with program coordinator

3.2 Certification requirements

- Complete training requirements
- Explain procedure
- Performs exam according to protocol

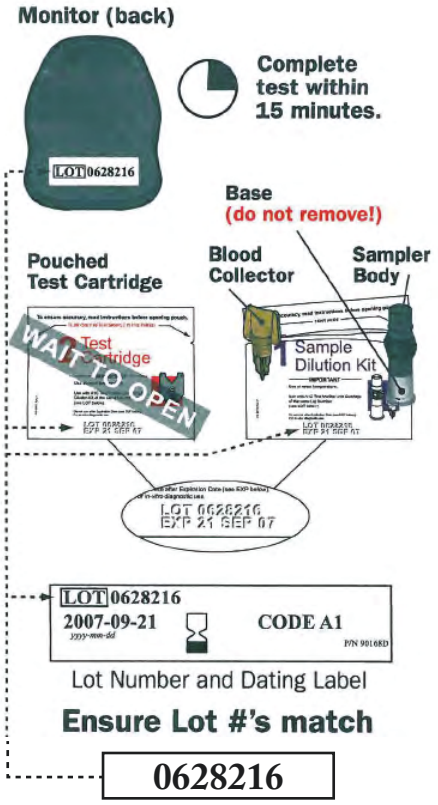
3.3 Quality assurance checklist

- Explains procedure
- Wears gloves
- Cleans finger with alcohol, correct use and disposal of lancet
- Obtains sample from lateral side of fingertip, wipes first drop of blood
- Ascertains bleeding has stopped

A1c Measurement

1. Equipment and Supplies.

- Alcohol wipe
- Gauze
- Bandaid
- A1cNow+ Test System (each system includes 3 items)
  - Monitor
  - 1. Sample Dilution Kit
  - 2. Test Cartridge



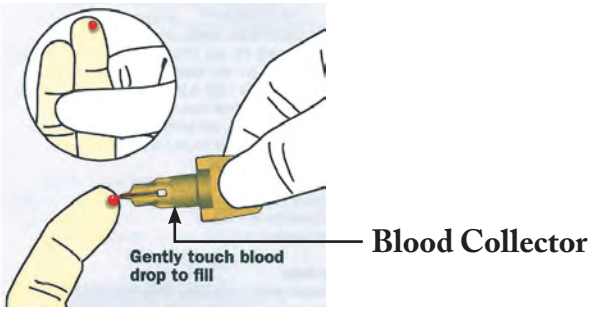
1.1. Before You Begin: Preparation of Test System

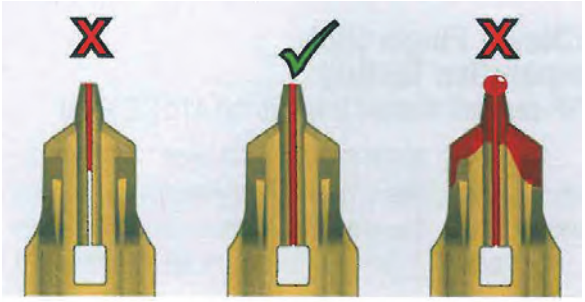
- Ensure all parts of the test kits are at the same temperature.
- All test parts are within the specified range. (Between 64 - 82 degrees F).
- NOTE: If the kit has recently been at high temperature (above 82 degress) or in the refrigerator, keep the kit at room temperature for at least one hour before use.
- NOTE: avoid running the test in direct sunlight, on hot or cold surfaces, or near sources of heat or cold. Quality control materials should be used to confirm the test kit is working properly. See Troubleshooting Section for more information.
- IMPORTANT! The Lot numbers should match the monitor, dilution kit, and test cartridge (DO NOT OPEN!).

2. Participant Preparation and A1c Measurement.

2.1. Collect Blood

- Use the lancet to draw blood.
- Wipe away the first drop of blood.
- Take blood collector and gently touch blood drop to fill.





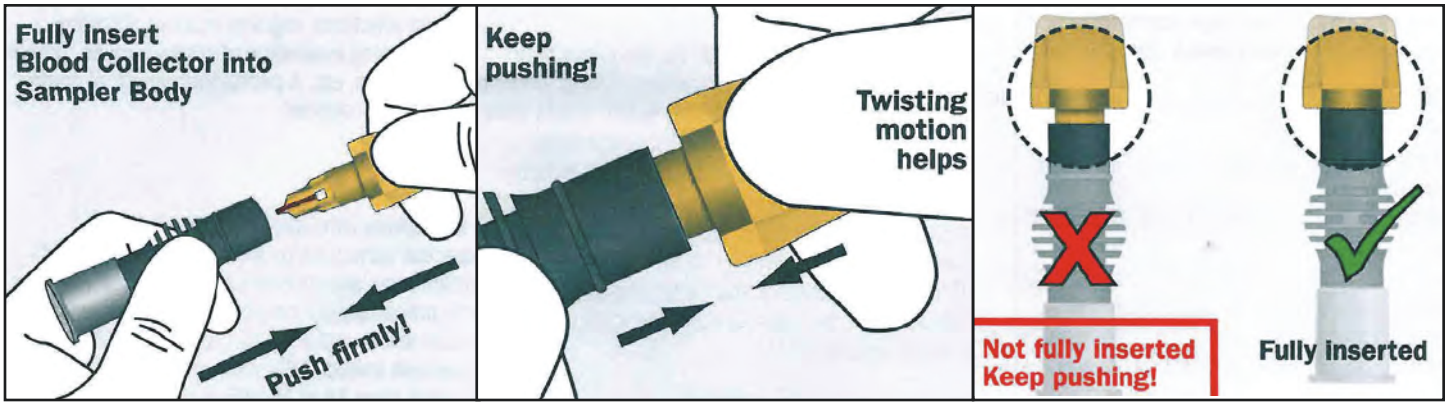
Too Little *Add More*

Just Right

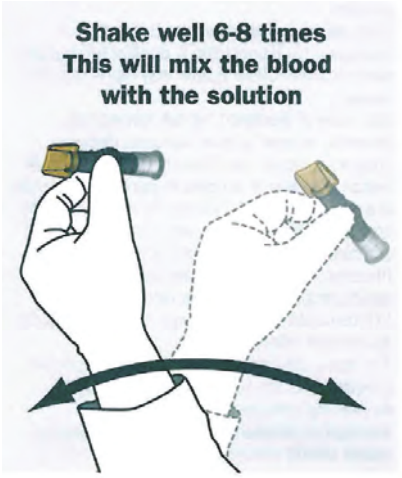
Too Much *Wipe Away*

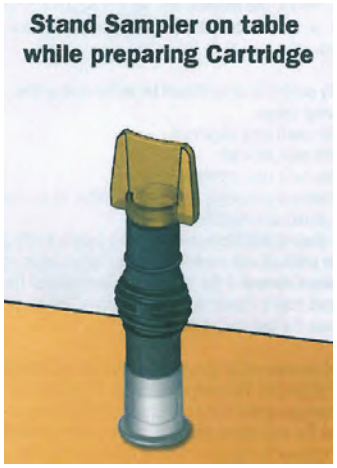
2.2. Insert Blood Collector

- Fully insert Blood Collector into Sampler Body.



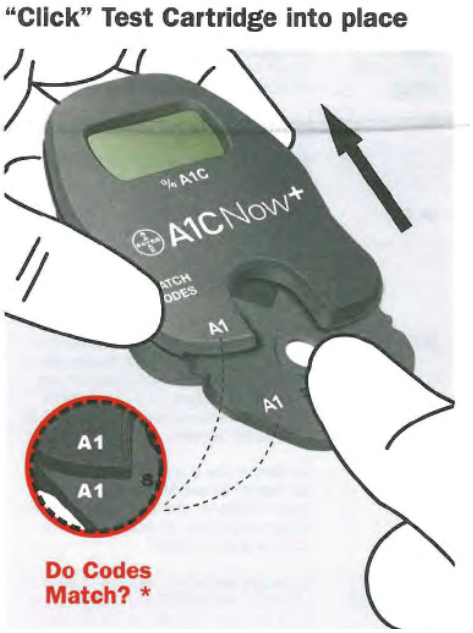
- Shake well 6-8 times to mix the blood with the solution.
- Stand the sampler on the table while preparing the Cartridge.





2.3. Insert Cartridge

- Open the Test Cartridge packet now. IMPORTANT: Must use the cartridge within 2 minutes.
- "Click" Test Cartridge into place. Monitor and Test Cartridge codes must match.



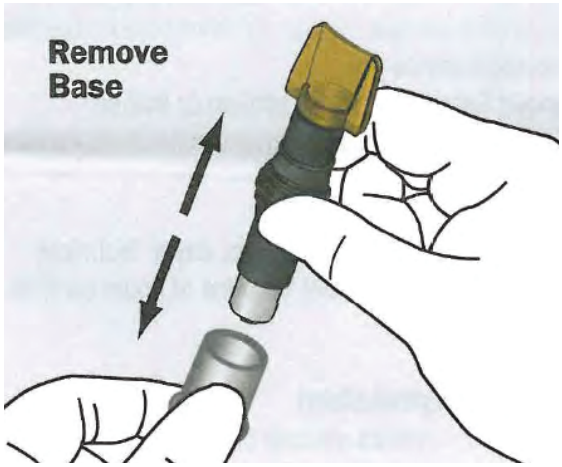
2.4. Prepare Monitor

- After clicking the test cartridge into place, monitor's display will say "WAIT".
- Wait until the display says "SMPL".
- When the display says "SMPL", the monitor is ready.

WAIT for SMPL to display

Ready for Sampler

- Ensure that the monitor is on a level surface.
- Remove the base from the blood collector.



2.5. Dispense Sample into Cartridge

- Push down the blood collector completely on the cartridge completely to dispense diluted sample. Remove quickly.
- IMPORTANT! Do not handle the monitor again until the test is complete.

Push down completely to dispense diluted sample Remove quickly

Do not handle Monitor again until test is complete!

2.6. Results

- It will take 5 minutes to display the results.
- The display will count down.
- After the 5 minutes, 3 items will be displayed.
  - "QCOK" - QC test result
  - "00.0" - A1c test result
  - "00TL" - Number of tests left
- This result cycle remains displayed for 60 minutes or until the next Test Cartridge is inserted.
- If "QCOK" is not displayed, please see the Troubleshooting section.
- Record A1c value in the data collection packet.

2.7. Troubleshooting

- See the table below for a description of A1cNOW+ operating and error codes.
- OR = Out of Range / QC = Quality Control / E = Monitor Error

Message	Description and Resolution
OR 1	The blood sample may have too little hemoglobin (less than 20% hematocrit), not enough blood was collected, or the blood was not well mixed inside the Sampler.* You may wish to check hematocrit by another method.
OR 2	The blood sample may have too much hemoglobin (greater than 60% hematocrit), or excess blood was collected.* You may wish to check hematocrit by another method.
OR 3	The blood sample may have too little A1C, or insufficient blood was collected.*
OR 4	The blood sample may have too much A1C, or excess blood was collected.*
OR 5	The Monitor temperature is below 180C (640F). Repeat the test at room temperature.
OR 6	The Monitor temperature is above 280C (820F). Repeat the test at room temperature.
<4.0	The %A1C is less than 4%.
>13.0	The %A1C is greater than 13%.
QC 2	Occurs when you insert a Test Cartridge that already has sample added to it. Do not remove and reinsert Test Cartridge after adding sample.*
QC 6	Sample was added to Test Cartridge before "SMPL" display. This counts down one test on the Monitor. Remove and discard Test Cartridge. To avoid this error, do not add sample until the "WAIT" prompt clears and "SMPL" appears.
QC 7	The Test Cartridge remained in the Monitor without sample addition for 2 minutes after "SMPL" prompt. This counts down one test on the Monitor. Discard the Test Cartridge and insert a fresh one when you are ready to dispense the Sampler.
QC 30-33	The Monitor was unable to obtain a valid initial reading. Be sure to remove the Sampler within one second after dispensing it into the sample port, and do not disturb the Monitor while the test is running. *
QC 50-51 QC 55-56	Insufficient sample was delivered to the Test Cartridge. To avoid this error be sure to fully insert the Blood Collector into the Sampler and shake immediately.*
All other QC codes	The quality control checks did not pass. Call Bayer Technical Support toll-free at 877-212-4968 x 1. The test will have to be repeated with another Test Cartridge and Sample Dilution Kit.
E1-E99	The Monitor has a Fatal Error. Call Bayer Technical Support toll-free at 877-212-4968 x 1.
**Carefully repeat the test using a new Test Cartridge and a new Sample Dilution Kit.*	

2.7. Reuse Monitor

- The Monitor is reusable (either 20 or 10 tests per test system).
- To run another test, use a new sampler and test cartridge from the same kit.
- Discard the test cartridge.

3. Quality Assurance.

3.1 Training requirements

The technician requires no special qualifications for performing this assessment. Training includes:

- Read and study manual and data collection packet
- Attend Living Well training session on techniques
- Practice on other staff or volunteers
- Discuss problems and questions with program coordinator

3.2 Certification requirements

- Complete training requirements
- Explain procedure and measure A1c on 2 volunteers according to protocol.

3.3 Quality assurance checklist

- Obtains sample per "obtaining blood sample" section of manual.
- Properly measures and records A1c measurementt.

3.4 Control

- Use liquid control solution to calibrate machine.
- Each A1CNow+ Monitor performs over 50 internal chemical and electronic quality control checks, including potential hardware and software errors (e.g. cartridge alignment, programming), and potential reagent strip errors (e.g. insufficient sample volume, invalid calculations). The Monitor has been programmed to report an error code if these quality checks are not passed.
- Quality control testing should be performed at the following times:
  - With each new shipment.
  - With each new lot.
  - With each new operator.
  - Whenever problems (storage, operator, instrument, or other) are identified.
  - To ensure that storage conditions have not affected the product, run a control sample before running a patient sample if the test kit has been stored for more than a month and it has been at least a month since the last control testing.
- The measured value should be within the acceptable limits stated for the control material. If the results obtained are outside the acceptable limit, please review the procedure and re-test the control material. If the measured value continues to fall outside the acceptable limit, please refrain from analyzing additional patient samples and contact Bayer Technical Support (877-212-4968).
- Good laboratory practices include a complete quality control program. This entails proper sample collection and handling practices, ongoing training of testing personnel, ongoing evaluation of control results, proper storage of test kits, etc. A permanent record of control results should be retained.

LDL Measurement

1. Equipment and Supplies

- CardioChek® Analyzer
- PTS Panels™ Test Strips
- Lot specific MEMo Chip™
- Sterile lancet
- Capillary blood collector or pipet
- Gauze
- Alcohol wipe

1.1 Maintenance

Each Day:

- Dampen a cloth with water and wipe the surfaces and the display area as needed. Be careful not to get the Test Strip Insert Opening (where the test strip is inserted) wet.
- Wipe the Test Strip Insert Opening with a clean, damp (not wet), lint-free tissue or cloth. Make sure the glass is very clean with no dust or fingerprints. The glass must be completely dry before running a test.
- Handle the gray Check Strip by the base of the plastic strip. Be careful not to scratch or damage the surface. Store the Instrument Check Strip in the analyzer carrying case when not in use. Do not store in the instrument.
- Check your analyzer with the Instrument Check Strip to verify proper functioning of the CardioChek's electronic and optical systems when:
  - You first receive it.
  - You drop the analyzer.
  - You get a result that is not expected.

How to Use the Instrument Check Strip:

1. Turn the analyzer ON by pressing either button.
2. When INSTALL MEMO CHIP or RUN TEST is displayed, press Next until UTILITY is displayed. Press Enter.
3. Press Enter when CK STRIP is displayed.
4. Insert the Check Strip, ribbed side up, into the Test Strip Insert opening when INSERT STRIP is displayed.
5. The analyzer should display PASSED. (If the display reads FAILED, see the NOTE at end of this section.)
6. Remove the Check Strip and store it in the analyzer carrying case.
7. Press Next until EXIT is displayed. Press Enter.
8. Press Next until RUN TEST is displayed.
9. Press Enter. The analyzer is ready to run tests.

Note — If the analyzer displayed FAILED:

1. Clean the CardioChek Test Strip Insert Opening (where the strip is inserted into the analyzer) with a soft, lint-free, damp cloth.
2. Inspect the Check Strip to make sure it is not dirty or damaged. Use the spare Check Strip and repeat.

2. Participant Preparation and Equipment Preparation

2.1 Participant preparation:

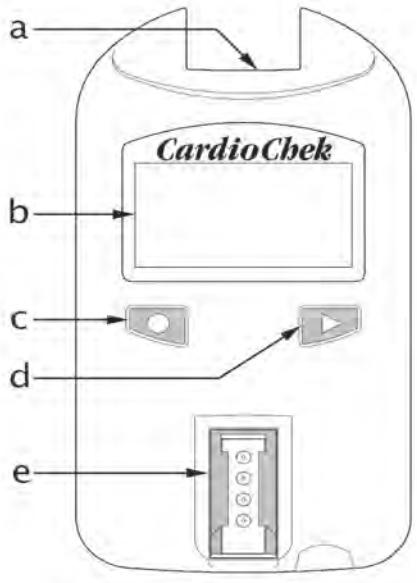
- Refer to “Obtaining Blood Samples” section of the protocol manual.

2.2 Equipment storage and operating conditions:

- Store the analyzer at room temperature (68-77°F) and 20-80% Relative Humidity.
- Do not store or operate the analyzer in direct light, such as sunlight, spotlight, under a lamp or by a window. Direct light may adversely effect test results. If room temperature falls below 64.4°F, allow analyzer to warm up at least 30 minutes – 1 hour before testing.

2.3 Parts of the CardioChek Test System:

- CardioChek Analyzer



MEMo Chip Port (a)
The MEMo Chip Port is on the top of the analyzer. A lot specifi MEMo Chip is inserted into this port.

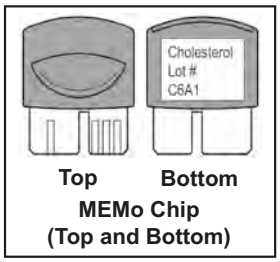
Display (b)
Display shows test results, messages, time, date, and stored results.

ENTER Button (c)
Press this button to turn the analyzer ON or to accept the current menu choice.

NEXT Button (d)
Press this button to turn the analyzer ON or to advance to the next menu option.

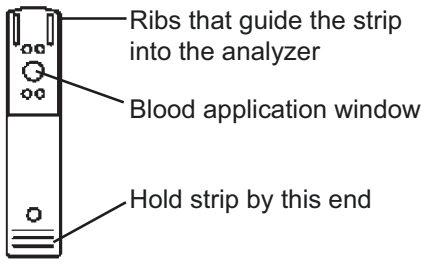
Test Strip Insert Opening (e)
The Test Strip Insert Opening is positioned in the lower front of the analyzer. The strip is inserted here with the raised lines facing up.

- MEMo Chip



MEMo Chip
The color-coded MEMo Chip contains the settings for each test. The top of the MEMo Chip has a finge notch. The bottom has a label with the test name and lot number.

- Test Strip



3. Measurement Procedures

3.1 Insert MEMo Chip

- Insert MEMo Chip with lot number that matches Test Strip vial lot number. Press either button to turn the CardioChek ON. Analyzer will display lot code.

Insert MEMo Chip with finger notch (top) side up, lot number code facing down.

2.2 Insert Strip

- When INSERT STRIP is displayed, hold by the raised lines and insert strip into the analyzer as far as it will go.

2.3. Apply Sample

- When APPLY SAMPLE is displayed, apply whole blood sample with a capillary pipet to blood application window.
- Use the Test Strip and lancet one time only. Dispose of properly.

Obtain a blood sample with capillary pipet (to black mark).

2.4. Results

- Within two minutes the result will appear on the display. Remove and discard strip. Do not add more blood to a Test Strip that has been used.

IMPORTANT ***Do not leave a used Test Strip or Check Strip in the analyzer Test Strip Opening. This prevents the analyzer from automatically shutting down and shortens battery life.***

2.5. Record Value

- Using the appropriate form, record value and time on Biometric Data Collection Form next to “LDL”. Initial the technician space.

2.6. How to review results stored in memory

Test results are automatically stored in the analyzer's memory. CardioChek can store up to 30 results of each chemistry and at least 10 results of each control test. The analyzer allows review of the results in order from the most recent to the oldest. Each result is displayed with time and date. Results stored in memory are not deleted when the batteries are changed.

1. Press either button to turn the analyzer ON. If the display reads, INSTALL MEMO CHIP, go to Step 2. If the display reads, INSERT STRIP, press Enter.
2. Press Next until MEMORY is displayed.
3. Press Enter. CHEM is displayed.
4. Press Enter, then Next to select the desired chemistry. (Note: Until the chemistry has been run at least once, the test name is not displayed.)
5. Press Enter to view the test result including time and date.
   a. To recall Control results, press Next until EXIT is displayed. Press Enter. Press Next until CONTROLS is displayed.
   b. Press Enter when the desired Control test is displayed.
   c. For example, to review Lipid Panel results, from the CHEM display, press NEXT until LIPIDS is displayed, then ENTER. The time and date will be displayed. Press ENTER when the desired test time and date is displayed. Press NEXT to scroll through results.
6. To exit, press Next until the display reads EXIT, then press Enter. Repeat this step until you return to RUN TEST.

3. Quality Assurance

3.1 Training requirements

The technician requires no special qualifications for performing this assessment. Training includes:

- Read and study manual
- Attend Living Well training session on techniques
- Practice on other staff or volunteers
- Discuss problems and questions with local expert

3.2 Certification requirements

- Complete training requirements
- Measure LDL on 2 volunteers according to protocol

3.3 Quality assurance checklist

- Explains procedure
- Obtains sample per "Obtaining Blood Samples" section of manual
- Obtains adequate blood sample
- Properly inserts Test Strip into analyzer
- Properly applies blood to the Test Strip
- Records LDL value on the Biometric Data Collection Form appropriately
- Discards used Test Strip
- Removes and discards Strip prior to obtaining next sample

Acknowledgments:
CardioChek® Brand Analyzers User Guide. PS-002450E Rev. 0 (06/06).

Weight Measurement

1. Equipment and Supplies

- Homedics SC-540 LCD 400 lb/180 kg Capacity Bath Scale

1.1 Maintenance

- When not in use the scale should be set to “off”
- Do not store anything on top of the scale
- At the end of each day, and as needed, wipe exposed parts with soft, slightly damp cloth

1.2 Accuracy Check

- On a monthly basis, the scale should be checked against a known 50kg weight
- Notify principal investigator there is great than a 1.0 pound discrepancy

2. Participant and Exam Room Preparation

The scale should be placed on a level, uncarpeted floor. If bare floor is unavailable, firm, non-compressible carpeting (e.g., indoor-outdoor) is acceptable.

Weight is measured without shoes or heavy jewelry. Study participants will be encouraged to empty their bladders and/or bowels prior to the measurement.

3. Measurement Procedures

Script: *“The measurement that we are about to take is more accurate if you use the bathroom before we measure you. If you need to use the bathroom it is down the hall.”*

1) Ask participant to step on the scale, positioning feet evenly on the scale platform
2) Display will show “HI”
3) Ask participant to stay still while weight is determined
4) Display will flash and then show weight
5) Repeat to confirm reading
6) Record value on Biometric Data Collection Form next to “weight”

Note: if the on/off button is pressed prior to standing on the scale, the scale will be prepared to measure body composition. Press on/off or wait 30 seconds for the scale to turn off and follow instructions above.

If a participant requires support from a cane while being weighed, weigh yourself with and without the participant’s cane, etc., to determine its weight. Subtract the weight of the aid from the participant’s weight before recording. In the event that it is necessary for the examiner to support the participant during weighing, provide the minimum support that is safe.

Error messages on scale

Err	Weight Mode: unstable weight, begin again
0_Ld	Weight overload, remove weight immediately
Lo	Low battery, replace

4.1 Training requirements

The technician requires no special qualifications for performing this assessment. Training includes:

- Read and study manual
- Attend Living Well training session on techniques
- Practice on other staff or volunteers
- Discuss problems and questions with local expert

4.2 Certification requirements

- Complete training requirements
- Conduct exam on 2 volunteers

4.3 Quality assurance checklist

- Participant encouraged to use bathroom prior to measurement
- Explains procedure
- Measurement made without shoes, heavy jewelry, or other clothing
- Ensures that participant stands still in center of platform
- Completes Biometric Data Collection Form appropriately

Acknowledgments:
Mr OS Visit 3 Operation Manuals Version 1.0. 1/18/2007

Height Measurement

1. Equipment and Supplies

- Seca 214 Portable Stadiometer

2. Participant and Exam Room Preparation

Assemble Seca 214 Stadiometer by firmly inserting the height rod into the floor plate and affixing the horizontal arm to the height rod. The stadiometer should be placed on a level, uncarpeted floor. If bare floor is unavailable, firm, non-compressible carpeting (e.g., indoor-outdoor) is acceptable. There should be about a foot or more of unoccupied wall space on either side of the stadiometer.

The participant should be relaxed. He should also be barefoot or wearing thin socks or stockings. Ask the participant to remove any hairpiece or rearrange any hair styling that might interfere with firm contact between the headboard and the scalp.

3. Measurement Procedures

3.1 General Issues

To perform this measurement accurately, it is important that the recorder observe both the position of the participant and of the stadiometer. The participant should be instructed to avoid slouching and the stadiometer brought down in the midline of the head.

3.2 Administration

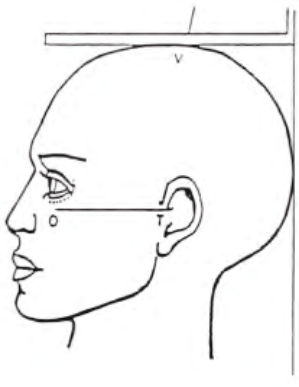
1) Have the participant stand in the center of the foot plate with their heels together and their back against the height rod. The back (scapulae), buttocks and both heels should be touching the height rod. Be sure that the participant maintains the correct posture during the measurement.

Script: *"Please stand with your back against the board mounted on this wall. Your legs should be together and your heels, your buttocks and your back should be touching the wallplate. Look straight ahead and stand tall." If necessary to achieve Frankfort Horizonal Plane: "Please raise/lower your chin."*

Note: The participant should be standing with head erect and in the Frankfort horizontal plane (see Figure 2), but, in general, the back of the head does not need to be in contact with the wall-plate. Check that the participant is in the correct position, starting with the heels and checking each point of contact with the wall-plate.

Check that the arms are relaxed and hanging loosely at the sides and that the shoulders are relaxed by running your hands over them and feeling the relaxed trapezius muscle. The head should be in the "Frankfort Horizontal Plane" in which the lowest point on the inferior orbital margin (orbitale) and the upper margin of the external auditory meatus (tragion) form a horizontal line (Figure 2). To verify that the head is in the Frankfort plane, hold the base of a clear plastic right angle (or T of a T-square) against the wall and make sure that the edge perpendicular to the wall is parallel to the "Frankfort Horizontal Plane".

Figure 2. Frankfort Plane for Measuring Body Height



ORBITALE:	Lower margin of eye socket
TRAGION:	Notch above tragus of ear or at upper margin of zygomatic bone at that point
FRANKFORT PLANE:	Orbitale tragion line horizontal

2) Bring the horizontal bar down firmly onto the top of the participant's head. It may be necessary, upon occasion, to alter the hair styling of some of the participants for the horizontal arm to make contact with the top of the scalp.

3) Have the participant breathe in deeply. They should not alter their position by, for example, raising the heels off the floor as they breathe in.

   Script: *"Take a deep breath."*

4) Just before the participant exhales, note the reading on the stadiometer to the nearest 0.5cm (round down).

   Script: *"Breathe out."*

5) Have the participant step away from the stadiometer, then step back in to the measurement position. Repeat steps 1 - 4 and take a second measurement.

6) If the two measurements differ by ≥ 4 mm, take an additional two measurements.

7) Record value on Biometric Data Collection Form next to "height" in inches and centimeters.

3.3 Deviations and exceptions to standard positioning:

Obese participants and those with a kyphotic posture may be unable to place heels, buttocks, and scapulae in a single vertical plane. These participants may be positioned so that only the buttocks, and possibly the scapula, are in contact with the wall-plate. The essential point is that the participant stand erect with the buttocks in contact with the wall plate and the legs as close together as possible. In very obese participants, if it is not possible to obtain contact between the headboard and the top of the skull, then the participant may need to lean back slightly (without tilting the head) until proper contact can be made.

For participants with severe spinal curvature, if the spine protrudes farthest, then that should be the part that is touching the wall plate, together with heels and buttocks. For participants with extreme kyphotic posture, it may not be possible to obtain contact between the headboard and scalp when the participant's back is against the wall-plate. In this case, measure height with the participant standing sideways (side of arm and shoulder in contact with the wall-plate) and positioned so that the headboard contacts the scalp. If the participant has 'knock-knees' then have them separate the heels so that the knees are in contact but do not overlap. Obese participants may also not be able to stand comfortably with the heels touching and may stand with the legs together and the heels separated.

4. Quality Assurance

4.1 Training requirements

The technician requires no special qualifications for performing this assessment. Training includes:

- Read and study manual
- Attend Living Well training session on techniques
- Practice on other staff or volunteers
- Discuss problems and questions with local expert

4.2 Certification requirements

- Complete training requirements
- Conduct exam on 2 volunteers

4.3 Quality assurance checklist

- Correct assembly of Seca 214 Stadiometer
- Explains procedure
- Hairpiece removed, hair style altered, if necessary
- Checks that heels are together
- Checks for heels, buttock, scapula touching wall-plate (all touching if possible)
- Two more measurements made if first two differ by ≥ 4 mm
- Completes Biometric Data Collection Form appropriately

Acknowledgments:
Mr OS Visit 3 Operation Manuals Version 1.0 1/19/2007

Medication List

The investigators and Peers require an accurate list of medications taken by the participants. This is a seemingly simple task, but can actually be challenging because participants may bring in medications they no longer take, not bring their insulin, take their medications in a way different than written on the prescription, or not bring their medications with them. There are special instructions for aspirin and insulin below.

The biometrics personnel must:

1. Generate as accurate a medication list as possible
2. Keep one copy for the researchers, make a copy for the participant, and if the participant is assigned a Peer, make a copy for the Peer

1. Instructions

If the participant has brought their medications, check the "Yes" box next to "Brought Medications" and for each medication:

1. Ask if the participant takes that medication
2. Ask if the participant take it as it is written on the prescription bottle.
   This is not meant to be a negative question and should not be asked in a way that assumes non-adherence. Sometimes doctors prescribe twice the dose and ask the patient to cut it in half to save the patient money, or they write for it to be take daily even though the patient only takes it "as needed" so that a "one month" supply lasts longer.
3. Record the medication (start on the #1 line, unless the medication is aspirin or insulin)
   a. Name
   b. Dose
   c. How often taken
4. Ask if the patient takes any other medications, either prescription or over-the-counter
   a. If so, follow directions for participant's who did not bring their medications (below)
5. If aspirin has not already been documented, ask if the patient takes aspirin
   a. If not, check the "no" box next to "Aspirin"
   b. If so, check the "yes" box follow and directions for aspirin (below)
6. If insulin has not already been documented, ask if the patient takes insulin
   a. If not, check the "no" box next to "Insulin"
   b. If so, check the "yes" box and follow directions for insulin (below)

Brought medications	☐ No	☐ Yes		
Aspirin	☐ No	☐ Yes	81 mg per day or _____ *(circle)*	☐ from memory
Insulin	☐ No	☐ Yes		

If the participant did not bring their medications check the "no" box next to "brought medications" and:

1. Ask if the participant knows his/her medications
   a. If yes, write down as much as the participant knows of the medications'
      i. Name
      ii. Dose
      iii. How often take
   b. Check the "From memory" box on each line in which the medication information is based solely on participant recall
2. Prompt for prescription, over-the-counter medication, aspirin, and insulin.

Aspirin, people often do not consider aspirin as a real medication and they often do not bring it with them. So the top of the Medication List has a space specifically to prompt about aspirin. Most people with diabetes should be taking an aspirin and most will be taking 81mg daily.

1. If the participant brought aspirin, check the "yes" box next to "Aspirin" and
   a. circle "81mg per day" if correct
   b. or cross out "81mg per day" and write in the dose/frequency the patient is taking
2. If the participant did not bring aspirin ask if the participant takes aspirin and check the boxes accordingly

Insulin, since insulin is stored in a glass vial and in the fridge, participants often forget to bring their insulin. And the directions are often not written on the insulin, so you will have to ask the participant how the insulin(s) are taken. Most people take one or two types of insulin (insulin names are listed below). We have left 3 lines for insulin at the top of the medication list.

1. Ask if the participant takes insulin and check the appropriate box.

If "yes",

2. If the participant brought insulin(s)
   a. Write the name
   b. Ask how much and how often the insulin is injected
      i. If the participant knows, record and do not check the "From Memory" box
      ii. If the participant does not know either the dose or the frequency
         1. Record what the participant does know
         2. Write "?" for information the participant doesn't know
         3. Check the "From Memory" box

3. If the participant did not bring insulin,
   a. Ask if the participant knows the type, dose, and frequency of insulin(s) taken
      i. If participant knows all 3, record and do not check "From Memory" box
      ii. If the participant does not know
         1. Record what the participant does know
         2. Write "?" for information the participant doesn't know
         3. Check the "From Memory" box
         4. You may prompt participant with names of different insulins if he/she thinks that will help them remember

4. Sliding scales. Some participants may not be on a fixed insulin dose, but may take a different amount of insulin depending on their glucose reading. Those people usually are also taking a fixed-dose long-acting insulin. Record the fixed doses and write S/S for sliding scale (example on next page). Do <u>not</u> check "From Memory" box.

5. Insulin pump. Some participants may be using an insulin pump. We do not need dosages or frequencies for those participants (example on next page). Do not check "From Memory" box, even if they do <u>not</u> know the name of the insulin in their pump.

Types of Insulins, trade name (and generic name)

<u>Combination insulins usually taken once or twice per day</u>

- Humalin 70/30 (NPH/regular insulin)
- Humalin 50/50 (NPH/regular insulin)
- Novalog 70/30 (insulin aspart protamine/ insulin aspart)
- Humalog 50/50 (insulin lispro protamine/ insulin lispro)
- Humalog 75/25 (insulin lispro protamine/ insulin lispro)

<u>Long-acting insulins usually taken one or twice per day</u>

- Humalin N (NPH insulin)
- Novalin N (NPH insulin)
- Lantus (insulin glargine)
- Levemir (insulin detemir)

<u>Short-acting insulins usually taken several times per day or used in an insulin pump</u>

- Humalin R (regular insulin)
- Novalin R (regular insulin)
- Humalog (insulin lispro)
- Novalog (insulin aspart)
- Apirdra (insulin glulisine)

Knows the name and frequency, but not the dose

	medication	dose	frequency	notes	from memory
insulin	70/30	?	Twice a day		X
					☐
					☐

Knows frequency and dose, but not the name

	medication	dose	frequency	notes	from memory
insulin	?	10 units	at night		X
	?	5 units	with meals		X
					☐

Only knows dosage

	medication	dose	frequency	notes	from memory
insulin	?	10 units	?		X
					☐
					☐

Only knows frequency

	medication	dose	frequency	notes	from memory
insulin	?	?	twice a day		X
					☐
					☐

Sliding scales

	medication	dose	frequency	notes	from memory
insulin	Lantus	20 units	every night		☐
	Novolog	s/s	twice a day		☐
	Novolog	s/s	as needed		☐

Insulin pump and doesn't know the type of insulin

	medication	dose	frequency	notes	from memory
insulin	?	pump	pump		☐
					☐
					☐

3. Quality Assurance

3.1 Training requirements

The technician requires no special qualifications for performing this assessment. Training includes:

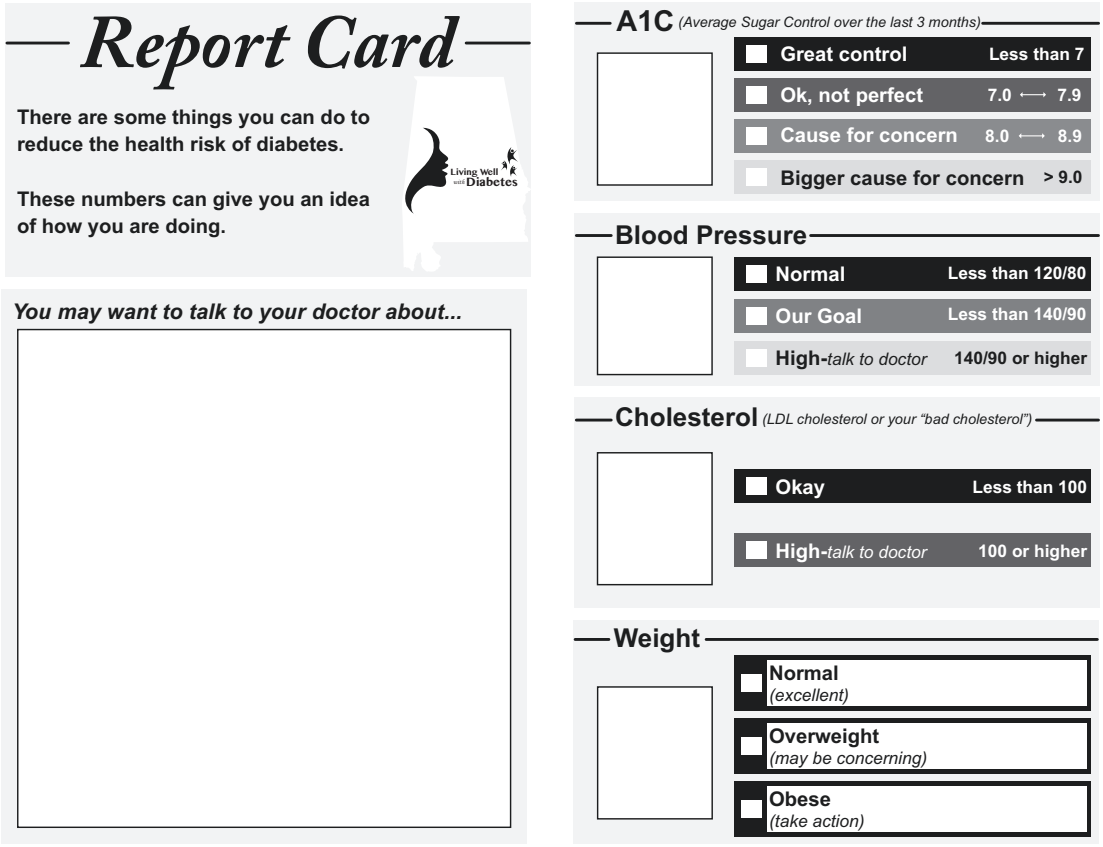
- Read and study manual
- Attend Living Well training session on techniques
- Practice on other staff or volunteers
- Discuss problems and questions with local expert

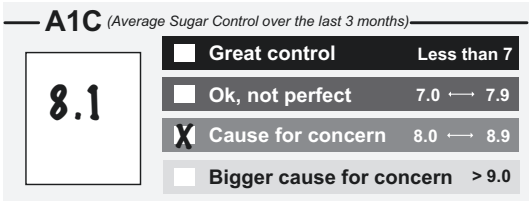
3.2 Certification requirements

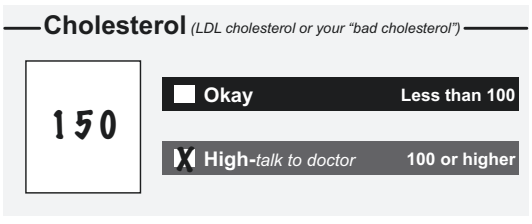
- Complete training requirements
- Generate a medication list for 2 volunteers according to protocol

3.3 Quality assurance checklist

- Ascertains if the participant brought his/her medications
- Ascertains if the participant takes his/her medications as written on the bottles
- Probes for over-the-counter, aspirin, and insulin use
- Gathers as much information as possible if participant did not bring medications
- Checks the “from memory” box when the participant did not bring medications
- Completes Medication List form appropriately







version 2016-March

Report Card

The participants will receive a report card providing the results from the biometrics exam. Biometrics personnel will also provide basic interpretation of the values, but in depth questions need to be referred to the participant's physician.

Report Card

There are some things you can do to reduce the health risk of diabetes.

These numbers can give you an idea of how you are doing.

You may want to talk to your doctor about...

A1C *(Average Sugar Control over the last 3 months)*

☐ **Great control** Less than 7
☐ **Ok, not perfect** 7.0 ⟷ 7.9
☐ **Cause for concern** 8.0 ⟷ 8.9
☐ **Bigger cause for concern** > 9.0

Blood Pressure

☐ **Normal** Less than 120/80
☐ **Our Goal** Less than 140/90
☐ **High-***talk to doctor* 140/90 or higher

Cholesterol *(LDL cholesterol or your "bad cholesterol")*

☐ **Okay** Less than 100
☐ **High-***talk to doctor* 100 or higher

Weight

☐ **Normal** *(excellent)*
☐ **Overweight** *(may be concerning)*
☐ **Obese** *(take action)*

1. Completing the Report Card

1) A1c

- Transcribe the A1c value from the Biometric Data Collection Form onto the Report Card
- Place a check mark in the appropriate box (if A1c < 7.0 great control, 7-7.9 okay, 8-9 Concerning, and >9 bigger concern).

2) LDL

- Transcribe the LDL value from the Biometric Data Collection Form onto the Report Card
- Place a check mark in the appropriate box.

A1C *(Average Sugar Control over the last 3 months)*

8.1

☐ **Great control** Less than 7
☐ **Ok, not perfect** 7.0 ⟷ 7.9
☒ **Cause for concern** 8.0 ⟷ 8.9
☐ **Bigger cause for concern** > 9.0

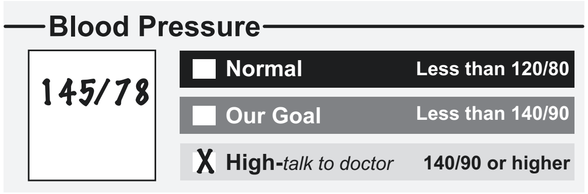
Cholesterol *(LDL cholesterol or your "bad cholesterol")*

150

☐ **Okay** Less than 100
☒ **High-***talk to doctor* 100 or higher

3) Blood Pressure

- Transcribe the lowest of the 2 research blood pressure reading values from the Biometric Data Collection Form onto the Report Card.
- Use the systolic value to determine the blood pressure category and place a check mark in the appropriate box (if SPB < 120 normal, <140 our goal, and >140 High)



Blood Pressure

145/78

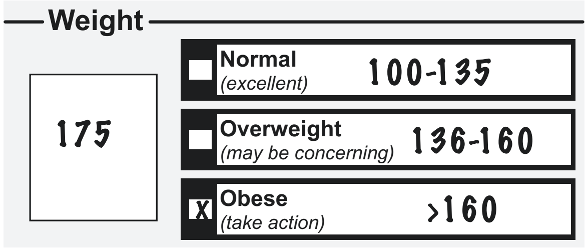
☐ **Normal** Less than 120/80

☐ **Our Goal** Less than 140/90

X **High-***talk to doctor* 140/90 or higher

4) Weight

- Transcribe the weight in pounds from the Biometric Data Collection Form onto the Report Card.
- Find the participant's height on the Height-Weight Reference Sheet and write the ranges next to Normal, Overweight, and Obese.
- Place a check mark in the appropriate box for Normal, Overweight, and Obese.



Weight

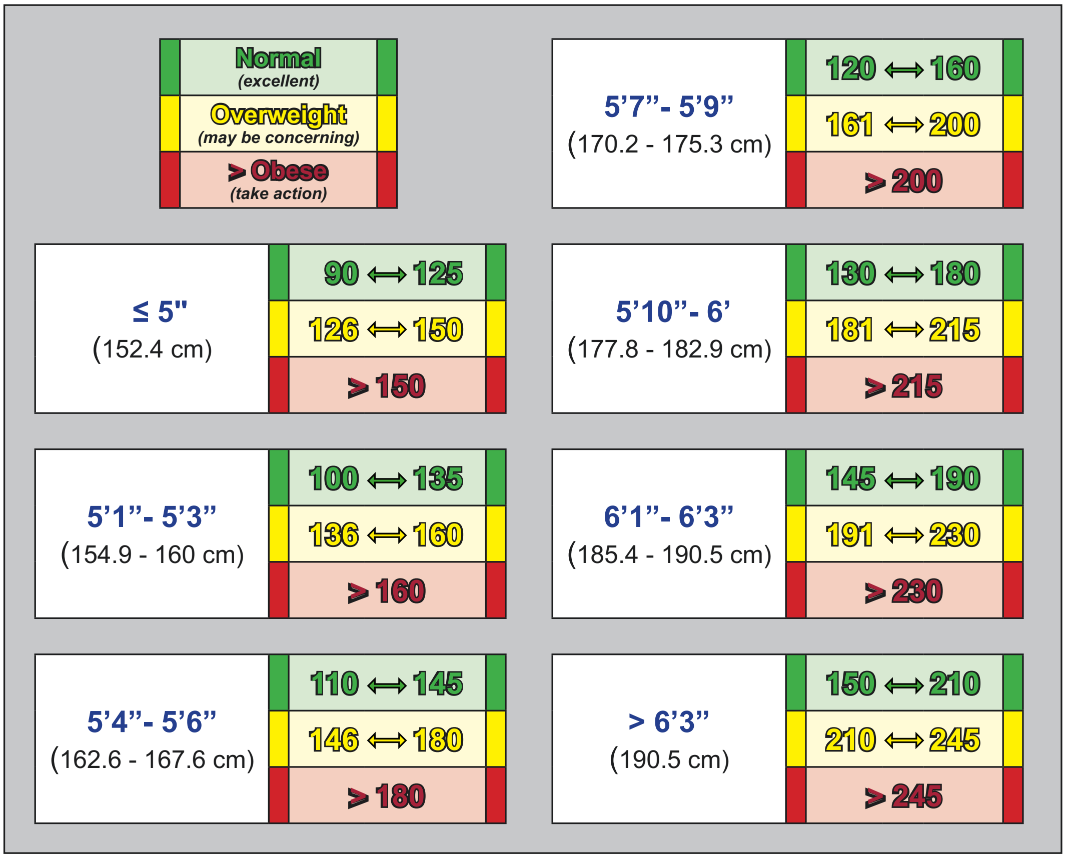
175

☐ Normal *(excellent)* 100-135

☐ Overweight *(may be concerning)* 136-160

☒ Obese *(take action)* >160

Height - Weight Ranges



	Normal *(excellent)*	Overweight *(may be concerning)*	> Obese *(take action)*
≤ 5" (152.4 cm)	90 ⟺ 125	126 ⟺ 150	> 150
5'1"- 5'3" (154.9 - 160 cm)	100 ⟺ 135	136 ⟺ 160	> 160
5'4"- 5'6" (162.6 - 167.6 cm)	110 ⟺ 145	146 ⟺ 180	> 180
5'7"- 5'9" (170.2 - 175.3 cm)	120 ⟺ 160	161 ⟺ 200	> 200
5'10"- 6' (177.8 - 182.9 cm)	130 ⟺ 180	181 ⟺ 215	> 215
6'1"- 6'3" (185.4 - 190.5 cm)	145 ⟺ 190	191 ⟺ 230	> 230
> 6'3" (190.5 cm)	150 ⟺ 210	210 ⟺ 245	> 245

6) You may want to talk to your doctor…

- Write the conditions which are in the "concerning" or "take action" ranges.

2. Interpreting Values for Participants

Living Well personnel should provide the results of the biometric measurements and explain what the numbers mean. Their role is not to provide medical advice. If participants have questions beyond the explanation of the values and the risks that may be associated with elevated values, participants should be instructed to talk to their health care providers. Below are suggested explanatory scripts.

1) A1c

Read the following text until the participant's A1c range is reached. For example, read the first 3 bullets for someone with an A1c of 6.5.]

A1c, also called hemoglobin A1c or glycosylated hemoglobin, indicates how well a person's diabetes is controlled. A1c is a blood test that indicates a person's glucose level over the last 2-3 months. Doctors order this test once a year if a person has excellent control of their diabetes and every 3 months when diabetes is not well controlled.

- People without diabetes have an A1c of about 5.
- A person with diabetes who has an A1c less than 7 is under excellent control. Their risk for diabetic complications such as damage to the blood vessels in the eyes, kidneys, heart, and brain (which can cause blindness, kidney failure, heart attack, and stroke) is low.
- Experts agree that when a person has an A1c from 7 to 8, they should do something. It may be changing their diet and exercise, starting medication, or increasing medication.
- A person with an A1c greater than 8 has poorly controlled diabetes. They are at risk for complications of diabetes. Experts recommend people with poorly controlled diabetes should have their medications increased or new medications should be started.

2) Blood pressure

Having high blood pressure, or hypertension, is especially troublesome when a person has diabetes. Research has shown that in people with diabetes, to protect the heart, kidneys, and brain, it is more important to control blood pressure than to control glucose. For this reason, experts suggest lower blood pressure goals for people with diabetes compared to people without diabetes. Doctors should check blood pressure at every visit.

- Although we look at both the top number, the systolic blood pressure, and the lower number, the diastolic blood pressure, a person's risk for complications is more associated with systolic blood pressure
- Your systolic blood pressure is [read only the statement coinciding to the participant's value]
  - o less than 120. So you don't need to be doing anything more than what you are already doing.
  - o less than 140 is your goal. Keep checking your blood pressure regularly, and if it goes over 140, you should speak with your doctor.
  - o greater than 140. Experts suggest that you and your doctor should take some action to decrease your blood pressure.

NOTE*: In the event of a hypertensive participant, the following protocol will be taken.*

- *Any participant with a blood pressure reading between 140/90 – 159/99 will be advised to talk to their doctor about their high blood pressure at their next visit with their doctor.*
- *Any participant with a BP reading between 160/100 – 179/109 will be advised to call their doctor on the same day if possible.*
- *For participant with a BP ready over 180/110, the research staff will stop and call Dr. Cherrington. Dr. Cherrington will speak with the participant develop a plan for the participant to obtain immediate medical attention.*

3) Weight

The weight ranges on this card are for a person of your height. Obesity makes it harder to control diabetes and places a person at increased risk for several medical problems including high blood pressure, arthritis and even some cancers. [Read only the statement coinciding to the participant's value.]

- Your weight is in the "normal" range for your height. This is considered a healthy weight. Starting or continuing healthy habits now can help prevent future weight gain and help you to maintain this healthy weight.
- Your weight is in the "overweight" range, which puts a person at higher risk for going on to become obese. Fortunately, incorporating healthy behaviors now can help prevent future weight gain.
- Your weight is in the "obese" range. The extra weight makes it is harder to control diabetes and increases the risk of heart disease and other diseases. Fortunately medical studies have shown that even a drop of 5% of body weight can lower the risk for developing many of these problems.

4) You may want to talk to your doctor…

- If all values are in the "Excellent/Good" ranges: You are doing great. You may want to talk to your doctor about healthy habits to keep yourself healthy.
- [*Read list of conditions in the "Concerning/Take Action" ranges.*]

REMINDER

Living Well personnel should not offer medical advice. If participants have questions more in depth than what has been stated in this script, they should be referred to their doctors.

Consent Form

CONSENT FORM

TITLE OF RESEARCH:	Living Well (Improving Medication Adherence in the Alabama Black Belt)-AIM 2
IRB PROTOCOL NO.:	X160301010
INVESTIGATOR:	Andrea Cherrington, MD MPH
SPONSOR:	Patient Centered Outcomes Research Institute (PCORI)
SPONSOR PROTOCOL NO.:	AD-1306-03565

Purpose of the Research

We are asking you to take part in a research study. This research study will test if Peer Advisors can help patients with diabetes better care for his or her diabetes to improve blood sugar levels, blood pressure, and quality of life. Peer advisors come from the same community as participants and have been trained to help people with diabetes. This study will enroll 500 participants. 250 participants will work with a peer advisor for 6 months and 250 participants in the general education group will receive health education videos. Which program you receive will depend on a random assignment process.

Explanation of Procedures

If you agree to participate in this study, you will be asked to take part in a telephone interview with a UAB study research assistants that will last approximately 45-60 minutes. During this call, you will be asked questions about you, your diabetes, your overall health, and topics related to your health such as your doctor, health care access, health knowledge, and current health behaviors. You do not have to answer any questions that you don't want to or that make your feel uncomfortable.

After the telephone interview, you will be asked to complete an in-person data collection visit that will last approximately 45-60 minutes. The data collection will be scheduled within 30 days of completing the telephone interview. The data collection visit will be conducted at a location in your community or in you home, depending of your preference. During the in person data collection visit, trained UAB study research assistants will conduct the following activities:

1. Test your blood sugar levels and your cholesterol levels by drawing blood from your finger
2. Measure your blood pressure 2 times
3. Measure your weight and height.
4. Make a list of all of your medications, including the doses and the frequency that you take the medicines.
5. Give you a health report card that provides you with the results of your blood sugar levels, cholesterol levels, blood pressure, and your weight.

Wearing a loose fitting shirt is recommended to the in-person data collection visit so that we are able to measure your blood pressure. We ask that you do not to not drink any caffeine (from coffee, tea, or soda), do not eat or do any heavy physical activity, smoke, ingest alcohol for 30 minutes prior to the in person data collection visit.

After the in-person data collection visit, you will start your 6-month program. You will receive one of two programs. Which program you receive will be determined by chance.

The first program is called the General Health Program. If you receive this program, you will receive health education videos. The videos cover the following topics: Dementia and Alzheimer's, Breast Cancer, Colorectal Cancer, Osteoporosis and Fall Prevention, Eye Health, Oral Health, Foot Care, and Driving Safety. The videos last between 15 to 30 minutes. If you are in this program, UAB study staff will call you on the phone 3 times during months 1, 3, and 5 to make sure the program is going well and to answer any questions you may have. These calls will last around 5 minutes. You will also receive post cards from UAB staff during months 2, 4, 6, and for holidays.

The second program is called the Living Well Program. In this program, you will be matched with a peer advisor. The peer advisor you are matched to depends on yours and peer advisor's availability. Your peer advisor will contact you on the phone within 2 weeks. You will watch videos that cover the following topics: diabetes basics, healthy eating, physical activity, stress reduction, and diabetes, cholesterol, blood pressure medications. The videos last between 20 to 40 minutes. You will then talk with your peer advisor on the phone using your study activity goal. During the phone calls with your peer advisor, you will set health goals and talk about the content covered in the videos. You will speak weekly for the first 8 weeks, bi-weekly for 1 month, and 1-3 times for month for the final 3 months. For the first 3 months, the calls with your peer advisor will last between 30-45 minutes. For the months 3-6, the calls with your peer advisor will last between 10-15 minutes. The total number of times and your peer advisor speak will be determined by you and your peer advisor but you will talk with your peer advisor around 13-16 times. If you are in this program, UAB study staff will call you on the phone 2 times during months 2 and 5 to make sure the program is going well and to answer any questions you may have. These calls will last around 5 minutes. You may also receive postcards from UAB staff for holidays. Finally, if you are in this program, you have the choice to use a study telephone. This phone will be yours to use for the 6 months when you are talking with your peer advisor. We ask that you only use the phone to talk with your peer advisor. You will need to return the phone to UAB after you finish the study. If you would like to use a study phone, the phone will be provided to you during the in person data collection visit. You will return the phone to UAB at the second in person data collection visit.

After 6 months, all participants in both programs will be asked to participate in a second in person data collection visit and a telephone interview. During month 6, UAB study staff will call you by telephone to schedule the in person visit and the telephone interview. The same information and tests will be collected during the second in person data collection visit as we

collected in the first in person visit. We will measure your blood sugar levels, cholesterol levels, two blood pressure measurements, and your weight and height. We will make another list of your medications, doses, and frequency. You will also receive a health report card with your measurements. At the second telephone interview, we will ask you many of the same questions that we asked at the first interview. The in-person data collection visit and phone interview will each take 45-60 minutes.

Risks and Discomforts

The risks in this study are minimal. There is a potential for loss of confidentiality. You may experience discomfort or pain during the blood test and may experience temporary redness and soreness on your finger. It is possible that your numbers may be high or low when we test them. A doctor or nurse will be available by phone to help you address any concerns you may have.

If you are working with a peer advisor, it is possible that the peer advisor may not always know the right answer. The study investigators will be helping the peer advisors and meeting with them weekly. Peer advisors are trained by study investigators. So the chance of the peer advisor giving you the wrong information is very small. If any time you have concerns, you can contact Dr. Cherrington.

You will be assigned to a program by chance, which may prove to be less effective than the other study group or available information.

Benefits

You may not benefit directly from taking part in this study. However, this study may help us better understand how to treat diabetes better in the future. You will receive a "health report card" at the data collection visits that tells your blood sugar number, cholesterol number, blood pressure, and weight.

Alternatives

The alternative to this study is not to participate and continue your routine diabetes treatment.

Confidentiality

Information obtained about you for this study will be kept confidential to the extent allowed by law. However, research information that identifies you may be shared with the UAB Institutional Review Board (IRB) and others who are responsible for ensuring compliance with laws and regulations related to research, including people on behalf of PCORI and the Office for Human Research Protections (OHRP). The information from the research may be published for scientific purposes; however, your identity will not be given out.

Some of your sessions with your peer advisors may be audio recorded. A study investigator will listen to these recordings to make sure that the peer advisor is conducting the sessions correctly. The recordings will be kept in a secure place, a locked cabinet in a locked office suite at UAB until they are listened to. The recordings will be erased after they are listened to.

A description of this clinical trial will be available on http://www.ClinicalTrials.gov, as required by U.S. Law. This Web site will not include information that can identify you. At most, the Web site will include a summary of the results. You can search this Web site at any time.

Voluntary Participation and Withdrawal

Whether or not you take part in this study is your choice. There will be no penalty if you decide not to be in the study. If you decide not to be in the study, you will not lose any benefits you are otherwise owed. You are free to withdraw from this research study at any time. Your choice to leave the study will not affect your relationship with UAB.

Cost of Participation

There will be no cost to you for taking part in this study.

Payment for Participation in Research

You receive a portable DVD player and $20 for participating in this study. You will receive the DVD player at the first in person data collection visit. You will receive a $20 VISA card at the second in person data collection visit.

Significant New Findings

You will be told by your doctor or the study staff if new information becomes available that might affect your choice to stay in the study.

Questions

If you have any questions, concerns, or complaints about the research, you may contact one of the studies investigators. For UAB, contact Dr. Andrea Cherrington. She will be glad to answer any of your questions. Dr. Cherrington's number is 205-996-2885.

If you have questions about your rights as a research participant, or concerns or complaints about the research, you may contact the UAB Office of the IRB (OIRB) at (205) 934-3789 or toll free at 1-855-860-3789. Regular hours for the OIRB are 8:00 a.m. to 5:00 p.m. CT, Monday through Friday. You may also call this number in the event the research staff cannot be reached or you wish to talk to someone else.

Legal Rights

You are not waiving any of your legal rights by signing this informed consent document.

Signatures

Your signature below indicates that you have read (or been read) the information provided above and agree to participate in this study. You will receive a copy of this signed consent form.

Signature of Participant	Date
Signature of Person Obtaining Informed Consent	Date
Signature of Witness	Date

Reviewed by:

Signature of Principal Investigator Reviewing Consent Document	Date

University of Alabama at Birmingham
AUTHORIZATION FOR USE/DISCLOSURE OF
PROTECTED HEALTH INFORMATION (PHI) FOR RESEARCH

Participant Name: _____
Research Protocol: Living Well (Improving Medication Adherence in the Alabama Black Belt)-AIM 2

UAB IRB Protocol Number: X160301010
Principal Investigator: Andrea Cherrington, MD MPH
Sponsor: PCORI

What is the purpose of this form? You are being asked to sign this form so that UAB may use and release your protected health information for research. Participation in research is voluntary. If you choose to participate in the research, you must sign this form so that your protected health information may be used for the research.

Why do the researchers want my protected health information? The researchers want to use your protected health information as part of the research protocol listed above and as described to you in the informed consent.

What protected health information do the researchers want to use? All medical information, including but not limited to information and/or records of any diagnosis or treatment of disease or condition, which may include sexually transmitted diseases (e.g., HIV, etc.) or communicable diseases, drug/alcohol dependency, etc.; all personal identifiers, including but not limited to your name, social security number, medical record number, date of birth, dates of service, etc.; any past, present, and future history, examinations, laboratory results, imaging studies and reports and treatments of whatever kind, including but not limited to drug/alcohol treatment, psychiatric/psychological treatment; financial/billing information, including but not limited to copies of your medical bills, and any other information related to or collected for use in the research protocol, regardless of whether the information was collected for research or non-research (e.g., treatment) purposes.

Who will disclose, use and/or receive my protected health information? All Individuals/entities listed in the informed consent documents, including but not limited to, the physicians, nurses and staff and others performing services related to the research (whether at UAB or elsewhere); other operating units of UAB, HSF, UAB Highlands, Children's of Alabama, Eye Foundation Hospital, and the Jefferson County Department of Health, as necessary for their operations; the IRB and its staff; the sponsor of the research and its employees and agents, including any CRO; and any outside regulatory agencies, such as the Food and Drug Administration, providing oversight or performing other legal and/or regulatory functions for which access to participant information is required.

How will my protected health information be protected once it is given to others? Your protected health information that is given to the study sponsor will remain private to the extent possible, even though the study sponsor is not required to follow the federal privacy laws. However, once your information is given to other organizations that are not required to follow federal privacy laws, we cannot assure that the information will remain protected.

How long will this Authorization last? Your authorization for the uses and disclosures described in this Authorization does not have an expiration date.

Can I cancel this Authorization? You may cancel this Authorization at any time by notifying the Principal Investigator, in writing, referencing the research protocol and IRB Protocol Number. If you cancel this Authorization, the study doctor and staff will not use any new health information for research. However, researchers may continue to use the protected health information that was provided before you cancelled your authorization.

Can I see my protected health information? You have a right to request to see your protected health information. However, to ensure the scientific integrity of the research, you will not be able to review the research information until after the research protocol has been completed.

Signature of participant: _____ Date: _____

or participant's legally authorized representative: _____ Date: _____

Printed Name of participant's representative: _____

Relationship to the participant: _____

In-person Data Collection Form

Living Well Baseline Data Collection Packet

Table of Contents

Your role as a data collector is very critical to this study. The information that you gather will help us make important decisions. Therefore, we have to have confidence in the conclusions that we make. We get that confidence from knowing that the data was collected in a standard, reliable way.

The information that you collect will help us:

- Better understand the day-to-day experiences of individuals living with diabetes.
- Determining what effects the project has on the health and well-being of study participants.

During today's session you will collect (in this order):

- Informed Consent
- Blood pressure
- Hemoglobin A1c
- LDL Cholesterol
- Height & weight
- Medication names, doses, and frequencies
- Provide the participant with information on their first contact with their Peer Advisor and provide them with the report card.

This packet is a guide to help you gather the data in a standard and reliable way.

Remember to complete each page, fill out each blank, and check each item off on the list as you complete them.

Use this packet along with the Living Well Biometric Protocol, v. 2016-May24
It is very important that you do not rush and the data that is collected is accurate. Document if anything unusual happens or if it was necessary to make changes to any of the protocol in the "Notes" sections.

Supplies:

At the end of the day, note any supply items that are running low.
Complete the Supply Request Checklist and fax to UAB: 205.975.6753 or call UAB.

At any point during the data collection a question arises, STOP and CALL the study manager at 205-617-7512

Data Collector NAME:	
Date of Data Collection:	

Client PID:	
Client Name:	

Client Contact Information

(Update as needed)

Telephone Numbers:

Mailing Address:

Directions / Notes:

☐ Data Collection in the Home / Residence	☐ Data Collection in the Community Venue *Venue Name / Location:*_____

Data Collection Time

Start Time	:	AM or PM	**End Time**	:	AM or PM
☐☐	☐☐		☐☐	☐☐	

Greet client and ask where would be a good location to set up for data collection.

The data collection area will need:

- ☐ 1 electrical plugs
- ☐ Area to set-up table and chair. ***Client must be able to rest his or her arm on the table***.
- ☐ Quiet area with privacy
- ☐ Not in direct sunlight

Supplies - Beginning of each day, make sure you have all of these items.

General Equipment:

- ☐ Informed Consent forms
- ☐ Data Collection Packet
- ☐ Extra Medication Lists
- ☐ Extra batteries: Double A and Triple A
- ☐ Biohazard and trash bags

Blood Pressure Measurement Supplies:

- ☐ Watch / clock
- ☐ Tape measure, eyebrow pencil
- ☐ Blood pressure monitor
- ☐ Blood pressure cuffs (regular, large, extra-large)

HBA1c and LDL-Cholesterol Measurement Supplies:

- ☐ A1c NOW Test kits (doublecheck that you have enough tests for that day)
- ☐ Cardiochek PA machine, Capillary tube, and test strips
- ☐ Lancet, alcohol wipes, bandaids, gloves, gauze, waste container

Height and Weight Measurement Supplies:

- ☐ Scale
- ☐ Stadiometer
- ☐ Step stool

Program Materials:

- ☐ DVD players and Signature log
- ☐ Client Specific Study Packet (General Health Program / Living Well Program)

Step 1: Blood Pressure

- ☐ Gather materials – BP cuff, BP monitor, tape measure, eyebrow pencil, alcohol wipe
- ☐ Check the BP monitor's battery life and change batteries or plug-in to a wall socket if available
- ☐ Squeeze all air from the BP cuffs
- ☐ Select arm (right arm, unless there is a reason to avoid measurement in this arm)
- ☐ Arm is bare to the shoulder

Client position

- ☐ Standing, facing away from you, arm bent at the elbow at a 90-degree angle (Hand on stomach)

Measure the arm

- ☐ Measure from the top of the shoulder (acromion / bony prominence of the shoulder girdle) to the tip of the elbow (olecranon process)
- ☐ Mark the midpoint on the back of the arm. At the mark, measure the circumference of the arm

Arm Circumference ☐☐ . ☐ cm

- ☐ Select correct cuff size.

Arm Circumference	Bladder Size	Cuff selected
24 – 35.5 cm	Regular / Medium	☐
36 – 42 cm	Large	☐
> 42 cm	Extra large	☐

- ☐ Client is seated comfortably in a chair with a back; both feet flat on the floor
- ☐ Arm is supported & resting comfortably on the table at a 90-degree angle with the palm facing up
- ☐ Room is quiet with no distractions

Apply cuff

- ☐ Find and mark the brachial artery with the eyebrow pencil
- ☐ Place cuff around the upper arm, approximately at heart level
- ☐ Wrap cuff snugly on the arm, inner bladder of cuff over the area of the brachial artery (insert first joint of two fingers under the cuff)
- ☐ Arm is resting on table with palm facing up and connect cuff to the monitor

Arm Used: ☐ Left Arm ☐ Right Arm

5 minute rest time begun ☐☐ : ☐☐ AM or PM

BP Measurement 1

Time 1 ☐☐ : ☐☐ AM or PM

BP 1 ☐☐☐ / ☐☐☐ Pulse 1 ☐☐☐

BP Measurement 2

Time 2 ☐☐ : ☐☐ AM or PM

BP 2 ☐☐☐ / ☐☐☐ Pulse 2 ☐☐☐

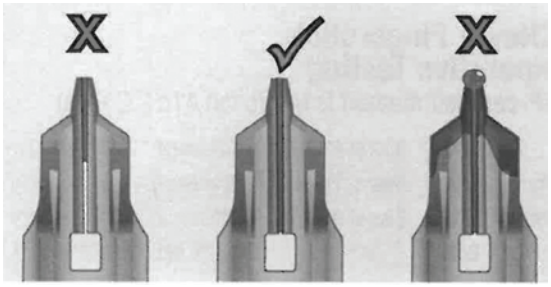
notes:

Remember! 1-minute rest is needed between measurement 1 and 2.

Step 2: Hemoglobin A1c and LDL Cholesterol Measurement

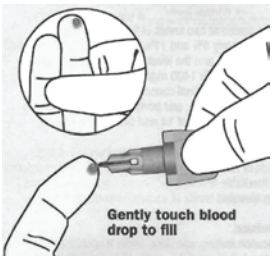
☐ Gather materials - gloves, lancet, gauze, alcohol wipe, band-aid, A1c NOW kit (3 items: machine, cartridge, & dilution kit) and cholesterol (Cardiochek PA machine, test strips, capillary tubes and plunger, test strips.

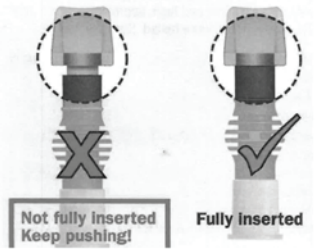
Before pricking finger, note time: ☐☐:☐☐ AM or PM

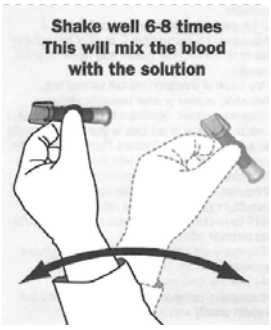


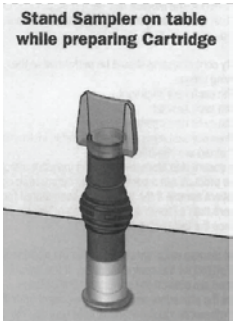
Collect Sample for A1c

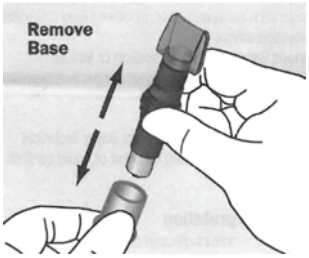
☐ Open dilution kit
☐ With alcohol wipe, clean finger, & allow alcohol to dry
☐ Use lancet, dispose into sharps bag
☐ Wipe away first drop of blood with gauze
☐ Use 2nd drop for the test. Collect blood sample by gently touching blood drop with collector to fill.
☐ Fully insert blood collector into Sampler Body. Shake well 6-8 times. Stand sampler on table.











Prepare Cartridge

☐ Open Test Cartridge packet. ***IMPORTANT: Use the cartridge within 2 minutes.***
☐ "Click" cartridge into place. Monitor and Test Cartridge codes must match.
☐ When display says "SMPL", the monitor is ready.
☐ Ensure monitor is on a level surface.
☐ Remove base from the blood collector.
☐ Push down blood collector on the cartridge completely to dispense sample. Remove quickly.
☐ **Do not handle the monitor again until test is complete**.

Recording the results

☐ results will display in 5 minutes.
☐ 3 items will be displayed: "QCOK" (QC test results), "00.0" (test results), "00TL" (# of test left)

Refer to the anthropromorphic protocol, page 11 for any error codes.

A1c ☐☐.☐	*notes:*

Remember:

- Machines should not be direct sunlight or near cold or heat sources
- Do not open the A1c NOW test kit materials until you are ready to begin that portion of the test
- Once test begins, do not move the machine until the test is complete

Step 3: LDL-Cholesterol Measurement

☐ After A1c test is being analyzed, collect sample for cholesterol machine.

Collect Sample for Cholesterol Test

- ☐ With alcohol wipe, clean finger, & allow alcohol to dry
- ☐ Use lancet, dispose into sharps bag
- ☐ Wipe away first drop of blood with gauze
- ☐ Use 3rd drop for the test. Collect blood sample by gently touching blood drop with capillary tube to fill to the black line on the tube.
- ☐ Deposit the sample on the test strip of the Cardiochek PA machine.
- ☐ **Do not handle the monitor again until test is complete**.

Recording the results

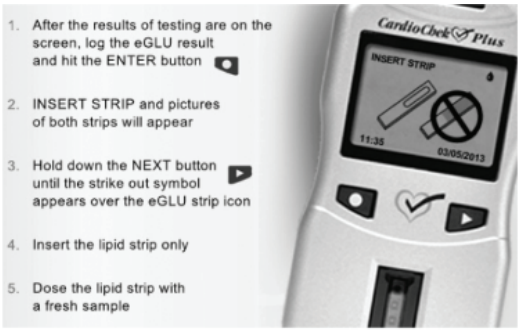
- ☐ Results will display in approximately 2 minutes.

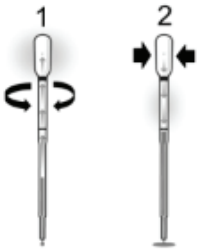
LDL ☐☐☐	*notes:*

Remember:

- Machines should not be direct sunlight or near cold or heat sources
- Prepare the Cardiochek PA machine (insert test strips in the machine, lay out capillary tube and plunger) before A1c test is started.
- Once test begins, do not move the machine until the test is complete

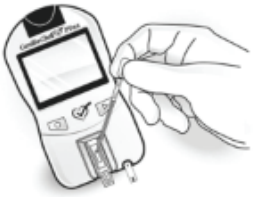
Insert MEMo Chip with finger notch (top) side up, lot number code facing down.





1) Collection:
Place your thumb and finger just ***under*** the bulb

2) Deposit:
Place your thumb and finger ***on*** the bulb.
Cover the air holes and *gently* expel the sample

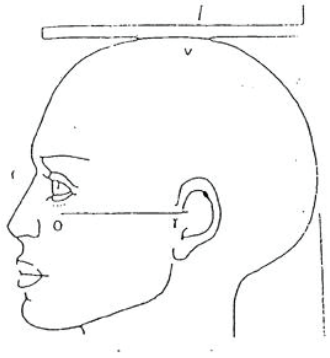


Deposit the entire sample
Do not touch the testing surface

Touch the tip of the capillary tube to the drop of blood
Fill completely to the black line with no air bubbles

Step 4: Height and Weight Measurement

- ☐ Gather materials - scale, stadiometer, step stool
- ☐ Check scale battery and replace if needed, calibrate on yourself



Height measurement

ORBITALE: Lower margin of eye socket
TRAGION: Notch above tragus of ear or at upper margin of zygomatic bone at that point
FRANKFORT PLANE: Orbitale-tragion horizontal line

Set up

- ☐ Scale and stadiometer is placed on level, uncarpeted floor
- ☐ Stadiometer – assemble by matching shapes on each segment
- ☐ Stadiometer's horizontal bar is correctly placed on the vertical rod.

Body Position

- ☐ Standing straight, not slouching, at the center of the foot plate
- ☐ Heels together, back against height rod
- ☐ Back, buttocks, heels touching height rod

Head Position

- ☐ Head is positioned correctly (Does not need to be touching the height rod)
- ☐ Client is looking straight ahead, ear and top of cheek bone should be level with the ground ***Ask client to raise or lower chin as needed***
- ☐ Horizontal bar is lowered firmly onto the top of the head - may need to alter hair styling to make contact with the top of the scalp

Measurement

- ☐ Ask client to breathe in deeply → **"Take a deep breath"**
- ☐ Just before client exhales, note the reading on the stadiometer → **"Breathe out"**
- ☐ **MEASURE IN CENTIMETERS**
- ☐ Repeat measuremet. ***If the measurement is different by .04 cm, repeat both measurements.***

Height 1 ☐☐☐.☐ **CM**	**Height 2** ☐☐☐.☐ **CM**
notes:	
☐ *not needed.* **Height 3** ☐☐☐.☐ **CM**	☐ *not needed.* **Height 4** ☐☐☐.☐ **CM**

Alternative Position - Client unable to place heels, buttocks, and back on the vertical height rod.

- Position client so that only the buttock & possibly the shoulders are in contact with the vertical rod
- It is important that these clients are standing straight and tall, legs together as much as possible with the buttock in contact with the vertical height rod.

Alternative Position - Clients with severe spine curvature

- Curvature of spine should touch the rod with the heels and buttocks
- If this is not possible, turn pt to the side, so the side of arm & shoulder is in contact with vertical rod

Remember to note any changes to the standard positions on the form above.

Weight measurement

Set up

- ☐ Scale is placed on uncarpeted floor / compressed carpet
- ☐ Scale is set on "lbs" not "kg"
- ☐ Client is not wear shoes or heavy jewelry or heavy clothing
- ☐ Ask client to use bathroom before measurement → ***"The measurement we are about to take is more accurate if you use the bathroom before we measure you."***

Measurement

- ☐ Ask client to step on the scale, feet positioned evenly on scale
- ☐ Client is still while weight is being determined, display will flash and then show the weight.
- ☐ Have client step off step off scale,
- ☐ ***Repeat 1-time, if different, repeat both measurements.***

Weight 1 ☐☐☐.☐ **lb**	**Weight 2** ☐☐☐.☐ **lb**
notes: ☐ weight greater than 400 lbs ☐ client needed support / help *(specify)*	
☐ *not needed.* **Weight 3** ☐☐☐.☐ **lb**	☐ *not needed.* **Weight 4** ☐☐☐.☐ **lb**

Notes to data collector:

- Make certain that the scale is on "LB"
- Weigh yourself while setting up to ensure that the scale is accurate
- Do not press the on/off button on the scale before measuring. Just step onto the scale.
- If the client needs support during the weighing, provide the minimum support that is safe and note on the form above.

Step 4: Medication List

- ☐ Double check that all medicines are listed
- ☐ Aspirin dose is noted
- ☐ Insulin is checked "yes" or "no"
- ☐ all doses and frequencies are listed
- ☐ ***For all medications – ask if it is taken as written on the bottle, if not, note on the form***

Brought Medications	☐ Yes ☐ Yes-from list	☐ No - schedule date/time for phone call:
Takes a daily aspirin	☐ No	☐ Yes - note the mg per day: _____mg

Insulin Name	Mix (__/__)	Unit (s)	# times per day	Total dose *(data entry only)*	Notes

Insulin = state the full name

Mix = state the mix values (i.e. 70/30)

 # Times per Day = state the number of times you take insulin in a day

Dose/total dose = (FOR DATA ENTRY ONLY) Use the # per day to determine the dose or doses of insulin the participant takes. Use this to calculate the total dose per day. (For example: # per day: 2, dose: 12 (am) & 25 (pm) → dose total: 37

Note any additional comments or concerns you might have about insulin:

Medication Name	*Combination* *Yes / No*	Freq 1 # pills taken	Freq 2 # times / day	Dose	Total dose *(data entry only)*	Notes
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					

- **Medication name** = Write the full name
- **Combination** = If yes, remember to write the dose for both medications
  (Ex. Glucovance contains glyburide and metformin HCl → be sure to state the two doses i.e. 15/500)
- **Freq 1** = State the number pills taken for the medicine (ex. 2 pills in the AM, 3 pills in the PM)
- **Freq 2** = State the number of times the pills are each day (ex. 2 times a day)
- **Dose** = the dose of the pill. ***Remember to write dose of both meds if a combination (ex: 15/500)***
- Total Dose = (FOR DATA ENTRY ONLY) use freq 1 and freq 2 to calculate (Ex. 1.5 mg = 1 pill, frequency = 2 pills are taken 3 times a day, dose = 3 mg & total dose: 9 mg)

Note any additional comments or concerns you might have about medication list

Medication Name	*Combination* *Yes / No*	Freq 1 # pills taken	Freq 2 # times / day	Dose	Total dose *(data entry only)*	Notes
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
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	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					

- **Medication name** = Write the full name
- **Combination** = If yes, remember to write the dose for both medications
  (Ex. Glucovance contains glyburide and metformin HCl → be sure to state the two doses i.e. 15/500)
- **Freq 1** = State the number pills taken for the medicine (ex. 2 pills in the AM, 3 pills in the PM)
- **Freq 2** = State the number of times the pills are each day (ex. 2 times a day)
- **Dose** = the dose of the pill. ***Remember to write dose of both meds if a combination (ex: 15/500)***
- Total Dose = (FOR DATA ENTRY ONLY) use freq 1 and freq 2 to calculate (Ex. 1.5 mg = 1 pill, frequency = 2 pills are taken 3 times a day, dose = 3 mg & total dose: 9 mg)

Note any additional comments or concerns you might have about medication list

☐ Additional pages needed (_____) pages attached.

Report Card

- ☐ Complete report card and present to the client.
- ☐ Living Well personnel should provide the results of the biometric measurements and explain what the numbers mean. **Their role is not to provide medical advice. If participants have questions beyond the explanation of the values and the risks that may be associated with elevated values, participants should be instructed to talk to their health care providers.**
- ☐ Review the script on page 29-30 of the Biometric Protocol.

Next Steps

- ☐ Peer Advisor will call you in 1-2 weeks.
- ☐ *Obtain preferences for times that peer should call.*

Best Times to Call

☐ **Morning**	☐ **Mon**	☐ **Thurs**	☐ **Sat**
☐ **Afternoons**	☐ **Tues**	☐ **Fri**	☐ **Sun**
☐ **Evenings**	☐ **Weds**		

If the participant is in the Living Well program:

- ☐ *Give participant Program packet.*
  - ☐ Please keep the DVD in a safe place. You will be able to keep the DVD at the end of the study, but it is very important for you to have for the study.
  - ☐ Also, please place the DVD player and program materials in a safe place. You will need these materials when your peer advisor calls you.
- ☐ *Offer study phone to the participant*
  - ☐ Study phone are available for you to use for the length of the research study. Please only use this phone with your calls with your peer advisor. Please do not use the phone for personal calls. This phone will need to be returned to UAB at the end of the research study. Would you like to use a study phone?
  - ☐ Yes, client will like to use a research study phone.
  - ☐ No, client declines the use of a research study phone.
- ☐ *Thank the client; another data collection will take place in 6 months. Show client where the phone numbers are to reach community coordinators and Birmingham staff.*

If the participant is in the General Health Program:

- ☐ *Give participant Program packet.*
- ☐ *Thank the client; another data collection will take place in 6 months. Show client where the phone numbers are to reach community coordinators and Birmingham staff.*

DVD Set Up

- ☐ Have client practice and set-up the DVD from the beginning.
- ☐ While cleaning-up and packing, have the client watch DVD 1.

Health Report Card

Report Card

There are some things you can do to reduce the health risk of diabetes.

These numbers can give you an idea of how you are doing.

Living Well with Diabetes

A1C *(Average Sugar Control over the last 3 months)*

Great control	Less than 7
Ok, not perfect	7.0 ⟷ 7.9
Cause for concern	8.0 ⟷ 8.9
Bigger cause for concern	> 9.0

Blood Pressure

Normal	Less than 120/80
Our Goal	Less than 140/90
High-*talk to doctor*	140/90 or higher

Cholesterol *(LDL cholesterol or your "bad cholesterol")*

Okay	Less than 100
High-*talk to doctor*	100 or higher

Weight

- **Normal** *(excellent)*
- **Overweight** *(may be concerning)*
- **Obese** *(take action)*

You may want to talk to your doctor about...

Appendix G

Participant Retention Postcards

General Health Education Program Video Fact

Did you know?

Living healthy can lower your risk of eye disease! Keep an eye on your health by eating fruits and vegetables, being active, and not smoking!

To find out more, please watch **Video 5: Eye Care** on the General Health Education Program DVD.

Have questions?
Contact the UAB Living Well study team at:

(205) 934-7163

Keep in touch!

Just a reminder, your 6 month visit is coming up!
We will be in contact to schedule this meeting soon.

Remember! Your 6 month visit is coming up soon!
Got questions? Call us at (205) 934 - 7163

Reminder!

Your **telephone appointment** has been scheduled for

*date:*_____

*time:*_____

We look forward to speaking you!

If you have questions, please call us using the numbers listed below.

We look forward to speaking with you!
If you have questions, please call us at: 205.934.7163


Season's Greetings!
from the UAB Living Well Study Team
Got questions? Call us at (205) 934 - 7163

Happy Thanksgiving

from the UAB Living Well Study Team

Got questions? Call us at (205) 934 - 7163

Wishing you a very

Happy Birthday

from the UAB Living Well Study Team

Got questions? Call us at (205) 934 - 7163

Retention Scripts

General Health Program Participant Phone Call Script – Month 1

Voicemail leave message 1 time only*:*
Hello, my name is _____, I am calling from the University of Alabama at Birmingham about the Living Well program. At your convenience, please call us at 205.934.7163. Thank you and have a nice day.

Hello _____, my name is _____ calling from the University of Alabama at Birmingham about the Living Well research program. How are you today?

May I please speak with _____?

- [If not speaking] Is _____ available?
- [If no] When may I call back to speak with _____? Thank you for your time.
  *[Document Date/Time to call back]*_____

- **[If yes continue when they come on the line]** Hello _____, my name is _____ calling from the University of Alabama at Birmingham about the Living Well study. How are you today?

I am calling today to welcome you to the Living Well General health research study and go over any questions you have about the study.

- Have you watched any videos from the General Health DVD? Do you have any questions about any of the materials?
- May I answer any questions that you may have about the study?

I would like to verify your contact information. Is this your correct mailing address and telephone number?
Yes – great thank you! *(move to next question)*
No – *obtain correct information and update spreadsheet.*

We also have _____(name) as a friend or family member who would know your whereabouts in case we have trouble contacting you. Is this still the correct phone number for _____(name)?
Yes – *go to close out*
No – Can you give me another person who would know your whereabouts in case we have trouble contacting you? Please think of someone who would not mind if we called them for this information.

Close out:

- *Thank you again for your time today.* A member of our team will be contacting you each month by mail or phone. If you would like to reach us before we talk again you can call us at the number listed on your DVD. If your phone number or address changes, or if you have any questions about the Living Well with Diabetes study, please call us at the same number. Thank you and have a wonderful day!

General Health Program Participant Phone Call Script – Month 3

Voicemail leave message 1 time only*:*
Hello, my name is _____, I am calling from the University of Alabama at Birmingham about the Living Well program. At your convenience, please call us at 205.934.7163. Thank you and have a nice day.

Hello _____, my name is _____ calling from the University of Alabama at Birmingham about the Living Well research program. How are you today?

May I please speak with _____?

- [If not speaking] Is _____ available?
- [If no] When may I call back to speak with _____? Thank you for your time.
  *[Document Date/Time to call back]*_____

- **[If yes continue when they come on the line]** Hello _____, my name is _____ calling from the University of Alabama at Birmingham about the Living Well study. How are you today?

I am calling today to check in with you and answer go over any questions you have about the study.

- Have you watched any videos from the General Health DVD? Do you have any questions about any of the materials?
- May I answer any questions that you may have about the study?

I would like to verify your contact information. Is this your correct mailing address and telephone number?

Yes – great thank you! *(move to next question)*
No – *obtain correct information and update spreadsheet.*

We also have _____(name) as a friend or family member who would know your whereabouts in case we have trouble contacting you. Is this still the correct phone number for _____(name)?

Yes – *go to close out*
No – Can you give me another person who would know your whereabouts in case we have trouble contacting you? Please think of someone who would not mind if we called them for this information.

Close out:

- *Thank you again for your time today.* A member of our team will be contacting you each month by mail or phone. If you would like to reach us before we talk again you can call us at the number listed on your DVD. If your phone number or address changes, or if you have any questions about the Living Well with Diabetes study, please call us at the same number. Thank you and have a wonderful day!

General Health Program Participant Phone Call Script – Month 5

Voicemail leave message 1 time only:
Hello, my name is _____, I am calling from the University of Alabama at Birmingham about the Living Well program. At your convenience, please call us at 205.934.7163. Thank you and have a nice day.

Hello _____, my name is _____ calling from the University of Alabama at Birmingham about the Living Well research program. How are you today?

May I please speak with _____?

- [If not speaking] Is _____ available?
- [If no] When may I call back to speak with _____? Thank you for your time.
  *[Document Date/Time to call back]*_____

- **[If yes continue when they come on the line]** Hello _____, my name is _____ calling from the University of Alabama at Birmingham about the Living Well study. How are you today?

I am calling today to check in with you and remind you that your 2nd study visit and telephone interview are coming up in 1 month.
Your 2nd telephone interview and your study visit are coming up in 1 month. Let me tell you a little about these visits. During the telephone interview, we will ask you some questions about you and your diabetes. At the in-person data collection visit, UAB staff will do a finger stick test to check your A1c number, which is your average blood sugar level, and your blood cholesterol. They will also measure your height, weight, blood pressure, and make a list of your medications.

- Remember, you will receive a $20 VISA gift card for completing the inperson study visit.
- Would you like to schedule this visit and telephone interview today?
  - if no: Okay, I will give you a in 2-3 weeks.
  - If yes, schedule date and times: Great! We see you on _____(date/time)!

- May I answer any questions that you may have about the study?

Close out:

- *Thank you again for your time today.* We will talk to you on [date/time] to complete your telephone interview and on [date/time] to complete your 2nd in person study visit.
- *For your in person study visit,* We ask that you do not to not drink any caffeine (from coffee, tea, or soda), should not eat or do any heavy physical activity, smoke, ingest alcohol for 30 minutes prior to the in person data collection visit. *Please wear a loose fitting shirt to the study visit.*
- Thank you and have a wonderful day!

Living Well Program Participant Phone Call Script – Month 2

Voicemail leave message 1 time only*:*
Hello, my name is _____, I am calling from the University of Alabama at Birmingham about the Living Well program. At your convenience, please call us at 205.934.7163. Thank you and have a nice day.

Hello _____, my name is _____ calling from the University of Alabama at Birmingham about the Living Well research program. How are you today?

May I please speak with _____?

- [If not speaking] Is _____ available?
- [If no] When may I call back to speak with _____? Thank you for your time.
  *[Document Date/Time to call back]*_____

- **[If yes continue when they come on the line]** Hello _____, my name is _____ calling from the University of Alabama at Birmingham about the Living Well study. How are you today?

I am calling today to check in with you and answer go over any questions you have about the study.

- Have you spoken to your peer advisor? How many times since the beginning of the program have you spoken to your peer (NAME HERE).
- May I answer any questions that you may have about the study?

I would like to verify your contact information. Is this your correct mailing address and telephone number?

Yes – great thank you! *(move to next question)*
No – *obtain correct information and update spreadsheet.*

We also have _____(name) as a friend or family member who would know your whereabouts in case we have trouble contacting you. Is this still the correct phone number for _____(name)?

Yes – *go to close out*
No – Can you give me another person who would know your whereabouts in case we have trouble contacting you? Please think of someone who would not mind if we called them for this information.

Close out:

- *Thank you again for your time today.* A member of our team will be contacting you each month by mail or phone. If you would like to reach us before we talk again you can call us at the number listed on your activity book. If your phone number or address changes, or if you have any questions about the Living Well with Diabetes study, please call us at the same number. Thank you and have a wonderful day!

Living Well Program Participant Phone Call Script – Month 5

Voicemail leave message 1 time only:
Hello, my name is _____, I am calling from the University of Alabama at Birmingham about the Living Well program. At your convenience, please call us at 205.934.7163. Thank you and have a nice day.

Hello _____, my name is _____ calling from the University of Alabama at Birmingham about the Living Well research program. How are you today?

May I please speak with _____?

- [If not speaking] Is _____ available?
- [If no] When may I call back to speak with _____? Thank you for your time.
  *[Document Date/Time to call back]*_____

- **[If yes continue when they come on the line]** Hello _____, my name is _____ calling from the University of Alabama at Birmingham about the Living Well study. How are you today?

I am calling today to check in with you and remind you that your 2nd study visit and telephone interview are coming up in 1 month.

- Have you spoken to your peer advisor? How many times in the past 4 weeks have you spoken to your peer (NAME HERE)
- Your 2nd telephone interview and your study visit are coming up in 1 month. Let me tell you a little about these visits. During the telephone interview, we will ask you some questions about you and your diabetes. At the in-person data collection visit, UAB staff will do a finger stick test to check your A1c number, which is your average blood sugar level, and your blood cholesterol. They will also measure your height, weight, blood pressure, and make a list of your medications.
- Remember, you will receive a $20 VISA gift card for completing the inperson study visit.
- Would you like to schedule this visit and telephone interview today?
  - if no: Okay, I will give you a in 2-3 weeks.
  - If yes, schedule date and times: Great! We will call you on the phone and send you a reminder in your mail before the visits as a reminder.
- May I answer any questions that you may have about the study?

I would like to verify your contact information. Is this your correct mailing address and telephone number?

Yes – great thank you! *(move to next question)*

No – *obtain correct information and update spreadsheet.*

We also have _____(name) as a friend or family member who would know your whereabouts in case we have trouble contacting you. Is this still the correct phone number for _____(name)?

Yes – *go to close out*

No – Can you give me another person who would know your whereabouts in case we have trouble contacting you? Please think of someone who would not mind if we called them for this information.

Close out:

- *Thank you again for your time today.* We will talk to you on [date/time] to complete your telephone interview and on [date/time] to complete your 2nd in person study visit. Thank you and have a wonderful day!