Testing a Coaching Program to Help Adults with Diabetes Living in Rural Alabama Take Their Medicine as Directed

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ABSTRACT

Background: The effects of medication nonadherence are especially profound in remote, economically depressed communities with a high burden of chronic diseases, such as the rural Alabama Black Belt region. We built on our previous work in this region to rigorously test a community member–delivered intervention designed in partnership with community peer coaches.

Specific Aims: With our community partners, using qualitative research methods, we developed a medication adherence intervention delivered by trained community members (aim 1) and then tested this intervention in a cluster-randomized trial of individuals with diabetes seeking help with adherence to their medications (aim 2).

Methods: We first conducted qualitative research with experienced peer coaches and community members to learn their perspectives on diabetes and the medications used to treat it. Using this information, the Corbin and Strauss framework of the lived experience of illness, Bandura’s social cognitive theory, and adult learning theory, we developed an 11-session telephone-delivered diabetes self-management intervention that stressed medication adherence, assessed barriers to adherence, and involved strategizing to overcome these barriers. The intervention, delivered by community peer coaches, also provided information on healthy eating, physical activity, and stress reduction, and encouraged communication with health care providers. We then conducted a cluster-randomized trial, using towns as clusters, to test the effectiveness of this intervention. The intervention was deployed by trained peer coaches who resided in the same communities as the participants. We collected baseline and 6-month follow-up data in the communities where participants were recruited. The primary outcomes were self-reported medication adherence and measures of hemoglobin A1c, blood pressure, low-density lipoprotein cholesterol, and body mass index. Secondary outcomes were quality of life (QOL), medication beliefs, and self-efficacy to use medications.

Results: We recruited a total of 473 participants, 403 of whom completed follow-up (85.4% retention), which was within the design specifications for the study. The mean age of the trial population was 57.2 years, 78.2% were women, 90.6% were African American, 69.3% reported an annual income of <$20,000, 26.7% were employed, and 43.8% were taking insulin. In the control arm, 239 (89%) participants completed the study, and in the intervention arm, 164 (81%) completed the study. The intervention dose was high, with 81.8% of intervention participants completing all 11 sessions of the program. Self-reported medication adherence improved more in the intervention arm than in the control arm ($P < .0001$), but the other primary outcomes did not differ significantly between the trial arms. QOL improved similarly across both trial arms, but beliefs about the need for medications, concerns about medications, and medication use self-efficacy improved more in intervention than in control participants. Satisfaction with the program was high.

Conclusions: This intervention was highly engaging and improved self-reported medication adherence and self-efficacy, but it did not improve glycemic control or other physiologic
parameters among mostly African American individuals desiring help with their diabetes medications and living in a remote, economically disadvantaged rural region.

**Limitations:** Real-world challenges created delays in data collection, which may have influenced the study results. The self-reported availability of healthy foods was limited, possibly limiting dietary changes recommended in the intervention, such as increasing the consumption of fresh fruits and vegetables. The intervention was entirely community based and without a clinical component; thus, medication titration to achieve better glycemic control was not included as part of the intervention and may have limited the intervention’s impact on physiologic parameters. The fact that the study was restricted to the Black Belt setting may limit the generalizability of the findings.
Medication nonadherence is both common and costly. Clinical trials have demonstrated that medications that lower blood glucose, lipids, and blood pressure (BP) can lower risks for blindness, kidney disease, amputation, stroke, and heart attack.\(^1\)\(^-\)\(^3\) However, adherence to these medications is suboptimal; as many as half of diabetic patients do not take recommended medications as directed,\(^4\) and a recent meta-analysis of studies examining adherence to oral diabetes agents estimated a pooled proportion of patients who were adherent (where adherence is defined by a medication possession ratio of $\geq 80\%$) to be $67.9\%$.\(^5\) In addition to negative health outcomes, medication nonadherence contributes to substantial economic burden. For example, Egede and colleagues\(^6\) examined medication adherence using medication possession ratios from Veterans Affairs pharmacy data for 740,195 veterans from 2002 to 2006; they estimated that improving adherence to $80\%$ in nonadherent individuals would have resulted in a cost savings of $993,679,348 over the 5-year period, and improving adherence to $100\%$ would have saved $1,158,009,119.\(^6\) The annual cost of nonoptimized medication use, including medication nonadherence, was estimated to be $290 billion in 2008,\(^6,\)^\(^7\) and a more recent analysis, published in 2018 by Watanabe and colleagues, estimated the annual cost of drug-related morbidity and mortality from nonoptimized medication use to be $528.4 billion.\(^8\)

Medication nonadherence is especially problematic in hard-to-reach populations heavily burdened with chronic diseases like diabetes, such as residents of the rural Black Belt region, whose residents face the triple threat of being minorities, poor, and rural.\(^9\)\(^-\)\(^11\) The Black Belt is a region with dark soil amenable to agriculture where cotton plantations and slaves were in greatest concentration. Initially named for the color of the soil, since the Civil War, the name has taken on political meaning and is used with pride by its residents.\(^12\) The Black Belt runs in an arc across east central Texas to Maryland; in Alabama, it is a 200-mile-wide belt across the southern half of the state. There is a substantial mismatch of need and resources in this region (Table 1), and the resulting disparities in outcomes are evident; for example, the 2017 age-adjusted diabetes mortality rate was 35.6 per 100,000 for Black Americans compared with 15.5 per 100,000 for White Americans.\(^13\) Nonadherence is common in this population, as shown in
Table 2, which contrasts participants of a past trial and Black participants with diabetes in a national epidemiology study.\textsuperscript{14,15} Other studies have reported lower medication adherence in minority patients with diabetes than in White patients.\textsuperscript{16-18}

Table 1. Characteristics of Target Communities in Rural Alabama Black Belt Counties

<table>
<thead>
<tr>
<th>Geographic area</th>
<th>Population</th>
<th>% Black\textsuperscript{a}</th>
<th>Annual income &lt;$20 000, %\textsuperscript{a}</th>
<th>Diabetes incidence\textsuperscript{b}</th>
<th>PCPs/10 000 people\textsuperscript{c}</th>
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<td><strong>Target counties</strong></td>
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<td>Choctaw</td>
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<td>24.5</td>
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<tr>
<td>Dallas</td>
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<td>69.4</td>
<td>34.7</td>
<td>11.9</td>
<td>10.1</td>
</tr>
<tr>
<td>Lowndes</td>
<td>11 147</td>
<td>73.7</td>
<td>31.4</td>
<td>12.2</td>
<td>1.5</td>
</tr>
<tr>
<td>Marengo</td>
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<td>52.0</td>
<td>25.9</td>
<td>11.7</td>
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<tr>
<td>Perry</td>
<td>11 861</td>
<td>68.8</td>
<td>35.4</td>
<td>17.5</td>
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<tr>
<td>Pickens</td>
<td>19 746</td>
<td>43.0</td>
<td>27.7</td>
<td>14.9</td>
<td>5.0</td>
</tr>
<tr>
<td>Sumter</td>
<td>14 798</td>
<td>73.6</td>
<td>38.7</td>
<td>12.2</td>
<td>3.6</td>
</tr>
<tr>
<td>Wilcox</td>
<td>13 183</td>
<td>72.2</td>
<td>39.9</td>
<td>12.2</td>
<td>3.1</td>
</tr>
<tr>
<td><strong>Alabama</strong></td>
<td>4 802 740</td>
<td>26.3</td>
<td>19.0</td>
<td>11.8</td>
<td>20.6</td>
</tr>
<tr>
<td><strong>United States</strong></td>
<td>314 918 000</td>
<td>12.6</td>
<td>15.9</td>
<td>8.3</td>
<td>25.7</td>
</tr>
</tbody>
</table>

Abbreviation: PCPs, primary care providers.
\textsuperscript{a}Data from the 2010 Census.
\textsuperscript{b}Data from the 2008 Alabama Department of Public Health and the Behavioral Risk Factor Survey System.
\textsuperscript{c}Data from the Board of Medical Examiners of Alabama and the Kaiser Family Foundation.
Although the literature has identified some factors that may influence medication adherence, such as age, race, out-of-pocket costs, insulin use, depression, health literacy, and health beliefs, there is limited understanding of the most impactful barriers in this population and no data on effective strategies to improve the situation. Decades of research on how to improve nonadherence have yielded only modest changes in medication adherence. Since the 2008 publication of a Cochrane review of medication adherence interventions, which concluded that the strategies used up to that point had not been very effective and that innovative programs were needed to assist adherence to long-term therapy, recent reviews have shown that developing effective interventions for medication adherence remains challenging. A 2017 systematic review and meta-analysis by Conn and Ruppar revealed that interventions to date have yielded only modest effects on adherence. For diabetes specifically, a review of studies published between 2007 and 2014 concerning adherence to glucose-lowering agents showed that adherence rates had remained unchanged since 2007.

To improve medication adherence, we undertook a fundamental re-examination of the biomedical model within which adherence is conceptualized. This 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, focusing the benefits of medications on disease outcomes may not resonate with
patients. Some patients may not have fully accepted their diagnosis, in which case taking medication disrupts their sense of identity and life trajectory. Other patients may deal with numerous competing demands and view self-care, including medication adherence, as hindering rather than facilitating the many kinds of identity-relevant work that they undertake throughout the day, which also decreases the likelihood that individuals will adhere consistently to long-term therapies. Failing to respond to such patient perspectives may be a 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\textsuperscript{24} and of Charmaz.\textsuperscript{25} The interrelated triad of body-biography-conceptions (BBC) of self has been called the BBC chain to emphasize the interrelatedness of each element (Figure 1). A chronic illness diagnosis requires work of reconceptualizing ourselves in our various life roles, with attempts to preserve our identity and functioning. This work can be stressful, with some individuals never establishing equilibrium and resorting to denying the existence of the illness, sometimes even years after diagnosis. This stress may play a role in medication nonadherence, yet it is rarely acknowledged in medication adherence interventions.\textsuperscript{26-28} Corbin and Strauss\textsuperscript{24} Chronic Illness Trajectory Framework stresses the importance of helping individuals come to terms with their illness and frames self-care behaviors, including medication adherence, in terms of maintaining or rebuilding their sense of identity and personal narrative; this framework also calls for assisting patients with integrating their illness-related tasks into everyday life tasks.\textsuperscript{29-31} We hypothesized that an intervention built on this patient-focused framework might facilitate changes in medication-taking behavior that would be maintained long term.
Using key concepts from Corbin and Strauss’ framework, Bandura’s social cognitive theory, and adult learning theory, this program used peer storytelling and self-management support from peer coaches. Storytelling by fellow community members can facilitate behavior change through modeling; Bandura’s social cognitive theory posits that behavior is influenced by watching others and the consequences of their behavior.\textsuperscript{32,33} In addition, hearing stories of “people like me with problems like mine” may assist individuals in coming to terms with their illness and change beliefs and norms regarding health-related behaviors.\textsuperscript{34} 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,” achieving “homophily,” or a feeling of relatedness to the storyteller.\textsuperscript{35–38} Peer storytelling had a remarkable effect on lowering BP in an urban setting, but peer storytelling has not been examined for diabetes or in rural settings.\textsuperscript{39,40} Peers can also be trained as interventionists.\textsuperscript{41–52} 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 overcome challenges within their community (Figure 2). 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. Peer support is being more widely evaluated for diabetes\textsuperscript{53,54} but, to our knowledge, is not within the Corbin and Strauss framework to improve medication adherence.\textsuperscript{53–56}
Building on ongoing partnerships with people living in Alabama’s Black Belt, we collaboratively developed a peer-delivered telephone intervention guided by the Corbin and Strauss framework, drawing on social cognitive theory and adult learning theory. We aimed to recruit 500 individuals with diabetes who reported medication nonadherence into a cluster-randomized trial of this intervention. The trial’s primary outcomes were patient-reported medication adherence and physiologic measures, and secondary outcomes were quality of life (QOL), medication beliefs, and self-efficacy. The aims of the proposed study were as follows:

**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 telephone 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 cluster-randomized 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 hemoglobin A\textsubscript{1c} (HbA\textsubscript{1c}), BP, and low-density lipoprotein cholesterol (LDL-C) as primary outcomes, and on QOL and self-efficacy as secondary outcomes.
PATIENT AND STAKEHOLDER ENGAGEMENT

Stakeholders who were engaged in the program included community members with diabetes and representatives from organizations that worked with our patient population, such as churches, nonprofit organizations, businesses, primary care offices, and health departments. We used 5 main strategies to engage stakeholders.

Integrate Community Members Into the Research Team

Two individuals from 2 communities located in the Black Belt were hired as community coordinators. As well as being longtime residents of their communities, the community coordinators had worked with the research team on 2 previous studies and therefore were knowledgeable about the research process. A third community member was hired as part of the study team as a data collector. As members of the study team, the community coordinators and the data collector provided day-to-day guidance and feedback on all aspects of the study protocol, from intervention development and participant recruitment and retention methods to the selection of data collection instruments. In addition to guidance at weekly meetings, they connected us with other key stakeholders and representatives from their communities. For example, early during the intervention development process, the community coordinators and data collector engaged a group of 14 individuals from their communities as study recruiters. The community recruiters and peer coaches from previous studies were engaged as needed to discuss specific questions about the study protocols and intervention development. Later during the intervention recruitment phase, recruiters worked closely with the community coordinators to refer potential study participants to the onsite staff in Birmingham, Alabama to conduct eligibility screening.

Discussion Groups With Patients With Diabetes

Early in the contract period, we conducted 3 discussion groups with members of a diabetes support group in Carrollton, Alabama, to solicit feedback on the diabetes medication educational video and diabetes medication messages to ensure cultural concordance.
Community Coalition Meetings

We held 4 community coalition meetings that provided a chance for patients to meet the research team and develop trust. The 4 meetings had a similar structure, with a theme selected by patients, breakout sessions and activities led by community members, educational content, and feedback on intervention components. The first meeting was held in partnership with the 11th Annual Black Belt Institute Meeting in Camden, Alabama, and hosted by the West Alabama Community Health Improvement League and the University of Alabama at Birmingham (UAB) Center for Community Health. The 76 attendees included patients and representatives from various health clinics, churches, the Cooperative Extension, the Wilcox County Chamber of Commerce and Board of Education, the Linden Health Department, and numerous community organizations (Community Action, Alabama Tombigbee, Vredenburgh Outreach Center, Bama Kids, and Youth on the Move). The second meeting was held in Livingston, Alabama, and attended by 96 participants, including patients with diabetes, and included presentations by the West Alabama Area Health Education Center, the Livingston Health and Wellness Education Center, and the Cooperative Extension. The third meeting was held in Camden, Alabama, on September 24, 2015, in partnership with the 12th Annual Black Belt Institute Meeting with the West Alabama Community Health Improvement League and UAB Center for Community Health and was attended by 114 community members, including patients with diabetes. Our final meeting was held on April 23, 2016, in Livingston, Alabama, and was attended by 60 community members, including patients with diabetes.

Formal Qualitative Research With Patients

This is described in the aim 1 subsection in the Methods section.

Community-Based Health Education

Finally, patients and organizations reached out to us with requests to provide health education at health fairs held at community churches. Our peer supporters led most of these activities, building a reciprocal trusting relationship with our communities.
During trial implementation, the relationships we developed with organizations during intervention development helped us identify and gain entry to community events for recruitment and data collection activities and develop recruitment and retention strategies and materials that positively impacted retention (Appendix H, Table 1). For example, the retention plan was modified to include mailing postcards every other month after receiving feedback from community members that telephone numbers often change for our targeted population, and mailing addresses are more stable. In addition, recruitment and retention scripts for data collection visits emphasized the individual who referred the patient to the study and the names of our community coordinators (full-time research staff members who lived in the community) so that patients were more comfortable with research staff coming into their homes for data collection. The data collection protocol was also impacted. After pretesting the survey assessment with community members, we shortened the instrument so that it could be administered in 30 minutes. Finally, program materials and study protocols were culturally concordant, as reflected in the high satisfaction ratings after program completion.
METHODS

Study Overview

This project was designed in collaboration with our community member partners and built on a 5-year partnership of community-engaged research on diabetes peer coaching interventions. We tested the hypothesis that an intervention designed within the Corbin and Strauss framework and developed with community members improves self-reported medication adherence and health outcomes compared with usual care.

Specific Aims

In aim 1, with our community partners, we used qualitative research methods to collaboratively develop the medication adherence intervention delivered by trained community members; in aim 2, we tested this intervention in a cluster-randomized trial of 500 individuals with diabetes seeking help with their medications.

Study Setting

Since 2008, before this study, we had conducted 2 trials of diabetes interventions in partnership with Black Belt communities. The ENCOURAGE trial (2008-2011) recruited 424 (target, N = 400) individuals with diabetes (75% African Americans) and engaged peer supporters. Responding to a call from our peer supporters, we developed the Living Healthy trial that tested community member–delivered interventions to overcome pain as a barrier to exercise in diabetes. The present study builds on a research partnership that includes a tested and durable collaborative approach to community-partnered research.

In June 2017, due to slow accrual of participants in rural areas, we received approval from the sponsor (PCORI) and expanded enrollment to clinics that serve low-income Black populations in the Birmingham area. The burden of chronic disease and difficulty accessing health care are similar to those faced by Black Belt residents, including transportation challenges and lack of availability of healthy foods. Recruitment efforts in this area focused on attending health fairs and posting flyers at community locations such as libraries and churches. The main focus of recruitment was in the county’s safety net clinic, in which 63% of the clinic’s
11,500 patients have an annual income <200% of the federal poverty level, and almost all are African American; 10% have Medicaid, 23% have Medicare, and the remainder are covered by the county’s indigent care program, which includes pharmacy benefits as well as ambulatory services. A second site was the UAB Department of Family Medicine’s clinic, which serves a similar patient base, with fewer uninsured patients but a similar demographic and income profile. Patients seen at both clinics are therefore vulnerable but still have access to pharmacy services required for the study, which focused on medication adherence.

**Aim 1: Collaborative Intervention Development**

We conducted focus groups, semistructured interviews, and nominal group discussions with community members to develop the intervention. We started with an existing diabetes self-management program delivered by peer coaches based on social cognitive theory with educational content focusing on diabetes basics, healthy eating, physical activity, and stress management. In that program, intervention participants viewed educational videos, followed by structured telephone sessions with their peer coach that included setting goals. Participants monitored behavioral goals daily and watched the next session’s video before their next telephone meeting with the peer coach. We retained those elements of this intervention that our peer coaches felt were particularly engaging and helpful.

The intervention was developed over 18 months, adapting our existing program of peer-delivered telephone diabetes self-management education and goal setting. Each telephone session was on a different self-management topic, preceded by an educational video that participants viewed at home before the telephone discussion with their peer coach. For this project, we developed new educational content and storytelling videos of community members sharing their own lived experience of diabetes following the Chronic Illness Trajectory Framework. We added the lived experience of diabetes to the educational videos by integrating short clips of community members sharing their experiences with diabetes self-management activities. Brief interviews were conducted with people at the park and at community events to include a wide variety of practical strategies used by fellow community members to remember to take medications, exercise, and eat healthy foods. Longer stories that
addressed other themes were recorded in a one-on-one interview format. Videos were integrated throughout the sessions and were also used as a starting point for discussions by peer coaches and participants during each telephone session. In the session videos, stories were used to introduce education topics or reinforce health messages. For example, the video session focusing on medications began with a series of community members sharing their motivations for taking their medications (eg, being there for their children, wanting to live a long healthy life). Another video session that discussed BP medication titration included a story of a gentleman talking about the process he went through to find the right combination of medications to manage his BP. Stories were collected from both men and women. The majority of the storytellers were African American to reflect our intended study population. The final *Living Well With Diabetes* intervention consisted of 11 sessions with educational DVDs with integrated storytelling about how community members accepted their disease and overcame barriers to medication adherence, plus one-on-one telephone peer coaching. These 11 sessions made up the intensive-intervention phase. In addition to the 11 intensive-intervention sessions, we included 2 types of brief check-ins during the less-intensive maintenance phase of the intervention, during which coaches contacted participants monthly (Table 3).
### Table 3. *Living Well With Diabetes* Intervention Topics and Timing

<table>
<thead>
<tr>
<th>Intensive-intervention phase&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Maintenance phase&lt;sup&gt;b&lt;/sup&gt;</th>
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Abbreviation: BP, blood pressure.

<sup>a</sup>Months 1 to 3 were the intensive phase, with weeks 1 to 8 having weekly contact and weeks 9 to 12 having biweekly contact.

<sup>b</sup>Months 4 to 6 were the maintenance phase, with monthly contacts.

<sup>c</sup>During the maintenance phase, no new content areas were introduced. The participants continued to work on their self-selected goals identified during the intensive phase in the following areas: (1) barriers to taking medications, (2) healthy eating, and (3) exercise. In the maintenance phase, peer coaches checked in monthly.

---

**Setting and Participants**

Community member participants were Black Belt adult residents taking medications for diabetes. Community coordinators approached members of their social networks and their communities to invite participation. Interested individuals were provided a telephone number to contact the study team or gave permission to be contacted. Purposive sampling ensured the inclusion of both men and women and of individuals experiencing and not experiencing difficulty with their diabetes medications.
Focus Groups With Patients

Three focus groups were conducted in community settings in Wilcox County, Alabama, in 2014 (Figure 3). The purpose of the focus groups was to gain an understanding of the patient perspective on living with diabetes in our targeted communities so that this perspective could be integrated into the intervention. After obtaining informed consent, a moderator guided the discussion, with a co-moderator taking notes. The moderator guide was developed using concepts from the Chronic Illness Trajectory Framework and focused on participants’ understanding of diabetes and diabetes complications, the impact of diabetes on the participants’ lives, and strategies to live well with diabetes. Each group session was audio recorded and lasted between 30 and 60 minutes. Participants received lunch and a $20 gift card.

Figure 3. Wilcox County in Relation to Jefferson County and Birmingham, Alabama
Focus groups were analyzed using open coding, an emergent process in which concepts, or codes, are derived from the text rather than applying codes that were determined a priori. Recordings were transcribed and analyzed using NVivo v.10 (QSR International). Transcripts were independently reviewed by 2 investigators to identify major themes and generate initial codes with definitions. Initial codes then formed the basis of a codebook that was used to code the transcripts through frequent meetings among investigators to resolve discrepancies.

**Semistructured Interviews With Patients**

To further explore themes emerging from the focus groups, we conducted 28 semistructured interviews with community members with diabetes. Because feedback from focus groups was used to identify various beliefs regarding diabetes and its impact on the daily lives of participants, we also interviewed some participants from the focus groups so that topics could be explored more in depth. For example, interviews explored the participants’ transition from initial diagnosis to their current experience of living with diabetes. As with the focus groups, we analyzed the interviews using the open-coding methods described previously.

**Nominal Group Sessions**

Focus groups and semistructured interviews were followed by nominal group sessions to identify and prioritize common questions about diabetes and self-management for integration into the intervention. Six nominal group sessions were conducted; 4 sessions were with community members with diabetes, and 2 sessions were with individuals who had worked with the research team as peer coaches in 2 previous diabetes self-management studies. Group discussions were conducted in our partnering communities. Participants provided informed consent and received a $20 gift card and a healthy lunch.

The nominal group technique is a semiquantitative method of structured group discussion that results in a prioritized list of responses to a specific question. Advantages over traditional focus groups include engaging each participant without discussion being dominated by a small number of participants. Participants first considered the question, “What are some questions that you have about your diabetes?” Peer coaches were asked to recall questions
their clients had over the course of delivering interventions from our 2 previous trials. Each participant first silently considered their answers and wrote them down. The moderator then asked each participant to share an item from their list in round-robin fashion until no new items emerged. Items were displayed in full view of all participants, and discussion centered on understanding the meaning and distinctness of each item.

Because of the high functional illiteracy in our partnering communities, the 4 nominal groups of participants included the generation of a list of responses but did not include the ranking phase, because community members found the ranking to be too confusing. The 2 groups of peer coaches also generated a list of responses; in addition, they were asked to prioritize items. Each participating coach selected their top 3 choices, which were weighted (5 points for their top choice, 3 points for their second choice, and 1 point for their third choice). The choices were then totaled and the prioritized list displayed for the group’s review. Peer coaches were also asked to consider a second question: “What are some topics your clients find difficult to talk to their doctors about?” They listed their responses and ranked them in a fashion analogous to the procedures described above.

Once collected, nominal group data were organized by research staff using card sorting. All items generated for the first question were listed, duplicates were identified, and unique items were sorted into groups by the researchers, who then met and came to consensus on the groupings, which were further categorized into larger domains. A similar approach was used to group the responses to the second question asked of peer coaches. The nominal groups yielded a list of questions that informed the development of the content of the intervention, emphasizing those questions prioritized by the coaches.

**Intervention Development**

The *Living Well With Diabetes* program was developed iteratively, incorporating aspects of the Chronic Illness Trajectory Framework, Bandura’s social cognitive theory, adult learning theory, and results from the qualitative research; additional discussions with community members; and community coalition meetings to develop an initial draft of the intervention
consisting of an 11-session program with videos (Table 3), a peer coach manual, and a participant activity book.

**Peer Coach Training and Pretesting**

The intervention development process combined peer coach training and intervention pretesting developed in a previous study and described in detail elsewhere.\(^6^2\) Training began with 2 in-person sessions that covered basic skills, like goal setting, motivational interviewing, and effective communication skills. This was followed by 3 months of training for pairs of peer coaches who role-played each intensive-intervention session and 1 maintenance session, once playing the role of a peer coach and once playing the role of a participant. Each coach was certified for each session by research staff, with the coach playing the role of coach and the research staff member playing the role of participant. Staff assessed (1) session fidelity, (2) understanding of session content, (3) relationship/rapport with the participant, and (4) other miscellaneous concerns identified by the certifier. Additional opportunities to practice with study staff or a community coordinator were offered to coaches who were not certified after the first evaluation session.

Study staff solicited suggestions for refinements at the certification session, which were incorporated into the intervention and data collection protocols. Our approach optimized peer coaches’ confidence in their ability to deliver the intervention, empowerment, and engagement, with coaches feeling ownership over the program.\(^6^2\) This approach results in few peer coach resignations later on, which is a problem in many coaching intervention programs.\(^6^3\)

Peer coaches were all women, were African American, had diabetes or cared for someone with diabetes, and were willing to work with participants by telephone. Peer coaches were hired as contractors by a community-based nonprofit organization, Health and Wellness Education Center of Sumter County. This organization had a subcontract with UAB to pay and supervise the peer coaches, providing ongoing support to coaches, offering encouragement, and identifying new coaches should a coach resign from the program.
Nineteen peer coaches completed training and certification. During the implementation period, 3 peer coaches dropped out (2 coaches due to health reasons and 1 coach due to an increase in work responsibilities not related to the study). Peer coaches were matched with an average of 14 participants over the intervention implementation period. The peer coaches dictated the number of participants with whom they wished to work at any one time, with most coaches opting for 3 to 6 participants at a time. Peer coaches had no previous medical experience and did not have a relationship with medical providers in the community.

**Aim 2: Cluster-Randomized Trial of the Intervention’s Effectiveness**

The trial schematic is shown in Figure 4. The trial was cluster randomized to reflect the clustering of patients within tightly knit small rural towns, with each town serving as the cluster. People talk frequently within these communities, and if 2 participants from the same town were in different trial arms and compared notes, the opportunity for contamination was great, which could change their behavior and threaten the validity of the study.

**Figure 4. Schematic of the Living Well With Diabetes Trial**

Abbreviation: R, randomization.
Setting and Participants

Eligible adults were aged ≥18 years, had been told by a doctor or nurse that they had diabetes, were taking oral diabetes medications, reported nonadherence with their diabetes medications or wanted help with their diabetes medications, and had seen a primary care doctor in the past 12 months. Nonadherence was assessed using the modified Green 3-item scale (Table 4) with an additional question: “Would you like help with taking your diabetes or sugar medicines?” If the individual responded “yes” to any 1 of these 4 questions, he or she was eligible for the study. Adults who were not community dwelling, were <18 years of age, were pregnant or planned on getting pregnant in the next 6 months, had an end-stage medical condition with limited life expectancy, did not have a primary care doctor, were expected to move out of the area in the next 6 months, or were unable to communicate in English by telephone with their peer coaches were not eligible to participate.

Table 4. Medication Adherence Scale Used in the Living Well With Diabetes Study

<table>
<thead>
<tr>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you ever forget to take your diabetes (or sugar) medications?</td>
</tr>
<tr>
<td>When you feel better, do you sometimes stop taking your diabetes (or sugar) medications?</td>
</tr>
<tr>
<td>Sometimes, if you feel worse when you take the diabetes (or sugar) medications, do you stop taking them?</td>
</tr>
</tbody>
</table>

We primarily used a chain referral sampling method for recruitment, an effective technique relying on social networks to engage hard-to-reach populations. Community coordinators also presented the study at local community events, placed newspaper advertisements and radio announcements, posted flyers in local venues, and made church announcements. Coordinators formed teams of community recruiters, provided them with study orientation, and then asked them to invite potentially eligible individuals in their social networks to participate.
In addition to community-based recruitment, we displayed flyers in local primary care practices along with interest cards. Research assistants or community coordinators were also stationed in the waiting rooms and screened interested patients referred by practice staff.

**Intervention and Comparator**

**Control** participants received a general health education DVD containing videos on dementia and Alzheimer disease, breast cancer screening, colorectal cancer screening, osteoporosis and fall prevention, eye health, oral health, foot care, and driving safety.

**Intervention** participants received the *Living Well With Diabetes* DVD covering 6 content areas and an activity workbook. The activity workbook included illustrations and activities to allow participants to follow each session’s structure in coordination with the peer coach. Participants used the activity book with their peer coaches during each of the 11 intervention sessions (Table 3). Medications were discussed at all program sessions, with each session beginning with a review of medication barriers and the participant’s behavioral goal related to their medications. Months 1 to 3 constituted the intensive-intervention phase; during weeks 1 to 8, contacts occurred weekly, and during weeks 9 to 12, contacts occurred biweekly. Months 3 to 6 constituted the maintenance phase, during which peer coaches called monthly to review goals, assess barriers, and problem solve to overcome barriers, and participants continued to work on goals set during the intensive phase.

The final *Living Well With Diabetes* program consisted of 11 sessions over 6 months. Before each session with the peer coach, participants watched a 15- to 30-minute video with that week’s educational content with integrated stories told by community members. Telephone sessions with the peer coach reinforced the video’s educational content through discussions and activities. During the session, peer coaches used a manual and client plan book, the latter being a new addition as a result of the feedback received during the training/pretesting. The plan book was used by the coach to track the participant’s behavioral goals. Participants followed along during the session using their activity book and monitored their behavioral goals between sessions. Diabetes medication barriers, including adverse effects
and cost issues, were assessed at every session, while healthy eating and physical activity goals were set during weeks 2 and 3 and monitored throughout the 6-month program.

Intervention fidelity was monitored weekly during one-on-one meetings with peer coaches and review of the program manuals. Fidelity was also monitored using random session recordings, reviewing completed program materials (as each participant completed the intervention, the peer coach submitted the manual used for that participant, which was then reviewed by the program staff with subsequent feedback to the coach), and meeting regularly with peer coaches throughout the implementation period. Approximately 10% of program sessions were recorded and reviewed by the program manager. Peer coaches individually met with a program staff member weekly. The primary purpose of this meeting was to provide support and encouragement to the peer coaches and to identify implementation issues quickly so they could be addressed in a timely manner. The agenda for this meeting included checking the progress of each of the peer coach’s participants, identifying difficulties related to program content, and identifying logistical challenges (such as helping with scheduling program sessions or tracking down new contact information as needed). Challenges in program implementation that needed to be addressed as a group (eg, several peer coaches having similar problems or having input regarding potential strategies to overcome problems) were added to the weekly group meeting agenda. During the weekly group meetings, in addition to discussing implementation challenges identified during the individual meetings, time was spent on issues that were identified by study staff during review of the program materials or through listening to session recordings.

**Study Outcomes**

The study was powered to detect clinically meaningful differences in physiologic risk factors and had 4 primary outcomes. Medication adherence was self-reported using a modified version of a 3-item adherence scale developed by Green et al (Table 4). The reliability coefficient of the modified scale for our study sample was $r = 0.41$. The scale was scored by summing the number of “yes” responses, resulting in possible scores of 0, 1, 2, or 3. The scale is commonly dichotomized, with adherence defined as 0 “yes” responses.
The 3 physiologic measures were HbA1c, BP, and low-density lipoprotein cholesterol (LDL-C), the “A-B-Cs” of diabetes care that were a central focus of the intervention. Each measure was assessed by the research team as described below (see the “Data Collection, Randomization, and Data Sources” section). HbA1c and LDL-C were assessed via finger-stick blood samples, as described below.

Secondary outcomes were health-related QOL and self-efficacy. Generic QOL was assessed using the Short Form 12-item (SF-12) questionnaire, and diabetes-specific QOL was assessed using the Diabetes Distress Scale. Self-efficacy was assessed using the Self-Efficacy for Appropriate Medication Use Scale and the Perceived Diabetes Self-Management Scale, which is associated with HbA1c levels.

To understand the pathways through which the intervention exerted its effects, we collected additional measures guided by our conceptual framework (Table 5). Where available, we selected validated scales tested in populations with low literacy. We also transcribed the name and dose of all diabetes, BP, and lipid medications at baseline and follow-up.

All study measures were collected by trained research staff following standardized protocols with quality control. To the extent possible, data assessors were blinded to the participant’s intervention assignment before data collection at baseline. Data were collected at baseline and again 6 months later.
Table 5. Additional Measures Used in the *Living Well With Diabetes* Study to Understand Mechanistic Pathways

<table>
<thead>
<tr>
<th>Theoretical construct</th>
<th>Measure(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient characteristics</strong></td>
<td>Age, sex, race, ethnicity, income, education, internet use, smoking status</td>
</tr>
<tr>
<td></td>
<td>Duration of diabetes</td>
</tr>
<tr>
<td></td>
<td>Insulin use</td>
</tr>
<tr>
<td></td>
<td>Comorbidities</td>
</tr>
<tr>
<td><strong>Health care access</strong></td>
<td>Health insurance</td>
</tr>
<tr>
<td></td>
<td>Distance from home to doctor</td>
</tr>
<tr>
<td></td>
<td>Access to care question</td>
</tr>
<tr>
<td><strong>Barriers to medication adherence</strong></td>
<td>Medication Barriers Scale</td>
</tr>
<tr>
<td><strong>Diabetes distress</strong></td>
<td>DDS4&lt;sup&gt;70&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Diabetes knowledge</strong></td>
<td>SKILLD&lt;sup&gt;71&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Depressive symptoms</strong></td>
<td>PHQ-8&lt;sup&gt;72&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Perceived stress</strong></td>
<td>PSS-10&lt;sup&gt;73&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Self-efficacy</strong></td>
<td>SEAMS&lt;sup&gt;68&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Perceived Diabetes Self-Management Scale&lt;sup&gt;74&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Self-care behaviors</strong></td>
<td>Diet questions&lt;sup&gt;75&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Exercise questions&lt;sup&gt;76&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Social support</strong></td>
<td>Chronic Illness Resources Survey&lt;sup&gt;77&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Social Support Scale&lt;sup&gt;78&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Trust</strong></td>
<td>Trust in medical researchers&lt;sup&gt;79&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Numeracy</strong></td>
<td>SNS&lt;sup&gt;80,81&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Abbreviations: DDS4, Diabetes Distress Scale; PHQ-8, Personal Health Questionnaire-8; PSS-10, Perceived Stress Scale; SEAMS, Self-Efficacy for Appropriate Medication Use Scale; SKILLD, Spoken Knowledge in Low Literacy in Diabetes; SNS, Subjective Numeracy Scale.
Process Measures

Process measures were selected to understand which aspects of the intervention were particularly effective, assessing both program satisfaction and peer coach effectiveness. To assess intervention fidelity, we collected additional process measures from peer coach workbooks, including notes from each session and data entered for specific activities. Therefore, the peer coach workbooks were the source of the number of contacts with participants. We also monitored intervention implementation and fidelity through weekly teleconferences with peer coaches and weekly outreach to each peer coach throughout the intervention period. During these conference calls, study staff collaboratively troubleshooted problems; ongoing advice often came from other peer coaches or community coordinators. Community coordinators were instrumental in finding participants whose telephone numbers had changed.

Sample Size Calculations and Power

Power estimates accounted for clustering of patients within towns, using a variance inflation factor, conservatively estimating power for intraclass correlation coefficients (ICCs) of 0.01 to 0.05, which were taken from the ENCOUARGE cluster-randomized trial conducted in the same region, which also used towns as clusters. We assumed 20% attrition, or 200 participants analyzed per arm. We estimated detectable differences in adherence proportions and the difference in mean changes between arms detectable with 80% power using 2-sided $\chi^2$ and $t$ tests with $\alpha = .05$ (Table 6). We hypothesized that the intervention would result in improved medication adherence. Eligibility required participants to self-report problems with medication adherence at baseline, eliminating ceiling effects and allowing us to reasonably anticipate large changes in the intervention arm and only modest changes in the control arm, as was seen in a storytelling intervention directed at BP. Adherence was assessed using the modified 3-item Green scale (Table 4). Because data on the clinical meaning of group mean changes in adherence as assessed by the Green scale are limited, we designed the study to detect clinically important changes in physiologic measures. We estimated we would have 80% power to detect differences of 0.28 to 0.32 SD for continuous outcomes; this translated to detectable
differences for the change in HbA\(_1c\) from 0.41% to 0.48%, in systolic BP of 3 to 4 mm Hg, and for LDL-C of 6.7 to 8.1 mg/dL, as well as differences as small as 3.7% to 4.4% for change in the Diabetes Distress Scale.

Table 6. Detectable Differences With 250 Participants Per Trial Arm, 80% Power\(^{19}\)

<table>
<thead>
<tr>
<th>n per arm</th>
<th>ICC</th>
<th>n(_{eff})(^a)</th>
<th>Detectable effect size for continuous outcomes</th>
<th>Detectable proportion in controls when proportion in intervention is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>250</td>
<td>0.00</td>
<td>250</td>
<td>0.251</td>
<td>0.376 0.236 0.110</td>
</tr>
<tr>
<td>250</td>
<td>0.01</td>
<td>230</td>
<td>0.262</td>
<td>0.371 0.232 0.107</td>
</tr>
<tr>
<td>250</td>
<td>0.05</td>
<td>176</td>
<td>0.299</td>
<td>0.353 0.216 0.096</td>
</tr>
<tr>
<td>200</td>
<td>0.00</td>
<td>200</td>
<td>0.281</td>
<td>0.362 0.224 0.101</td>
</tr>
<tr>
<td>200</td>
<td>0.01</td>
<td>187</td>
<td>0.290</td>
<td>0.357 0.220 0.098</td>
</tr>
<tr>
<td>200</td>
<td>0.05</td>
<td>150</td>
<td>0.325</td>
<td>0.341 0.206 0.088</td>
</tr>
</tbody>
</table>

Abbreviation: ICC, intraclass correlation coefficient.

\(^a\)n\(_{eff}\), effective sample size once clustering is accounted for. These estimates show the detectable differences in effect sizes for continuous measures, such as surveys with a range of results or a physiologic measure. They also show detectable proportions for measures such as the proportion of participants who are nonadherent.

**Time Frame for the Study**

Data collection occurred at baseline and 6 months to ensure adequate time for changes in biologic outcomes and allowed us to assess whether behavioral changes were maintained, because all intervention content was covered during the first 8 sessions.

**Data Collection, Randomization, and Data Sources**

Referred individuals were screened by study staff for eligibility. Interested individuals were scheduled for a 45- to 60-minute telephone interview and were mailed the informed consent form. Telephone interviews were scheduled at the earliest convenient date after screening and were conducted by trained UAB study staff. For quality assurance, we randomly selected 10% of interviews for the program coordinator or data coordinator to listen to.
After completing the interview, participants were randomly assigned, and in-person data collection visits were scheduled. The clusters were towns (or, in Birmingham, neighborhoods) blocked on small (<1000 residents), medium (1000-1999 residents), and large (≥2000 residents) community sizes. For the Birmingham area, clusters were the 99 neighborhoods in Birmingham, all of which were considered to be large communities because all include ≥2000 residents. With 55 clusters in 2 regions participating in the 400-participant ENCOURAGE study,\textsuperscript{19} we conservatively estimated that this study would enroll participants from 80 to 100 clusters, with the addition of 2 new regions. The first member of a given cluster determined the study arm of that cluster. All subsequent residents were placed into the same trial arm as the first participant from that cluster.

Participants met research staff at a community location or in their homes for obtaining physiologic outcome data as well as additional study data. Data collectors were trained and certified by the study investigators. Participants were asked not to drink any caffeine (from coffee, tea, or soda), eat, do any heavy physical activity, smoke, or ingest alcohol for 30 minutes before the appointment. During the visit, the participant signed informed consent. The following measures were collected:

- **HbA\textsubscript{1c}** was measured using the A\textsubscript{1c}Now\textsuperscript{+} system, a National Glycohemoglobin Standardization Program–certified, Clinical Laboratory Improvement Amendments (CLIA)-waived system that provides HbA\textsubscript{1c} results using a finger stick to obtain capillary whole blood.

- **LDL-C** was measured using the CardioChek PA analyzer, a CLIA-waived system that provides LDL-C results using a finger stick to collect capillary whole blood.

- **BP** was measured following recommendations of the American Heart Association.\textsuperscript{82} Participants were asked to sit quietly for 5 minutes with both feet flat on the floor and their back supported. Arm circumference was measured at the midway point between the olecranon and the acromial process to determine the appropriate cuff size. The cuff was placed over the bare arm with the cuff at heart level, and 2 BP measures were taken 1 minute apart using a LifeSource UA-789 digital BP monitor. Participants were asked to refrain from reading, texting, or speaking with anyone by telephone or in person during this process.
• Body mass index (BMI) was calculated from measured height and weight.

During the data collection visit, participants were asked to produce all medications currently taken; the name of the medication, dose, and frequency were recorded from the medication bottle.

After completing baseline data collection, participants were given a portable DVD player that was theirs to keep, as well as a health report card with their HbA1c, LDL-C, BP, and weight data. Participants in the control arm were given the general health education DVD. Participants in the intervention arm were given the name of their peer coach, an activity book, and the intervention DVD and were offered the use of a study cell phone for the duration of the study. Participants received a $20 Visa gift card at the 6-month in-person data collection visit. The procedures for data collection at the 6-month visit were identical to those used at baseline.

Data were entered into Research Electronic Data Capture (REDCap) database for management.83,84 Field-based data collectors used paper forms that were later entered into the data management system. Data collectors were trained and certified to maximize data completeness and accuracy, and data collection forms were reviewed by study coordinators, with retraining provided as needed.

**Participant Retention**

During the 6-month intervention period, UAB research staff contacted all participants 2 to 3 times for brief calls to answer questions, update contact information, and provide help as needed in accessing study education materials. Figure 5 shows the study flow from referral to study completion.
Figure 5. Living Well With Diabetes Trial Flow

Abbreviations: BP, blood pressure; LDL-C, low-density lipoprotein cholesterol; Pts, patients; UAB, University of Alabama at Birmingham.
Analytic Approach

The main study hypotheses tested were that intervention participants would have higher medication adherence, significantly greater improvement in HbA1c, BP, LDL-C, and measures of QOL, and greater self-efficacy than with control participants. Analysis began by calculating ICCs for each outcome to assess the magnitude of clustering; all regression models for outcomes with ICCs of ≥0.01 used generalized estimating equations (GEEs) to account for clustering. The intervention acted at the individual level; thus, analyses were at the individual level. Statistical significance for the comparison of the study arms was judged by \( P < .05 \) for the coefficient for study arm in regression models. For each continuous or ordinal outcome measure, we calculated the change from baseline to 6-month follow-up for each participant. These change scores were the units of analysis. We proceeded to examine summary statistics, histograms, and scatterplots of the measured outcomes for outliers and data trends. We then tested for unadjusted differences in changes between the intervention and control arms using \( t \) tests, Mann-Whitney-Wilcoxon tests, or regression models with GEEs to account for clustering as appropriate. We then adjusted for baseline values of outcome variables and any factors that were imbalanced at baseline. We used the complete-case approach to analyses because all individuals with baseline and follow-up data were included; those who did not complete follow-up were not included in the analyses. Among participants who participated in the 6-month follow-up, there were no missing data for HbA1c, QOL, and medication adherence; 3 participants were missing data for BP; 10 participants were missing data for BMI; and 76 participants were missing data for LDL-C. Appendix H, Table 2 shows the final analytic sample size for each outcome by treatment arm. All analyses were carried out in SAS v9.4.

Changes to the Original Study Protocol

Medication adherence was originally proposed to be assessed by self-report and by electronic pill bottles (MEMS TrackCaps). However, early during aim 1, our community partners expressed concerns that MEMS TrackCaps would disrupt the usual routine of medication taking (such as using pill boxes). Furthermore, most individuals enrolled in the study were expected to be taking multiple medications for diabetes as well as taking BP and cholesterol medications.
The MEMS TrackCaps system would have required the participant to use a cap for each medication. We discussed these concerns with the funding agency, and the use of the MEMS cap was removed from the protocol. A second change was the expansion of the study’s recruitment area to include Birmingham, which was not originally planned.
RESULTS

Aim 1: Qualitative Research Results

**Intervention Development**

Three focus groups were conducted with 16 community members. Twelve participants were ≥51 years, 15 participants were women, 15 participants had a high school or higher education, and 10 participants were employed (Table 7). Twenty-one of the 28 interview participants were ≥51 years, 21 participants had high school or higher education, and 15 participants were men (Table 8). Findings from the focus groups and interviews identified topics to add to the education content and to guide storytelling videos and culturally appealing messaging related to medications (Table 9).

**Table 7. Participant Characteristics for the Focus Groups**

<table>
<thead>
<tr>
<th></th>
<th>All (N = 16)</th>
<th>Group 1 (n = 4)</th>
<th>Group 2 (n = 8)</th>
<th>Group 3 (n = 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age, No., y</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤40</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>41-50</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>51-60</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>&gt;60</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Female, No.</strong></td>
<td>15</td>
<td>4</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td><strong>Education, No.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Completed high school</td>
<td>8</td>
<td>3</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Some college or greater</td>
<td>7</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td><strong>Employment, No.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Part time</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Not employed</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 8. Characteristics of 28 Participants in Semistructured Interviews

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age, y</strong></td>
<td></td>
</tr>
<tr>
<td>≤40</td>
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<tr>
<td>41-50</td>
<td>5</td>
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<tr>
<td>51-60</td>
<td>9</td>
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<tr>
<td>&gt;60</td>
<td>12</td>
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<td>Women</td>
<td>13</td>
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<td><strong>Education</strong></td>
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<tr>
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<td>Completed high school</td>
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<td>Some college or greater</td>
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<td><strong>Employment</strong></td>
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<tr>
<td>Full time</td>
<td>7</td>
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<tr>
<td>Part time</td>
<td>3</td>
</tr>
<tr>
<td>Not employed</td>
<td>18</td>
</tr>
</tbody>
</table>

Table 9. Themes for Storytelling Videos That Emerged From Focus Groups and Interviews

- Positive messages that focus on living well and daily QOL rather than disease management
- Emotional experience of first being diagnosed with diabetes
- Challenges encountered in integrating self-management tasks into daily routine
- Future goals/motivation to do the work of self-management
- Reasons why the decision was made to change diet/start exercising/take medications
- Concrete strategies other people with diabetes use to make and sustain behavior changes
- Emphasizing that taking care of your diabetes can help improve the health of your entire family
- Ways to access resources in the community

Abbreviation: QOL, quality of life.
Four nominal groups engaged 37 individuals with diabetes (Table 10), and 2 groups engaged 13 experienced peer coaches (Table 11). Nominal group findings were used to identify knowledge gaps about diabetes self-management and medications to guide education content development (Table 12).
Table 10. Characteristics of Participants in Patient Nominal Groups in Camden (2 Groups), Monroe (1 Group), and Pine Apple (1 Group), Alabama

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>All (N = 37)</th>
<th>Camden (n = 14)</th>
<th>Pine Apple (n = 14)</th>
<th>Monroe (n = 9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, No.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤50 y</td>
<td>7</td>
<td>1</td>
<td>6</td>
<td>0</td>
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<tr>
<td>51-60 y</td>
<td>12</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>≥61 y</td>
<td>18</td>
<td>10</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Sex, No.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>22</td>
<td>10</td>
<td>12</td>
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<tr>
<td>Male</td>
<td>15</td>
<td>4</td>
<td>2</td>
<td>9</td>
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<tr>
<td>Education, No.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Less than high school</td>
<td>11</td>
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<td>3</td>
<td>2</td>
</tr>
<tr>
<td>High school or GED</td>
<td>15</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Some college or greater</td>
<td>11</td>
<td>13</td>
<td>9</td>
<td>6</td>
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<tr>
<td>Employed, No.</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Full time</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>2</td>
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<tr>
<td>Part time</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Not employed or retired</td>
<td>28</td>
<td>13</td>
<td>9</td>
<td>6</td>
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<tr>
<td>Last time saw a doctor, visited a clinic, or went to a hospital, No.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>&lt;1 mo</td>
<td>15</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>1-3 mo</td>
<td>19</td>
<td>6</td>
<td>5</td>
<td>3</td>
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<tr>
<td>4-6 mo</td>
<td>1</td>
<td>2</td>
<td>4</td>
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<td>&gt;6 mo</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
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<tr>
<td>Has medical insurance, No.</td>
<td>29</td>
<td>10</td>
<td>13</td>
<td>6</td>
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<tr>
<td>Regular source of health care, No.</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Private or personal doctor</td>
<td>18</td>
<td>8</td>
<td>6</td>
<td>4</td>
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<tr>
<td>Other clinic, by appointment</td>
<td>15</td>
<td>6</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Walk-in clinic, no appointment</td>
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<td>2</td>
<td>1</td>
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<tr>
<td>Hospital emergency department</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>No. of diabetes medications taken daily</td>
<td>1</td>
<td>19</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Characteristics</td>
<td>All (N = 37)</td>
<td>Camden (n = 14)</td>
<td>Pine Apple (n = 14)</td>
<td>Monroe (n = 9)</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--------------</td>
<td>-----------------</td>
<td>--------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>2-5</td>
<td>13</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Takes insulin, No.</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Age diabetes diagnosed, mean ± SD, y</td>
<td>49.5 ± 13.5</td>
<td>51.1 ± 16.9</td>
<td>46.3 ± 12.9</td>
<td>53.3 ± 7.5</td>
</tr>
<tr>
<td>Years taking diabetes medications, mean ± SD</td>
<td>9.5 ± 10.3</td>
<td>14.2 ± 13.8</td>
<td>9.1 ± 9.2</td>
<td>5.4 ± 6.4</td>
</tr>
</tbody>
</table>

Abbreviation: GED, general education degree.
Table 11. Characteristics of 13 Peer Coaches in Nominal Groups Held in Camden (n = 9) and Livingston (n = 4), Alabama

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
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<tbody>
<tr>
<td>Age, y</td>
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<tr>
<td>≤50</td>
<td>6</td>
</tr>
<tr>
<td>51-60</td>
<td>5</td>
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<tr>
<td>≥61</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>13</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>0</td>
</tr>
<tr>
<td>High school or GED</td>
<td>1</td>
</tr>
<tr>
<td>Some college or greater</td>
<td>12</td>
</tr>
<tr>
<td>Employed</td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>6</td>
</tr>
<tr>
<td>Part time</td>
<td>2</td>
</tr>
<tr>
<td>Not employed or retired</td>
<td>5</td>
</tr>
<tr>
<td>Last time saw a doctor, visited a clinic, or went to a hospital</td>
<td></td>
</tr>
<tr>
<td>&lt;1 mo</td>
<td>7</td>
</tr>
<tr>
<td>1-3 mo</td>
<td>2</td>
</tr>
<tr>
<td>4-6 mo</td>
<td>2</td>
</tr>
<tr>
<td>&gt;6 mo</td>
<td>2</td>
</tr>
<tr>
<td>Has medical insurance</td>
<td>13</td>
</tr>
<tr>
<td>Regular source of health care</td>
<td></td>
</tr>
<tr>
<td>Private or personal doctor</td>
<td>12</td>
</tr>
<tr>
<td>Hospital emergency department</td>
<td>1</td>
</tr>
<tr>
<td>Has diabetes or cares for a family member with diabetes</td>
<td></td>
</tr>
<tr>
<td>Has diabetes</td>
<td>2</td>
</tr>
<tr>
<td>Cares for a family member with diabetes</td>
<td>11</td>
</tr>
</tbody>
</table>

Abbreviation: GED, general education degree.
Table 12. Content Included in the Diabetes Medication Session Based on Nominal Group Findings

- Why do I need medication to treat diabetes?
- Won’t diabetes go away if I eat right, lose weight, and exercise more?
- What about my blood sugar? What should it be?
- What are the medicines used to treat diabetes and how do they work?
- What are the side effects of the different medications?
- What about newer diabetes medications?
- Why do I need a second pill?
- How much do these medicines cost?
- Why are there different kinds of insulin?
- What about the inhaled insulin?
- Do I need to check my blood sugar at home?
- My blood sugar was normal in the morning; do I still need my diabetes medicine today?
- What’s the difference between brand name and generics?
- Why do some people get side effects and other don’t?
- What happens if I don’t take my diabetes medication? Do I really need it?
- What should I do if I forgot a dose?
- How can I remember to take all these different medicines at the right time?

The drafts of the peer coach manual, participant activity book, and session videos were pretested and refined as part of peer coach training (Table 13). Tables 14 to 17 summarize information learned that resulted in changes made to the intervention based on stakeholder engagement. Many of these themes were integrated into the session content as points of emphasis (Table 13).
Table 13. Content of the *Living Well With Diabetes* Intervention

<table>
<thead>
<tr>
<th>Session</th>
<th>Session content</th>
<th>Goals/homework</th>
</tr>
</thead>
</table>
| Introduction to *Living Well with Diabetes* | • Introduction to the program  
• Getting to know each other  
• Review of the program schedule  
• Expectations for peer coach and participant  
• Making a commitment to the program  
• Setting a goal for taking DM medication | • Plan for taking DM medications |
| Healthy eating | • Review of previous week’s session  
• 3 rules of eating healthy (portion size, avoiding second helpings, and avoiding fried foods, fats, and sugar-sweetened beverages  
• Assess my eating – what did I eat in the past day | • Plan for taking DM medications  
• Healthy eating goal |
| Physical activity and your health | • Review of previous week’s session  
• 3 rules of physical activity  
• Assessing current activity levels | • Plan for taking DM medications  
• Healthy eating goal  
• Physical activity goal |
| DM medications | • Review of previous week’s sessions  
• Learning to connect medication to future goals  
• Discussing participant’s HbA1c number | • Plan for taking DM medications  
• Healthy eating goal  
• Physical activity goal |
| BP and cholesterol medications | • Review of previous week’s sessions  
• Learning to connect medication to future goals  
• Discussing participant’s BP and cholesterol numbers | • Plan for taking DM medications  
• Healthy eating goal  
• Physical activity goal |
| Stress and your health | • Review of previous week’s sessions  
• Learn stress reduction techniques  
• Prepare for next session in 2 wk – discuss how participant can re-evaluate and increase goals by themselves before the next call | • Plan for taking DM medications  
• Healthy eating goal  
• Physical activity goal |
| Practice and planning for the future, part 1 | • Review of previous week’s session  
• Review homework and progress of goals  
• Discuss content covered so far and which activities have helped the most  
• Help participant identify a health buddy | • Plan for taking DM medications  
• Healthy eating goal  
• Physical activity goal  
• Identifying a health buddy |
<table>
<thead>
<tr>
<th>Session</th>
<th>Session content</th>
<th>Goals/homework</th>
</tr>
</thead>
</table>
| Practice and planning for the future, part 2  | • Review of previous week’s session  
• Review homework and progress of goals  
• Discuss how a health buddy can help the participant keep going when the program ends | • Plan for taking DM medications  
• Healthy eating goal  
• Physical activity goal  
• Identifying a health buddy |
| Monthly maintenance sessions                   | • Provide encouragement to participants  
• Troubleshoot if participant is having difficulty with any of the homework/activities                                                                 | • Plan for taking DM medications  
• Healthy eating goal  
• Physical activity goal |
| Final monthly maintenance session              | • Provide encouragement to participants  
• Troubleshoot if participant is having difficulty with any of the homework/activities  
• Reinforce content covered during the program  
• Help participant create a plan to keep moving forward after the program ends | • Plan for taking DM medications  
• Healthy eating goal  
• Physical activity goal |

Abbreviations: BP, blood pressure; DM, diabetes mellitus.
Table 14. Themes From Focus Groups Regarding Misinformation and Misperceptions About Medications

| Sense of personal failure if medications continue to be needed | “Well, I really wasn’t in denial, I just thought it was something that I could control. . . . So, and then they was like, ‘If you can lose 20 pounds, you can probably control it.’ But I can’t control it without medication.”

“I’ve tried eating garlic, I take cinnamon, I do everything, and it’s still, I have to take that medicine.”

“Well, I know my cousin, he had that problem, sex life. And what he did, he walked every day 2 hours a day and what he did at first, he was on that insulin and they took him off that. And then he continued to walk and now he on nothing. He don’t even take a pill. It’s the exercise that is the key.” |
| --- | --- |
| Lack of understanding regarding how medications work | “But I don’t know what the medication is. I don’t know if it’s helping keeping my eyes from going bad. ‘Cause in the long run, the diabetes will affect your eyes, your kidney, your liver, you know, your heart, and stuff like that. You know, I don’t know what the medication is doing, I would like to know that myself.”

[Moderator: “And how do you think the medications affect these complications that can happen?”]

“Worse, cause your vision gets bad, I don’t think it all comes from the sugar. I think a lot of it comes from the medication you have to take. ‘Cause my vision was 20/20 before and then, all of a sudden, you know, the doctor said, well, you can get reading glasses.” |
| Belief that need for medication is temporary and episodic | “So, sometimes, I don’t take the glucoside in the morning, because I don’t need it, and if I need my medicine I take it, but if I don’t need it, because some mornings I don’t take medication at all, that’s because I make sure I take my blood sugar every day, and when my blood sugar is like 90 or 105, I don’t need to take it.”

“In order to stop taking medication, we have to keep our bodies in tip-top shape, ‘cause I know, when I was on my strict diet and walking for exercise, I got my A1c down to a 5, I lived to see it, I did, and then the doctor said you’re not a diabetic.” |
Table 1. Themes From Focus Groups Regarding Reactions to Diagnosis, Impact on Daily Activities, and Coping Mechanisms

<table>
<thead>
<tr>
<th>Reaction to diagnosis</th>
<th>Denial</th>
<th>“I was in denial. I said, ‘Not me.’ And at first, they gave me some pills for my sugar, and I didn’t take it. I said, ‘I’m too young to have sugar. I’m not fooling with that mess.’”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear</td>
<td>“You’re scared, you’re like, and be trying to understand, and you’re scared, you think, Oh lord, what’s going wrong with me.” “So it’s scary, you know, being a diabetic.”</td>
<td></td>
</tr>
<tr>
<td>Shock</td>
<td>“I didn’t know what to say, cuz you know, I knew it had been running in my family, but I was just surprised cuz I didn’t have no kind of warning signal that I would know of.”</td>
<td></td>
</tr>
<tr>
<td>Devastation</td>
<td>“I broke down and cried. I cried so much that the doctor forgot to give me a prescription. ... Because I had taken care of people with diabetes and I had seen their legs being removed and their fingers. ... I was just devastated. And to see what that diabetes could do to a person, to destroy their whole world.”</td>
<td></td>
</tr>
<tr>
<td>Impact on daily activities</td>
<td>Planning</td>
<td>“I love to travel so you know you always have to plan ahead, make sure you have your medicine, and I just [got] one of those daily planners things to put your medicine so I try to have at least a week’s worth of medicine when I leave, when I go out of town or whatever so I don’t get stuck without my medicine. ‘Cause you just never know.”</td>
</tr>
<tr>
<td>Diet changes</td>
<td>“Only thing about it, I’m careful about what I eat or drink. Cuz, I’ll drink a drink every day, but it’s a diet drink. If I have it with lunch, I drink 1 drink.”</td>
<td></td>
</tr>
<tr>
<td>Physical limitations</td>
<td>“Yeah, it changed my working habit and you know, I stopped working earlier and you know, because I was tired all of the time. And I couldn’t do what I used to do.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“I’m not able to walk like I normally did before I got diabetes because my feets and everything else I can manage pretty well, but uh, like going shopping, staying in a store, you know, 5 hours like I used to – I can’t do that now cuz, with me having neuropathy in my feets, my feets goes to hurting and getting tingly and stuff and aching, so I can’t do all that stuff like I used to.”</td>
<td></td>
</tr>
<tr>
<td>Coping mechanisms</td>
<td>Prayer/religion</td>
<td>“I think what we need to do more than the medication, we need to pray too. There’s a line between the medication and prayer. You need to pray first then take the medication. Because only God knows what’s going to happen so if you ask and talk to him and then you take that medication you can get him to do anything”</td>
</tr>
<tr>
<td>Category</td>
<td>Response</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Exercise/physical activity</td>
<td>“And walking, you know, is the best thing you can do. It helps with that stress—with that stress level. And it motivates you to do anything you wanna do. It helps you with diabetes and blood pressure and stress and everything else. And it gets the weight down too. It gets you back to where you be a 5. A₁c be a 5.”</td>
<td></td>
</tr>
<tr>
<td>Support from family/friends</td>
<td>“So it is encouraging to know that people care about your well-being because some people see you on the street, they will step over you and then you have people that care if you are taking care of yourself, eating right, if there is something they can do to encourage you, it makes a lot of difference.”</td>
<td></td>
</tr>
<tr>
<td>Active participation</td>
<td>“I had to learn to control it and not let it control me.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Now you take charge. You prick your finger, you check the sugar. You take your pill every day. You exercise as much as you can.”</td>
<td></td>
</tr>
<tr>
<td>Domain</td>
<td>Subdomain</td>
<td>Example</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Medications</td>
<td>Medication effectiveness</td>
<td>“I am taking my medications as prescribed, so why is my diabetes not getting better?”</td>
</tr>
<tr>
<td></td>
<td>Adverse effects</td>
<td>“Should I be alarmed about side effects from medications?”</td>
</tr>
<tr>
<td></td>
<td>Logistics of taking medicine</td>
<td>“Can I skip a dose of medicine and still be okay with my diabetes?”</td>
</tr>
<tr>
<td></td>
<td>Cost</td>
<td>“How can I afford my medicines?”</td>
</tr>
<tr>
<td></td>
<td>Concerns about medicine</td>
<td>Double-checking prescription/errors with filling medications at pharmacy</td>
</tr>
<tr>
<td></td>
<td>Emergency supply</td>
<td>Emergency supply of medicines somewhere</td>
</tr>
<tr>
<td>Self-care behaviors</td>
<td>Diet&lt;sup&gt;b&lt;/sup&gt;</td>
<td>“Why can I have certain foods that contain sugar, but not others?”&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“How can I afford to eat healthy?”&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Exercise</td>
<td>“When do I stop exercising when I’m in pain?”</td>
</tr>
<tr>
<td></td>
<td>Blood sugar management</td>
<td>“What is a good target blood sugar level for me?”</td>
</tr>
<tr>
<td></td>
<td>Treating diabetes without medicine</td>
<td>“What are other treatments for diabetes besides medications?”</td>
</tr>
<tr>
<td></td>
<td>Effect of diabetes on the body&lt;sup&gt;b&lt;/sup&gt;</td>
<td>“Does diabetes affect all of your organs?”</td>
</tr>
<tr>
<td></td>
<td>Heritability and causes of diabetes</td>
<td>“Why is diabetes inherited by only some members of a family?”&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Curing diabetes</td>
<td>“Will my diabetes go away?”&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Definition/pathophysiology</td>
<td>“What is the difference between type 1 and type 2 diabetes?”</td>
</tr>
<tr>
<td></td>
<td>Questions related to depression plus pain</td>
<td>“What can I do when I feel depressed?”</td>
</tr>
<tr>
<td></td>
<td>Impact of diabetes on life</td>
<td>“Will I lose my independence?”</td>
</tr>
<tr>
<td></td>
<td>Logistical help</td>
<td>“Can I get help with transportation?”</td>
</tr>
<tr>
<td>Information about the disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes impact on ability to live quality life</td>
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</tbody>
</table>

<sup>a</sup>Questions that were rated by peer coaches as being of high interest to participants.

<sup>b</sup>Bold subdomains received the most questions.
Table 17. Topics Patients Find Difficult to Discuss With Their Doctor

<table>
<thead>
<tr>
<th>Domain</th>
<th>Subdomain</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine related</td>
<td>Adverse effects</td>
<td>Do not ask or talk about side effects&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Cost</td>
<td>Concerned about medication cost</td>
</tr>
<tr>
<td></td>
<td>Medication changes</td>
<td>Bringing up the possibility of changing medications</td>
</tr>
<tr>
<td>Questions about the disease</td>
<td>Diabetes effect on body</td>
<td>Hesitant to discuss personal symptoms, for example, yeast infections</td>
</tr>
<tr>
<td></td>
<td>Definition/pathophysiology</td>
<td>Hesitant to ask for explanation of tests and blood work</td>
</tr>
<tr>
<td>Discomfort with doctor</td>
<td>Uncomfortable sharing personal information</td>
<td>Do not want to share potentially embarrassing medical history</td>
</tr>
<tr>
<td></td>
<td>Nervous about visit</td>
<td>Nervous about doctor’s visit&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do not know what questions to ask the doctor&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup>Answers that were reported by peer coaches to be particularly important to participants.

Findings from Qualitative Research

Focus group findings suggested that area residents viewed diet and exercise as more important than medications, which they viewed as required only if one is unsuccessful with diet and exercise. Many displayed a lack of knowledge that medications were used to lower risks of longer-term complications, and many believed that oral medications are only needed if morning glucose readings were abnormal. Three major themes emerging from the focus groups and interviews included the common perception of personal failure if diabetes medications continue to be needed, a profound lack of understanding of how medications work, and the belief that the need for medication was temporary and episodic (Table 14).

The focus groups also provided insights into the lived experience of diabetes for individuals living in our partnering communities. Participants reported feelings of fear, shock/disbelief, and devastation in reaction to a diabetes diagnosis. Many described periods of denial. They reported the need for extensive planning, particularly related to food and medicine. Fear of low blood sugar drove much of their behavior. Participants noted physical limitations, feeling that they could no longer do what they once were able to do. Participants
also described coping strategies, including religion, exercise, support from family/friends, and active participation in self-management (Table 15).

Findings from the nominal groups identified knowledge gaps that were organized into domains and subdomains of major topics (Table 16). The 2 subdomains that contained the most questions (n = 12) were “questions related to diet” and “effect of diabetes on the body.” The subdomains with the next largest number of questions contained only 6. Other subdomains with a significant number of responses were “medication effectiveness,” “logistics of taking medicine,” “blood sugar management,” and “heritability and causes of diabetes.” Peer coaches rated questions about “adverse effects,” “effect of diabetes on the body,” and “nervous about visit” as being the most commonly asked by participants. Almost all topics that were difficult to discuss with the doctor had a significant number of questions (Table 17). Peer coaches commented that patients often are nervous about the doctor visit in general and that the patient’s “mind goes blank,” even for questions that were not noted to be particularly difficult to discuss.

Aim 2: Trial Results

Eligibility Screening and Study Enrollment

Recruitment resulted in 1735 community members being referred for screening, with 553 individuals (32%) from community organization partners, 412 individuals (24%) from community coordinators and UAB staff, 340 individuals (20%) from previous studies who wanted to be informed about future studies, 160 individuals (9%) from flyers distributed in the community, 125 individuals (7%) referred by other community members, 85 individuals (5%) referred by study peer coaches, and 60 individuals (3%) for whom referral information was unknown or missing (Figure 6). Of the 1735 individuals referred for screening, 473 (27%) were enrolled, 402 (23%) declined to participate, 507 (29%) were not eligible, and 353 (20%) could not be contacted (Figure 7). Eighty-two individuals (17.4%) in the sample were enrolled from Birmingham. Individuals who declined to participate in the study before completing the eligibility screening gave as reasons lack of interest (n = 315 of 401 [78.6%]), no time to
participate (n = 53 [13.2%]), illness or a family member who was ill (n = 26 [6.5%]), or offered no specific reason for declining (n = 8 [2.0%]). Table 18 shows reasons for ineligibility among those screened. The most common reason for ineligibility was not being prescribed a pill for diabetes.

**Figure 6. Sources of Referrals of Enrolled Participants**

Of 473 participants randomly assigned, 203 were allocated to the intervention arm and 270 to the control arm. Of these 473 participants, 85.4% completed the 6-month follow-up (81% of intervention arm participants and 89% of control arm participants). The reasons for discontinuing the study are listed in Figure 7. The final number of clusters in the trial was 114. Of the 58 intervention clusters, the largest cluster had 32 participants, and the smallest cluster had 1 participant. Of the 56 control clusters, the largest cluster had 41 participants, and the smallest cluster had 1 participant. The imbalance in participants by study arm reflected variability in recruitment rates by cluster.
Figure 7. CONSORT Diagram for the Cluster-Randomized Trial of the *Living Well With Diabetes* Intervention

**Assessed for eligibility (n = 1735)**

- Excluded (n=1262)
  - Not meeting inclusion criteria (n=507)
  - Declined to participate (n=402)
  - Unable to contact for screening or lost contact during screening process (353)

**Randomized (n=473)**

- Allocated to Intervention (n=203)
- Allocated to Control (n=270)

**Follow-Up**

- **Completed (n=165)**
  - Discontinued study (38)
    - Unable to contact (8)
    - Health reasons (7)
    - No time (6)
    - Family health reasons (4)
    - No longer interested, no reason given, or did not want to do final data collection (3)

- **Completed (n=239)**
  - Discontinued study (31)
    - Unable to contact (27)
    - Health reasons (2)
    - No time (2)

**114 total clusters**

<table>
<thead>
<tr>
<th></th>
<th>56 control</th>
<th>58 intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Largest</td>
<td>41 participants</td>
<td>32 participants</td>
</tr>
<tr>
<td>Smallest</td>
<td>1 participant</td>
<td>1 participant</td>
</tr>
</tbody>
</table>
Table 18. Reasons for Ineligibility

<table>
<thead>
<tr>
<th>Reasons</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not take pills for diabetes</td>
<td>186 (36.7)</td>
</tr>
<tr>
<td>Did not complete data collections</td>
<td>93 (18.3)</td>
</tr>
<tr>
<td>Always took medications</td>
<td>74 (14.6)</td>
</tr>
<tr>
<td>Did not have diabetes</td>
<td>51 (10.1)</td>
</tr>
<tr>
<td>Declined to work with a peer coach</td>
<td>31 (6.1)</td>
</tr>
<tr>
<td>Diabetes care going well, does not want help</td>
<td>15 (3.0)</td>
</tr>
<tr>
<td>On chemotherapy for cancer, or on dialysis</td>
<td>10 (2.0)</td>
</tr>
<tr>
<td>Did not have a doctor or had not seen doctor in 12 mo</td>
<td>9 (1.8)</td>
</tr>
<tr>
<td>Planned to move in the next 12 mo</td>
<td>9 (1.8)</td>
</tr>
<tr>
<td>Did not want to talk on the phone</td>
<td>6 (1.2)</td>
</tr>
<tr>
<td>Other inclusion criteria with &lt;5 participants (age, in another study, not an English speaker, hard of hearing, pregnant, not community dwelling, incarcerated, declined consent)</td>
<td>23 (4.5)</td>
</tr>
</tbody>
</table>

Baseline Characteristics of Study Participants

There were no significant differences in baseline demographic characteristics between the 69 participants who did not complete 6-month follow-up and those who did (Appendix H, Table 3). Examination of the baseline demographic characteristics for the Black Belt and Birmingham study populations showed that the Birmingham population had slightly more non-Black persons, fewer were married or living with a partner, and more were taking insulin. There were no significant differences in age, sex, education, income, or employment (Appendix H, Table 4).

Table 19 presents baseline characteristics of the 403 study participants who completed follow-up, overall and by study arm. Their mean age was 57 years, 78% were women, 91% were Black, 56% had a high school education or less, and 69% had an annual income of <$20 000. Only race differed significantly by trial arm. At baseline, 42% (n = 171) of participants reported that they were adherent to their medications, using the 3-item Green scale, but still wanted
help with their diabetes medications. The mean HbA$_1c$ was 8.4%, mean systolic BP was 129 mm Hg, the mean LDL-C was 83.0 mg/dL, and the mean BMI was 36.7.

Table 19. Baseline Characteristics of 403 Participants With Follow-up Data in the *Living Well With Diabetes* Trial

<table>
<thead>
<tr>
<th></th>
<th>All (N = 403)</th>
<th>Control (n = 239)</th>
<th>Intervention (n = 164)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age, mean ± SD, y</strong></td>
<td>57.16 ± 10.95</td>
<td>56.5 ± 11.71</td>
<td>58.12 ± 9.67</td>
</tr>
<tr>
<td><strong>Female, No. (%)</strong></td>
<td>316 (78.2)</td>
<td>187 (78.2)</td>
<td>129 (78.2)</td>
</tr>
<tr>
<td><strong>Race, No. (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>366 (90.6)</td>
<td>222 (92.9)</td>
<td>144 (87.3)</td>
</tr>
<tr>
<td>All others</td>
<td>38 (9.4)</td>
<td>17 (7.1)</td>
<td>21 (12.7)</td>
</tr>
<tr>
<td><strong>Education, No. (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>85 (21.0)</td>
<td>26 (19.3)</td>
<td>39 (23.6)</td>
</tr>
<tr>
<td>High school graduate</td>
<td>143 (35.4)</td>
<td>89 (37.2)</td>
<td>54 (32.7)</td>
</tr>
<tr>
<td>More than high school</td>
<td>176 (43.6)</td>
<td>104 (43.5)</td>
<td>72 (43.6)</td>
</tr>
<tr>
<td><strong>Annual income, No. (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$20 000</td>
<td>268 (69.3)</td>
<td>161 (70.3)</td>
<td>107 (67.7)</td>
</tr>
<tr>
<td>≥$20 000</td>
<td>119 (30.8)</td>
<td>68 (29.7)</td>
<td>51 (32.3)</td>
</tr>
<tr>
<td><strong>Marital status, No. (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married or living with partner</td>
<td>147 (36.5)</td>
<td>86 (36.1)</td>
<td>61 (37.0)</td>
</tr>
<tr>
<td>Never married, divorced, widowed, separated</td>
<td>256 (63.5)</td>
<td>152 (63.9)</td>
<td>104 (63.0)</td>
</tr>
<tr>
<td><strong>Employment, No. (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed for wages or self-employed</td>
<td>107 (26.7)</td>
<td>63 (26.6)</td>
<td>44 (26.8)</td>
</tr>
<tr>
<td>Not working (retired, out of work, homemaker, unable to work)</td>
<td>294 (73.3)</td>
<td>174 (73.4)</td>
<td>120 (73.2)</td>
</tr>
<tr>
<td><strong>Taking insulin, No. (%)</strong></td>
<td></td>
<td>177 (43.8)</td>
<td>99 (41.2)</td>
</tr>
<tr>
<td><strong>Medication adherence score, mean ± SD</strong></td>
<td>0.75 ± 0.79</td>
<td>0.74 ± 0.79</td>
<td>0.78 ± 0.80</td>
</tr>
<tr>
<td><strong>HbA$_1c$, mean ± SD, %</strong></td>
<td>8.36 ± 2.04</td>
<td>8.3 ± 1.99</td>
<td>8.4 ± 2.11</td>
</tr>
<tr>
<td><strong>Systolic BP, mean ± SD, mm Hg</strong></td>
<td>128.97 ± 19.55</td>
<td>129.3 ± 19.5</td>
<td>128.5 ± 19.6</td>
</tr>
<tr>
<td><strong>LDL-C, mean ± SD, mg/dL</strong></td>
<td>83.03 ± 36.67</td>
<td>80.7 ± 36.3</td>
<td>84.6 ± 38.4</td>
</tr>
<tr>
<td><strong>BMI, mean ± SD</strong></td>
<td>36.73 ± 8.48</td>
<td>36.5 ± 8.0</td>
<td>37.0 ± 9.1</td>
</tr>
</tbody>
</table>

Abbreviations: BMI, body mass index; BP, blood pressure; HbA$_{1c}$, hemoglobin A$_{1c}$; LDL-C, low-density lipoprotein cholesterol.
Main Results: Primary Outcomes

The unadjusted differences in the primary outcomes of the trial are shown in Table 20. All unadjusted outcome changes favored the intervention arm, with no significant differences.

Table 20. Mean Unadjusted Change From Baseline to 6-Month Follow-up in Primary Outcome Measures in the Living Well With Diabetes Trial

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Trial arm</th>
<th>Baseline, mean ± SD</th>
<th>Follow-up, mean ± SD</th>
<th>Change, mean ± SD</th>
<th>P valueb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication adherence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>score c</td>
<td>Control</td>
<td>0.74 ± 0.79</td>
<td>0.62 ± 0.76</td>
<td>−0.12 ± 0.71</td>
<td>.06</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td>0.78 ± 0.80</td>
<td>0.53 ± 0.66</td>
<td>−0.25 ± 0.70</td>
<td></td>
</tr>
<tr>
<td>HbA1c, %</td>
<td>Control</td>
<td>8.3 ± 1.99</td>
<td>8.1 ± 1.8</td>
<td>−0.24 ± 1.55</td>
<td>.41</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td>8.4 ± 2.11</td>
<td>8.1 ± 1.9</td>
<td>−0.37 ± 1.71</td>
<td></td>
</tr>
<tr>
<td>Systolic BP, mm Hg</td>
<td>Control</td>
<td>129.3 ± 19.5</td>
<td>133.6 ± 18.4</td>
<td>4.1 ± 20.5</td>
<td>.44</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td>128.5 ± 19.6</td>
<td>130.6 ± 20.7</td>
<td>2.5 ± 19.5</td>
<td></td>
</tr>
<tr>
<td>LDL-C, mg/dL</td>
<td>Control</td>
<td>80.7 ± 36.3</td>
<td>82.2 ± 31.0</td>
<td>1.5 ± 38.2</td>
<td>.20</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td>84.6 ± 38.4</td>
<td>80.1 ± 33.1</td>
<td>−4.5 ± 38.6</td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td>Control</td>
<td>36.5 ± 8.0</td>
<td>36.4 ± 7.9</td>
<td>0.01 ± 2.8</td>
<td>.08</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td>37.0 ± 9.1</td>
<td>36.5 ± 9.1</td>
<td>−0.45 ± 2.6</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: BMI, body mass index; BP, blood pressure; HbA1c, hemoglobin A1c; LDL-C, low-density lipoprotein cholesterol.

aThe results use the complete-case method and include all participants who completed 6-month follow-up; they are thus intention-to-treat analyses.
bP values from 2-sample t tests.
cThe medication adherence score range is 0 to 3, with a higher score indicating worse adherence.
The main results from the trial for the primary outcomes are shown in Table 21, which shows parameter estimates from analysis of covariance (ANCOVA) models adjusted for baseline values and covariate imbalance across treatment arms (race). The ICC for medication adherence was 0.055, with a 95% CI of −0.018 to 0.145, thus not statistically significant. However, the lower bound of the 95% CI was very close to 0; thus, to be conservative, we also present adjusted results that include baseline values and race, and we account for clustering using GEE models. As can be seen, differences in medication adherence were statistically significantly different between treatment arms in both the analyses with and without adjustment for clustering. However, the observed changes in adherence were relatively small in magnitude and of uncertain clinical importance, because the study arms did not differ in HbA1c, BP, and LDL-C outcomes. Point estimates for other outcomes were all better in the intervention than in the control arm, but these differences were not statistically significant in either model.

### Table 21. Parameter Estimates (95% CI) and P Values for Tests of Differences in Primary Outcomes From Adjusted Analyses Comparing Control With Intervention Arms in the Living Well With Diabetes Trial

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Adjusted for baseline value and race, b parameter estimates (95% CI)</th>
<th>P value</th>
<th>Adjusted for baseline value, race, and clustering, c parameter estimates (95% CI)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication adherence d</td>
<td>−0.12 (−0.24 to −0.00)</td>
<td>.01</td>
<td>−0.25 (−0.35 to −0.15)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>HbA1c, %</td>
<td>−0.05 (−0.33 to 0.23)</td>
<td>.71</td>
<td>−0.05 (−0.32 to 0.22)</td>
<td>.72</td>
</tr>
<tr>
<td>Systolic BP, mm Hg</td>
<td>−2.3 (−5.81 to 1.12)</td>
<td>.19</td>
<td>−2.65 (−6.25 to 0.95)</td>
<td>.15</td>
</tr>
<tr>
<td>LDL-C, mg/dL</td>
<td>−3.33 (−10.38 to 3.72)</td>
<td>.35</td>
<td>−3.48 (−10.56 to 3.60)</td>
<td>.34</td>
</tr>
<tr>
<td>BMI</td>
<td>−0.48 (−1.00 to 0.04)</td>
<td>.07</td>
<td>−0.13 (−0.55 to 0.30)</td>
<td>.56</td>
</tr>
</tbody>
</table>

Abbreviations: BMI, body mass index; BP, blood pressure; HbA1c, hemoglobin A1c; LDL-C, low-density lipoprotein cholesterol.

a The results use the complete-case method and include all participants who completed 6-month follow-up; they are thus intention-to-treat analyses.
b Adjustment using analysis of covariance.
c Adjustment using GEEs.
d The medication adherence score range is 0 to 3, with a higher score indicating worse adherence.
Main Results: Secondary Outcomes

The unadjusted secondary outcome results are shown in Table 2. For the 2 domains of QOL, changes in SF-12 scores were very modest and did not differ significantly by trial arm. For the 4 domains of medication beliefs, changes in the intervention arm were in the anticipated direction, indicating a favorable treatment effect for the domains, and were statistically different from the control arm for necessity, concerns, and harm but not overuse. Medication use self-efficacy increased significantly more in the intervention arm than in the control arm.
Table 2. Unadjusted Arm Mean Changes in Secondary Outcome Measures From Baseline to 6-Month Follow-up in the Living Well With Diabetes Trial\(^a\)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Trial arm</th>
<th>Baseline, mean ± SD</th>
<th>Follow-up, mean ± SD</th>
<th>Change, mean ± SD</th>
<th>P value(^b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>QOL as assessed with the SF-12(^c)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCS scores</td>
<td>Control</td>
<td>42.3 ± 7.0</td>
<td>42.1 ± 7.2</td>
<td>−0.2 ± 8.5</td>
<td>.45</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td>42.7 ± 7.5</td>
<td>42.0 ± 6.9</td>
<td>−0.7 ± 8.6</td>
<td></td>
</tr>
<tr>
<td>PCS scores</td>
<td>Control</td>
<td>40.1 ± 7.7</td>
<td>40.4 ± 7.9</td>
<td>0.3 ± 8.1</td>
<td>.27</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td>39.0 ± 8.2</td>
<td>40.4 ± 8.3</td>
<td>1.4 ± 7.7</td>
<td></td>
</tr>
<tr>
<td>Medication beliefs(^d)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Necessity (beliefs about the necessity of medications)</td>
<td>Control</td>
<td>19.6 ± 3.9</td>
<td>19.4 ± 4.2</td>
<td>−0.2 ± 3.7</td>
<td>.004</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td>19.1 ± 3.6</td>
<td>20.0 ± 3.9</td>
<td>0.9 ± 3.5</td>
<td></td>
</tr>
<tr>
<td>Concerns (about the negative effects of medications)</td>
<td>Control</td>
<td>14.9 ± 4.2</td>
<td>14.7 ± 8.9</td>
<td>−0.2 ± 3.9</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td>15.4 ± 3.9</td>
<td>14.0 ± 3.8</td>
<td>−1.5 ± 4.0</td>
<td></td>
</tr>
<tr>
<td>Overuse (concerns about the way doctors use medications)</td>
<td>Control</td>
<td>12.7 ± 3.4</td>
<td>12.6 ± 3.4</td>
<td>−0.1 ± 3.3</td>
<td>.28</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td>13.3 ± 3.2</td>
<td>12.6 ± 3.4</td>
<td>−0.6 ± 3.3</td>
<td></td>
</tr>
<tr>
<td>Harm (beliefs that medications are harmful)</td>
<td>Control</td>
<td>9.8 ± 2.8</td>
<td>9.7 ± 2.8</td>
<td>−0.1 ± 2.8</td>
<td>.01</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td>10.6 ± 2.7</td>
<td>9.8 ± 2.7</td>
<td>−0.8 ± 2.5</td>
<td></td>
</tr>
<tr>
<td>Medication use self-efficacy(^e)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>32.2 ± 6.0</td>
<td>33.1 ± 5.5</td>
<td>0.9 ± 5.0</td>
<td>.01</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td>31.9 ± 5.6</td>
<td>33.9 ± 5.1</td>
<td>2.0 ± 5.6</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: MCS, Mental Component Summary; PCS, Physical Component Summary; QOL, quality of life; SF-12, Short Form 12-item.

\(^a\)The results use the complete-case method and include all participants who completed 6-month follow-up; they are thus intention-to-treat analyses.

\(^b\)P value from 2-sample t tests.

\(^c\)Scores on the SF-12 MCS and PCS range from 0 to 100; higher scores indicate greater QOL.

\(^d\)Scores on the Beliefs About Medicines Questionnaire range from 5 to 25; higher scores indicate stronger beliefs.

\(^e\)Scores on the Self-Efficacy for Appropriate Medication Use Scale range from 13 to 39; higher scores indicate higher levels of self-efficacy for medication adherence.

The adjusted results for the secondary outcomes were similar to the unadjusted results (Table 23). The exception was the harm domain of the medication beliefs scale; the ANCOVA led to a nonsignificant difference between trial arms, and the GEE analysis led to a significantly greater difference in the intervention arm, indicating fewer beliefs about the harms of medications.
Table 23. Parameter Estimates (95% CI) and P Values for Tests of Differences in Secondary Outcomes From Adjusted Analyses Comparing Control With Intervention Arms in the Living Well With Diabetes Trial

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Adjusted for baseline value and race, parameter estimates (95% CI)</th>
<th>P value</th>
<th>Adjusted for baseline value, race, and clustering, parameter estimates (95% CI)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>QOL as assessed with the SF-12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCS scores</td>
<td>−0.17 (−1.53 to 1.19)</td>
<td>.81</td>
<td>−0.43 (−1.55 to 0.68)</td>
<td>.45</td>
</tr>
<tr>
<td>PCS scores</td>
<td>0.56 (−0.83 to 1.95)</td>
<td>.43</td>
<td>0.55 (−0.42 to 1.53)</td>
<td>.27</td>
</tr>
<tr>
<td>Medication beliefs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Necessity (beliefs about the necessity of medications)</td>
<td>0.87 (0.20-1.53)</td>
<td>.01</td>
<td>0.87 (0.27-1.47)</td>
<td>.004</td>
</tr>
<tr>
<td>Concerns (about the negative effects of medications)</td>
<td>−0.98 (−1.64 to −0.31)</td>
<td>.004</td>
<td>−0.91 (−1.35 to −0.47)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Overuse (concerns about the way doctors use medications)</td>
<td>−0.29 (−0.87 to 0.30)</td>
<td>.34</td>
<td>−0.21 (−0.60 to 0.17)</td>
<td>.28</td>
</tr>
<tr>
<td>Harm (beliefs that medications are harmful)</td>
<td>−0.32 (−0.79 to 0.16)</td>
<td>.19</td>
<td>−0.50 (−0.89 to −0.10)</td>
<td>.01</td>
</tr>
<tr>
<td>Medication use self-efficacy</td>
<td>0.94 (0.05-1.83)</td>
<td>.04</td>
<td>1.00 (0.23-1.76)</td>
<td>.01</td>
</tr>
</tbody>
</table>

Abbreviations: MCS, Mental Component Summary; PCS, Physical Component Summary; QOL, quality of life; SF-12, Short Form 12-item.

aThe results use the complete-case method and include all participants who completed the 6-month follow-up; they are thus intention-to-treat analyses.
bAnalysis of covariance adjusting for baseline value of the measure and race.
cGeneralized estimating equation models, accounting for clustering and adjusting for baseline values and race.
dScores on the SF-12 MCS and PCS range from 0 to 100; higher scores indicate greater QOL.
eScores on the Beliefs About Medicines Questionnaire range from 5 to 25; higher scores indicate stronger beliefs.
fScores on the Self-Efficacy for Appropriate Medication Use Scale range from 13 to 39; higher scores indicate higher levels of self-efficacy for medication adherence.

Program Completion and Timing of Data Collection in the Intervention Arm

Program satisfaction was high for both control and intervention participants (Appendix H, Table 5). As noted previously, 165 (81.3%) of the 203 participants allocated to the intervention arm completed follow-up data collection. Uptake of the intervention was robust,
with 166 (81.8%) of the 203 intervention participants completing all program sessions, 8 participants (3.9%) completing 6 to 9 sessions, 15 participants (7.4%) completing 1 to 5 sessions, and 14 participants (6.9%) completing no sessions. Satisfaction with program components was high (Appendix H, Table 6). Eleven participants who completed all program sessions did not complete the follow-up. Of the 165 participants who completed the follow-up, 154 participants completed all program sessions. Those who did not complete all 11 sessions had higher baseline HbA1c (9.3%) than did program completers (8.4%) (Table 2). Furthermore, for those who completed the follow-up, HbA1c did not change much (−0.1% HbA1c) between baseline and follow-up for those completing <11 sessions, whereas HbA1c improved (0.4% HbA1c) for intervention completers with both baseline and follow-up HbA1c values; these differences were not statistically significant. This difference between completers and noncompleters should be interpreted in light of the known limitations of a per-protocol analysis.

There were differences in the time elapsed between baseline data collection and session 1 completion. Our goal of completing session 1 within 30 days of enrollment was often not realized for various reasons, such as participant availability and logistical issues. As a result, 106 (52%) of the 203 intervention participants completed session 1 within 30 days, and 166 (81.8%) intervention participants completed session 1 within 60 days of enrollment. Differences in the change in HbA1c were not significantly different between those who completed session 1 within 30 days and those who did not (P for difference = .99), or between those who completed session 1 within 60 days and those who did not (P for difference = .49) (Table 2).
Table 24. Program Completion, Timing of Data Collection, and Unadjusted Change in HbA\textsubscript{1c} Between Baseline and 6-Month Follow-up in Intervention Participants of the Living Well With Diabetes Trial\textsuperscript{a}

<table>
<thead>
<tr>
<th>HbA\textsubscript{1c} comparison</th>
<th>Baseline, No., mean ± SD</th>
<th>Follow-up, No., mean ± SD</th>
<th>Change, mean ± SD</th>
<th>(P) value\textsuperscript{b}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed whole program (11 sessions)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No (≤10 sessions)</td>
<td>11, 9.3 ± 2.3</td>
<td>10, 9.2 ± 2.2</td>
<td>−0.1 ± 2.1</td>
<td>.36</td>
</tr>
<tr>
<td>Yes</td>
<td>154, 8.4 ± 2.1</td>
<td>151, 8.0 ± 1.9</td>
<td>−0.4 ± 1.7</td>
<td></td>
</tr>
<tr>
<td>Session 1 completed within 30 d of enrollment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>66, 8.6 ± 2.2</td>
<td>65, 8.2 ± 2.1</td>
<td>−0.4 ± 1.7</td>
<td>.99</td>
</tr>
<tr>
<td>Yes</td>
<td>94, 8.3 ± 2.1</td>
<td>91, 7.9 ± 1.7</td>
<td>−0.4 ± 1.7</td>
<td></td>
</tr>
<tr>
<td>Session 1 completed within 60 d of enrollment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>18, 8.5 ± 2.2</td>
<td>18, 8.2 ± 2.0</td>
<td>−0.2 ± 1.1</td>
<td>.49</td>
</tr>
<tr>
<td>Yes</td>
<td>142, 8.4 ± 2.1</td>
<td>138, 8.0 ± 1.9</td>
<td>−0.4 ± 1.7</td>
<td></td>
</tr>
<tr>
<td>Final data collection completed within 30 d of final program session</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>112, 8.2 ± 1.9</td>
<td>112, 7.9 ± 1.8</td>
<td>−0.3 ± 1.7</td>
<td>.18</td>
</tr>
<tr>
<td>Yes</td>
<td>38, 8.9 ± 2.5</td>
<td>38, 8.3 ± 2.2</td>
<td>−0.7 ± 1.5</td>
<td></td>
</tr>
<tr>
<td>Final data collection completed within 60 d of final program session</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>46, 8.5 ± 1.8</td>
<td>46, 8.4 ± 2.1</td>
<td>−0.05 ± 1.9</td>
<td>.08</td>
</tr>
<tr>
<td>Yes</td>
<td>104, 8.4 ± 2.2</td>
<td>104, 7.8 ± 1.8</td>
<td>−0.57 ± 1.6</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviation: HbA\textsubscript{1c}, hemoglobin A\textsubscript{1c}.

\textsuperscript{a}The results use the complete-case method and include all participants who completed the 6-month follow-up; they are thus intention-to-treat analyses.

\textsuperscript{b} \(P\) values from 2-sample \(t\) tests of differences in group mean changes in HbA\textsubscript{1c}.

**Post Hoc Sensitivity and Exploratory Analyses**

After the final program session with the peer coach, our goal was to complete follow-up within 30 days. HbA\textsubscript{1c} reflects a participant’s average blood glucose over the previous 90 days, with greater impact for the previous 30 days; if the intervention exerted a beneficial effect that decayed over time, delays in data collection could dilute intervention effects. In addition to the
effectiveness of the intervention attenuating quickly, it is also possible that those participants with whom it was difficult to schedule the follow-up study visits may also be less adherent to their medications in general, perhaps reflecting an overall difficulty with adherence or dealing with competing demands. Finally, because the delays in follow-up data collection could be an indicator of engagement of the participants in the intervention itself (ie, those who were challenging to contact and schedule for the data collections were less engaged in the intervention), we conducted exploratory analyses examining the impact of the timing of data collection.

We compared HbA1c changes between baseline and 6-month follow-up for those who completed follow-up within 30 and 60 days of their last program session. Again, due to scheduling challenges, only 38 (25.3%) of 150 participants with final follow-up and completion of the program completed follow-up within 30 days, and 104 (69.3%) participants completed follow-up within 60 days. The point estimate for change in HbA1c was greater for program completers who completed follow-up within 30 days than for those who did not (Table 24). Similar differences were evident for those who completed follow-up within 60 days vs those who did not. Neither of these differences reached statistical significance, but both differences were near the prespecified detectable differences in HbA1c (0.4%) for the trial, suggesting that the timing of final data collection may have influenced the outcomes of the trial.

To further explore the impact of the timing of data collection, we conducted an analysis of group differences in change in HbA1c between baseline and 6-month follow-up for only the 121 intervention participants who completed the intervention and final data collection within 60 days of completing the intervention and for the 239 control arm participants; we adjusted for baseline values and race and separately accounted for clustering (Table 25). These results demonstrated differences in the point estimates for change in HbA1c between baseline and 6-month follow-up (−0.26 using ANCOVA and −0.28 using GEE) between control and intervention arm participants who both completed the program and completed follow-up within 60 days of completing the intervention; P values approached but did not reach statistical significance. The
The magnitude of these differences was less than the 0.4% HbA1c detectable difference used to design the trial, but the 95% CIs around the change did include 0.4.

Table 25. HbA1c at Baseline and Follow-up, and Adjusted Change in HbA1c Among All Control Participants Compared With Intervention Participants Who Completed Follow-up Data Collection Within 60 Days of Their Last Program Session

<table>
<thead>
<tr>
<th>Arm</th>
<th>Baseline, No., mean HbA1c ± SD</th>
<th>Follow-up, No., mean HbA1c ± SD</th>
<th>Adjusteda parameter estimate (95% CI), P value</th>
<th>Adjustedb parameter estimate accounting for clustering (95% CI), P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>239, 8.3 ± 2.0</td>
<td>235, 8.1 ± 1.8</td>
<td>-0.26 (−0.55 to 0.03), .077</td>
<td>-0.28 (−0.57 to 0.23), .07</td>
</tr>
<tr>
<td>Intervention</td>
<td>121, 8.4 ± 2.1</td>
<td>121, 7.8 ± 1.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Abbreviation: HbA1c, hemoglobin A1c.

aAnalysis of covariance testing the difference in the change from baseline to follow-up between arms, adjusting for baseline HbA1c.
bGeneralized estimating equation models testing the difference in the change from baseline to follow-up between arms, accounting for clustering and baseline HbA1c.

Program Satisfaction and Peer Coach Evaluation Results

Satisfaction with the study was high, with 92% of the control and 95% of the intervention participants expressing that they were extremely satisfied or satisfied with the program (Table 26). More than 99% of all participants found the study staff to be helpful and friendly, and >90% of all participants expressed interest in participating in future similar studies. Notably, although more intervention participants than control participants reported that they discussed the results of their first report card with their doctor, only 36.4% of intervention participants did so, despite this being a topic in the intervention.
Table 26. Program Satisfaction and Program Evaluation Questions

<table>
<thead>
<tr>
<th>Question/item</th>
<th>Trial arm</th>
<th>Response options, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Extremely satisfied or satisfied</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neutral, dissatisfied, extremely dissatisfied, or don’t know</td>
</tr>
<tr>
<td>To what degree are you satisfied with the Living Well With Diabetes Program?</td>
<td>Control</td>
<td>220 (92.4)</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td>157 (95.2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18 (7.6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8 (4.8)</td>
</tr>
<tr>
<td>The Living Well With Diabetes staff was helpful and friendly</td>
<td>Control</td>
<td>237 (99.6)</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td>164 (99.4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 (0.4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 (1.2)</td>
</tr>
<tr>
<td>Did you discuss the results of your first report card with your doctor?</td>
<td>Control</td>
<td>69 (29.0)</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td>60 (36.4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>169 (71.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>105 (63.6)</td>
</tr>
<tr>
<td>Would you be interested in participating in future studies like Living Well</td>
<td>Control</td>
<td>229 (96.2)</td>
</tr>
<tr>
<td>With Diabetes?</td>
<td>Intervention</td>
<td>151 (91.5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9 (3.8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>14 (8.5)</td>
</tr>
</tbody>
</table>

Intervention participants expressed high program satisfaction (Table 27). Most participants found the program materials to be helpful, with 92.6% reporting that they used the program activity book and found it helpful and 98.2% of participants watching the videos and finding them helpful. Furthermore, most participants reported that working with a peer coach was a positive experience: 88.8% reported that working with a peer coach was helpful, 89.7% reported that it was easy to reach their peer coach, 91.3% reported that it was easy to talk to their peer coach, 91.9% reported that the support they received from their peer coach was good or great, and 91.9% reported that their peer coach understood them. Overall, 96.3% would recommend their peer coach to a friend or relative with a similar health condition.
Table 27. *Living Well With Diabetes* Intervention and Peer Coach Evaluation Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Response options, No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you use the activity book? If yes, did you find it helpful?</td>
<td>Yes, used it and found it helpful; Yes, used it but didn’t find it helpful; no, didn’t use it; or declined to answer</td>
</tr>
<tr>
<td></td>
<td>150 (92.6)</td>
</tr>
<tr>
<td></td>
<td>12 (7.4)</td>
</tr>
<tr>
<td>Did you watch the program videos?</td>
<td>Yes, No or declined to answer</td>
</tr>
<tr>
<td></td>
<td>160 (98.2)</td>
</tr>
<tr>
<td></td>
<td>3 (1.8)</td>
</tr>
<tr>
<td>If yes, watched the videos: Did you like the videos?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>156 (98.1)</td>
</tr>
<tr>
<td></td>
<td>3 (1.9)</td>
</tr>
<tr>
<td>If yes, watched the videos: Did you find the videos helpful?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>158 (99.4)</td>
</tr>
<tr>
<td></td>
<td>1 (0.6)</td>
</tr>
<tr>
<td>In thinking about your overall experience, how much were you helped by</td>
<td>Very much or a lot; A little, not at all, or declined to answer</td>
</tr>
<tr>
<td>working with your peer coach?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>144 (88.8)</td>
</tr>
<tr>
<td></td>
<td>18 (11.1)</td>
</tr>
<tr>
<td>How easy was it to reach your peer coach?</td>
<td>Easy; Somewhat easy, neither difficult nor easy, somewhat difficult, difficult, or declined to answer</td>
</tr>
<tr>
<td></td>
<td>140 (89.7)</td>
</tr>
<tr>
<td></td>
<td>16 (10.3)</td>
</tr>
<tr>
<td>Was talking with your peer coach difficult, somewhat difficult, neither</td>
<td>147 (91.3)</td>
</tr>
<tr>
<td>difficult nor easy, somewhat easy, or easy?</td>
<td>14 (8.7)</td>
</tr>
<tr>
<td>If talking with the peer coach was difficult or somewhat difficult, why</td>
<td>1 endorsed “She doesn’t understand my problems”; 1 endorsed “She doesn’t listen”; and 2 declined to answer</td>
</tr>
<tr>
<td>do you think this was so?</td>
<td></td>
</tr>
<tr>
<td>Was the support you received from your peer coach poor, fair, average,</td>
<td>Good or great; Poor, fair, average, don’t know, or refused to answer</td>
</tr>
<tr>
<td>good, or great?</td>
<td>148 (91.9)</td>
</tr>
<tr>
<td></td>
<td>13 (8.1)</td>
</tr>
<tr>
<td>Did you feel that your peer coach understood you?</td>
<td>Usually or always; Never, sometimes, not sure, don’t know, or refused to answer</td>
</tr>
<tr>
<td></td>
<td>147 (91.9)</td>
</tr>
<tr>
<td></td>
<td>13 (8.1)</td>
</tr>
<tr>
<td>Question</td>
<td>Response options, No. (%)</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------</td>
</tr>
<tr>
<td></td>
<td>Very well or fairly well</td>
</tr>
<tr>
<td>How well did your peer coach know the program?</td>
<td>153 (95.6)</td>
</tr>
<tr>
<td></td>
<td>Never</td>
</tr>
<tr>
<td>Did you feel that your peer coach seemed too busy for you?</td>
<td>142 (88.8)</td>
</tr>
<tr>
<td>Did you feel comfortable with your peer coach always, most of the time, sometimes, or never?</td>
<td>Always or most of the time</td>
</tr>
<tr>
<td></td>
<td>152 (95.0)</td>
</tr>
<tr>
<td>Would you recommend your peer coach to a friend or relative with a similar health condition?</td>
<td>Definitely yes or probably yes</td>
</tr>
<tr>
<td></td>
<td>154 (96.3)</td>
</tr>
</tbody>
</table>
Aim 1

In aim 1, we collaboratively adapted an existing intervention based on social cognitive theory to integrate the Corbin and Strauss Chronic Illness Trajectory Framework and peer storytelling. The final *Living Well With Diabetes* intervention consisted of educational DVDs with integrated storytelling about how community members accepted their disease and overcame barriers to medication adherence, plus one-on-one telephone peer coaching with a trained peer coach to encourage medication adherence in the context of a diabetes self-management intervention. The findings provided insights in our target communities regarding commonly held beliefs regarding medications, the impact of diabetes on the daily lives of individuals living with diabetes, and common questions about diabetes and diabetes medications.

Although community members acknowledged the importance of controlling their diabetes, our results showed that they may misconstrue the role of medications in diabetes self-management. Moreover, focus group results provided a deeper understanding of the lived experience of individuals living with diabetes in rural Alabama by their thoughts and attitudes about diabetes, what kinds of coping mechanisms they used, and the major impacts that diabetes had on their daily lives. Three overarching themes that emerged included reaction to diagnosis, the impact of diabetes on daily activities, and coping strategies.

Participants reported a range of reactions when diagnosed with diabetes, including shock, denial, fear, and total devastation. Being diagnosed with diabetes had a huge psychological impact on participants, consistent with published reports indicating that being diagnosed with diabetes significantly impacts one’s emotional health and well-being. Delivering the diagnosis of diabetes should be approached with empathy by a provider who knows the patient when possible, as many participants described enduring something similar to the grieving process after being diagnosed with type 2 diabetes. Such an approach may not be routinely implemented in most current primary care contexts.
Similarly, we found that diabetes had a significant impact on daily activities. Diabetes was seen as a burden that restricted spontaneity. Participants emphasized the need for daily planning regarding both diet and medications. Medication management and the complexity of planning ahead, knowing how to modify medications based on blood glucose readings, and remembering to plan and take medications were all common themes. Although participants recognized the benefits of a healthy diet, they expressed how difficult it is to follow such a diet, with cited challenges including traveling, which is a frequent need in rural areas. While interventions are unlikely to completely overcome these barriers related to planning and diet, increased empathy and understanding by health care providers could better engage patients and more effectively encourage them to persevere in their self-care efforts.

Participants also reported burdensome physical limitations attributed to diabetes, such as pain in their feet, increased fatigue, and impaired vision. The literature demonstrates that a greater proportion of people with diabetes have physical limitations than do people without diabetes. One study found that people with diabetes had a higher proportion of physical limitations than did people without diabetes overall (66% vs 29%, respectively; \( P < .001 \)). In fact, disability is a key indicator of the degree of morbidity associated with chronic diseases such as type 2 diabetes. While the current literature suggests that physical activity can improve insulin sensitivity, glycemic control, and cardiovascular risk factors in people with diabetes, physical limitations were especially frustrating to many participants who stated that they knew physical activity was key to controlling their disease but that the disease itself was preventing them from being physically active. Although physical activity may alleviate some of these concerns, undoubtedly, many people with diabetes and physical limitations must learn to cope with their condition, and supportive, empathic health care providers could ensure that they remain engaged in their self-management. Notably, few studies have tested interventions specifically designed to increase provider empathy, especially in those who care for rural Black individuals.

Among the more prevalent coping strategies are prayer and religiosity. The use of solitary prayer has been cited numerous times in articles and was reported as the most
common source of complementary and alternative medicine used by patients, regardless of their chronic condition. Previous studies also suggest that many patients and physicians believe that personal spiritual practices can play an important and beneficial role in coping with health and illness. The current literature suggests an important role for peer or social support in managing chronic illnesses like type 2 diabetes, as cited by our study’s participants. A study by Tang et al suggested a role for social support in diabetes-specific QOL and self-management. That study in conjunction with our findings supports the importance of involving family and friends as well as religion in supporting this population.

One final coping strategy expressed by participants in our study was active participation in health care. The current literature supports this finding: Participatory decision-making during primary care encounters by patients with type 2 diabetes resulted in improvements in HbA1c and LDL-C levels by improving patient activation, which in turn improved medication adherence.

Finally, nominal group findings provided insights into common questions about diabetes and other topics that patients find difficult to discuss with their doctor. Providers’ understanding of these questions and how to best answer them is key to engaging and empowering patients and thereby improving their outcomes. The nominal group results suggest that patients have many questions about topics they find difficult to discuss with their doctor. This finding indicates that many patients may not feel comfortable obtaining the information they need about diabetes during their doctor visits. Studies need to explore how making such information available outside the office encounter impacts patient engagement and activation. With limited access to the internet, Black Belt–area residents often rely on information from family or friends, and we learned that misinformation is common. Peer coaches are a solution to this dilemma, because they are already integrated into their community and can share information through direct contact. They are therefore a potential resource when asking the doctor is too difficult. However, community health workers and peer coaches have limited medical training, and these types of health extenders are usually trained to avoid answering medical questions or giving medical advice. When we trained peer coaches, we emphasized the
importance of referring patients back to their doctor or nurse for such questions, but coaches reported that their clients frequently asked questions anyway, especially about medications. Resources with reliable, easily understood information that can support community peer coaches would be helpful. Physicians can also reduce the information gap through understanding a patient’s reluctance to ask questions, being proactive when talking with patients, and ensuring that patients feel comfortable discussing their concerns.

Aim 2

The *Living Well with Diabetes* intervention resulted in significant improvements in self-reported medication adherence and in consistent but not statistically significant improvements in HbA1c, systolic BP, LDL-C, and BMI. The intervention did not impact physical or mental functioning, but it resulted in significant improvements in several other secondary outcomes, including beliefs about medications and self-efficacy in adhering to medications.

Although not an outcome, a remarkable finding of this study was the extraordinarily high adherence to and satisfaction with this peer-delivered supportive intervention founded on the shared experience of living with a chronic illness. One potential reason for this finding is that a Corbin and Strauss–inspired intervention strategy holds promise, integrating the lived experience of illness through peer storytelling about how difficult it can be to accept the diagnosis of diabetes, the impact of diabetes on individuals’ lives, and the importance of setting achievable goals and tracking progress. In our ENCOURAGE trial, the intervention was also supported and delivered by trained community members, but it did not incorporate the Corbin and Strauss approach; also, the mean number of completed sessions was 13.8 (with a wide SD of 8.1 sessions) in a 17-session yearlong program, and only 32% of participants completed all 17 sessions. This contrasts with the 82% completion rate of all 11 sessions of the *Living Well With Diabetes* intervention, suggesting that incorporating the shared experience of chronic illness into an intervention may be more engaging.

The results of this study were potentially impacted by the realities of collecting data in real-world settings. We specifically selected geographically remote, “hardly reached” settings due to their burden of chronic diseases like diabetes and the paucity of medical resources; the
choice of this setting came with challenges that may have contributed to the lack of significant findings for glycemic control. Specifically, the timing of data collection relative to the time of intervention completion was particularly challenging, a problem that was previously reported. The variation in data collection timing may have impacted the results, but our sensitivity analyses suggested only a modest influence on the results.

The multiple influences on glycemic control are important to consider when interpreting our findings. Although medications are a cornerstone of glycemic control once HbA1c levels rise above normal, diet and physical activity are also critical. A highly compliant patient may still not achieve glycemic control if they do not eat a healthy diet or engage in regular physical activity. Our intervention included information on healthy eating and encouraged goal setting to improve diet, but it was not a lifestyle intervention per se. Participants had many questions about what to eat and about how to afford and access healthy foods, because many buy the majority of their groceries at convenience stores, such as dollar stores or gas stations. Questions related to diet were also among those rated as the most difficult for patients to discuss with their doctor. Additional practical information about how to follow a healthy diet in rural food deserts, such as the Alabama Black Belt, is needed.

Additionally, the intervention emphasized the importance of physical activity, but many participants expressed concerns about their inability to engage in enough physical activity due to pain. Our previous intervention successfully overcame pain as a barrier to exercise in patients with diabetes with chronic pain, but it did not change glycemic control. Future interventions integrating the successful elements of the Living Well With Diabetes intervention, our past intervention on physical activity, and more emphasis and practical information on healthy eating may prove more effective at achieving glycemic control than would an intervention focused on only 1 of these 3 vital components of successful diabetes management.

Clearly, this study demonstrated the feasibility of training community members to deliver a supportive and well-liked telephone intervention in these communities. It is noteworthy that 40% of our study participants were insulin users, among whom glycemic
control can be more difficult to achieve. Future work building on the findings of the Living Well With Diabetes study are clearly warranted.

Subpopulation Considerations

Although this study was not designed to examine the response to the intervention vs the control in specific subgroups (heterogeneity of treatment effect), several sensitivity analyses were conducted on subgroups based on the timing of data collection and intervention completion, as discussed previously. Although behavioral intervention studies often conduct analyses of individuals who received the full intervention dose, this was not pursued here because so many participants received all 11 sessions of the intervention and so few received less than the full dose of sessions.

Study Limitations

Limitations include the delays in data collection that could impact the HbA₁c findings; our sensitivity analyses suggest that these effects, if present, were not large. The intervention was delivered by community members by telephone, and although we did monitor some of these interactions, we were not able to monitor all interactions, creating the possibility of lapses in intervention fidelity. Greater emphasis and more practical advice on healthy eating may have resulted in a greater impact on HbA₁c. We were unable to assess medication adherence by objective means and therefore had to rely on self-reported adherence. Past studies show that both pharmacy-derived medication adherence measures and self-reported measures are correlated with levels of physiologic measures, but the need to rely only on self-reported adherence is a clear limitation of this study. There was a real possibility that the most nonadherent patients were least likely to enroll in a randomized trial given the deep-rooted mistrust that many area residents have toward the health care system and especially medical research. It is possible that this type of intervention could have the largest effect on such individuals, so that underenrollment of such individuals could dilute the intervention effect observed in this study. This intervention did not engage physicians, because failure to titrate medications would influence physiologic measures. Randomized trials ideally should use blinding where feasible, but this is often not practical in behavioral interventions such as the
one described here. Self-reported measures were used for secondary outcomes and process and program evaluation assessments, which are subject to bias. We conducted this trial in rural Black residents of the Black Belt, possibly limiting generalizability, a limitation counterbalanced by the dire health care and economic needs of the residents of the Black Belt region, especially in light of their historical significance, which we feel warrants research to benefit this population specifically. Finally, participants in this sample were mostly women, possibly limiting generalizability to men.

Future Research/Lessons Learned

This was an intensive intervention with excellent adherence and good fidelity. Even though it did not result in statistically significantly improved clinical outcomes, the intervention did provide evidence that lay members of the community with no previous medical training could be trained as peer coaches and can provide the support and education to change medication self-efficacy and negative beliefs regarding medications, which is a critical first step in improving medication adherence. Because of the multiple and complex influences on clinical outcomes such as HbA1c levels (medication adherence, medication regimen, weight, diet, physical activity), future interventions should more closely link community peer coaches to health care providers for medication titration and place greater emphasis on weight loss, dietary modification, and physical activity. To provide ongoing, timely support for self-management alongside evidence-based care, there have been increasing efforts to integrate lay health workers into health care delivery teams, with varying degrees of integration. Programs range from nurse case manager–community health worker teams93,94 to state agency initiatives that connect patients to community health workers, such as the Clinical-Community Health Worker Initiative, a program of the Mississippi State Department of Health aimed at decreasing heart disease and stroke in the Mississippi Delta region.95 Supervised by a program manager and registered nurses, the community health workers work with patients who are referred from federally qualified health centers and rural clinics, and they offer counseling on healthy behaviors, reduce barriers to health care access, and contact clinical systems in the event of elevated BP readings. Further research is needed to determine optimal strategies for lay health worker supervision and sustainability.
CONCLUSIONS

The Living Well With Diabetes intervention resulted in improved self-reported medication adherence, more accurate beliefs about medications, and increased confidence in medication use self-efficacy. However, it did not result in significant improvements in glycemic control, BP, or LDL-C. Our qualitative research revealed that participants had substantial knowledge deficits and many questions about diabetes, especially about what to eat and how to afford healthy diets, suggesting that more educational resources are needed. We also learned that many individuals experience emotional distress when first diagnosed with diabetes, signaling the importance of empathy when delivering this diagnosis. Last, this study demonstrated the promise of training community members to deliver a telephone-based diabetes medication adherence intervention in this remote area.
REFERENCES


RELATED PUBLICATIONS


ACKNOWLEDGMENTS

Thank you to all of the participants who volunteered for this research study. This project would not have been possible without the work of our community coordinators, Ms Ethel Johnson and Ms Debra Clark, and our community data collector, Ms Sheree Moultry.
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.

For questions, please call the UAB Study Team at (205) 934-7163
Appendix B. Peer Advisor Candidate Screening Form
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 a 10-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 1 2 3 4 5 6 7 8 9 10 very confident

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 1 2 3 4 5 6 7 8 9 10 very easy

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?

<table>
<thead>
<tr>
<th>Community:</th>
<th>Time:</th>
</tr>
</thead>
</table>

- 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

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

16. People who take medicines should stop their treatment for a while every now and again

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

17. Most medicines are addictive

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

18. Natural remedies are safer than medicines

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

19. Medicines do more harm than good

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

20. All medicines are poisons

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

21. Doctors place too much trust on medicines

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

22. If doctors had more time with patients they would prescribe fewer medicines

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>How long did the peer candidate take to complete the task?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the peer candidate have any trouble completing the task? If yes, please provide details.</td>
</tr>
</tbody>
</table>
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’s Program Tools (Client Plan Book), Participant Material (Activity Book),
You will receive the name and study cell phone number of your client from your community coordinator or one of the research team members from 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.*

<table>
<thead>
<tr>
<th>Client name:</th>
<th>Study cell phone number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Notes:</th>
<th>Home number:</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Work number:</th>
</tr>
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<td></td>
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</table>

**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.
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**

<table>
<thead>
<tr>
<th>Dates</th>
<th>Times</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attempt 1</td>
<td></td>
<td>□ no answer / phone busy □ rescheduled □ left message / voicemail □ bad phone number**</td>
</tr>
<tr>
<td>Attempt 2</td>
<td></td>
<td>□ no answer / phone busy □ rescheduled □ left message / voicemail □ bad phone number**</td>
</tr>
<tr>
<td>Attempt 3</td>
<td></td>
<td>□ no answer / phone busy □ rescheduled □ left message / voicemail □ bad phone number**</td>
</tr>
<tr>
<td>Attempt 4</td>
<td></td>
<td>□ no answer / phone busy □ rescheduled □ left message / voicemail □ bad phone number**</td>
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<tr>
<td>Attempt 5</td>
<td></td>
<td>□ no answer / phone busy □ rescheduled □ left message / voicemail □ bad phone number**</td>
</tr>
<tr>
<td>Attempt 6</td>
<td></td>
<td>□ no answer / phone busy □ rescheduled □ left message / voicemail □ bad phone number**</td>
</tr>
<tr>
<td>Attempt 7</td>
<td></td>
<td>□ no answer / phone busy □ rescheduled □ left message / voicemail □ bad phone number**</td>
</tr>
<tr>
<td>Attempt 8</td>
<td></td>
<td>□ no answer / phone busy □ rescheduled □ left message / voicemail □ bad phone number**</td>
</tr>
</tbody>
</table>

**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?

<table>
<thead>
<tr>
<th>Date of Session 1:</th>
<th>Time:</th>
</tr>
</thead>
</table>

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

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?

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 you feel when you first learned you had diabetes?

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 are 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 are 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 has trouble 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 does not have trouble 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.
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.

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!
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.

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**Call Log**

<table>
<thead>
<tr>
<th>Dates</th>
<th>Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attempt 1</td>
<td>![Call Log Details]</td>
</tr>
<tr>
<td>Attempt 2</td>
<td>![Call Log Details]</td>
</tr>
<tr>
<td>Attempt 3</td>
<td>![Call Log Details]</td>
</tr>
<tr>
<td>Attempt 4</td>
<td>![Call Log Details]</td>
</tr>
<tr>
<td>Attempt 5</td>
<td>![Call Log Details]</td>
</tr>
<tr>
<td>Attempt 6</td>
<td>![Call Log Details]</td>
</tr>
<tr>
<td>Attempt 7</td>
<td>![Call Log Details]</td>
</tr>
<tr>
<td>Attempt 8</td>
<td>![Call Log Details]</td>
</tr>
</tbody>
</table>

---

**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:
Greetings

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

☐ 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 bloodstream. 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.*
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?

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?

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?

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?
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, that’s great. Now, give me a minute to total this up.

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:

<table>
<thead>
<tr>
<th>ME</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of second helpings of meat or starch</td>
<td>0</td>
</tr>
<tr>
<td>Number of fruits</td>
<td>3-4</td>
</tr>
<tr>
<td>Number of vegetables</td>
<td>3-4</td>
</tr>
<tr>
<td>Number of sugar-sweetened drinks</td>
<td>0</td>
</tr>
<tr>
<td>Number of desserts</td>
<td>0-1</td>
</tr>
<tr>
<td>Number of servings of fried foods</td>
<td>0</td>
</tr>
</tbody>
</table>
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

[Box containing table with columns: Day 1 (today), Day 2, Day 3, Day 4, Day 5, Day 6, Day 7. Each column has two options: Yes, No.]

Notes:

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 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 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 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 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.

☐ 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.

☐ 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!
**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.

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**Call Log**

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**“All phone numbers provided are disconnected or 8 call attempts made”**

1. Community coordinator notified (note date / time):

   date __________________________ time __________________________

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2. Community coordinator calls back with Next Steps:
Greeting

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

☐ 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?

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?

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 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.
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.

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<thead>
<tr>
<th></th>
<th>Took all my medications?</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>Day 2</td>
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<td>Day 3</td>
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<td>□ Yes □ No</td>
</tr>
<tr>
<td>Day 7</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

☐ 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:
If the 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 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 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.

☐ 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 healthy 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.

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!
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.

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<td>Attempt 7</td>
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<tr>
<td>Attempt 8</td>
</tr>
</tbody>
</table>

“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:
**Greeting**

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

☐ 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.

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.

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.

<table>
<thead>
<tr>
<th>A1c number</th>
<th>What it means</th>
<th>What you should do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 7</td>
<td>Great control</td>
<td>Praise, encourage to keep taking medicine, emphasize if they stop it, A1c will go up</td>
</tr>
<tr>
<td>7-8</td>
<td>OK, not perfect</td>
<td>Review diet, exercise, and whether they are taking medicines right. Reinforce importance of taking medicine.</td>
</tr>
<tr>
<td>8-9</td>
<td>Cause for concern</td>
<td>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.</td>
</tr>
<tr>
<td>9 or higher</td>
<td>Bigger cause for concern</td>
<td>Review diet, exercise, how they are taking medicines. If they are taking medicines correctly, coach them to call the doctor and request more medicine.</td>
</tr>
</tbody>
</table>

☐ 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.
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.

<table>
<thead>
<tr>
<th>Took all my medications?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1 (today)</td>
</tr>
<tr>
<td>Day 2</td>
</tr>
<tr>
<td>Day 3</td>
</tr>
<tr>
<td>Day 4</td>
</tr>
<tr>
<td>Day 5</td>
</tr>
<tr>
<td>Day 6</td>
</tr>
<tr>
<td>Day 7</td>
</tr>
</tbody>
</table>

☐ 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:
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!

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

<table>
<thead>
<tr>
<th>Day 1 (today)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 3</td>
<td></td>
<td></td>
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<tr>
<td>Day 4</td>
<td></td>
<td></td>
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<tr>
<td>Day 5</td>
<td></td>
<td></td>
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<tr>
<td>Day 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
“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

☐ 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 healthy 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!
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.
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?

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

OK, let’s review what we learned last week. 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.

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 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 no 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 MEDICATIONS BUT NOT 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 MEDICATIONS 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.*

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**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 NOT 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.

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.

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

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.

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.
- 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.

- 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].

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<th>Exercise minutes</th>
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<td><strong>Day 1 (today)</strong> minutes</td>
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<td><strong>Day 7</strong> minutes</td>
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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

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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.

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<th>Call Log</th>
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“*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:
**Greeting**

☐ Great, do you have your Activity Book handy?  
*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.*
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.
**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.

<table>
<thead>
<tr>
<th>Day 1 (today)</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 2</td>
<td>☐ Yes</td>
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<tr>
<td>Day 3</td>
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<td>Day 6</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
<tr>
<td>Day 7</td>
<td>☐ Yes</td>
<td>☐ No</td>
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</tbody>
</table>

☐ 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

☐ 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 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.

- 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 not able 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 able 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.

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- **If there were issues with side effects or cost, but not able 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 able 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.

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<th>Notes:</th>
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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 not able 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 able 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 not able 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 able 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:
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:
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 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 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.

<table>
<thead>
<tr>
<th>Call Log</th>
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<tbody>
<tr>
<td>Dates</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>Attempt 1</td>
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<td>Attempt 6</td>
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<tr>
<td>Attempt 7</td>
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<tr>
<td>Attempt 8</td>
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</tbody>
</table>

“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:
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.
☐ 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

<table>
<thead>
<tr>
<th>month</th>
<th>day</th>
<th>year</th>
<th>start time</th>
<th>end time</th>
<th>peer initials</th>
</tr>
</thead>
</table>

Say hello and make sure the client is still okay with speaking for about ten minutes today.
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.

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<table>
<thead>
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<th>Notes</th>
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<tr>
<td></td>
<td></td>
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<td>left message / voicemail</td>
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</tbody>
</table>

"All phone numbers provided are disconnected or 8 call attempts made"

1. Community coordinator notified (note date / time):

<table>
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<th>date</th>
<th>time</th>
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2. Community coordinator calls back with Next Steps:
**Greeting**

- Great, do you have your Activity Book handy? *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 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.
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.

<table>
<thead>
<tr>
<th>Day 1 (today)</th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 2</td>
<td>□ Yes</td>
<td>□ No</td>
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<tr>
<td>Day 3</td>
<td>□ Yes</td>
<td>□ No</td>
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<tr>
<td>Day 4</td>
<td>□ Yes</td>
<td>□ No</td>
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<tr>
<td>Day 5</td>
<td>□ Yes</td>
<td>□ No</td>
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<tr>
<td>Day 6</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Day 7</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

Notes:

☐ 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.

<table>
<thead>
<tr>
<th>Day 1 (today)</th>
<th>□ Yes</th>
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<tr>
<td>Day 2</td>
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<td>Day 3</td>
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<td>Day 4</td>
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<tr>
<td>Day 5</td>
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<td>Day 6</td>
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</tr>
<tr>
<td>Day 7</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

Notes:
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 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 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.

☐ 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].

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Ate healthy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Day 2</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Day 3</td>
<td>□ Yes □ No</td>
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<tr>
<td>Day 4</td>
<td>□ Yes □ No</td>
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<td>Day 5</td>
<td>□ Yes □ No</td>
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<tr>
<td>Day 6</td>
<td>□ Yes □ No</td>
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<tr>
<td>Day 7</td>
<td>□ Yes □ No</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Week 2</th>
<th>Ate healthy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Day 2</td>
<td>□ Yes □ No</td>
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<tr>
<td>Day 3</td>
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<td>Day 4</td>
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<td>Day 6</td>
<td>□ Yes □ No</td>
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<tr>
<td>Day 7</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Day</th>
<th>Exercise minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1 (today)</td>
<td>minutes</td>
</tr>
<tr>
<td>Day 2</td>
<td>minutes</td>
</tr>
<tr>
<td>Day 3</td>
<td>minutes</td>
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<tr>
<td>Day 4</td>
<td>minutes</td>
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<tr>
<td>Day 5</td>
<td>minutes</td>
</tr>
<tr>
<td>Day 6</td>
<td>minutes</td>
</tr>
<tr>
<td>Day 7</td>
<td>minutes</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Day</th>
<th>Exercise minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (today)</td>
<td>minutes</td>
</tr>
<tr>
<td>2</td>
<td>minutes</td>
</tr>
<tr>
<td>3</td>
<td>minutes</td>
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<tr>
<td>4</td>
<td>minutes</td>
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<tr>
<td>5</td>
<td>minutes</td>
</tr>
<tr>
<td>6</td>
<td>minutes</td>
</tr>
<tr>
<td>7</td>
<td>minutes</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>If needed, you can talk with client about the three rules of eating healthy:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>One and Done</strong> – this rule reminds us to avoid second helpings</td>
</tr>
<tr>
<td>2. <strong>Respect the Border</strong> – 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</td>
</tr>
<tr>
<td>3. <strong>Be Sweet On Yourself</strong> – this rule reminds us to eat less fried foods and fats, and drink fewer sugar-sweetened drinks</td>
</tr>
</tbody>
</table>

☐ How about exercise? What have you learned about living a physically active life?

<table>
<thead>
<tr>
<th>If needed, you can talk about the client about the three rules of physical activity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Be Smart, Exercise Your Heart</strong> – this rule reminds us that exercise has many benefits</td>
</tr>
<tr>
<td>2. <strong>Walk Down Your Blood Sugar</strong> – this rule reminds us that walking and other kinds of physical activity can help lower our blood sugar</td>
</tr>
<tr>
<td>3. <strong>Sitting is the New Smoking</strong> – 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</td>
</tr>
</tbody>
</table>

☐ And what have you learned about your diabetes medications and what they can do for you?

<table>
<thead>
<tr>
<th>If needed, you can talk about some of the basics of diabetes medications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>Medications are important for diabetes, but they aren’t perfect</strong> – diabetes progresses, even on medications. So, even if you’re doing everything right, you may eventually need a second or third medication.</td>
</tr>
<tr>
<td>• <strong>However, diabetes progresses much more quickly without medications.</strong> Medications, together with diet and exercise, can prevent or delay complications like stroke, dialysis, heart attack, and amputations.</td>
</tr>
<tr>
<td>• <strong>Side effects can be a problem, but you should discuss with your doctor before stopping.</strong> 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.</td>
</tr>
<tr>
<td>• <strong>Another problem with medications can be how much they cost.</strong> However, there are generic medications for diabetes that work as well as brand-name drugs and cost much less.</td>
</tr>
</tbody>
</table>
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?
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.
☐ 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 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 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!
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.

<table>
<thead>
<tr>
<th>Call Log</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates</td>
</tr>
<tr>
<td>Attempt 1</td>
</tr>
<tr>
<td>Attempt 2</td>
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<tr>
<td>Attempt 3</td>
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<td>Attempt 4</td>
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<td>Attempt 5</td>
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<td>Attempt 6</td>
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<tr>
<td>Attempt 7</td>
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<tr>
<td>Attempt 8</td>
</tr>
</tbody>
</table>

“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:
Check In  --------------------------------------------------------------

☐ 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]  __________/__________/__________  __________/__________  peer initials

  month  day  year  start time  end time
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”

1. Community coordinator notified (note date/time):

   date   time

2. Community coordinator calls back with Next Steps:
**Greeting**

- 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**

1. Community coordinator notified (note date/time):
   - 
   - 

2. Community coordinator calls back with next steps:
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.

<table>
<thead>
<tr>
<th></th>
<th>Day 1 (today)</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
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<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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</table>

Notes:

☐ 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.

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<thead>
<tr>
<th></th>
<th>Day 1 (today)</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
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<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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</tbody>
</table>

Notes:
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.

<table>
<thead>
<tr>
<th>Day 1 (today)</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
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<td>Day 2</td>
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<td>Day 7</td>
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</table>

**Notes:**

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.

<table>
<thead>
<tr>
<th>Day 1 (today)</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>Day 2</td>
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<tr>
<td>Day 7</td>
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</table>

**Notes:**
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:
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 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 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, so what would you like to do over the next four weeks to help you get the most out of your medications?

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.

☐ 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.

☐ 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.

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.

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.

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.

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.

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.

<table>
<thead>
<tr>
<th>Day</th>
<th>Exercise minutes</th>
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<tbody>
<tr>
<td>Day 1</td>
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<td>Day 6</td>
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<tr>
<td>Day 7</td>
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</table>

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].
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 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 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.

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!
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.

```
Call Log

<table>
<thead>
<tr>
<th>Dates</th>
<th>Times</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Attempt 1
- no answer / phone busy
- rescheduled
- left message / voicemail
- bad phone number**

Attempt 2
- no answer / phone busy
- rescheduled
- left message / voicemail
- bad phone number**

Attempt 3
- no answer / phone busy
- rescheduled
- left message / voicemail
- bad phone number**

Attempt 4
- no answer / phone busy
- rescheduled
- left message / voicemail
- bad phone number**

Attempt 5
- no answer / phone busy
- rescheduled
- left message / voicemail
- bad phone number**

Attempt 6
- no answer / phone busy
- rescheduled
- left message / voicemail
- bad phone number**

Attempt 7
- no answer / phone busy
- rescheduled
- left message / voicemail
- bad phone number**

Attempt 8
- no answer / phone busy
- rescheduled
- left message / voicemail
- bad phone number**

---

**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.

---

1. Community coordinator notified (note date/ time):
   - date
   - time

2. Community coordinator calls back with Next Steps:
**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.

- 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.
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:

Table:

<table>
<thead>
<tr>
<th>Day 1 (today)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
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<td>Day 4</td>
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<td>Day 6</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Day 7</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

☐ 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:
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:**

---

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:**
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:
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 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 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.

☐ 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.

☐ 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.

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.

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.

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.

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.

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.

<table>
<thead>
<tr>
<th>Exercise minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1 (today)</td>
</tr>
<tr>
<td>Day 2 minutes</td>
</tr>
<tr>
<td>Day 3 minutes</td>
</tr>
<tr>
<td>Day 4 minutes</td>
</tr>
<tr>
<td>Day 5 minutes</td>
</tr>
<tr>
<td>Day 6 minutes</td>
</tr>
<tr>
<td>Day 7 minutes</td>
</tr>
</tbody>
</table>

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:
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.

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!
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.

<table>
<thead>
<tr>
<th>Call Log</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dates</strong></td>
</tr>
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<tr>
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<tr>
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<tr>
<td>Attempt 6</td>
</tr>
<tr>
<td>Attempt 7</td>
</tr>
<tr>
<td>Attempt 8</td>
</tr>
</tbody>
</table>

“All phone numbers provided are disconnected or 8 call attempts made”

1. Community coordinator notified (note date / time): ___________ ___________

2. Community coordinator calls back with Next Steps: ___________ ___________
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.

☐ 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

1. Community coordinator notified (note date / time):

   date

   time

2. Community coordinator calls back with next steps:
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.

<table>
<thead>
<tr>
<th>Day 1 (today)</th>
<th>Took all my medications?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Day 2</th>
<th>□ Yes □ No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Day 3</th>
<th>□ Yes □ No</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Day 4</th>
<th>□ Yes □ No</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>Day 5</th>
<th>□ Yes □ No</th>
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<table>
<thead>
<tr>
<th>Day 6</th>
<th>□ Yes □ No</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Day 7</th>
<th>□ Yes □ No</th>
</tr>
</thead>
</table>

Notes:

☐ 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.

<table>
<thead>
<tr>
<th>Day 1 (today)</th>
<th>Took all my medications?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Yes □ No</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Day 2</th>
<th>□ Yes □ No</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Day 3</th>
<th>□ Yes □ No</th>
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<table>
<thead>
<tr>
<th>Day 4</th>
<th>□ Yes □ No</th>
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<table>
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<tr>
<th>Day 5</th>
<th>□ Yes □ No</th>
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<table>
<thead>
<tr>
<th>Day 6</th>
<th>□ Yes □ No</th>
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</table>

<table>
<thead>
<tr>
<th>Day 7</th>
<th>□ Yes □ No</th>
</tr>
</thead>
</table>

Notes:
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:

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:
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 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 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.

☐ 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.

☐ 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.

☐ 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.

☐ 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.*

© 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.

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 2<sup>nd</sup> week
  - Evaluated goal after 2<sup>nd</sup> week, did not increase goal for 3<sup>rd</sup> week
  - Evaluated goal after 2<sup>nd</sup> week, increased goal for 3<sup>rd</sup> week

Notes and new exercise goal for 2<sup>nd</sup> 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.

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 3<sup>rd</sup> week
  - Evaluated goal after 3<sup>rd</sup> week, did not increase goal for 4<sup>th</sup> week
  - Evaluated goal after 3<sup>rd</sup> week, increased goal for 4<sup>th</sup> week

Notes and new exercise goal for 2<sup>nd</sup> 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.

<table>
<thead>
<tr>
<th>Day</th>
<th>Exercise minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1 (today)</td>
<td>minutes</td>
</tr>
<tr>
<td>Day 2</td>
<td>minutes</td>
</tr>
<tr>
<td>Day 3</td>
<td>minutes</td>
</tr>
<tr>
<td>Day 4</td>
<td>minutes</td>
</tr>
<tr>
<td>Day 5</td>
<td>minutes</td>
</tr>
<tr>
<td>Day 6</td>
<td>minutes</td>
</tr>
<tr>
<td>Day 7</td>
<td>minutes</td>
</tr>
</tbody>
</table>

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.

☐ 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

<table>
<thead>
<tr>
<th>month</th>
<th>day</th>
<th>year</th>
</tr>
</thead>
</table>

Next appointment date and time in 4 weeks:

<table>
<thead>
<tr>
<th>start time</th>
<th>end time</th>
</tr>
</thead>
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<table>
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<tr>
<th>peer initials</th>
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</thead>
</table>
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.

### Call Log

<table>
<thead>
<tr>
<th>Dates</th>
<th>Times</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attempt 1</td>
<td>□ no answer / phone busy</td>
<td>□ left message / voicemail</td>
</tr>
<tr>
<td></td>
<td>□ rescheduled</td>
<td>□ bad phone number**</td>
</tr>
<tr>
<td>Attempt 2</td>
<td>□ no answer / phone busy</td>
<td>□ left message / voicemail</td>
</tr>
<tr>
<td></td>
<td>□ rescheduled</td>
<td>□ bad phone number**</td>
</tr>
<tr>
<td>Attempt 3</td>
<td>□ no answer / phone busy</td>
<td>□ left message / voicemail</td>
</tr>
<tr>
<td></td>
<td>□ rescheduled</td>
<td>□ bad phone number**</td>
</tr>
<tr>
<td>Attempt 4</td>
<td>□ no answer / phone busy</td>
<td>□ left message / voicemail</td>
</tr>
<tr>
<td></td>
<td>□ rescheduled</td>
<td>□ bad phone number**</td>
</tr>
<tr>
<td>Attempt 5</td>
<td>□ no answer / phone busy</td>
<td>□ left message / voicemail</td>
</tr>
<tr>
<td></td>
<td>□ rescheduled</td>
<td>□ bad phone number**</td>
</tr>
<tr>
<td>Attempt 6</td>
<td>□ no answer / phone busy</td>
<td>□ left message / voicemail</td>
</tr>
<tr>
<td></td>
<td>□ rescheduled</td>
<td>□ bad phone number**</td>
</tr>
<tr>
<td>Attempt 7</td>
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<td>□ left message / voicemail</td>
</tr>
<tr>
<td></td>
<td>□ rescheduled</td>
<td>□ bad phone number**</td>
</tr>
<tr>
<td>Attempt 8</td>
<td>□ no answer / phone busy</td>
<td>□ left message / voicemail</td>
</tr>
<tr>
<td></td>
<td>□ rescheduled</td>
<td>□ bad phone number**</td>
</tr>
</tbody>
</table>

“**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 ___________

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.
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.

☐ 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.

<table>
<thead>
<tr>
<th>Day 1 (today)</th>
<th>Took all my medications?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Day 2</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Day 3</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Day 4</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Day 5</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Day 6</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Day 7</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Day 1 (today)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 2</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Day 3</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Day 4</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Day 5</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Day 6</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Day 7</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### Notes:

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.

<table>
<thead>
<tr>
<th>Day 1 (today)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 2</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Day 3</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Day 4</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Day 5</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Day 6</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Day 7</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### Notes:
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.

<table>
<thead>
<tr>
<th></th>
<th>Took all my medications?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day 1</strong> (today)</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td><strong>Day 2</strong></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td><strong>Day 3</strong></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td><strong>Day 4</strong></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td><strong>Day 5</strong></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td><strong>Day 6</strong></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td><strong>Day 7</strong></td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

Notes:
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 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 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.

☐ 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.

☐ 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.*

☐ 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.*

☐ 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 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.

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.

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:**

<table>
<thead>
<tr>
<th>Day</th>
<th>Exercise minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (today)</td>
<td>minutes</td>
</tr>
<tr>
<td>2</td>
<td>minutes</td>
</tr>
<tr>
<td>3</td>
<td>minutes</td>
</tr>
<tr>
<td>4</td>
<td>minutes</td>
</tr>
<tr>
<td>5</td>
<td>minutes</td>
</tr>
<tr>
<td>6</td>
<td>minutes</td>
</tr>
<tr>
<td>7</td>
<td>minutes</td>
</tr>
</tbody>
</table>
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.*

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 2\textsuperscript{nd} week
  - Evaluated goal after 2\textsuperscript{nd} week, did not increase goal for 3\textsuperscript{rd} week
  - Evaluated goal after 2\textsuperscript{nd} week, increased goal for 3\textsuperscript{rd} week

<table>
<thead>
<tr>
<th>Exercise minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1 (today)</td>
</tr>
<tr>
<td>Day 2</td>
</tr>
<tr>
<td>Day 3</td>
</tr>
<tr>
<td>Day 4</td>
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<tr>
<td>Day 5</td>
</tr>
<tr>
<td>Day 6</td>
</tr>
<tr>
<td>Day 7</td>
</tr>
</tbody>
</table>

Notes and new exercise goal for 2\textsuperscript{nd} 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.*

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 3\textsuperscript{rd} week
  - Evaluated goal after 3\textsuperscript{rd} week, did not increase goal for 4\textsuperscript{th} week
  - Evaluated goal after 3\textsuperscript{rd} week, increased goal for 4\textsuperscript{th} week

<table>
<thead>
<tr>
<th>Exercise minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1 (today)</td>
</tr>
<tr>
<td>Day 2</td>
</tr>
<tr>
<td>Day 3</td>
</tr>
<tr>
<td>Day 4</td>
</tr>
<tr>
<td>Day 5</td>
</tr>
<tr>
<td>Day 6</td>
</tr>
<tr>
<td>Day 7</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Week 4</th>
<th>Exercise minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>minutes</td>
</tr>
<tr>
<td>Day 2</td>
<td>minutes</td>
</tr>
<tr>
<td>Day 3</td>
<td>minutes</td>
</tr>
<tr>
<td>Day 4</td>
<td>minutes</td>
</tr>
<tr>
<td>Day 5</td>
<td>minutes</td>
</tr>
<tr>
<td>Day 6</td>
<td>minutes</td>
</tr>
<tr>
<td>Day 7</td>
<td>minutes</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>month</th>
<th>day</th>
<th>year</th>
<th>start time</th>
<th>end time</th>
<th>peer initials</th>
</tr>
</thead>
</table>
Peer Advisor’s Program Tools
(Client Plan Book)
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### Client A1c, Blood Pressure, and Cholesterol

#### A1C (average blood sugar over three months)

<table>
<thead>
<tr>
<th>Today’s A1c</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7 or Less</td>
<td>Great Control</td>
<td></td>
</tr>
<tr>
<td>7 – 7.9</td>
<td>Okay, not perfect</td>
<td></td>
</tr>
<tr>
<td>8 – 8.9</td>
<td>Cause for concern</td>
<td></td>
</tr>
<tr>
<td>9 or higher</td>
<td>Bigger cause for concern</td>
<td></td>
</tr>
</tbody>
</table>

#### Blood Pressure

<table>
<thead>
<tr>
<th>Today’s Blood Pressure</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 120/80</td>
<td>Normal</td>
<td></td>
</tr>
<tr>
<td>Less than 140/90</td>
<td>Our goal</td>
<td></td>
</tr>
<tr>
<td>140/90 or higher</td>
<td>High-talk to doctor</td>
<td></td>
</tr>
</tbody>
</table>

Take medication for blood pressure?
- Yes-Listed on page 19
- No

#### Cholesterol (LDL Cholesterol)

<table>
<thead>
<tr>
<th>Today’s LDL Cholesterol</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 100</td>
<td>Okay</td>
<td></td>
</tr>
<tr>
<td>100 or higher</td>
<td>High talk to doctor</td>
<td></td>
</tr>
</tbody>
</table>

Take medication for cholesterol?
- Yes-Listed on page 23
- No
Client Long-Term Goals

-----Long-Term Goals-----
<table>
<thead>
<tr>
<th>Diabetes Medication Name</th>
<th>Dose, Frequency, and Other Instructions</th>
<th>Taking as Prescribed?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td>Notes:</td>
</tr>
<tr>
<td>Side effects?</td>
<td>Yes No</td>
<td>Notes:</td>
</tr>
<tr>
<td>If yes, what’s the side effect?</td>
<td></td>
<td>Notes:</td>
</tr>
<tr>
<td>Is the side effect causing missed doses?</td>
<td>Yes No</td>
<td>Notes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
</tr>
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<td>2.</td>
<td></td>
<td>Notes:</td>
</tr>
<tr>
<td>Side effects?</td>
<td>Yes No</td>
<td>Notes:</td>
</tr>
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<td></td>
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</tr>
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### Diabetes Medications – Other Barriers

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<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very often</th>
</tr>
</thead>
<tbody>
<tr>
<td>I just forget to take my diabetes medicine.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I forgot to fill my diabetes prescription in time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I don’t know what dose of my diabetes medicine to take.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I’m not sure exactly what each medicine is for.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>There are too many doses of my diabetes medicine to take each day</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It’s too hard to keep track of what I am supposed to take when.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My diabetes medicine are unpleasant to take.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have heard about side effects from diabetes medicines that I am afraid I might get.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Getting to the pharmacy to pick up my diabetes medicine is difficult.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The pharmacy could not fill my diabetes prescription.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My doctor or nurse forgot to write a new diabetes prescription.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I ran out of diabetes medication before I could call or visit my doctor or nurse.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I don’t have enough time to talk with my doctor or nurse about problems I am having with my diabetes medicines.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>I sometimes forget to ask my doctor or nurse about problems that I am having with my diabetes medicines.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I don’t feel my diabetes medicines are helping me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I just don’t like taking medicines in general.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Taking diabetes medicines makes my health worse.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I sometimes find it hard to ask my doctor or nurse questions about my diabetes medications.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>If my blood sugar is normal in the morning, I don’t take my diabetes medications.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
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## Client Healthy Eating Assessment

*Note: If yesterday was an unusual day (for example, they were traveling), then ask client to think back to the last normal day and what they ate then.*

<table>
<thead>
<tr>
<th></th>
<th>Breakfast</th>
<th>Lunch</th>
<th>Dinner</th>
<th>Snack</th>
<th>Total</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of second helpings of meat or starch</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Number of fruits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3-4</td>
</tr>
<tr>
<td>Number of vegetables</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3-4</td>
</tr>
<tr>
<td>Number of sugar-sweetened drinks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Number of desserts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0-1</td>
</tr>
<tr>
<td>Number of servings of fried foods</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
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## Plan for Healthy Eating

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<th>Date of plan (mm/dd/yy):</th>
</tr>
</thead>
</table>

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):

<table>
<thead>
<tr>
<th>Meal(s) of the day:</th>
<th>Days of the week:</th>
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What client will do instead to get around barrier(s):
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<tr>
<th>Date of plan (mm/dd/yy):</th>
<th>Current exercise (what is it and how much):</th>
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<tbody>
<tr>
<td></td>
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<tr>
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**Plan for Physical Activity (Continued – page 2)**

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<td>Blood Pressure Medication Name</td>
<td>Dose, Frequency, and Other Instructions</td>
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<tr>
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<td>1.</td>
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# Plan for Cholesterol Medicine – Taking Correctly, but Cholesterol Still High

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### Examples of strategies to overcome each medication barrier:

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<tr>
<th>Barrier</th>
<th>Strategy</th>
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<tbody>
<tr>
<td>I just forget to take them:</td>
<td>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</td>
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<tr>
<td>I forgot to fill my prescription in time:</td>
<td>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</td>
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<tr>
<td>I don’t know what dose to take:</td>
<td>Have the client read the label to you and go over how to take it; if needed, call the doctor together to clarify</td>
</tr>
<tr>
<td>I’m not sure exactly what each medicine is for:</td>
<td>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</td>
</tr>
<tr>
<td>There are too many doses to take each day:</td>
<td>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.)</td>
</tr>
<tr>
<td>It’s too hard to keep track of what I am supposed to take when:</td>
<td>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)</td>
</tr>
<tr>
<td>They are unpleasant to take:</td>
<td>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</td>
</tr>
<tr>
<td>I can’t afford them</td>
<td>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</td>
</tr>
<tr>
<td>My medicines make me feel bad or have side effects I don’t like.</td>
<td>Talk to the doctor about cutting back the dose, or switching to a cheaper medicine</td>
</tr>
<tr>
<td>I have heard about side effects that I am afraid I might get</td>
<td>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 medicine</td>
</tr>
<tr>
<td>Issue</td>
<td>Solution</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>medication (ex: eating food with medications)</td>
<td>-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</td>
</tr>
<tr>
<td>11. Getting to the pharmacy to pick them up is difficult</td>
<td>Ask for a 90 day supply, ask a friend or family member for help, plan ahead, use a mail-order pharmacy</td>
</tr>
<tr>
<td>12. The pharmacy could not fill my prescription</td>
<td>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)</td>
</tr>
<tr>
<td>13. My doctor or nurse forgot to write a new prescription</td>
<td>Call the doctor and ask them to phone it in to the pharmacy</td>
</tr>
<tr>
<td>14. I ran out of medication before I could call or visit my doctor or nurse</td>
<td>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</td>
</tr>
</tbody>
</table>
| 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)
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:
Session 1
Introduction to the Living Well with Diabetes Program + Diabetes Basics

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

Many Years

A1c, blood sugar levels
Blood Pressure
Cholesterol
Diet
Exercise

Diabetes

Complications

Brain
Eyes
Heart
Kidney & Bladder
Nerves
Blood Vessels

Living Well With Diabetes

Sheree’s Story
Program Schedule

<table>
<thead>
<tr>
<th>Month</th>
<th>Sessions</th>
</tr>
</thead>
</table>
| 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 |
| 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 |
| 3     | No session this week  
       | Check-in  
       | No session this week  
       | Session 8: Planning for the Future – Part 2 |
| 4     | No session this week  
       | No session this week  
       | No session this week  
       | Session 9: Monitoring Our Progress |
| 5     | No session this week  
       | No session this week  
       | No session this week  
       | Session 10: Monitoring Our Progress |
| 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
☐ I carried out my diabetes medication plan
☐ I watched the Session 2 Video on Healthy Eating 🍎

My next session is:
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

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
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-sweetened beverages

What did I eat in the past day?

<table>
<thead>
<tr>
<th>ME</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of 2nd Helpings of Meat or Starch</td>
<td>0</td>
</tr>
<tr>
<td>Number of Fruits</td>
<td>3 - 4</td>
</tr>
<tr>
<td>Number of Vegetables</td>
<td>3 - 4</td>
</tr>
<tr>
<td>Number of Sugar-Sweetened Drinks</td>
<td>0</td>
</tr>
<tr>
<td>Number of Desserts</td>
<td>0 - 1</td>
</tr>
<tr>
<td>Number of Servings of Fried Foods</td>
<td>0</td>
</tr>
</tbody>
</table>

Some examples of starchy foods are...

- Rice
- Pasta
- Bread
- Potato
- Corn

My Goal Is
This Week’s Homework

<table>
<thead>
<tr>
<th>Day</th>
<th>Took My Diabetes Medications?</th>
<th>Eat Healthy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
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<tr>
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<tr>
<td>Day 6</td>
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<tr>
<td>Day 7</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

☐ I carried out my diabetes medication plan
☐ I carried out my healthy eating plan
☐ I watched the Session 3 Video 🌟

My next session is:

Remember!
Healthy Grocery Shopping at the Dollar Store

• **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.)

### 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!**

### 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 potatoes, 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)

During the summer, check outside for a produce stand. **Fresh fruits and vegetables are much tastier than canned!**

**Whole-wheat bread (even white bread is okay if you eat the correct portion!)**

**Starchy vegetables (like potatoes, 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**

**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.)**
Session 3
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-sweetened beverages

No 2nds today!
Remember the 3 Rules for Physical Activity

**Rule 1**
*Be Smart!*
Exercise Your Heart

**Rule 2**
*Walk down your blood sugar*

**Rule 3**
*Sitting is the New Smoking*

**Feel Better**
Think Better
Live Better

**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

<table>
<thead>
<tr>
<th></th>
<th>Took My Diabetes Medications?</th>
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<th>Exercise Minutes?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1 (today)</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>minutes</td>
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<td>Day 7</td>
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<td>□ Yes □ No</td>
<td>minutes</td>
</tr>
</tbody>
</table>

☐ 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:

Remember!
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

- Be Smart, Exercise Your Heart
- Walk Down Your Blood Sugar
- Sitting is the New Smoking

Recommended: 30 minutes of brisk walking on 5 or more days per week

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 medicines

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.
We all have plans for our future, or occasions we’d like to be part of.

Are my diabetes medicines working for me?

☐ 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:

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

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</tbody>
</table>
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

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.

Diabetes progresses even on medicines.

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
High blood pressure is a chronic disease that develops over years.

**High blood pressure causes**
- Stroke
- Heart Attack
- Dialysis
- Blindness

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**

- **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.

This Week’s Homework

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</tr>
</tbody>
</table>

☐ 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:

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
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

Last Session Review

Important to keep blood pressure and cholesterol under control.

**High blood pressure causes**
- Stroke
- Heart Attack
- Dialysis
- Blindness

**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

**High cholesterol causes**
- Stroke
- Heart Attack

**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 medications

- Work with your doctor to find a pill that works for you!
- **Don’t Just Stop: talk to your doctor!**
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
Homework for the following week

*Try to add more healthy eating and exercise!*

<table>
<thead>
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</tbody>
</table>

- 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:**

[Image of a hand pointing to a box with text: Remember!]

Appendix Page | 247
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

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

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### Week 2

*Try to add more healthy eating and exercise!* 

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**Making Changes in Your Life**

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Appendix Page | 251
**Week 3**
Try to add more healthy eating and exercise!

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Try to add more healthy eating and exercise!

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- ☐ I carried out my diabetes medication plan
- ☐ I carried out my healthy eating plan
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**Call in 2 weeks is:**

**Call in 4 weeks:**
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

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…

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Homework

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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

Homework

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*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

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- ☐ 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:**

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Remember!
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Session 11 Final Session

In Today’s Session

- Review homework
- Continue working on healthy eating, exercise, and taking your medicines as the doctor prescribed

Keep Going On Your Own!

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Appendix D. Recruitment Flyer, Participant Interest Card, Patient Eligibility Screening Script
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!
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  ☐ Mon  ☐ Thurs  ☐ Sat
☐ Afternoons ☐ Tues  ☐ Fri  ☐ Sun
☐ Evenings  ☐ Weds

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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!

<table>
<thead>
<tr>
<th>Community member called UAB</th>
<th>Community member signed and submitted a study interest card</th>
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**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:

**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?
- ☐ Not a good time to talk ➔ When would be a better time to call you?
- ☐ 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.
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:
  - Is someone who lives in your community
  - Was trained by study investigators to help people take care of their diabetes
  - 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?
- 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?
- When you feel better, do you sometimes stop taking your diabetes (or sugar) medicines?
- Sometimes, if you feel worse when you take the diabetes (or sugar) medicines, do you stop taking it?
- Would you like help with taking your diabetes or sugar medicines?

- 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 → 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 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
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  

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  

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  

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  

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?

<table>
<thead>
<tr>
<th>excellent</th>
<th>very good</th>
<th>good</th>
<th>fair</th>
<th>poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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."

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>□</td>
</tr>
</tbody>
</table>

13. Do you smoke cigarettes every day, some days, or not at all?

<table>
<thead>
<tr>
<th>Everyday</th>
<th>Somedays</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>Yes, a lot</th>
<th>Yes, a little</th>
<th>No, not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>Yes, a lot</th>
<th>Yes, a little</th>
<th>No, not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

16. During the past 4 weeks, as a result of your physical health, have you accomplished less than you would like? Yes or no?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>□</td>
</tr>
</tbody>
</table>

17. During the past 4 weeks, as a result of your physical health, were you limited in any kind of work or other activities? Yes or no?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>□</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>□</td>
</tr>
</tbody>
</table>

19. During the past 4 weeks, as a result of any emotional problems, such as feeling depressed or anxious, did you work less carefully than usual? Yes or no?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>□</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>a good bit of the time</th>
<th>Some of the time</th>
<th>a little of the time</th>
<th>none of the time</th>
<th>DK</th>
<th>NA</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

21. During the past 4 weeks, how much of the time have you felt calm and peaceful?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Good bit of the time</th>
<th>Some of the time</th>
<th>Little of the time</th>
<th>None of the time</th>
<th>DK</th>
<th>NA</th>
<th>Ref</th>
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</thead>
<tbody>
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</tr>
</tbody>
</table>

22. During the past 4 weeks, how much of the time did you have a lot of energy?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Good bit of the time</th>
<th>Some of the time</th>
<th>Little of the time</th>
<th>None of the time</th>
<th>DK</th>
<th>NA</th>
<th>Ref</th>
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</thead>
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</tr>
</tbody>
</table>

23. During the past 4 weeks, how much of the time have you felt downhearted and blue?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Good bit of the time</th>
<th>Some of the time</th>
<th>Little of the time</th>
<th>None of the time</th>
<th>DK</th>
<th>NA</th>
<th>Ref</th>
</tr>
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<tbody>
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<td></td>
</tr>
</tbody>
</table>

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)?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Good bit of the time</th>
<th>Some of the time</th>
<th>Little of the time</th>
<th>None of the time</th>
<th>DK</th>
<th>NA</th>
<th>Ref</th>
</tr>
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<tbody>
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</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Number</th>
<th>Statement</th>
<th>Agree to: Not at all</th>
<th>Agree to: Somewhat</th>
<th>Agree to: To a large extent</th>
<th>Agree to: Completely</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>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?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
<tr>
<td>26</td>
<td>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?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
<tr>
<td>27</td>
<td>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?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
<tr>
<td>28</td>
<td>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?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
<tr>
<td>29</td>
<td>My diabetes controls my life. Do you agree with this statement not at all, somewhat agree, agree to a large extent, or completely agree?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
<tr>
<td>30</td>
<td>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?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
<tr>
<td>31</td>
<td>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?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
<tr>
<td>32</td>
<td>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?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
<tr>
<td>33</td>
<td>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?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
<tr>
<td>34</td>
<td>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?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
<tr>
<td>35</td>
<td>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?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
<tr>
<td>36</td>
<td>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?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
<tr>
<td>37</td>
<td>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?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
<tr>
<td>38</td>
<td>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?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
<tr>
<td>39</td>
<td>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?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
<tr>
<td>40</td>
<td>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?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
<tr>
<td>41</td>
<td>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?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
<tr>
<td>42</td>
<td>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?</td>
<td>N</td>
<td>S</td>
<td>T</td>
<td>C</td>
<td>DK Ref</td>
</tr>
</tbody>
</table>

Notes
The next few questions are about prescription medications you take for your diabetes or sugar.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>DK</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>43. Do you ever forget to take your diabetes (or sugar) medicines?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45. When you feel better, do you sometimes stop taking your diabetes medicines?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46. Sometimes, if you feel worse when you take the diabetes medicines, do you stop taking it?</td>
<td>Yes</td>
<td>No</td>
<td>DK</td>
<td>Ref</td>
</tr>
</tbody>
</table>

These questions are about beliefs about medication. For each statement, please tell me if you strongly agree, agree, are neutral, disagree, or strongly disagree.

<table>
<thead>
<tr>
<th>Question</th>
<th>strongly agree</th>
<th>agree</th>
<th>not sure</th>
<th>disagree</th>
<th>strongly disagree</th>
<th>SA</th>
<th>A</th>
<th>NS</th>
<th>D</th>
<th>SD</th>
<th>DK</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>47. My medicine protects me from becoming worse. Do you strongly agree, agree, are not sure, disagree, or strongly disagree?</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48. My health, right now, depends on my medicines. Do you strongly agree, agree, are not sure, disagree, or strongly disagree?</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
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</tr>
<tr>
<td>49. My health in the future depends on my medicine. Do you...</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50. Without my medicine, I would be very ill. Do you...</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
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</tr>
<tr>
<td>51. My life would be impossible without my medicine. Do you...</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
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<tr>
<td>52. I sometimes worry about the long-term effects of my medicine. Do you...</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
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<tr>
<td>53. My medicine is a mystery to me. Do you...</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
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<tr>
<td>54. I sometimes worry about becoming too dependent on my medicine. Do you...</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
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<tr>
<td>55. Having to take medicines worries me. Do you...</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
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<tr>
<td>56. My medicine disrupts my life. Do you...</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
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<tr>
<td>57. Doctors use too many medicines. Do you...</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
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<tr>
<td>58. If doctors had more time with patients, they would prescribe fewer medicines. Do you...</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
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<tr>
<td>59. Doctors place too much trust in medicines. Do you...</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
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<tr>
<td>60. Natural remedies are safer than medicines. Do you...</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
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<tr>
<td>61. Most medicines are addictive. Do you...</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
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<tr>
<td>62. People who take medicines should stop their treatment for a while every now and again. Do you...</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63. Medicines do more harm than good. Do you...</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
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<td></td>
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<tr>
<td>64. All medicines are poisons. Do you...</td>
<td>SA</td>
<td>A</td>
<td>NS</td>
<td>D</td>
<td>SD</td>
<td>DK</td>
<td>Ref</td>
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</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Question</th>
<th>Very often</th>
<th>often</th>
<th>sometimes</th>
<th>rarely</th>
<th>never</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>65. I just forget to take my diabetes medications. Does this statement apply to you very often, often, sometimes, rarely, or never?</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>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?</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>67. I don’t know what dose to take. Does this statement apply to you very often, often, sometimes, rarely, or never?</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>68. I’m not sure exactly what each diabetes medicine is for. Does this apply to you...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>69. There are too many doses to take each day. Does this apply to you...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>70. It’s too hard to keep track of what I am supposed to take when. Does this apply to you...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>71. My diabetes medicines are unpleasant to take. Does this apply to you...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>72. I can’t afford my diabetes medicines. Does this apply to you...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>73. My diabetes medicines make me feel bad or have side effects I don’t like. Does this apply to you...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>74. I have heard about side effects that I am afraid I might get. Does this apply to you...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>75. Getting to the pharmacy to pick up my diabetes medicines is difficult. Does this apply to you...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>76. The pharmacy could not fill my prescription for my diabetes medicines. Does this apply to you...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>77. My doctor or nurse forgot to write a new prescription for my diabetes medicine. Does this apply to you...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>78. I ran out of diabetes medication before I could call or visit my doctor or nurse. Does this apply to you...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>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...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>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...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>81. I don’t feel my diabetes medicines are helping me. Does this apply to you...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>82. I just don’t like taking diabetes medicine in general. Does this apply to you...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>83. Taking diabetes medicines makes my health worse. Does this apply to you...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>84. I sometimes find it hard to ask my doctor or nurse questions about my diabetes medications. Does this apply to you...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
<tr>
<td>85. If my blood sugar is normal in the morning, I don’t take my diabetes medications. Does this apply to you...</td>
<td>VO</td>
<td>O</td>
<td>S</td>
<td>R</td>
<td>N</td>
<td>DK</td>
</tr>
</tbody>
</table>
The next few questions are about all your prescription medications.

<table>
<thead>
<tr>
<th>Question</th>
<th>Confidence Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>86. How confident are you that you can take your medicines correctly <strong>when you take several different medicines each day?</strong> Are you not at all confident, somewhat confident, or very confident?</td>
<td>Not</td>
</tr>
<tr>
<td>87. How confident are you that you can take your medicines correctly <strong>when you take medicines more than once a day?</strong> Are you not at all confident, somewhat confident, or very confident?</td>
<td>Not</td>
</tr>
<tr>
<td>88. How confident are you that you can take your medicines correctly <strong>when you are away from home?</strong> Are you not at all confident, somewhat confident, or very confident?</td>
<td>Not</td>
</tr>
<tr>
<td>89. How confident are you that you can take your medicines correctly <strong>when you have a busy day planned?</strong> Are you not at all confident, somewhat confident, or very confident?</td>
<td>Not</td>
</tr>
<tr>
<td>90. How confident are you that you can take your medicines correctly <strong>when they cause some side effects?</strong> Are you not at all confident, somewhat confident, or very confident?</td>
<td>Not</td>
</tr>
<tr>
<td>91. How confident are you that you can take your medicines correctly <strong>when no one reminds you to take the medicine?</strong> Are you not at all confident, somewhat confident, or very confident?</td>
<td>Not</td>
</tr>
<tr>
<td>92. How confident are you that you can take your medicines correctly <strong>when the schedule to take the medicine is not convenient?</strong> Are you not at all confident, somewhat confident, or very confident?</td>
<td>Not</td>
</tr>
<tr>
<td>93. How confident are you that you can take your medicines correctly <strong>when your normal routine gets messed up?</strong> Are you not at all confident, somewhat confident, or very confident?</td>
<td>Not</td>
</tr>
<tr>
<td>94. How confident are you that you can take your medicines correctly <strong>when you are not sure how to take the medicine?</strong> Are you not at all confident, somewhat confident, or very confident?</td>
<td>Not</td>
</tr>
<tr>
<td>95. How confident are you that you can take your medicines correctly <strong>when you are not sure what time of the day to take your medicine?</strong> Are you not at all confident, somewhat confident, or very confident?</td>
<td>Not</td>
</tr>
<tr>
<td>96. How confident are you that you can take your medicines correctly <strong>when you are feeling sick (like having a cold or the flu)?</strong> Are you not at all confident, somewhat confident, or very confident?</td>
<td>Not</td>
</tr>
<tr>
<td>97. How confident are you that you can take your medicines correctly <strong>when you get a refill of your old medicines and some of the pills look different than usual?</strong> Are you not at all confident, somewhat confident, or very confident?</td>
<td>Not</td>
</tr>
<tr>
<td>98. How confident are you that you can take your medicines correctly <strong>when a doctor changes your medicines?</strong> Are you not at all confident, somewhat confident, or very confident?</td>
<td>Not</td>
</tr>
</tbody>
</table>
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.

100. How many days during the PAST 7 DAYS did you have a second serving at a meal?

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.

102. How many days during the PAST 7 DAYS did you eat 5 or more servings of fruits and vegetables?

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]

104. How many days during the PAST 7 DAYS did you engage in intense physical activity, enough to work up a sweat?

105. How many days during the PAST 7 DAYS have you walked for exercise?

106. How many days during the PAST 7 DAYS did you do other forms of exercise besides walking?

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?

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.

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all confident</th>
<th>Somewhat confident</th>
<th>Very confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
<td>Not</td>
<td>Somewhat</td>
<td>Very</td>
</tr>
<tr>
<td>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?</td>
<td>Not</td>
<td>Somewhat</td>
<td>Very</td>
</tr>
<tr>
<td>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?</td>
<td>Not</td>
<td>Somewhat</td>
<td>Very</td>
</tr>
<tr>
<td>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?</td>
<td>Not</td>
<td>Somewhat</td>
<td>Very</td>
</tr>
<tr>
<td>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?</td>
<td>Not</td>
<td>Somewhat</td>
<td>Very</td>
</tr>
<tr>
<td>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?</td>
<td>Not</td>
<td>Somewhat</td>
<td>Very</td>
</tr>
<tr>
<td>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?</td>
<td>Not</td>
<td>Somewhat</td>
<td>Very</td>
</tr>
<tr>
<td>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?</td>
<td>Not</td>
<td>Somewhat</td>
<td>Very</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Question</th>
<th>Not a problem</th>
<th>Slight problem</th>
<th>Moderate problem</th>
<th>Somewhat serious problem</th>
<th>Serious problem</th>
<th>Very serious problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>116. Feeling overwhelmed by the demands of living with diabetes. Is this...</td>
<td>Not</td>
<td>Slight</td>
<td>Moderate</td>
<td>Somewhat serious</td>
<td>Serious</td>
<td>Very serious</td>
</tr>
<tr>
<td>117. Feeling that I am often failing with my diabetes routine. Is this...</td>
<td>Not</td>
<td>Slight</td>
<td>Moderate</td>
<td>Somewhat serious</td>
<td>Serious</td>
<td>Very serious</td>
</tr>
<tr>
<td>118. Not feeling motivated to keep up my diabetes self-management. Is this...</td>
<td>Not</td>
<td>Slight</td>
<td>Moderate</td>
<td>Somewhat serious</td>
<td>Serious</td>
<td>Very serious</td>
</tr>
<tr>
<td>119. Feeling angry, scared, and/or depressed when I think about living with diabetes. Is this...</td>
<td>Not</td>
<td>Slight</td>
<td>Moderate</td>
<td>Somewhat serious</td>
<td>Serious</td>
<td>Very serious</td>
</tr>
</tbody>
</table>
Over the last 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over the last 2 weeks, you were bothered by having <strong>little interest or pleasure in doing things</strong>? Has this been a problem for you not at all, several days, more than half the days, or nearly every day?</td>
<td>□ 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)</td>
<td>Ref</td>
</tr>
<tr>
<td>Over the last 2 weeks, you were bothered by <strong>feeling down, depressed, or hopeless</strong>? Has this been a problem for you not at all, several days, more than half the days, or nearly every day?</td>
<td>□ 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)</td>
<td>Ref</td>
</tr>
<tr>
<td>Over the last 2 weeks, you were bothered by having <strong>trouble falling or staying asleep, or sleeping too much</strong>? Has this been a problem for you not at all, several days, more than half the days, or nearly every day?</td>
<td>□ 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)</td>
<td>Ref</td>
</tr>
<tr>
<td>Over the last 2 weeks, you were bothered by <strong>feeling tired or having little energy</strong>? Has this been a problem for you not at all, several days, more than half the days, or nearly every day?</td>
<td>□ 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)</td>
<td>Ref</td>
</tr>
<tr>
<td>Over the last 2 weeks, you were bothered by <strong>poor appetite or overeating</strong>? Has this been a problem for you not at all, several days, more than half the days, or nearly every day?</td>
<td>□ 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)</td>
<td>Ref</td>
</tr>
<tr>
<td>Over the last 2 weeks, you were bothered by <strong>feeling bad about yourself, or that you are a failure, or have let yourself or your family down</strong>? Has this been a problem for you not at all, several days, more than half the days, or nearly every day?</td>
<td>□ 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)</td>
<td>Ref</td>
</tr>
<tr>
<td>Over the last 2 weeks, you were bothered by <strong>trouble concentrating on things, such as reading the newspaper or watching television</strong>? Has this been a problem for you not at all, several days, more than half the days, or nearly every day?</td>
<td>□ 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)</td>
<td>Ref</td>
</tr>
<tr>
<td>Over the last 2 weeks, you were bothered by <strong>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</strong>? Has this been a problem for you not at all, several days, more than half the days, or nearly every day?</td>
<td>□ 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)</td>
<td>Ref</td>
</tr>
</tbody>
</table>
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.

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<tr>
<td>128. In the last month, <strong>how often have you been upset because of something that happened unexpectedly?</strong> Have you felt this way never, almost never, sometimes, fairly often, or very often?</td>
<td>Never</td>
<td>Almost never</td>
<td>Sometimes</td>
<td>Fairly often</td>
<td>Very often</td>
<td>DK Ref</td>
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<tr>
<td>129. In the last month, <strong>how often have you felt that you were unable to control the important things in your life?</strong> Have you felt this way never, almost never, sometimes, fairly often, or very often?</td>
<td>Never</td>
<td>Almost never</td>
<td>Sometimes</td>
<td>Fairly often</td>
<td>Very often</td>
<td>DK Ref</td>
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</tr>
<tr>
<td>130. In the last month, <strong>how often have you felt nervous and “stressed”?</strong> Have you felt this way never, almost never, sometimes, fairly often, or very often?</td>
<td>Never</td>
<td>Almost never</td>
<td>Sometimes</td>
<td>Fairly often</td>
<td>Very often</td>
<td>DK Ref</td>
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</tr>
<tr>
<td>131. In the last month, <strong>how often have you felt confident about your ability to handle your personal problems?</strong> Have you felt this way never, almost never, sometimes, fairly often, or very often?</td>
<td>Never</td>
<td>Almost never</td>
<td>Sometimes</td>
<td>Fairly often</td>
<td>Very often</td>
<td>DK Ref</td>
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</tr>
<tr>
<td>132. In the last month, <strong>how often have you felt that things were going your way?</strong> Have you felt this way never, almost never, sometimes, fairly often, or very often?</td>
<td>Never</td>
<td>Almost never</td>
<td>Sometimes</td>
<td>Fairly often</td>
<td>Very often</td>
<td>DK Ref</td>
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</tr>
<tr>
<td>133. In the last month, <strong>how often have you found that you could not cope with all the things that you had to do?</strong> Have you felt this way never, almost never, sometimes, fairly often, or very often?</td>
<td>Never</td>
<td>Almost never</td>
<td>Sometimes</td>
<td>Fairly often</td>
<td>Very often</td>
<td>DK Ref</td>
<td></td>
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</tr>
<tr>
<td>134. In the last month, <strong>how often have you been able to control irritations in your life?</strong> Have you felt this way never, almost never, sometimes, fairly often, or very often?</td>
<td>Never</td>
<td>Almost never</td>
<td>Sometimes</td>
<td>Fairly often</td>
<td>Very often</td>
<td>DK Ref</td>
<td></td>
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</tr>
<tr>
<td>135. In the last month, <strong>how often have you felt that you were on top of things?</strong> Have you felt this way never, almost never, sometimes, fairly often, or very often?</td>
<td>Never</td>
<td>Almost never</td>
<td>Sometimes</td>
<td>Fairly often</td>
<td>Very often</td>
<td>DK Ref</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>136. In the last month, <strong>how often have you been angered because of things that were outside your control?</strong> Have you felt this way never, almost never, sometimes, fairly often, or very often?</td>
<td>Never</td>
<td>Almost never</td>
<td>Sometimes</td>
<td>Fairly often</td>
<td>Very often</td>
<td>DK Ref</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>137. In the last month, <strong>how often have you felt difficulties were piling up so high that you could not overcome them?</strong> Have you felt this way never, almost never, sometimes, fairly often, or very often?</td>
<td>Never</td>
<td>Almost never</td>
<td>Sometimes</td>
<td>Fairly often</td>
<td>Very often</td>
<td>DK Ref</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Little</th>
<th>Moderate amount</th>
<th>Quite a bit</th>
<th>Great Deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
<td>N</td>
<td>L</td>
<td>M</td>
<td>Q</td>
<td>G</td>
</tr>
<tr>
<td>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?</td>
<td>N</td>
<td>L</td>
<td>M</td>
<td>Q</td>
<td>G</td>
</tr>
<tr>
<td>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?</td>
<td>N</td>
<td>L</td>
<td>M</td>
<td>Q</td>
<td>G</td>
</tr>
<tr>
<td>141. Over the past 6 months, to what extent have you had a flexible work schedule that you could adjust to meet your needs?</td>
<td>N</td>
<td>L</td>
<td>M</td>
<td>Q</td>
<td>G</td>
</tr>
<tr>
<td>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)?</td>
<td>N</td>
<td>L</td>
<td>M</td>
<td>Q</td>
<td>G</td>
</tr>
<tr>
<td>143. Over the past 6 months, to what extent have you had control over your job in terms of making decisions and setting priorities?</td>
<td>N</td>
<td>L</td>
<td>M</td>
<td>Q</td>
<td>G</td>
</tr>
</tbody>
</table>

Great. Now I will ask you about your health care.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
<td>Yes</td>
</tr>
<tr>
<td>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?”</td>
<td>□ Yes, only 1</td>
</tr>
<tr>
<td>146. Was there a time in the past 6 months when you needed to see a doctor but could not because of cost?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>□ Within the past 1-3 months</td>
</tr>
<tr>
<td>148. Routine diabetes care checkups:</td>
<td>City:</td>
</tr>
<tr>
<td>149. Emergency care:</td>
<td>City:</td>
</tr>
<tr>
<td>150. Overnight stays in a hospital:</td>
<td>City:</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Question</th>
<th>City:</th>
<th>Miles:</th>
</tr>
</thead>
<tbody>
<tr>
<td>148. Routine diabetes care checkups:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>149. Emergency care:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>150. Overnight stays in a hospital:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For each of the following questions, please tell me on how good you are at doing the following things.

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating Options</th>
</tr>
</thead>
</table>
| 151. How good are you at working with fractions? Are you not good at all, | □ Not good at all  
□ A little good  
□ Somewhat good  
□ Very good  
□ Extremely good |
| a little good, somewhat good, very good, or extremely good?             | DK Ref                                                                        |
| 152. How good are you at working with percentages? Are you not good at | □ Not good at all  
□ A little good  
□ Somewhat good  
□ Very good  
□ Extremely good |
| all, a little good, somewhat good, very good, or extremely good?        | DK Ref                                                                        |
| 153. How good are you at calculating a 15% tip? Are you not good at all, | □ Not good at all  
□ A little good  
□ Somewhat good  
□ Very good  
□ Extremely good |
| a little good, somewhat good, very good, or extremely good?             | DK Ref                                                                        |
| 154. How good are you at figuring out how much a shirt will cost if it | □ Not good at all  
□ A little good  
□ Somewhat good  
□ Very good  
□ Extremely good |
| is 25% off? Are you not good at all, a little good, somewhat good, very | DK Ref                                                                        |
| good, or extremely good?                                              |
| 155. When reading the newspaper, how helpful do you find tables and | □ Never  
□ Rarely  
□ Sometimes  
□ Often  
□ Very often |
| graphs that are parts of a story? Do you find tables and graphs helpful | DK Ref                                                                        |
| never, rarely, sometimes, often, or very often?                        |
| 156. When people tell you the chance of something happening, do you     | □ Always prefer words  
□ Usually prefer words  
□ No preference  
□ Usually prefer numbers  
□ Always prefer numbers |
| prefer that they use words ("it rarely happens") or numbers ("there's a | DK Ref                                                                        |
| 1% chance")? Do you always prefer words, usually prefer words, have no | prefer percentages  
□ Usually prefer percentages  
□ No preference  
□ Usually prefer words  
□ Always prefer words |
| preference, usually prefer numbers, or always prefer numbers?           |
| 157. When you hear a weather forecast, do you prefer predictions using | □ Never  
□ Rarely  
□ Sometimes  
□ Often  
□ Very often |
| percentages (e.g., “there will be a 20% chance of rain today”) or | DK Ref                                                                        |
| predictions using only words (e.g., “there is a small chance of rain   | prefer percentages  
□ Usually prefer percentages  
□ No preference  
□ Usually prefer words  
□ Always prefer words |
| today”)? Do you always prefer percentages, usually prefer percentages, | DK Ref                                                                        |
| have no preference, usually prefer words, or always prefer words?      |
| 158. How often do you find numerical information to be useful? Do you   | □ Never  
□ Rarely  
□ Sometimes  
□ Often  
□ Very often |
| find numerical information useful never, rarely, sometimes, often, or   | DK Ref                                                                        |
| very often?                                                            |

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating Options</th>
</tr>
</thead>
</table>
| 159. Doctors who do medical research only care about what is best for   | Strongly disagree  
Disagree  
Neutral  
Agree  
Strongly agree |
| each patient. Do you strongly disagree, disagree, are neutral, agree,  | DK Ref                                                                        |
| or strongly agree?                                                      |
| 160. Doctors tell their patients everything they need to know about     | Strongly disagree  
Disagree  
Neutral  
Agree  
Strongly agree |
| being in a research study. Do you strongly disagree, disagree, are      | DK Ref                                                                        |
| neutral, agree, or strongly agree?                                      |
| 161. Medical researchers treat people like “guinea pigs”. Do you strongly| Strongly disagree  
Disagree  
Neutral  
Agree  
Strongly agree |
| disagree, disagree, are neutral, agree, or strongly agree?              | DK Ref                                                                        |
| 162. I completely trust doctors who do medical research. Do you strongly| Strongly disagree  
Disagree  
Neutral  
Agree  
Strongly agree |
| disagree, disagree, are neutral, agree, or strongly agree?              | DK Ref                                                                        |
The next questions are about your diabetes.

163. How old were you when you first found out you had diabetes?  
   Age:  
   Year (if needed)  
   DK  
   NA  
   Ref

164. How 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

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, bunions, 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.  
   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?  

[ ] Employed for wages  [ ] Self-employed  [ ] Out of work for 1 year or more  [ ] Out of work for less than 1 year  [ ] Retired  [ ] Unable to work  [ ] A student  [ ] Homemaker  
[ ] Married  [ ] Divorced  [ ] Widowed  [ ] Separated  [ ] Never married  [ ] Living with a partner  

177. Are you married, divorced, widowed, separated, never married, or living with a partner?  

[ ] Employed for wages  [ ] Self-employed  [ ] Out of work for 1 year or more  [ ] Out of work for less than 1 year  

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)  

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 preferred: (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, Consent Form, In-Person Data Collection Form, Health Report Card
Anthropomorphomorphic and Biometric Measurements Protocol

Living Well with Diabetes

Protocol Version 2016-March
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- **Report Card** ................................................................. 27
- **Interpreting the Report Card** ....................................... 29
Introduction

The Living Well with Diabetes Study is a randomized controlled trial enrolling 500 participants in rural Alabama.

Your role 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 activities:

- 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.

Monthly:
   • Inspect cuff and tubing for cracks or tears. If a leak is suspected, 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.

<table>
<thead>
<tr>
<th>Arm Circumference</th>
<th>Cuff Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 - 35.5 cm</td>
<td>9.4 - 14.1 in</td>
</tr>
<tr>
<td>36 - 42 cm</td>
<td>14.2 - 16.5 in</td>
</tr>
<tr>
<td>&gt; 42 cm</td>
<td>&gt; 16.5 in</td>
</tr>
</tbody>
</table>


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:

- WHAS Operations Manual. Section 3.5 Blood Pressure Measurements. 6/18/93.
- 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.


   3.1 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 degrees) 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!).


2.1. 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.
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 and SMPL images]

- Ensure that the monitor is on a level surface.
- Remove the base from the blood collector.

![Remove Base image]

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.

![Dispense sample image]
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

<table>
<thead>
<tr>
<th>Message</th>
<th>Description and Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR 1</td>
<td>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.</td>
</tr>
<tr>
<td>OR 2</td>
<td>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.</td>
</tr>
<tr>
<td>OR 3</td>
<td>The blood sample may have too little A1C, or insufficient blood was collected.*</td>
</tr>
<tr>
<td>OR 4</td>
<td>The blood sample may have too much A1C, or excess blood was collected.*</td>
</tr>
<tr>
<td>OR 5</td>
<td>The Monitor temperature is below 180C (640F). Repeat the test at room temperature.</td>
</tr>
<tr>
<td>OR 6</td>
<td>The Monitor temperature is above 280C (820F). Repeat the test at room temperature.</td>
</tr>
<tr>
<td>&lt;4.0</td>
<td>The %A1C is less than 4%.</td>
</tr>
<tr>
<td>&gt;13.0</td>
<td>The %A1C is greater than 13%.</td>
</tr>
<tr>
<td>QC 2</td>
<td>Occurs when you insert a Test Cartridge that already has sample added to it. Do not remove and reinsert Test Cartridge after adding sample.*</td>
</tr>
<tr>
<td>QC 6</td>
<td>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.</td>
</tr>
<tr>
<td>QC 7</td>
<td>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.</td>
</tr>
<tr>
<td>QC 30-33</td>
<td>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.*</td>
</tr>
<tr>
<td>QC 50-51</td>
<td>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.*</td>
</tr>
<tr>
<td>QC 55-56</td>
<td>All other QC codes</td>
</tr>
<tr>
<td>E1-E99</td>
<td>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.</td>
</tr>
</tbody>
</table>

*Carefully repeat the test using a new Test Cartridge and a new Sample Dilution Kit.

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 measurement.

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

  ![CardioChek Diagram]

  **MEMo Chip Port (a)**
  The MEMo Chip Port is on the top of the analyzer. A lot specific 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 Diagram]

  **MEMo Chip**
  The color-coded MEMo Chip contains the settings for each test. The top of the MEMo Chip has a finger notch. The bottom has a label with the test name and lot number.

- Test Strip

  ![Test Strip Diagram]

  **Ribs that guide the strip into the analyzer**
  **Blood application window**
  **Hold strip by this end**
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.

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.

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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>Err</td>
<td>Weight Mode: unstable weight, begin again</td>
</tr>
<tr>
<td>0_Ld</td>
<td>Weight overload, remove weight immediately</td>
</tr>
<tr>
<td>Lo</td>
<td>Low battery, replace</td>
</tr>
</tbody>
</table>

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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 Horizontal 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 (trigion) 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”.

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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 participant 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)

<table>
<thead>
<tr>
<th>Brought medications</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>81 mg per day or</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>____________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>from memory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insulin</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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 not 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 not know the name of the insulin in their pump.

Types of Insulins, trade name (and generic name)

<table>
<thead>
<tr>
<th>Combination insulins usually taken once or twice per day</th>
<th>Long-acting insulins usually taken one or twice per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Humalin 70/30 (NPH/regular insulin)</td>
<td>- Humalin N (NPH insulin)</td>
</tr>
<tr>
<td>- Humalin 50/50 (NPH/regular insulin)</td>
<td>- Novalin N (NPH insulin)</td>
</tr>
<tr>
<td>- Novolog 70/30 (insulin aspart protamine/insulin aspart)</td>
<td>- Lantus (insulin glargine)</td>
</tr>
<tr>
<td>- Humalog 50/50 (insulin lispro protamine/insulin lispro)</td>
<td>- Levemir (insulin detemir)</td>
</tr>
<tr>
<td>- Humalog 75/25 (insulin lispro protamine/insulin lispro)</td>
<td></td>
</tr>
</tbody>
</table>

Short-acting insulins usually taken several times per day or used in an insulin pump

- Humulin R (regular insulin)
- Novalin R (regular insulin)
- Humalog (insulin lispro)
- Novolog (insulin aspart)
- Apirdra (insulin glulisine)
### Knows the name and frequency, but not the dose

<table>
<thead>
<tr>
<th>medication</th>
<th>dose</th>
<th>frequency</th>
<th>notes</th>
<th>from memory</th>
</tr>
</thead>
<tbody>
<tr>
<td>insulin</td>
<td>70/30</td>
<td>Twice a day</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Knows frequency and dose, but not the name

<table>
<thead>
<tr>
<th>medication</th>
<th>dose</th>
<th>frequency</th>
<th>notes</th>
<th>from memory</th>
</tr>
</thead>
<tbody>
<tr>
<td>insulin</td>
<td>?</td>
<td>10 units</td>
<td>at night</td>
<td></td>
</tr>
<tr>
<td>insulin</td>
<td>?</td>
<td>5 units</td>
<td>with meals</td>
<td></td>
</tr>
</tbody>
</table>

### Only knows dosage

<table>
<thead>
<tr>
<th>medication</th>
<th>dose</th>
<th>frequency</th>
<th>notes</th>
<th>from memory</th>
</tr>
</thead>
<tbody>
<tr>
<td>insulin</td>
<td>?</td>
<td>10 units</td>
<td>?</td>
<td></td>
</tr>
</tbody>
</table>

### Only knows frequency

<table>
<thead>
<tr>
<th>medication</th>
<th>dose</th>
<th>frequency</th>
<th>notes</th>
<th>from memory</th>
</tr>
</thead>
<tbody>
<tr>
<td>insulin</td>
<td>?</td>
<td>twice a day</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Sliding scales

<table>
<thead>
<tr>
<th>medication</th>
<th>dose</th>
<th>frequency</th>
<th>notes</th>
<th>from memory</th>
</tr>
</thead>
<tbody>
<tr>
<td>insulin</td>
<td>Lantus</td>
<td>20 units</td>
<td>every night</td>
<td></td>
</tr>
<tr>
<td>insulin</td>
<td>Novolog</td>
<td>s/s</td>
<td>twice a day</td>
<td></td>
</tr>
<tr>
<td>insulin</td>
<td>Novolog</td>
<td>s/s</td>
<td>as needed</td>
<td></td>
</tr>
</tbody>
</table>

### Insulin pump and doesn’t know the type of insulin

<table>
<thead>
<tr>
<th>medication</th>
<th>dose</th>
<th>frequency</th>
<th>notes</th>
<th>from memory</th>
</tr>
</thead>
<tbody>
<tr>
<td>insulin</td>
<td>?</td>
<td>pump</td>
<td>pump</td>
<td></td>
</tr>
</tbody>
</table>
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
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.

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.
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...

### Report Card

**A1C**
- **Average Sugar Control over the last 3 months**
  - > 9.0: Bigger cause for concern
  - 8.0-8.9: Cause for concern
  - 7.0-7.9: Ok, not perfect
  - Less than 7: Great control

**Blood Pressure**
- 140/90 or higher: High - talk to doctor
- Our Goal: Normal

**Weight**
- Normal (excellent)
- Overweight (may be concerning)
- Obese (take action)

### Living Well

**Diabetes with Cholesterol** (LDL cholesterol or your “bad cholesterol”)
- Less than 140/90
- Less than 120/80
- 100 or higher
- Less than 100: High - talk to doctor

### 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)

### 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.

### Height - Weight Ranges

- **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
- **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”**
  - 120 ≤ 160
  - 161 ≤ 200
  - > 200
- **5’10”- 6’**
  - 130 ≤ 180
  - 181 ≤ 215
  - > 215
- **5’1”- 5’3”**
  - 100 ≤ 135
  - 136 ≤ 160
  - > 160
- **5’4”- 5’6”**
  - 110 ≤ 145
  - 146 ≤ 180
  - > 180

### 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]
  - less than 120. So you don’t need to be doing anything more than what you are already doing.
  - less than 140 is your goal. Keep checking your blood pressure regularly, and if it goes over 140, you should speak with your doctor.
  - 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](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**

<table>
<thead>
<tr>
<th>Participant Name:</th>
<th>UAB IRB Protocol Number: X160301010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research Protocol:</td>
<td>Principal Investigator: Andrea Cherrington, MD MPH</td>
</tr>
<tr>
<td></td>
<td>Sponsor: PCORI</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Signature of participant:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>or participant’s legally authorized representative:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

| Printed Name of participant’s representative: | |
| Relationship to the participant: | |

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In-person Data Collection Form
Living Well Baseline Data Collection Packet

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Report Card & Visit Wrap-up ................................................................................................. 12

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

<table>
<thead>
<tr>
<th>Start Time</th>
<th>End Time</th>
<th>AM or PM</th>
<th>AM or PM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

☐ Select correct cuff size.

<table>
<thead>
<tr>
<th>Arm Circumference</th>
<th>Bladder Size</th>
<th>Cuff selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 – 35.5 cm</td>
<td>Regular / Medium</td>
<td>□</td>
</tr>
<tr>
<td>36 – 42 cm</td>
<td>Large</td>
<td>□</td>
</tr>
<tr>
<td>&gt; 42 cm</td>
<td>Extra large</td>
<td>□</td>
</tr>
</tbody>
</table>

☐ 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

<table>
<thead>
<tr>
<th>Time 1</th>
<th>AM or PM</th>
<th>BP 1</th>
<th>Pulse 1</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>Time 2</th>
<th>AM or PM</th>
<th>BP 2</th>
<th>Pulse 2</th>
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</thead>
<tbody>
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</table>

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.

<table>
<thead>
<tr>
<th>A1c</th>
<th>notes:</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>LDL</th>
<th>notes:</th>
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</table>

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.

![Insert MEMo Chip with finger notch](image)
Step 4: Height and Weight Measurement

- Gather materials - scale, stadiometer, step stool
- Check scale battery and replace if needed, calibrate on yourself

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 measurement. If the measurement is different by .04 cm, repeat both measurements.

<table>
<thead>
<tr>
<th>Height 1</th>
<th>Height 2</th>
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<tbody>
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<td></td>
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<td>CM</td>
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notes:

- not needed.

<table>
<thead>
<tr>
<th>Height 3</th>
<th>Height 4</th>
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<td>CM</td>
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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.

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<thead>
<tr>
<th>Weight 1</th>
<th>Weight 2</th>
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</table>

Notes:

☐weight greater than 400 lbs
☐client needed support / help (specify)

<table>
<thead>
<tr>
<th>Weight 3</th>
<th>Weight 4</th>
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</table>

□ not needed.

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
- No - schedule date/time for phone call:
  - Yes-from list

**Takes a daily aspirin**

- No
- Yes - note the mg per day: _________________mg

<table>
<thead>
<tr>
<th>Insulin Name</th>
<th>Mix (<strong>/</strong>)</th>
<th>Unit (s)</th>
<th># times per day</th>
<th>Total dose (data entry only)</th>
<th>Notes</th>
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**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:**

(PID:__________________)
<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Combination</th>
<th>Freq 1</th>
<th>Freq 2</th>
<th>Dose</th>
<th>Total dose</th>
<th>Notes</th>
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<tbody>
<tr>
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<td># times / day</td>
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</table>

- **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*
<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Combination</th>
<th>Freq 1</th>
<th>Freq 2</th>
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<td># pills taken</td>
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  *(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.**

<table>
<thead>
<tr>
<th>Best Times to Call</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Morning</td>
</tr>
<tr>
<td>☐ Afternoons</td>
</tr>
<tr>
<td>☐ Evenings</td>
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<td>☐ Mon</td>
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<td>☐ Sun</td>
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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
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...

---

**Report Card**

**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: 140/90 or higher

**Cholesterol** (LDL cholesterol or your “bad cholesterol”)
- Okay: Less than 100
- High: 100 or higher

**Weight**
- Normal (excellent)
- Overweight (may be concerning)
- Obese (take action)
Appendix G. Participant Retention Postcards
General Health Education Program Video Fact

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
### 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!
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 in-person study visit.
   - Would you like to schedule this visit and telephone interview today?
     o if no: Okay, I will give you a in 2-3 weeks.
     o 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!
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?  
  o if no: Okay, I will give you a 2-3 weeks.
  o 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!
Appendix H. Appendix Tables
Improving Medication Adherence in Rural Alabama
Andreae LJ, Andreae SJ, Cherrington AL, Richman JS, Safford MM

Appendix H: Appendix Tables

Appendix Table 1. Living Well with Diabetes study participant retention protocol.

<table>
<thead>
<tr>
<th>Mo.</th>
<th>Control Participants</th>
<th>Mo.</th>
<th>Intervention Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Phone Call: Welcome to the study, answer questions</td>
<td>1</td>
<td>No contact</td>
</tr>
<tr>
<td>2</td>
<td>Postcard: Reminder to look at videos</td>
<td>2</td>
<td>Phone Call: answer questions, identify problems, update contact info.</td>
</tr>
<tr>
<td>3</td>
<td>Phone Call: answer questions, identify problems, update contact info.</td>
<td>3</td>
<td>No contact</td>
</tr>
<tr>
<td>4</td>
<td>Postcard: Keep in touch post card</td>
<td>4</td>
<td>No contact</td>
</tr>
<tr>
<td>5</td>
<td>Phone Call: answer questions, identify problems, update contact info.</td>
<td>5</td>
<td>Phone Call: answer questions, identify problems, update contact info.</td>
</tr>
<tr>
<td>6</td>
<td>Postcard: reminder of upcoming data collection</td>
<td>6</td>
<td>No contact</td>
</tr>
</tbody>
</table>

All participants received postcards for birthdays, holiday cards (Thanksgiving, Christmas).

Appendix Table 2. Analytic sample size for each outcome by treatment arm.

<table>
<thead>
<tr>
<th></th>
<th>ALL</th>
<th>Control</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication adherence</td>
<td>404</td>
<td>239</td>
<td>165</td>
</tr>
<tr>
<td>A1c</td>
<td>404</td>
<td>239</td>
<td>165</td>
</tr>
<tr>
<td>Systolic Blood Pressure</td>
<td>401</td>
<td>236</td>
<td>165</td>
</tr>
<tr>
<td>LDL-Cholesterol</td>
<td>328</td>
<td>193</td>
<td>135</td>
</tr>
<tr>
<td>Body mass index</td>
<td>394</td>
<td>235</td>
<td>159</td>
</tr>
<tr>
<td>Health related quality of life</td>
<td>404</td>
<td>239</td>
<td>165</td>
</tr>
</tbody>
</table>

Appendix Table 3. Baseline characteristics of those who completed and who didn’t complete the study.

<table>
<thead>
<tr>
<th></th>
<th>ALL</th>
<th>Completed N=404</th>
<th>Did not complete N=69</th>
<th>( \chi^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age±SD</td>
<td>57.1±11.5</td>
<td>57.2±10.9</td>
<td>56.8±14.3</td>
<td>0.80</td>
</tr>
<tr>
<td>Women, n (%)</td>
<td>371 (78.4)</td>
<td>316 (78.2)</td>
<td>55 (79.7)</td>
<td>0.78</td>
</tr>
<tr>
<td>Race, n (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>428 (90.5)</td>
<td>366 (90.6)</td>
<td>62 (89.9)</td>
<td>0.85</td>
</tr>
<tr>
<td>All others</td>
<td>45 (9.5)</td>
<td>38 (9.4)</td>
<td>7 (10.1)</td>
<td></td>
</tr>
<tr>
<td>Education, n (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;High School</td>
<td>97 (20.6)</td>
<td>85 (21.0)</td>
<td>12 (17.7)</td>
<td>0.81</td>
</tr>
<tr>
<td>High School(^2)</td>
<td>168 (35.6)</td>
<td>143 (35.4)</td>
<td>25 (36.8)</td>
<td></td>
</tr>
<tr>
<td>&gt;High School</td>
<td>207 (43.9)</td>
<td>176 (43.6)</td>
<td>31 (45.6)</td>
<td></td>
</tr>
<tr>
<td>Annual income, n (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$20,000</td>
<td>318 (70.4)</td>
<td>268 (69.3)</td>
<td>50 (79.9)</td>
<td>0.21</td>
</tr>
<tr>
<td>≥$20,000</td>
<td>134 (29.7)</td>
<td>119 (30.8)</td>
<td>15 (23.1)</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married or living with partner</td>
<td>169 (35.8)</td>
<td>147 (36.5)</td>
<td>22 (31.9)</td>
<td>0.46</td>
</tr>
<tr>
<td>Never married, divorced, widowed, or separated</td>
<td>303 (64.2)</td>
<td>256 (63.5)</td>
<td>47 (68.1)</td>
<td></td>
</tr>
<tr>
<td>Employment, n (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed for wages or self-employed</td>
<td>125 (26.6)</td>
<td>107 (26.7)</td>
<td>18 (26.1)</td>
<td>0.92</td>
</tr>
<tr>
<td>Not working (Retired, out of work, homemaker, unable to work)</td>
<td>345 (73.4)</td>
<td>294 (73.3)</td>
<td>51 (73.9)</td>
<td></td>
</tr>
<tr>
<td>Taking Insulin, n (%)</td>
<td>207 (43.8)</td>
<td>177 (43.8)</td>
<td>30 (43.5)</td>
<td>0.96</td>
</tr>
</tbody>
</table>

\(^1\) T-test or \( \chi^2 \) testing between group differences. \(^2\) 12th grade, GED, or High School diploma
### Appendix Table 4. Characteristics of Birmingham area participants versus participants from other areas.

<table>
<thead>
<tr>
<th></th>
<th>ALL N=472</th>
<th>Birmingham participants N=82</th>
<th>Non-Birmingham participants N=390</th>
<th>P^1</th>
</tr>
</thead>
<tbody>
<tr>
<td>N, Mean age±SD</td>
<td>57.1±11.5</td>
<td>55.3±8.8</td>
<td>57±11.9</td>
<td>0.11</td>
</tr>
<tr>
<td>Women, n (%)</td>
<td>371 (78.4)</td>
<td>64 (78.1)</td>
<td>307 (78.5)</td>
<td>0.93</td>
</tr>
<tr>
<td>Race, n (%)</td>
<td></td>
<td></td>
<td></td>
<td>0.001</td>
</tr>
<tr>
<td>African American</td>
<td>428 (90.5)</td>
<td>66 (80.5)</td>
<td>362 (92.6)</td>
<td></td>
</tr>
<tr>
<td>All others</td>
<td>45 (9.5)</td>
<td>16 (19.5)</td>
<td>29 (7.4)</td>
<td></td>
</tr>
<tr>
<td>Education, n (%)</td>
<td></td>
<td></td>
<td></td>
<td>0.31</td>
</tr>
<tr>
<td>&lt;High School</td>
<td>97 (20.6)</td>
<td>12 (14.6)</td>
<td>85 (21.8)</td>
<td></td>
</tr>
<tr>
<td>High School graduate^2</td>
<td>168 (35.6)</td>
<td>33 (40.2)</td>
<td>135 (34.6)</td>
<td></td>
</tr>
<tr>
<td>&gt;High School</td>
<td>207 (43.9)</td>
<td>37 (45.1)</td>
<td>170 (43.6)</td>
<td></td>
</tr>
<tr>
<td>Annual household income, n (%)</td>
<td></td>
<td></td>
<td></td>
<td>0.26</td>
</tr>
<tr>
<td>&lt;$20,000</td>
<td>318 (70.4)</td>
<td>59 (75.6)</td>
<td>259 (69.3)</td>
<td></td>
</tr>
<tr>
<td>≥$20,000</td>
<td>134 (29.7)</td>
<td>19 (24.4)</td>
<td>115 (30.7)</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td>0.03</td>
</tr>
<tr>
<td>Married or living with partner</td>
<td>169 (35.8)</td>
<td>21 (25.6)</td>
<td>148 (38.0)</td>
<td></td>
</tr>
<tr>
<td>Never married, divorced, widowed, or separated</td>
<td>303 (64.2)</td>
<td>61 (74.4)</td>
<td>242 (62.0)</td>
<td></td>
</tr>
<tr>
<td>Employment, n (%)</td>
<td></td>
<td></td>
<td></td>
<td>0.96</td>
</tr>
<tr>
<td>Employed for wages or self-employed</td>
<td>125 (26.6)</td>
<td>22 (26.8)</td>
<td>103 (26.6)</td>
<td></td>
</tr>
<tr>
<td>Not working (retired, out of work, homemaker, unable to work)</td>
<td>345 (73.4)</td>
<td>60 (73.2)</td>
<td>285 (73.5)</td>
<td></td>
</tr>
<tr>
<td>Taking Insulin, n (%)</td>
<td>207 (43.8)</td>
<td>51 (62.2)</td>
<td>156 (40.0)</td>
<td>0.0002</td>
</tr>
</tbody>
</table>

^1T-test or X^2 testing between group differences. ^212th grade, GED, or High School Diploma

### Appendix Table 5. Program satisfaction and program evaluation questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Trial arm</th>
<th>Response Options, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what degree are you satisfied with the Living Well Program?</td>
<td>Control</td>
<td>Extremely satisfied or satisfied: 220 (92.4), 157 (95.2)</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td></td>
</tr>
<tr>
<td>The Living Well staff was helpful and friendly</td>
<td>Control</td>
<td>Strongly agree or agree: 237 (99.6), 164 (99.4)</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td></td>
</tr>
<tr>
<td>Did you discuss the results of your first report card with your doctor?</td>
<td>Control</td>
<td>Yes: 69 (29.0), 60 (36.4)</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td></td>
</tr>
<tr>
<td>Would you be interested in participating in future studies like Living Well?</td>
<td>Control</td>
<td>229 (96.2), 151 (91.5)</td>
</tr>
<tr>
<td></td>
<td>Intervention</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Response Options, n (%)</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Did you use the activity book? If yes, did you find it helpful?</td>
<td>Yes, used it and found it helpful 150 (92.6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes, used it but didn’t find it helpful, no didn’t use it, or declined to answer 12 (7.4)</td>
<td></td>
</tr>
<tr>
<td>Did you watch the program videos?</td>
<td>Yes 160 (98.2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No or declined to answer 3 (1.8)</td>
<td></td>
</tr>
<tr>
<td>Did you watch the program videos: Did you like the videos?</td>
<td>156 (98.1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 (1.9)</td>
<td></td>
</tr>
<tr>
<td>Did you watch the program videos: Did you find the videos helpful?</td>
<td>158 (99.4)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 (0.6)</td>
<td></td>
</tr>
<tr>
<td>In thinking about your overall experience, how much were you helped by</td>
<td>Very much or a lot 144 (88.8)</td>
<td></td>
</tr>
<tr>
<td>working with your peer advisor?</td>
<td>A little, not at all, or declined to answer 18 (11.1)</td>
<td></td>
</tr>
<tr>
<td>How easy was it to reach your peer advisor?</td>
<td>Easy 140 (89.7)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Somewhat easy, neither difficult or easy, somewhat difficult, or declined 16 (10.3)</td>
<td></td>
</tr>
<tr>
<td>Was talking with your peer advisor difficult, somewhat difficult,</td>
<td>147 (91.3)</td>
<td></td>
</tr>
<tr>
<td>neither difficult or easy, somewhat easy, or easy?</td>
<td>14 (8.7)</td>
<td></td>
</tr>
<tr>
<td>If talking with the peer was difficult or somewhat difficult, why do you</td>
<td>1 endorsed “She doesn’t understand my problems”; 1 endorsed “She doesn’t listen”; and 2 declined to answer</td>
<td></td>
</tr>
<tr>
<td>think this was so?</td>
<td>Was the support you received from your peer advisor poor, fair, average, good, or great?</td>
<td>Good or great 148 (91.9)</td>
</tr>
<tr>
<td></td>
<td>Poor, fair, average, don’t know or refused 13 (8.1)</td>
<td></td>
</tr>
<tr>
<td>Did you feel that your peer advisor understood you?</td>
<td>Usually or always 147 (91.9)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Never, sometimes, not sure, don’t know, or refused 13 (8.1)</td>
<td></td>
</tr>
<tr>
<td>How well did your peer advisor know the program?</td>
<td>Very well or fairly well 153 (95.6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not at all, slightly, somewhat, don’t know, or refused 7 (4.4)</td>
<td></td>
</tr>
<tr>
<td>Did you feel that your peer advisor seemed too busy for you?</td>
<td>Never 142 (88.8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Always, most of the time, sometimes, don’t know, or refused 18 (11.3)</td>
<td></td>
</tr>
<tr>
<td>Did you feel comfortable with your peer advisor always, most of the</td>
<td>Always or most of the time 152 (95.0)</td>
<td></td>
</tr>
<tr>
<td>the time, sometimes, or never?</td>
<td>Sometimes, never, don’t know, or refused 8 (5.0)</td>
<td></td>
</tr>
<tr>
<td>Would you recommend your peer advisor to a friend or relative with a</td>
<td>Definitely yes or probably yes 154 (96.3)</td>
<td></td>
</tr>
<tr>
<td>similar health condition?</td>
<td>Definitely not, probably not, not sure, don’t know, or refused 6 (3.7)</td>
<td></td>
</tr>
</tbody>
</table>
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