Peer Support Interventions: Training, Ensuring Competencies, and Intervention Tracking (The Peers for Progress Network)

Society of Behavioral Medicine 33rd Annual Meeting & Scientific Sessions, New Orleans, LA
Wednesday 11th April 2012

Presenters

- Andrea Cherrington, MD, MPH, Assistant Professor, Department of Medicine, University of Alabama, Birmingham
- Tricia Tang, PhD, Associate Professor, Department of Medicine, University of British Columbia
- Guadalupe X. “Suchi” Ayala, PhD, MPH, Professor, Graduate School of Public Health, San Diego State University
Part 1: Setting the Stage
Setting the Stage:  
Part 1

Society of Behavioral Medicine  
April 11, 2012

- Responsive both to the need for/promise of peer support and need for further research  
  (Boothroyd & Fisher, Family Practice 2010 27 Supp 1: i62-68)
- Mission: Accelerate and promote best practices in peer support as a regular part of health, health care, and prevention around the world
- Doing so requires attention to
  - Evidence and evaluation
  - Global networking (knowledge management and exchange)
  - Advocacy and promotion

www.peersforprogress.org
Fourteen research projects were funded to document the contributions of peer support to diabetes management and demonstrate models for peer support programs around the world.
Presenters

• **Andrea Cherrington, MD MPH**, Assistant Professor, Department of Medicine, University of Alabama, Birmingham

• **Tricia Tang, PhD**, Associate Professor, Department of Medicine, University of British Columbia

• **Guadalupe X. “Suchi” Ayala, PhD, MPH**, Professor, Graduate School of Public Health, San Diego State University

Participant Introductions

- Name
- Affiliation
- One thing you want to get out of the seminar
Organization of Seminar

• Brief description of each project
• Training peer leaders
  – Similarities
  – Differences
• Evaluating training outcomes
  – Similarities
  – Differences
• Tracking intervention fidelity
  – Similarities
  – Differences

Learning Objectives

• Identify design features that may differ across peer support programs based on culture and context.
• Describe effective strategies for training peer supporters
• Demonstrate various methods for evaluating training outcomes
• Describe approaches to measure intervention fidelity
Conceptual Issues

- **Standardization by function but not content**
  - Assistance and consultation in applying management plan in daily life
  - Social and emotional support
  - Linkage to clinical care
  - Ongoing support, extended over time

- **Volunteerism**
Where is this research occurring?

See Appendix A for a description of each study.

Chan [Hong Kong]
Oldenburg [Australia]
Simmons: England
Awah [Cameroon]
Uganda: please see Baumann pilot in US
Gagliardino [Argentina]
SYDNEY [Australia]
Sanguanprasit [Thailand]

Seven (7) US-based grantees:
Please see US map

Gagliardino
[Argentina]

Mbanya [Cameroon]
Awah [Cameroon]

SYDNEY [Australia]

Where is this research occurring?

YELLOW = Evaluation Grants (N=8)  AQUA = Pilot Evaluation Grants (N=6)

See Appendix A for a detailed description of each project.

Ayala [San Diego State Univ]
Rotheram-Borus [University of California, Los Angeles; with University of Western Cape and Women for Peace, see South Africa]

Bodenheimer [University of California at San Francisco]

Baumann [University of Wisconsin, with Mulago Hospital - see Uganda]

Baumann [University of Wisconsin, with Mulago Hospital - see Uganda]

Baumann [University of Wisconsin, with Mulago Hospital - see Uganda]

Tang & Heisler [University of Michigan]

Tang & Heisler [University of Michigan]

Tang & Heisler [University of Michigan]

Knox [AAFP National Research Network with Latino Health Access, LA Net, and WellMed]

Rotheram-Borus [University of California, Los Angeles; with University of Western Cape and Women for Peace, see South Africa]

Ayala [San Diego State Univ]

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Encourage
Peer Support for Diabetes

www.peersforprogress.org

Alabama: Dallas, Greene, Perry, Sumter, Wilcox Counties

- Residents: 86,614
- 54% female
- 71.7% are African American
- Median household income $25,563
- 31% residents live below poverty line

<table>
<thead>
<tr>
<th>Peer Advisors</th>
<th>N=35</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age</td>
<td>42 (SD = 15.0)</td>
</tr>
<tr>
<td>Female</td>
<td>91% (32)</td>
</tr>
<tr>
<td>African American race</td>
<td>80% (28)</td>
</tr>
<tr>
<td>Married</td>
<td>46% (16)</td>
</tr>
<tr>
<td>Employed full or part-time</td>
<td>37% (13)</td>
</tr>
<tr>
<td>College Degree</td>
<td>46% (16)</td>
</tr>
<tr>
<td>Good to excellent health</td>
<td>83% (29)</td>
</tr>
</tbody>
</table>
Background

- **Context:** Ypsilanti, Michigan
- **Target population:** African-Americans (primarily Mexican-origin) over 21 years of age recruited using community-based approaches
- **Partnership:** Parkridge Community Center and Ypsilanti Health Center
- Peer supporters are called **peer leaders**
Ypsilanti, Michigan

- Residents: 19,435
- 52% female
- 29% are African American
- 64% 21 years and older
- 23% are married
- Avg. household income $31,322

<table>
<thead>
<tr>
<th>Peer Leaders</th>
<th>N=8</th>
</tr>
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<tbody>
<tr>
<td>Average age</td>
<td>63 (SD = 7.2)</td>
</tr>
<tr>
<td>Female</td>
<td>75% (6)</td>
</tr>
<tr>
<td>Average years since diagnosis</td>
<td>14.3</td>
</tr>
<tr>
<td>College degree</td>
<td>75% (6)</td>
</tr>
<tr>
<td>African American race</td>
<td>100% (8)</td>
</tr>
</tbody>
</table>
Background

- **Context**: Imperial County, California

- **Target population**: Latinos (primarily Mexican-origin) over 18 years of age randomly sampled from a federally-qualified health center

- **Partnership**: Clinicas de Salud del Pueblo, Inc.

- Peer supporters are called **peer leaders** or **lideres** to distinguish from promotores(as)

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**Imperial County, CA, USA**

<table>
<thead>
<tr>
<th></th>
<th>Imperial Co.</th>
<th>California</th>
<th>U.S.</th>
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<tbody>
<tr>
<td>% Latino</td>
<td>72%</td>
<td>32%</td>
<td>13%</td>
</tr>
<tr>
<td>% female</td>
<td>48%</td>
<td>50%</td>
<td>51%</td>
</tr>
<tr>
<td>% over 18 years</td>
<td>69%</td>
<td>63%</td>
<td>74%</td>
</tr>
<tr>
<td>% in poverty</td>
<td>23%</td>
<td>14%</td>
<td>12%</td>
</tr>
<tr>
<td>% linguistically isolated(^1)</td>
<td>68%</td>
<td>40%</td>
<td>18%</td>
</tr>
<tr>
<td>% foreign born</td>
<td>32%</td>
<td>26%</td>
<td>11%</td>
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\(^1\) speak language other than English
Objects of the study are to

1) In Phase I (months 0-8), to perform a qualitative needs assessment with Peer Advisors and health care providers to inform Peer Advisor roles and responsibilities (i.e., the intervention) and Peer Advisor recruitment strategies, curriculum and training; and patient recruitment plans.

2) Also in Phase I, to pilot our collaboratively developed intervention and, based on pilot test results, to recruit and train 67 Peer Advisors for the intervention, link them with participating intervention practices and begin patient recruitment.

3) In Phase II, in partnership with our Diabetes Research Translation Center, community partners and the Peer Advisors, conduct the group randomized implementation trial and evaluate it using the Reach, Effectiveness, Adoption, Implementation, Maintenance (RE-AIM) framework.

The Peer Advisors live in and understand the communities of their clients. They themselves have diabetes or have helped a close friend or family member with day-to-day care. Peer supporters receive 2-day training in motivational training, “SMART” goal setting, diabetes basics, research basics, role-playing, and study forms, and they complete a certification process.

The intervention is delivered one-on-one by telephone, after a face-to-face initial contact. The intervention has 2 phases with additional contact prior to and after a doctor visit. The first phase is the intensive intervention phase, which is initiated with a 1-hour baseline needs assessment that is conducted face-to-face on or shortly after Enrollment Day and followed by weekly telephone contacts for 8 weeks. During maintenance phase, contacts are made monthly. Prior to each doctor visit, the peer advisors makes an additional telephone contact to “raise the BAR on your office visit”. Participants are encouraged to Be prepared, writing down their problems and then Asking and learning at the visit. After the visit, they Reflect together with their peer advisor on the phone about how things went, and collaboratively develop an action plan if problems are identified that were not addressed.

During the baseline needs assessment, peers work with clients to review their diabetes report card and develop a list of areas that the client would like to work on. The peer advisor uses motivational interviewing skills to set a specific, measurable, achievable, realistic, and time-oriented (SMART) goal with the client, and identifies a monitoring plan to track progress. A week later on the phone, the peer advisor checks if there are any identified problems with medications, and then the peer advisor and client together assess progress toward the goal set the previous week, modifying it if needed. If the goal has been met, a new goal can be set.

The peer advisors meet by conference call with the study team weekly during the first 4 weeks after they meet their clients. They also meet in person with their community coordinator monthly for booster sessions, to submit their data collection forms and to receive advice and support on the program.

Data are collected on both participants and peer advisors at baseline, 6 and 12 months.

Project Title:
“ENCOURAGE: Evaluating Community Peer Advisors and Diabetes Outcomes in Rural Alabama”

ENCOURAGE is a group-randomized controlled implementation trial including 400 individuals with diabetes living in Alabama’s impoverished and rural Black Belt area. The 200 participants in the intervention arm will be teamed in groups of 3-5 with a Peer Advisor for one year. Peer advisors will work with their clients primarily over the telephone, at first weekly, and then at least monthly to assist and support their clients in succeeding with day-to-day diabetes management. Peer Advisors will also link their clients into clinical care and community resources.
Design and Methods

Approaches to Implementing Peer Support

- Peer Leader Training will focus on diabetes-related knowledge, strategies (e.g., 5-step empowerment goal setting model) and communication skills
- Intervention consists of a 3-month, theoretically-driven diabetes self-management education (DSME) program (one-on-one sessions, bi-weekly phone calls, appointment preparation) followed by a Peer-Led Empowerment-based Approach to Self-management Efforts in Diabetes (PLEASED): 12-months of ongoing, peer-led diabetes self-management support (DSMS) (weekly sessions based on patients’ priorities, questions, and concerns to build motivation, set goals, draft action plans, problem-solve; follow-up phone calls as needed; matched with at least one “peer buddy” for ongoing support)

Audience and Setting

- African American adults in a community-based setting (Ypsilanti, MI) and Latino adults (Spanish and English-speaking) in a clinic-based setting (Detroit, MI)
- Participants recruited by provider/community organization referral, advertisements in newspapers and flyers, clinic-based computerized databases, invited presentations at churches

Organization: University of Michigan Medical School, Department of Medical Education and Department of Internal Medicine, and the University of Michigan School of Public Health, Department of Health Behavior and Health Education

Principal Investigators: Tricia S. Tang, PhD and Michele Heisler, MD, MPA

Co-Investigators: Robert Anderson, MEd, EdD; Martha Funnell, MS, RN, CDE; John Piette, PhD; Michael Spencer, MSW, PhD; Felix Valbuena, MD (Community Health & Social Services)

Outcome measures include A1c, blood pressure, lipid control, self-management behaviors (Summary of Diabetes Self-Care Activities), quality of life (Diabetes Distress Scale), and reach to and engagement of intended audience (RE-AIM framework)

A program of the American Academy of Family Physicians Foundation and supported by the Eli Lilly and Company Foundation, Inc.
**Organization:** San Diego State University and Clinicas de Salud del Pueblo, Inc.

**Principal Investigators:** Guadalupe X. Ayala, PhD, MPH and John P. Elder, PhD, MPH

**Other Investigators and Key Personnel:** Leticia Ibarra, MPH, Andrea Cherrington, MD, MPH, Mark Snyder, PhD, Afshan N. Baig, MD, Ming Ji, PhD, Lucy Horton, MPH, MS, Humberto Parada, MPH, Erika Hernandez, MPH, MA, Maria Belen Luna, Cecilia Cota,

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### Audience and Setting

- U.S.-Mexico border in California, southern end of agricultural belt
- Adult Mexicans/Mexican-Americans; 23% live in poverty
- 336 patients randomly sampled from Clinicas roster

### Approaches to Implementing Peer Support

- **Peer supporters:** 30 *Lideres*, individuals who were former participants in a diabetes education program; empathetic, warm, and committed; may or may not have diabetes
- **Recruitment and Retention:**
  - Mailed recruitment letters
  - Targeted telephone calls
  - Biannual celebrations; 6 months is larger with community leader involvement
- **10 Training Sessions**
- **Peer Supporter assigned to 6 patients with diabetes:**
  - **Goal:** Help improve diabetes self-management behaviors relevant in multiple contexts (clinic, community, home)
  - **Dose:** Minimum of 8 contacts in first 6 months; less frequent contact in subsequent 6 months
  - **Modes:** Family home visits, support groups, and clinic tours

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### Design and Methods

- Randomized controlled trial with two conditions: peer support vs. usual care
- Data collected at baseline, 6 months, and 12 months
- Measures from medical records: HbA1C, BMI, BP, cholesterol, age of diabetes diagnosis, diabetes medications, hospitalizations, last eye and foot exams, other diagnosed medical conditions
- Measures from survey: medication use/adherence, health care access, health literacy, diabetes self-care, quality of life, acculturation, demographics, other health behaviors
- Process Evaluation to assess: participant engagement, nature of volunteer peer supporters in Latino community, study design using RE-AIM model
Part 2: Training
Peer Training: Where do I start?

• *Step 1:*
  Develop a clear understanding of the peer’s roles and activities.
  – Will they Educate? Facilitate? Counsel?
  – Will they work one-on-one? In groups?
  – Will they be in the community? Clinic?
  – Are peers volunteer or paid?
  – What outcomes are they trying to achieve?
Peer Training: Where do I start?

**Step 2:**
Design training content and structure

– Information - What do they need to know? How much is too much?
– Skills - Communication skills? Setting behavioral goals? Making action plans?
– Teaching methods – activities, role-plays, simulations, sending material to review prior to training?
– Location - Community-based? Clinic-based?
**Peer Advisor Roles, Activities, and Objectives**

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<th>Encourage Peer Advisor will:</th>
<th>Assist:</th>
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<td></td>
<td>by helping people with diabetes do better with day-to-day diabetes management</td>
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<th>Support:</th>
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<tr>
<td>- by encouraging and motivating them,</td>
</tr>
<tr>
<td>- by modeling positive attitudes, beliefs, and behaviors</td>
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<th>Link:</th>
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<tr>
<td>- by helping patients make the most out of their doctor visits,</td>
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<tr>
<td>- by getting patients help from pharmacist, doctor, or nurse when they need it</td>
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<th>Expectations:</th>
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<td>Attend 2 days of training</td>
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| Attend Enrollment Day and meet 5-7 clients |

**Training content & structure**

- Two 8-hour training sessions
- Held in the community
- Based on Adult Learning Theory
  - Interactive sessions
  - Role-play

**www.peersforprogress.org**
Encourage Peer Advisor Training Locations

Trainings 2 & 3

Training 1

1. Introduction to
   Overview of Intervention
   Motivations & Expectations
   Roles & Responsibilities

2. Diabetes Basics
   Types of Diabetes, Diabetes risk factors
   Symptoms of Uncontrolled Diabetes
   Complications of Diabetes
   Hyperglycemia & Hypoglycemia
   ABC’s of Diabetes
   Diabetes Myths (game)

3. Healthy Eating / Lunch
   Introduction to Traffic Light Diet
   Portion Sizes
   Barriers to Healthy Eating

4a. Introduction to SMART Goals
   Setting SMART GOALS
   Long & Short Term Goals
   Communication Skills
   Motivational Interviewing
   Identifying Barriers / Problem Solving
   Role-playing

4b. Physical Exercise & Stress Management
   Stress Management
   Physical Exercise (DVD)
   Needs Assessment
   Homework Assigned

www.peersforprogress.org
Training, Day 2

1a. Communication, Problem Solving, & Setting Goals
   Review Contact Log / Goal
   Review SMART Goal
   Not-So-SMART Goal:
   Do better on my diabetes.

1a. Protocol
   Review Homework, Forms
   Buddy System
   Getting the Most out MD Visit
   Linking to MD, RN, Pharmacist
   Peer Advisor FAQ’s
   Asset Mapping/Community Resources

2. Lunch / Needs Assessment Modeled
   Introduction to Traffic Light Diet
   Portion Sizes
   Barriers to Healthy Eating

3a. Research & Ethics
   Handling Client Information
   Principles that guide ethical research
   Privacy & Confidentiality
   Safety in the Community
   Post Assessment

3b. Certification
   Small Group Certifications

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Program Components

• Knowledge acquisition
  – ADA’s nine core diabetes education topics

• Skills development
  – Active listening
  – 5-step behavioral goal-setting process
  – Making an action plan
  – Empowerment-based facilitation

• Experiential learning
  – Facilitation simulations
  – Playing the role of “peer leaders”
### TABLE 1: INSTRUCTIONAL METHODS

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<th>INSTRUCTIONAL METHOD</th>
<th>PURPOSE</th>
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<tbody>
<tr>
<td>Quizlettes</td>
<td>Reinforce content</td>
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<tr>
<td>Peer Leader simulations</td>
<td>Increase comfort in talking before a group</td>
</tr>
<tr>
<td>Group brainstorming</td>
<td>Practice leading activity to generate ideas, examples or responses</td>
</tr>
<tr>
<td>Group sharing</td>
<td>Practice leading discussion of personal experiences, feelings and thoughts</td>
</tr>
<tr>
<td>Skill building</td>
<td>Effective communication and behavior change skills</td>
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<td>Role-plays</td>
<td>Apply skills learned working in pairs</td>
</tr>
<tr>
<td>Pair and share</td>
<td>Share personal diabetes-related experiences with other participant</td>
</tr>
<tr>
<td>Group facilitation simulations</td>
<td>Practice group facilitation skills</td>
</tr>
<tr>
<td>Lectureettes</td>
<td>Practice presenting content in a short, focused way</td>
</tr>
</tbody>
</table>

---

**SKILL BUILDING:**

**MAKING REFLECTIONS**

This skill involves reflecting back to the person who is speaking what you believe he/she has said in order to verify or clarify your understanding, and to encourage the speaker to continue elaborating on his/her point of view. You can reflect back the content, thoughts, or feelings that the speaker conveys. However, it is most important to focus on the feelings, so the speaker knows you understand his/her emotions.

**Essence of reflections:**

- Statements, not questions
- End with a down turn in your voice
- Don’t worry about getting it perfect – even reflections that are not quite right bring out useful information
- Clarify what was said – “I’m not sure I fully understood what you mean. Let me see if I have this right.”
- Can start with “I hear you saying…” or “It sounds like…” “It seems like…”

**Example:**

**Participant:** Every time I leave the house, I have to remember to take my insulin pen, my meter, and some hard candy just in case I have a low. Having diabetes is a full-time job.

**Peer Leader:** It sounds like you are feeling overwhelmed with all you have to do because of your diabetes.
### Active Listening Observation Scale (ALOS)

<table>
<thead>
<tr>
<th>Items</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Is not distracted during the conversation</td>
<td>□_1</td>
<td>□_2</td>
<td>□_3</td>
<td>□_4</td>
<td>□_5</td>
</tr>
<tr>
<td>b. Is not off-hand, hurried or dismissive</td>
<td>□_1</td>
<td>□_2</td>
<td>□_3</td>
<td>□_4</td>
<td>□_5</td>
</tr>
<tr>
<td>c. Listens attentively</td>
<td>□_1</td>
<td>□_2</td>
<td>□_3</td>
<td>□_4</td>
<td>□_5</td>
</tr>
<tr>
<td>d. Gives patient time and space to present the problem</td>
<td>□_1</td>
<td>□_2</td>
<td>□_3</td>
<td>□_4</td>
<td>□_5</td>
</tr>
<tr>
<td>f. Uses open-ended questions</td>
<td>□_1</td>
<td>□_2</td>
<td>□_3</td>
<td>□_4</td>
<td>□_5</td>
</tr>
<tr>
<td>g. Expresses understanding verbally and non-verbally</td>
<td>□_1</td>
<td>□_2</td>
<td>□_3</td>
<td>□_4</td>
<td>□_5</td>
</tr>
<tr>
<td>h. Makes an effort to state back understanding of what the other is communicating</td>
<td>□_1</td>
<td>□_2</td>
<td>□_3</td>
<td>□_4</td>
<td>□_5</td>
</tr>
<tr>
<td>i. Avoids giving advice or expressing judgments</td>
<td>□_1</td>
<td>□_2</td>
<td>□_3</td>
<td>□_4</td>
<td>□_5</td>
</tr>
</tbody>
</table>
5-step behavioral goal-setting model

Step One: Define the problem
What is the hardest thing about caring for diabetes for you?
Please tell me more about that.
Are there some specific examples you can give me?

Step Two: Recognize your feelings
What are your thoughts about this?
Are you feeling (insert feeling) because (insert meaning)?

Step Three: Choose a goal
What do you want?
How would this situation have to change for you to feel better about it?
What are your options?
What are barriers for you?
What are the costs and benefits for each of your choices?
What would happen if you do not do anything about it?
Let’s develop a plan.

Step Four: Make a plan (I-SMART) to reach your goal
Are you willing to do what you need to do to solve this problem?
How important is it to you on a scale of 1-10?
How confident are you that you will be able to reach this goal?
What are some steps you could take to help you reach this goal?
What are you going to do?
When are you going to do it?

Step Five: Experience and Evaluate the Plan
How did it go?
What did you learn?
What barriers did you encounter?
What, if anything, would you do differently next time?
What will you do when you leave here today?

My I-SMART Diabetes Action Plan

Inspiring - Specific Measurable Achievable Relevant Time-specific

Inspiring:  What is the most important to YOU to work on?
On a scale of 0-10, how important is this to you?

Specific:  What will you do? Where will you do it? When will you do it?

Measurable:  How much will you do? How often will you do it?

Achievable:  What barriers, if any, do you expect to face? How will you overcome these barriers?
On a scale of 0-10, how confident are you that you can complete this specific plan?

Relevant:  How will this step help you achieve your overall goal?

Time-specific:  How long will you do this experiment?
Training goals

Prepare peer leaders (lideres) to provide social support to assigned patients.

Peer support for enactment of diabetes self-management behaviors in a variety of contexts.

Strive for at least 8 contacts in the first 6 months with less frequent contact in subsequent 6 months. Variation in type and frequency of contact is okay.

Support can be provided during home visits, in small groups, and in the clinic. Resources available to provide support by mail and phone.

1. Individual
2. Interpersonal
3. Organizational
4. Community

**Assistance in daily living:**
1: Knowledge and skill building
2: Healthy control of social and physical home environment
4: Problem solve community-level social and physical barriers to management

**Ongoing social and emotional support**
1: Depression and diabetes
2: Eliciting family support
4: Walking and cooking groups

**Linkages and assistance with clinical care AND other resources**
3: Provider communication; facilitate use of clinical resources
4: Resource awareness
**Líder training** (≈ 40 hours\(^a\))

1. Introduction to *Puentes*
2. Introduction to peer support
3. Diabetes and nutrition
4. Diabetes and physical activity
5. Diabetes and emotional health
6. Medical management of diabetes
7. Conducting home visits
8. Conducting clinic visits
9. Conducting support groups
10. Monitoring your support

---

\(^a\)This includes time spent completing a consent form and survey, but does not include booster training since that differed by leader.

---

**Primary trainer**

- Male
- Employed by the clinic
- MD from Mexico
- Bilingual and bicultural
- Trained by project staff
  - and monitored during initial implementation to correct fidelity issues

---

www.peersforprogress.org
Training methods

- Started with an inspirational song
- Interactive
- Manual to standardize content
- Guest speakers
  - to build connections between people and organizations
  - provide skill and knowledge development opportunities

Registered Dietician from hospital.

Leader training manual

- Page 1: Inspirational leader story
- Page 2: Index and session learning objectives
- Page 3: Your motivation
  - Where you are starting?
  - Where are you headed?
  - Reaching your goals.
Boosters trainings and leader support

- Booster training
  - How to conduct a walking group
  - How to conduct a cooking group
  - Motivational interviewing principles

- Biweekly or monthly peer leader group meeting with coordinator

Similarities
Similarities: Content

- Training content reflected similar roles
  - Assist, link, and support
- Included
  - Diabetes basics
  - Communication skills
  - Heavy emphasis on goal setting & problem solving

Similarities: Approach

- All training programs based on principles of Adult Learning
- Used experiential learning and role play
Differences

Differences: Content

• Content differences reflected differences in intended delivery mode and site
  – Depending on whether intervention was to be delivered by telephone, face to face, in group, in the community or in the clinic
  – MI and AL included principles of Motivational Interviewing, SD included personal reflection on individual counseling styles
Differences: Approach

- Most notable differences in the structure of training programs
  - Example: 2 eight hour training sessions VS over 40 hours of training over several weeks
  - Example: Primary Trainer vs Training Team

Lessons Learned
Lessons Learned

• Simplify manuals, emphasize training on behavioral skills outside of the training sessions
• Acquiring new skills takes time, include lots of practice over time
• Plan for evolution of the intervention, increasing intensity
Learning Objectives:

• Discuss diabetes in the African American community.
• Know about the different types of diabetes.
• List risk factors for diabetes.
• Describe signs and symptoms of uncontrolled diabetes.
• Identify complications that can occur from having diabetes.
• List the ABCs of diabetes control (A1c, Blood Pressure, and Cholesterol).
• Discuss why controlling the ABCs is important.
• Steps to achieving healthier ABC levels.
• Describe what people can do to manage diabetes and lower risks for complications.
• Common myths about diabetes.

A SMART Goal:
“Start using a pill box today.”

Not-So-SMART Goal:
“Do better on my diabetes.”

ENCOURAGE your clients to...

• Help themselves - Ask Open-ended questions, Affirm, Reflect, Summarize
• Set “SMART” goals - Specific, Measurable, Achievable, Realistic, Time
• Reach out for help - Other peers, Client family, Doctor, Pharmacist

Remember!
Diabetes in the African American Community:

A Brief Overview

Sometimes it seems as if everyone knows someone who is living with diabetes. This disease is a growing problem in the U.S., even more so in the African American community. More than 1 in 9 African American adults have diabetes. African American adults are twice as likely to have diabetes as non-Hispanic white adults of the same age.¹

African Americans are twice as likely to have diabetes as non-Hispanic Whites of the same age.¹

In the Alabama Black Belt, 1 in 3 adults over the age of 50 has diabetes. Studies show that if diabetes continues to increase at its current rate, 1 in 3 children born in the year 2000 will develop diabetes in their lifetime—unless something changes. For this reason, it is important to learn about diabetes, its symptoms, and how to properly manage the disease.

---

Health Impact of Diabetes*

- 6th leading cause of death
- Risk of death increases 2 times
- Life expectancy decreases 5-10 years
- Risk of heart disease increases 2-4 times
- Risk of stroke increases 2-4 times
- Neuropathy in 60-70% of patients
- Hypertension in 73% of patients
- Nerve damage in 60-70% of patients
- Most common cause of renal failure

The Different Types of Diabetes

Diabetes is a disease in which the body does not produce insulin and/or does not use it properly.

Insulin is a hormone made by a gland called the pancreas. When a person digests food, glucose (or sugar) is produced as a basic fuel for cells of the body. The purpose of insulin is to help the sugar move from the blood into the cells.

When a person without diabetes digests food, the pancreas produces the right amount of insulin to move sugar from the blood into the cells. In people with diabetes, however, either the pancreas produces little or no insulin, or the cells of the body do not use the insulin correctly. When sugar can not get into the cells, it builds up in the blood. A person’s blood glucose (sugar) level then becomes too high, and the result is pre-diabetes or diabetes.

There is no single cause of diabetes; many factors play a role. There are several different types of diabetes.

notes:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
### The Different Types of Diabetes

#### Type 1 Diabetes

Type 1 diabetes most often occurs in people younger than 30 years and must be controlled by injecting insulin or by using an insulin pump. There is no known cause of type 1 diabetes. Currently, there is no way to prevent it. In type 1 diabetes, the body does not produce insulin.

#### Type 2 Diabetes

In type 2 diabetes, either the body does not produce enough insulin or the cells do not use the insulin properly (they are “insulin resistant”). Type 2 diabetes is the most common form of diabetes. It can occur at any age, even during childhood. Type 2 diabetes occurs most often in people who do not exercise and are overweight. Type 2 diabetes can be controlled through losing weight and exercising regularly, but in addition to watching what they eat and exercising, most people with type 2 diabetes also take pills or insulin.

#### Gestational Diabetes

Gestational diabetes is a type of diabetes that can happen during pregnancy in women. Women who have had gestational diabetes also have a much higher chance of getting type 2 diabetes later in life. The child is also at increased risk for developing type 2 diabetes. Both mother and child can reduce this risk by exercising and by healthy eating to lose weight or to avoid becoming overweight. The ENCOURAGE Project will not include people with this kind of diabetes, because their treatment is very different than for type 1 or type 2 diabetes.

---

**Notes:**
Risk Factors for Diabetes

While there are many individuals who have diabetes, there are some people that are more likely to develop the disease than others. Risk factors include:

- Family members with diabetes (blood relative)
- Older age (type 2 diabetes is more common as people get older. About 1 in 10 people over age 20 years have diabetes but for people aged 60 and older, 1 in 5 has diabetes)

If you, a family member, or friend has one or more of these risk factors, make sure you talk to your doctor. He or she can monitor your health and together you may be able to prevent this disease.

- Being overweight or obese
- Sedentary lifestyle (not much physical activity)
- History of diabetes during pregnancy
- Being African American, Hispanic/Latino, American Indian/Alaska Native, or Asian American and Pacific Islander.

How Do We Get Diabetes?

too little exercise  →  increasing weight  →  too little exercise  →  Type 2 Diabetes

DNA / genes

over eating  →  slightly too much sugar  →  over eating

YEARS
Common Symptoms of Diabetes

It can be difficult to diagnosis diabetes. A blood test is the best way to determine for sure. But, there are certain symptoms that indicate that you may have or be developing diabetes. These symptoms are present when the blood sugar is high. They can include:

- Frequent urination
- Excessive thirst
- Dry mouth
- Blurred vision
- Dizziness or lightheadedness
- Tingling or numbness in hands and feet
- Tiredness
- Sores that are slow to heal or will not heal
- Change in weight (i.e., weight loss)
- Persistent vaginal yeast infection
- More skin infections than usual

While these are common symptoms for diabetes, there are some people with the disease who experience NO symptoms at all. In fact, on average, when they are diagnosed, most people with diabetes have had the disease for 8-10 years, but didn't know it. That is why it is very important to have regular check-ups with your doctor, especially if you have a family history of diabetes.

notes:

________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________
Complications from Diabetes

While these are common symptoms for diabetes, there are some people with the disease who experience NO symptoms at all. In fact, on average, when they are diagnosed, most people with diabetes have had the disease for 8-10 years, but didn’t know it. That is why it is very important to have regular check-ups with your doctor, especially if you have a family history of diabetes.

• **Eye problems**: glaucoma, blurry vision, retinal bleeding, blindness

• **Kidney problems**: protein, ketones, and sugar in the urine, and dialysis or kidney transplant

• **Nerve damage**: including numbness of the hands and feet

• **Gut problems**: constipation, diarrhea, problems with digestion

• **Emotional problems**: depression, anxiety, feeling overwhelmed

• **Infection problems**: frequent vaginal yeast infections, wounds are slow to heal, urinary tract infections

• **Foot problems**: numbness in the feet can lead to injuries and slow healing wounds can lead to amputations

• **Heart and blood vessel disease**: including stroke and heart attack

• **Periodontal (gum) disease**

• **Impotence**
Emergencies related to Diabetes

Hyperglycemia  Hyperglycemia is high blood sugar. When hyperglycemia is extreme, it can be a medical emergency. This can be caused by failure to take one’s medication, or getting sick unrelated to diabetes. This can be life threatening if not addressed. Symptoms include:

• Tiredness
• Thirst
• Frequent urination
• Fruity-smelling breath
• Coma and death (if left untreated)

Hyperglycemia can be prevented by proper diet, physical activity, and medication. Regular blood glucose tests and doctors visits are recommended for proper management of diabetes.

Regular blood glucose tests and doctors visits are recommended for proper management of diabetes.

Hypoglycemia  Hypoglycemia is low blood sugar and occurs when the sugar in the blood is below normal. Too much insulin, too little food, or too much activity without adjusting medications can cause hypoglycemia. Severe hypoglycemia can cause a coma and brain damage. Symptoms of severe hypoglycemia include:

• Trembling of hands
• Dizziness
• Sweating
• Hunger
• Headache
• Confusion
• Coma and death (if left untreated)

A person suffering from a hypoglycemic crisis needs to drink or eat something right away. If nothing else is available, orange juice, glucose tablets or candy are acceptable. Hypoglycemia can be prevented by not skipping meals after taking diabetes medications.
What happens if I get sick?

Sick day management is an important part of diabetes management. When you feel sick, you often don’t eat the same as when you feel well. If you have diabetes, this can make your blood sugar control change as well.

The main goal of sick day management is to avoid hypoglycemia, or, for type 1 diabetes patients, to avoid ketoacidosis.

Encourage your clients to talk to their doctor about their sick day program (see Chapter 7 on tips for how to get the most out of the doctor visit). Some patients will be advised to cut their medicine doses in half, or to continue their insulin, but at a different dose. If your client has a home monitor available, it is wise to check their sugar more frequently. Eating frequent small meals or snacks, and drinking plenty of liquids is wise. If they have nausea or vomiting, diet ginger ale may be a good choice.

Encourage your clients to write their sick day program down so they don’t forget.

If you have diabetes, take a moment to write down your sick day program, so you feel comfortable helping your clients to write down theirs.

My sick day program:
Oral care includes prevention of both common oral diseases, tooth decay and periodontal (gum) diseases.

_Dental and oral care is particularly important for people with diabetes because they face a higher than normal risk of oral health problems due to poorly controlled blood sugars. The less well-controlled the blood sugar, the more likely oral health problems will arise._

- **Common signs of oral problems:**
  - Dry mouth
  - Gum swelling, soreness or redness
  - Oral sores that heal slowly
  - “Thrush” — yeast infection of the mouth

- **Day-to-Day Oral Health Care Tips**
  - Have your teeth and gums cleaned and checked by your dentist twice a year. (Your dentist may recommend more frequent visits depending upon your condition.)
  - Prevent plaque buildup on teeth by using dental floss at least once a day.
  - Brush your teeth after every meal. Use a soft-bristled toothbrush.
  - If you wear dentures, remove them and clean them daily.
  - If you smoke, talk to your doctor about ways to quit.
There are steps you can take to avoid eye problems.

- **First and most important, keep your blood sugar levels under the numbers set by your health care provider.**

- **Second, bring high blood pressure under control.** High blood pressure can make eye problems worse.

- **Third, if you smoke, quit!**

- **Fourth, see your eye care professional at least once a year for a dilated eye exam.** An optometrist or ophthalmologist can do this exam.

- **Fifth, see your eye care professional if -**
  - your vision becomes blurry
  - you have trouble reading signs or books
  - you see double
  - one or both of your eyes hurt
  - your eyes get red and stay that way
  - you feel pressure in your eye
  - you see spots or floaters
  - straight lines do not look straight
  - you can’t see things at the side as you used to
• **Examine your feet EVERY DAY with a hand mirror to:**
  - Look for cuts, sores, blisters, redness, and callous, etc.
  - If you have anything of that nature, and it doesn’t heal in a day or two, notify your healthcare provider.
  - If you have trouble seeing or reaching your feet, ask someone to help, or use a mirror to help you see better.

• **Wash your feet EVERY DAY with lukewarm water and mild soap.**
  - Dry them carefully and thoroughly with a soft towel.
  - Dust your feet with talcum powder, (avoid powder between toes) to help keep them dry.
  - Don’t soak your feet- this will make your skin too dry.

• **DON’T use lotion or cream between your toes, as this can lead to infection.**
  - If you have dry skin on your feet, use a moisturizer to prevent cracking, especially on the heels. Petroleum jelly works best on the heels.
  - Use a pumice stone or file to smooth calluses or corns.

• **If you have corns or calluses, DO NOT cut them, don’t use corn plasters or liquid corn and callus removers.**

• **Keep your toenails trimmed using a toenail clipper after you have washed and dried your feet.**
  - Trim the nails following the shape of your toes, and smooth them with an emery board or nail file. Don’t cut into the corners of the nail, which could trigger an ingrown toenail.
  - If your nails are very thick or yellowed, have a foot care specialist trim them.

• **Don’t go barefoot - not even indoors.**
  - Always wear socks, stockings, or nylons with your shoes to help avoid blisters and sores.
  - Choose soft socks made of cotton, wool, or a cotton-polyester blend, which will help keep your feet dry.
  - Avoid mended socks or those with seams, which can rub to cause blisters.
  - Avoid wearing socks or hose that are too tight around your legs. Knee-high or thigh-high stockings as well as elasticized men’s dress socks can constrict circulation to your legs and feet.
Monitoring Blood Sugar at Home

Why do people with diabetes need to monitor their blood sugar?
Monitoring your blood sugar (also called glucose) level can help you take better care of your diabetes. Checking your blood sugar will help you learn how food, activity levels, stress, medicine and insulin change your blood sugar level. This information will help you stay healthy and prevent or delay the complications related to diabetes such as blindness and kidney failure.

Always write down your levels, the time you checked it, and when your last meal was.

How often should I check my blood sugar level?
It is important to monitor your blood sugar as your doctor or nurse recommends. Some people with diabetes don’t need to monitor, others should. Ask your healthcare provider how often you should check your blood sugar level and at what time of day. If they recommend you do monitor at home, many people start by checking their blood sugar 2 times a day: before breakfast and before supper.

After a few weeks, some people are able to measure their blood sugar level only 2 or 3 times a week.

If you wake up in the middle of a night and do not feel well, having nightmares or restlessness at around 2 or 3 AM, check your blood sugar. These feelings and events may be signs that your sugar is abnormal.

Checking your blood sugar at different times of the day can help your healthcare provider understand how your diabetes medication is working. Checking both before a meal and 2 hours after a meal may provide you with helpful information.
How to Measure Your Blood Sugar Level

Follow your healthcare provider’s advice and the instructions that come with your glucose meter. In general, you will follow the steps below. Different glucose meters work differently, so be sure to check with your healthcare provider for advice specifically for you.

1. Wash your hands and dry them well before doing the test.

2. Use an alcohol pad to clean the area that you’re going to prick. With many glucose meters, you get a drop of blood from your fingertip. However, with some meters, you can also use your forearm, thigh or the fleshy part of your hand. Ask your doctor what area you should use with your meter.

3. Prick yourself with a sterile lancet to get a drop of blood. (If you prick your fingertip, it may be easier and less painful to prick it on one side, not on the pad.)

4. Place the drop of blood on the test strip.

5. Follow the instructions for inserting the test strip into the glucose meter.

6. The meter will give you a number for your blood sugar level.

What if I can’t get a drop of blood?
If you get blood from your fingertip, try washing your hands in hot water to get the blood flowing. Then dangle your hand below your heart for a minute. Prick your finger quickly and then put your hand back down below your heart. You might also try slowly squeezing the finger from the base to the tip.

What do I do with the results?
Write down the results in a record book. You can use a small notebook or ask your doctor for a blood testing record book. You may also want to keep track of what you have eaten, when you took medicine or insulin, and how active you have been during the day. This will help you see how these things affect your blood sugar. Talk with your healthcare provider about what is a good range for your blood sugar level and what to do if your blood sugar is not within that range.
If you have diabetes, take control of your health by knowing your ABCs. What do we mean by knowing your ABCs? **We mean knowing and controlling your A1c level, your Blood pressure level, and your Cholesterol.** Maintaining good levels of your A1c, blood pressure, and cholesterol is essential for remaining healthy if you have diabetes.

**A is for A1c**  
The A1c test—short for hemoglobin A1c—measures your average blood glucose level over the past 3 months. It is the best test to tell you how you are doing in controlling your blood glucose levels. High blood glucose levels can harm your kidneys, feet, heart, nerves and eyes. The numbers are usually between 5 and 12. Normal is 6.4 or below. When the A1c goes over 7, it is often time to take action. A1c target for most people with diabetes: less than 7.

**B is for Blood Pressure**  
High blood pressure makes your heart work too hard. The suggested target for your blood pressure is below 130/80 (130 over 80). High blood pressure and diabetes are a bad combination, increasing your risk for stroke and heart attacks and kidney damage. That’s why the blood pressure goal for people with diabetes is lower than that for people without diabetes. Blood pressure target for most people with diabetes: less than 130 over 80.

**C is for Cholesterol**  
Bad cholesterol, or LDL, builds up and clogs your arteries. The suggested target for your LDL level is below 100. Eating a diet high in animal or saturated fats (fats that are usually solid at room temperature) can lead to a build-up of bad cholesterol (LDL), which can clog your arteries and cause heart disease. If you have heart disease and diabetes, an even lower LDL may be wise. Diabetes and high cholesterol are a ‘double whammy’ for the heart and blood vessels. Ask your doctor what your LDL should be. LDL target for most people with diabetes: 100 or less.

**Keeping track of your “numbers” is important in maintaining health. You should ask your doctor to discuss your ABC’s with you at every visit. Know your targets!**
Target Numbers

\[ \text{A}1\text{c} = \text{less then 7.0} \]

\[ \text{Blood Pressure} = \text{less than 130/80} \]

\[ \text{Cholesterol} = \text{less than 100} \]

Maintaining Good ABC Levels

Controlling your A1C, blood pressure, and cholesterol and maintaining them at good levels is an extremely important step in managing diabetes. There are ways to keep all three healthy:

- Eat right! (see Chapter 4)
- Limit portion sizes—eat less
- Eat more fruits and vegetables
- Eat less meat and fats
- Be physically active (see Chapter 5)
- Take medications as prescribed by your doctor
- Check blood glucose levels (sugar levels) as directed by your doctor

The ABCs of Diabetes:

A1C, Blood Pressure, and Cholesterol are the key to controlling diabetes.

notes:
Your clients will receive a diabetes report card with their ABC’s.

There are some things you can do to reduce the health risk of diabetes. The numbers inside can give you an idea of how you are doing.

- **A1C**
  - Excellent: < 6.0
  - Good: 6.0 → 6.9
  - Concerning: 7.0 → 8.0
  - Take Action: > 8.0

- **Blood Pressure**
  - Excellent: < 130/80
  - Concerning: 130/80 → 140/90
  - Take Action: > 140/90

- **Cholesterol**
  - LDL Cholesterol (Bad Cholesterol)
    - Excellent: < 100
    - Good: 100 → 129
    - Concerning: 130 → 160
    - Take Action: > 160

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

You may want to talk to your doctor about...
Diabetes Basics

Diabetes Myths Uncovered

While diabetes is a serious disease and can lead to big complications if left untreated, it is an illness that can be managed and controlled. It is important to have correct information to fully understand diabetes and its management. Below are common myths or incorrect information about diabetes.

Share what you learn with others. It can save their lives.

Myth #1  You can catch diabetes from someone else. No. Although we don’t know exactly why some people develop diabetes, we know diabetes is not contagious. It can’t be caught like a cold or flu. There seems to be some genetic link in diabetes, particularly type 2 diabetes. Lifestyle factors also play a part.

Myth #2  People with diabetes should eat special “diabetic” foods. No. A healthy meal plan is the same for everyone, with or without diabetes. The single most important message is – don’t overeat! A low fat diet with lots of fresh fruits and vegetables and infrequent meats and fats is good for all of us. Diabetic and “dietetic” versions of sugar-containing foods are still not good for you. They still raise blood glucose levels, are usually more expensive and can also have a laxative effect if they contain sugar alcohols such as sorbitol. The most important point is not to eat too much, no matter what it is.

Myth #3  People with diabetes can never eat sweets or chocolate. Well, may be not “never”. People with diabetes can occasionally eat small amounts of sweets and desserts as a part of a healthy meal plan. Although these foods can be eaten in small amounts, they should not be eaten too often and should be combined with exercise.

Myth #4  Eating too much sugar causes diabetes. No. Diabetes is caused by a combination of genetic and lifestyle factors, such as overeating, being overweight or obese, and not exercising. Being overweight increases your risk for developing type 2 diabetes and eating too much sugar leads to being overweight!
Myth #5  **Fruit is a healthy food. Therefore, it is okay to eat as much of it as you wish.** Yes and no. While fruit is definitely healthy, fruit contains a type of sugar. The sweeter the fruit, the more you should avoid eating it in large quantities. Especially important is to avoid drinking fruit juices. They have a lot of calories and you should choose water instead.

Myth #6  **If you have diabetes, you should only eat small amounts of starchy foods, such as bread, potatoes and pasta.** Not necessarily. Many people with diabetes do find that starchy foods like bread, pasta or rice raise their blood sugar. However, this is not necessarily true for everyone. If starchy foods make your blood sugar rise, you should avoid them, but if you have checked your blood sugar after a starchy meal and it is not high, you may be able to eat starches. But beware: starches do tend to have a lot of calories, and too many calories are your main enemy in preventing weight gain.

Myth #7  **People with diabetes are more likely to get colds and other illnesses.** No. You are no more likely to get a cold or similar illness if you have diabetes. However, all people with diabetes are advised to get flu shots. This is because any infection interferes with your blood glucose management, putting you at risk of high blood glucose. High glucose does affect the immune system though, so people with poorly controlled diabetes can have a harder time fighting some infections.

Myth #8  **Insulin causes atherosclerosis (hardening of the arteries), blindness, kidney failure, and high blood pressure.** No, insulin does not cause these diseases. Early research raised some questions about whether insulin causes atherosclerosis, blindness, and kidney failure, but now we know it is not the insulin, but rather uncontrolled diabetes that is causing this problem. High blood pressure, which can be caused by being overweight and not exercising, is common in people with diabetes, but is not caused by insulin. Do not let fears about insulin prevent you from taking this life-saving medicine if your doctor recommends it.
Myth #9  Insulin causes weight gain, and because obesity is bad for you, insulin should not be taken. Several studies have shown that the benefit of glucose management with insulin far outweighs (no pun intended) the risk of weight gain. However, insulin can and often does cause weight gain, on average 10 pounds in the year after it is started. This is not a reason to decide not to take insulin. Often, people are started on insulin when pills no longer work.

Myth #10  You don’t need to change your diabetes regimen unless your A1c is greater than 8 or 9 percent. The better your glucose control, the less likely you are to develop complications of diabetes. The American Diabetes Association recommends a goal A1c of less than 7 percent for most people with diabetes. However, you increase your risk of hypoglycemia as your goal lowers, especially if you have type 1 diabetes. Talk with your doctor about the best goal for you.

Did you think any of these myths were true? Chances are someone you know does too. Share what you learn with family and friends because they may not know all the facts. Information is the first step to understanding, managing, and controlling diabetes.

notes:
Share what you learn with your family and friends because they may not know all the facts. It is important to remember that information is the first step to understanding, managing, and controlling diabetes.

**Remember!**

- African Americans are twice as likely to have diabetes as non-Hispanic whites of the same age.
- The 3 types of diabetes are type 1, type 2, and gestational; type 2 is the most common.
- The ABCs of diabetes are: A1C, Blood pressure, and Cholesterol.
- It is important to track your levels and talk about your ABCs with your doctor regularly.
- Ignoring diabetes can lead to serious complications.
- Diabetes can be managed through healthy eating, physical activity, and medication.
- Share what you learn with others. It can save their life!

*Your clients will receive some information on diabetes - a copy of this handout is on the next page.*
Diabetes Basics

ABC’s of Diabetes Management for Type 2 Diabetes

**A**

**A1c**
- Reflects glucose (sugar) during the past 2-3 months.
- Keeping your A1c under control can help reduce your chance of blindness, kidney failure, dialysis, and amputation.
- Have your A1c checked once a year.
- Medications, exercise, and healthy eating can help keep your A1c down. For more information, ask your doctor.

**The A1c target for most people with diabetes is below 7%.**

**B**

**Blood Pressure (BP)**
- Medicines, healthy eating (including a low-salt diet), and physical activity can help you reach your blood pressure target.
- Many pharmacies check it for you also.
- Know your number! Write it down, and if it is not at the goal, talk to your doctor.
- Keeping your blood pressure under control can reduce your chances of having a stroke or heart attack, and also blindness, kidney failure, and amputation.

**The BP target for most people is:**
- The 1<sup>st</sup> number below 130.
- The 2<sup>nd</sup> number below 80.

**C**

**Cholesterol**
- Keeping your cholesterol levels under control can help reduce your chance of heart attack and stroke.
- Have your cholesterol levels checked at least once a year.
- Low density lipoprotein is “bad” or LDL cholesterol.
- Medicine and healthy eating can keep your cholesterol down.

**The LDL target is below 100.**

**What should I do to take care of my diabetes?**
- Eat healthy.
- Take my medicines.
- Brush and floss daily.
- Have my eyes checked yearly.
- Exercise every day for 30 minutes.
- If I smoke, quit!
- Check my feet daily.
- Cope with stress.

Client handout: Diabetes Basics
Eat a wide variety of foods.
- Choose a diet rich in grains, vegetables, and fruits.

Eat regularly throughout the day.
- Eat 3 small meals and 1-2 small snacks during the day.

Limit intake of certain foods (moderation).
- Fat –
  - Eating too much fat and cholesterol can lead to heart disease and stroke.
  - Cook with a vegetable or olive oil spray instead of ham hocks or animal fat.
- Salt –
  - High blood pressure? Eat less salt.
  - Avoid using salt when cooking. Avoid canned or prepared foods.
- Sugar or Naturally Sweet Foods –
  - Enjoy sweet foods occasionally and in small portions.
  - Avoid sugar-sweetened drinks like soda, fruit juices, or sweet tea.
  - Use sugar substitutes.

Watch portion sizes – most of us eat too much!
- Use a 9-inch plate to estimate serving sizes.
- Vegetables should take up 1/2–3/4 of the plate.
- Starches (rice, pasta) should take up no more than 1/4 of the plate.
- Meat, fish, or another protein-rich food should take up 1/4 of the plate.
- Add 1 serving each of fat-free milk and fruit for a balanced meal.

Remember, moderation!

How to Dine Out and Stay Within Your Meal Plan
- Choose grilled, broiled, or baked foods.
- Avoid fatty meats and fried foods.
- Look for “heart-healthy” or “light” meals on the menu.
- Avoid a lot of cheeses, bacon, or creamy salad dressings.
- Drink water, not soda or shakes.
- Serving sizes are usually too large–share with someone or take some home.
- Don’t eat out too often! Make it a treat.
Raise the **BAR** for your Doctor’s Visit

*How to get the most out of your visit with the doctor*

**Before the Visit: Be Prepared**

- **Write down any questions you want to discuss.**
  - Be specific.
  - What are the symptoms? When did they start? What triggers them? What makes them better?

- **Bring your medicines to the visit!**
  - Don’t forget nonprescription medications, vitamins, herbal/home remedies, and other supplements.
  - Discuss problems, cost, side effects, or if you don’t understand why you are on it.

**At the Visit: Ask & Learn**

**Your doctor should...**

- Provide information about your condition and any tests in a way you can easily understand.
- Answer your questions thoroughly.
- Give you specific instructions for treating your condition and taking any medications that are prescribed.
- Encourage you to participate in decisions about your care.

**You should...**

- **Be honest.** Your doctor can’t help you if you don’t share your problems. Tell about your lifestyle, diet, use of alcohol or other drugs, smoking history, sexual history, and other health care you receive, even if the news is bad.
- **Inform** the doctor about your cultural or religious beliefs that may affect your treatment. Don’t assume the doctor knows.
- **Make sure** you understand your doctor. If you don’t, ask the doctor questions until you do!
- **Take notes.**
  - If you can’t follow the advice you are given, **speak up**! It’s important that both you and your doctor know what you can and can’t do. Develop a plan that is realistic for you.

**After the Visit: Reflect & Review**

- **Take time to reflect on the visit.**

- **Look over your notes.**

- **Did you understand everything?** If not, call the office to clarify.
  - Don’t just wait for the next visit. You cannot follow advice you do not understand.
**Diabetes Basics**

**ABC’s of Diabetes Management for Type 2 Diabetes**

### A1c
- Reflects glucose (sugar) during the past 2-3 months.
- Keeping your A1c under control can help reduce your chance of blindness, kidney failure, dialysis, and amputation.
- Have your A1c checked once a year.
- Medications, exercise, and healthy eating can help keep your A1c down. For more information, ask your doctor.

### Blood Pressure (BP)
- Medicines, healthy eating (including a low-salt diet), and physical activity can help you reach your blood pressure target.
- Many pharmacies check it for you also.
- Know your number! Write it down, and if it is not at the goal, talk to your doctor.
- Keeping your blood pressure under control can reduce your chances of having a stroke or heart attack, and also blindness, kidney failure, and amputation.

### Cholesterol
- Keeping your cholesterol levels under control can help reduce your chance of heart attack and stroke.
- Have your cholesterol levels checked at least once a year.
- Low density lipoprotein is “bad” or LDL cholesterol.
- Medicine and healthy eating can keep your cholesterol down.

### What should I do to take care of my diabetes?
- Eat healthy.
- Take my medicines.
- Brush and floss daily.
- Have my eyes checked yearly.
- Exercise every day for 30 minutes.
- If I smoke, quit!
- Check my feet daily.
- Cope with stress.
**Importance of Exercise**

**Regular exercise can...**
- Lower blood glucose (sugar) levels.
- Protect against heart disease and stroke.
- Help in weight management.
- Increase energy and relieve stress.

**There are many types of exercise...**
- Brisk walking is the best!
- Jogging
- Bicycling
- Swimming
- Dancing
- Soccer
- Basketball

**How often should you exercise?**
- Aim to exercise at least 5 times a week for 30 minutes.
- Keep exercise sessions short at first.
- Don’t overdo it.
- Every little bit counts - if you can’t exercise all at once, try four 5-minutes sessions per day and add more minutes as you can!

**Exercise Tips**
- Before beginning an exercise program, get your doctor or nurse’s okay.
- Drink water before, during, and after exercise. However, avoid sports drinks!
- Carry diabetes identification with you.
- Protect your feet by wearing socks and comfortable shoes designed for exercise.
- Make it fun! Exercise with a friend to keep you motivated.
Recognize the warning signs of stress

**How does stress make a person feel?**
- Worried, “Down”, Tense

**How do stressed people act?**
- Forgetful
- Can’t sleep
- Avoiding friends
- Unable to get things done
- Nagging, bad temper
- Drinking or smoking more

**How does stress affect the body?**
- Fatigue, headaches, rashes
- Changes in appetite, upset stomach

---

8 Healthy Ways to Cope with Stress

1. Before beginning an exercise program, get your doctor's okay.
2. Be physically active EVERY DAY. When you’re active, your body releases hormones that make you happy and give you energy.
3. Take a 10-minute “time out.” Go for a walk. Do stretches at your desk or workstation.
4. Get support from friends. Talk about what’s bothering you. Friends can give you a different point of view.
5. Give yourself positive messages every day. Boost your spirits and give yourself the encouragement you need to face the day.
6. Pray, meditate, or worship.
7. Learn how to problem-solve.
8. Learn different ways to relax, such as deep breathing.

**ONE more thing** - Sometimes people are not just stressed but feel “down,” sad, or blue most of the time, for weeks on end. This may be depression. Stress and depression can be hard to tell apart. Main difference: depression affects you nearly every day, for most of the day, for weeks at a time. It is VERY common for people with diabetes to be depressed. Stress is a normal part of life. Depression is not.

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What can I do about depression?

- Tell your doctor. Left untreated, depression can last for years. There are treatments available to help you.
- Set realistic goals. Do what you can as you can. Break large tasks into small ones and set priorities.
- Try to be with other people. Talk to someone.
- Let your family and friends help you.
- Participate in activities that make you feel better (exercise, movies, ball games, church, social activities).
- Don’t make important decisions until your depression has lifted.
Why Exercise is Important

Session 4

Life seems to have taken a great turn for Laura now that she is involved in the *Bridges to a Better Life* program. She is making new friends and is feeling great about herself. This new sense of confidence has given her that extra motivation to become more physically active. **Now that she has the support from her fellow leaders, regular exercise seems like a real possibility.**
### Table of contents

1. **Your motivation**

2. **Building your foundation**
   - Physical activity
   - Benefits of physical activity
   - Types of physical activity
   - The FITT principle
   - Being safe during physical activity

3. **Putting it into practice**

4. **Reaffirming your motivation**

### In this session...

You will learn why it is important to exercise to help manage diabetes and how to set up an exercise action plan. You will learn general safety tips for exercising.
Your motivation

Your foundation

When we seek out new opportunities, we may meet new people or reconnect with people who we may not have seen in a while. We are reminded of how great it feels to be connected to the outside world.

Becoming physically active provides an additional opportunity to meet others who care about their health.

Finding your direction

Becoming physically active may feel like a chore, but if you find new ways to make it interesting, it can be very rewarding.

Spending time with others, especially when exercising, creates an opportunity to share your joys and struggles while burning a few calories.

Being physically active also can help you clear your mind and achieve a peaceful mood. Walking around your neighborhood or a nearby park is often the best way to deal with upset or sad feelings.

Ensuring success

Call a friend and invite him/her to walk in a scenic area or a place that you have always been curious about but never explored. When you get home, write down the thoughts or feelings you experienced while walking in discovery.
Physical activity

Physical activity is an important part of managing diabetes. Specifically, it helps control glucose levels and generally improves one’s overall quality of life.

<table>
<thead>
<tr>
<th>Benefits of physical activity:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHYSICAL HEALTH</strong></td>
</tr>
<tr>
<td>Lowers blood pressure</td>
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<tr>
<td>Lowers cholesterol levels</td>
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<tr>
<td>Lowers blood glucose levels</td>
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<tr>
<td>Improves fitness by strengthening heart and lungs</td>
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<tr>
<td>Improves posture and balance</td>
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<tr>
<td>Helps maintain a healthy weight</td>
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<tr>
<td>Strengthens muscles and bones</td>
</tr>
<tr>
<td>Keeps joints flexible</td>
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<tr>
<td><strong>EMOTIONAL HEALTH</strong></td>
</tr>
<tr>
<td>Improves self-esteem</td>
</tr>
<tr>
<td>Increases energy levels</td>
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<tr>
<td>Reduces stress levels</td>
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<tr>
<td>Improves mood</td>
</tr>
<tr>
<td>Makes it easier to play with your children</td>
</tr>
<tr>
<td>Helps ensure independent living in later life</td>
</tr>
</tbody>
</table>

What are some additional benefits of physical activity?
Recommended levels of physical activity

Adults should get **150 minutes** of moderate-intensity aerobic activity every week and 2 or more days a week of muscle strengthening activities.

150 minutes a week may seem like a lot, but you can spread out your activity throughout the week and engage in activity in smaller intervals of time during the day. For example you can go for a 10-minute walk, 3 times a day, 5 days a week to accomplish your goal of 150 minutes per week or a 30 minute walk five days a week.

**How much physical activity are you currently getting? Are you meeting these guidelines?**

---

**Build your skills** List two barriers to getting more physical activity. How will you overcome them?

---
Different types of physical activity

There are three different types of physical activity. Each has its own benefits.

**Aerobic**
- **Benefits:** Activities that work your heart, lungs, and circulatory system, keeping them healthy and giving you more energy.
- **Examples:** walking, jogging, running, bicycling, aerobics class, and swimming.

  *Walking with a pedometer is a great aerobic activity.*

**Strength**
- **Benefits:** Activities that use your muscles and help make your muscles and bones strong.
- **Examples:** resistance bands, lifting weights, and core training.

  *Using the stretch band is a great strength training activity.*

**Flexibility**
- **Benefits:** Activities that help you move more easily and keep your muscles relaxed and joints mobile.
- **Examples:** Stretching, yoga, and Tai Chi, and stability ball.

  *Stretching is a good flexibility exercise.*

What is the biggest competitor to physical activity?
**Aerobic activities**

Aerobic activities can be light, moderate or vigorous. Here are some examples of each. Your goal is to do moderate-to-vigorous activity.

**LIGHT**
Folding laundry, playing with children, light walking, playing catch, doing the dishes, grocery shopping.

**MODERATE**
Brisk walking, carrying heavy items, moving furniture, vacuuming, washing a car, working in the yard.

**VIGOROUS**
Jogging, aerobics classes, play basketball.

---

### TEST YOUR KNOWLEDGE

Circle the intensity level that best fits the activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>Light</th>
<th>Moderate</th>
<th>Vigorous</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Washing windows</td>
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<tr>
<td>2. Walking up a hill</td>
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<td>3. Making the bed</td>
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<tr>
<td>4. Running</td>
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<tr>
<td>5. Bicycling</td>
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<tr>
<td>6. Swimming</td>
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<tr>
<td>7. Putting groceries away</td>
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<tr>
<td>8. Soccer</td>
<td></td>
<td></td>
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<tr>
<td>9. Dancing</td>
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</tbody>
</table>

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Strength training

Strength training involves muscle movement against resistance, such as weights, rubber tubing, stretch band, or one’s own body weight against gravity.

For your peers, strength training can improve their quality of life by allowing them to continue to perform everyday activities such as walking, lifting, and climbing stairs as you get older. Strength training can also help reduce risk of painful fractures.

A strength training program should consist of 8 to 12 repetitions each of 8 to 10 different exercises working all the major muscle groups -- chest, back, shoulders, arms, abdominals, and legs.

A repetition is how many times you lift the weight, pull the rubber tubing, do a pushup, or whatever.

Squats, push-ups, and sit-ups are strength training exercises that don’t cost anything and can be done anywhere.

A walking program that combines aerobic activity and strength training might appeal to your peers.
Building your foundation

Flexibility

STRETCHING

Stretching is an importance practice to do before and after engaging in any physical activity. It allows your body to become flexible to avoid any injuries.

Stretching should be a slow movement, with no jerking or bouncing, holding each stretch for 10-20 seconds.

YOGA

Yoga is a set of exercises that consists of stretching, flexibility, and strength conditioning.

Yoga can help people with diabetes by:

- Reducing blood glucose levels and controlling it
- Stimulating insulin production
- Helping to lose weight
- Controlling illnesses

It is important that you learn how to practice yoga with a certified instructor to avoid injury to your neck or spine by practicing moves incorrectly.
The FITT principle is a simple way to think about how to make sure you are getting enough physical activity.

**FREQUENCY:**

How often should you be physically active?

You should work toward the following goals:

- Aerobic: 4-7 days per week
- Strength: 2-4 days per week
- Flexibility: 4-7 days per week

**INTENSITY:**

How intensely should you be physically active? Low, moderate or vigorous intensity?

You will notice how much effort you are putting into your exercise by observing the following:

- How hard you breathe
- How fast your heart beats
- How warm you feel during activity

**TIME:**

How long should you be physically active?

- Aerobic: 30-45 minutes per day
- Strength: 15-30 minutes per day or 5-10 different exercises
- Flexibility: 10-20 minutes per day or 4-10 different stretches

**TYPE**

What type of physical activity should you do?

- Aerobic: walking, playing a sport, swimming, riding your bike
- Strength: sit-ups or push-ups, lifting weights, squats
- Flexibility: Stretching, yoga
Using the FITT principles to create a Physical Activity Action Plan

Use this Physical Activity Action Plan to set up personal goals for yourself and your peers following the FITT principle.

**Frequency** How many times per week?

**Intensity** Light, moderate or vigorous?

**Time** When will I do it and for how long?

**Type** What should I do and where?

**Build your skills** | What else should you think about as you prepare to be more physically active? Share your ideas with other leaders.
10 general safety tips

1. Take 3–5 minutes at the beginning of any physical activity to properly warm up your muscles. Cool down when you are done by decreasing activity slowly and stretching to help prevent muscle soreness.

2. Use appropriate equipment and clothing for the activity. Clothing should be breathable, comfortable and layered in cool weather.

3. Start at an easy pace. Increase time or distance slowly.

4. Drink plenty of water.

5. Alternate activities that will exercise different parts of the body. Try not to do the same exercise every day. This will help reduce injuries caused by over use of the same muscles and give you the chance to find a variety of exercises that you like.

6. Listen to your body by monitoring how tired you feel, your heart rate, and your discomfort level. Be aware of shortness of breath and rest if you can’t breathe or if you are breathing too fast.

7. Use sunscreen, sunglasses, and protective clothing (hat, long sleeve shirt) when exercising outdoors.

8. Avoid exercising outside during the hottest time of day.

9. Be aware of your surroundings; having a buddy will help you feel safe.

10. Rest. Do not feel you have to exercise daily to get results.
Building your foundation

Special safety tips for people with diabetes

1. Physical activity can lead to low blood sugar. Know the symptoms and rest if you start to feel these symptoms.

   • Have a piece of candy in your pocket just in case you experience symptoms associated with low blood sugar.

2. Take care of your feet. People with diabetes are at greater risk of having foot problems due to poor circulation which leads to numbness.

   • Check your feet immediately after being active to make sure you don’t have any sores or blisters.
   • Wear lightweight, breathable cotton socks.
   • Wear tennis shoes to protect our feet.

3. Check with your doctor before beginning an exercise program. Symptoms of low blood sugar include:

   • Hunger
   • Shakiness
   • Nervousness
   • Sweat
   • Dizziness or light-headedness
   • Sleepiness
   • Confusion
   • Difficulty speaking
   • Anxiety
   • Weakness

Minimizing injuries is important for staying motivated to be physically active. Are there other safety tips that peers and leaders should consider? Share your ideas with other leaders.
Now that you have learned about physical activity, what can you do to help your peers’ being physically active at home, at the clinic, and in the community?

CARE AT HOME

CLINIC

COMMUNITY
Achieving a healthy weight and a limber body by exercising is very important for helping control diabetes and living a better life.

Today you learned:

The importance of physical activity for your health

- Different types of physical activity
- The FITT principles and how to design an action plan

Being a role model is a very effective way of demonstrating your commitment to others. If you are physically active, you can better motivate your peers to do the same.

Remember that regular physical activity leads to higher self-esteem and a better mood. It can help you be a better you and a better leader.

Next session:

In the next session, you will learn how emotional health affects diabetes. You will learn about stress and depression.

Before the next session, think of a time when you were stressed or depressed as a result of your diabetes or having to care for someone with diabetes. Think about how others helped you or could have helped you.
Part 3: Evaluation
Evaluation Considerations

• Outcomes
  – Training outcomes
    • Diabetes-related knowledge
    • Active listening skills
    • Empowerment-based facilitation skills
    • Self-efficacy
  – Process outcomes
• Approaches
Certification requirements

• Working knowledge of diabetes basics
  – Assessed using “open book” quiz
• Coaching skills
  – Use collaborative, client-centered approach
  – Help client set SMART goal

Role Play Scenarios for CHA Certification

Scenario 1:
Age: 62 years
Medical History: Diabetes for 14 years, hypertensive
Social History: Married, for 45 years
  2 adult children that live in Birmingham
  Spouse has many medical conditions and your client is the primary caregiver
  Their faith is very important to them and they will believe God will provide

Psych history: Sometimes feels somewhat depressed and hopeless
Health Behavior: Does not always take medication as should – forgetful and also worried about side effects
No time for physical activity
Diet is pretty good, they enjoy cooking healthy meals

Relationship w/ physician: Very good
Barriers: Self care seems selfish
  Does not always know how best to take care of their diabetes
  Doesn’t believe they have an extra time to take care of their health

www.peersforprogress.org
Scenario 2. 
Age: 38
Medical History: Diagnosed with diabetes 1 year ago, no other medical comorbidities
Social History: Single
3 small children at home, 3, 8, 11
Unemployed and looking for work
Psych History: In good spirits. Sometimes is anxious about making ends meet.
Health Behavior: Smokes 8 cigarettes a day – helps cope with the stress of being a single-parent and unemployed
Exercise once a week for 10 minutes, figures she does enough
Exercise running after kids
Thinks healthy food is unappetizing –...
Is not on medication yet for diabetes, and is not interested in taking any

Relationship with physician: Poor: Feels nervous about asking questions and expressing concerns

Barriers: High levels of stress interfere with health behaviors
Doesn't think diabetes is that much of a problem (or a serious disease)
Little social support

68 attended training

28 certified
39 not certified
1 person did not complete 2nd day

22 matched
2 not matched, concerns from community
4 dropped out

21 declined remediation
18 remediation

13 certified
5 not certified
Training evaluation

- Peer Advisor Training satisfaction
  - Assessed at 6 months
Diabetes-related knowledge

- Diabetes knowledge test (DKT) – 80% correct
- Diabetes knowledge questionnaire (DKQ) – 80% correct
- Understanding Management Practice (UMP) – Mean score of ≥ 4 of 5-point Likert scale
Active Listening Skills: Standardized Patient Scenario

Ms. Grayson

<table>
<thead>
<tr>
<th>Case Name</th>
<th>Ms. Grayson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age/Gender</td>
<td>38</td>
</tr>
<tr>
<td>Presenting</td>
<td>You are working with a peer as part of this project. Your primary goal for joining the program is weight loss and support.</td>
</tr>
<tr>
<td>Symptoms</td>
<td>None, other than tired all the time</td>
</tr>
<tr>
<td>Medication</td>
<td>On metformin to treat diabetes, plus a blood pressure and cholesterol lowering medicine.</td>
</tr>
<tr>
<td>Past Medical History</td>
<td>Diagnosed 12 months ago with Type 2 diabetes</td>
</tr>
<tr>
<td>Cultural Issues</td>
<td>You want very much to stop taking so many medications. For you, medications are untried, full of chemicals and bad for your body.</td>
</tr>
<tr>
<td>Family History</td>
<td>Both of your parents had diabetes and your father died from kidney failure related to diabetes about 10 years ago. You don’t want what happened to him to happen to you.</td>
</tr>
<tr>
<td>Social History</td>
<td>Busy elementary school teacher with 2 children who have many after school activities. You feel these are important to keep them busy and out of trouble. Because you are a teacher, you feel strongly that you need to be involved with your children’s homework so that they do well. Most of the responsibility for the children and the household fall to you as your husband is very busy at work and frequently works late. He is the primary breadwinner, while your income is supplemental. This school year has been especially difficult because the principal is new and there are behavioral and learning and behavioral problems in your classroom. Because of cutbacks, you have less time to prepare your lesson plans at school so much of that work is done in the evening.</td>
</tr>
<tr>
<td>Psychological History</td>
<td>Stressful, busy days with very little time caring for the needs of work, family and spouse. Feel tired and stressed all of the time. Your main goal is weight loss and while you do work during the day, suppers and evenings are your downfall. You are disappointed with yourself and feel that weight loss is “impossible” for you. Dinner is usually rushed with little time for preparation and everyone is in a hurry to get to homework or. You have lost weight in the past with high protein diets, but when the diet and the menus were too restrictive. Leads to husband, a close friend at work, sister who lives in town and church for support, but recognizes that eating is your main way of coping with stress.</td>
</tr>
</tbody>
</table>

Diagnosis: Evidence of sadness, frustration, guilt and anger directed at yourself and others.
### Active Listening Observation Scale (ALOS)

<table>
<thead>
<tr>
<th>Items</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Is not distracted during the conversation</td>
<td></td>
<td></td>
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<tr>
<td>b. Is not off-hand, hurried or dismissive</td>
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<tr>
<td>c. Listens attentively</td>
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<tr>
<td>d. Gives patient time and space to present the problem</td>
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<td>f. Uses open-ended questions</td>
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<tr>
<td>g. Expresses understanding verbally and non-verbally</td>
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<tr>
<td>h. Makes an effort to state back understanding of what the other is communicating</td>
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</tr>
<tr>
<td>i. Avoids giving advice or expressing judgments</td>
<td></td>
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</tr>
</tbody>
</table>

### Training Vignettes

- **AI**
- **Arlivia**
- **Ayana**
- **Dorothy**
- **Edna**
- **Genell**
- **Lois**
- **Nate**
- **Regina**
- **Tameka**
Empowerment Rating Form

- +2 points = Exploring problem and feelings
- +1 points = Focusing on goal
- 0 points = miscellaneous
- -1 points = Giving advice
- -2 points = Judging the person

Trainees must score a +2 on 3 of 6 vignettes and at least a +1 on the other 3 vignettes.

Lois – Vignette 2

- Do you think it would help if you explain your intake of food and what you expect from them?
- Sounds like it angers you that your family tries to control your eating
- Can you let your friends know that you can eat all kinds of things even if you are diabetic?
Genell – Vignette 1

• Sounds like taking insulin is very scary for you.
• What do you think is going to happen to your health if you don’t take insulin?
• Can you keep an open mind about medication and then decide what is the best approach?

Self-Efficacy – Core Skills

<table>
<thead>
<tr>
<th>I feel confident that I can…</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ask open-ended questions</td>
<td>□_1</td>
<td>□_2</td>
<td>□_3</td>
<td>□_4</td>
<td>□_5</td>
</tr>
<tr>
<td>2. reflect back what participants tell me</td>
<td>□_1</td>
<td>□_2</td>
<td>□_3</td>
<td>□_4</td>
<td>□_5</td>
</tr>
<tr>
<td>3. use the 5-step behavioral goal setting model with participants</td>
<td>□_1</td>
<td>□_2</td>
<td>□_3</td>
<td>□_4</td>
<td>□_5</td>
</tr>
<tr>
<td>4. help participants make an I-SMART action plan</td>
<td>□_1</td>
<td>□_2</td>
<td>□_3</td>
<td>□_4</td>
<td>□_5</td>
</tr>
<tr>
<td>5. defer to a health care professional when participants ask clinical questions that I don’t know.</td>
<td>□_1</td>
<td>□_2</td>
<td>□_3</td>
<td>□_4</td>
<td>□_5</td>
</tr>
<tr>
<td>6. facilitate the weekly support groups</td>
<td>□_1</td>
<td>□_2</td>
<td>□_3</td>
<td>□_4</td>
<td>□_5</td>
</tr>
</tbody>
</table>
### Process evaluation: Quantitative

#### Training Program Satisfaction

<table>
<thead>
<tr>
<th>Item</th>
<th>Not effective</th>
<th>Somewhat effective</th>
<th>Moderately effective</th>
<th>Very effective</th>
<th>Extremely effective</th>
<th>Feedback and suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The length of the training program was just right.</td>
<td></td>
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<tr>
<td>2. The length of the training seminars was just right.</td>
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<tr>
<td>3. The balance between classroom education content &amp; child development was just right.</td>
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<tr>
<td>4. I feel prepared to co-facilitate a support group.</td>
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<tr>
<td>5. I felt prepared to work one-on-one with participants.</td>
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</tbody>
</table>

### Process evaluation: Quantitative

#### Teaching activities effectiveness

<table>
<thead>
<tr>
<th>Teaching activities</th>
<th>Not effective</th>
<th>Somewhat effective</th>
<th>Moderately effective</th>
<th>Very effective</th>
<th>Extremely effective</th>
<th>Feedback and suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Quizzes</td>
<td></td>
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<tr>
<td>7. Lectures</td>
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<tr>
<td>8. Individual peer leader simulations</td>
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<tr>
<td>9. Group brainstorming</td>
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<td>10. Group sharing</td>
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<td>11. Role-play</td>
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<tr>
<td>12. Facilitated peer leader simulations</td>
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<tr>
<td>13. Reading assignments</td>
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</tbody>
</table>
Process evaluation: Qualitative

• What was most effective about the training program?
• What was least effective about the training program?
• Do you have any suggestions for improving the training program?
Certification requirements

Diabetes knowledge (T/F):
Post training, 6- and 12-mos post baseline

Open-ended test questions:
Post training

Participants who scored < 80% on the test at post-training were given additional Instructions in key areas.
Satisfaction with training and program support
6 and 12 months post baseline

Closed-ended

- Hours spent per week on Puentes activities
- Satisfaction with training and program support
- Effectiveness of training
- Confidence in being a leader
- Perceived program efficacy
- Interest in continuing to serve as a leader

Open-ended

- Satisfaction with the training
- Biggest challenges
- Greatest accomplishments
- How to improve support
- How to improve the program
34 leaders received training certificates

<table>
<thead>
<tr>
<th></th>
<th>N=34</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age (SD)</td>
<td>44 (9)</td>
</tr>
<tr>
<td>Female</td>
<td>97% (33)</td>
</tr>
<tr>
<td>Foreign born (in Mexico)</td>
<td>82% (28)</td>
</tr>
<tr>
<td>Married or living as married</td>
<td>79% (27)</td>
</tr>
<tr>
<td>Employed full or part-time</td>
<td>53% (18)</td>
</tr>
<tr>
<td>High school educated</td>
<td>59% (20)</td>
</tr>
<tr>
<td>Other volunteer activities</td>
<td>38% (13)</td>
</tr>
</tbody>
</table>

Similarities
Similarities: Outcomes

• Diabetes-related knowledge
• Active listening/Client-centered skills
• Program satisfaction

Similarities: Approaches

• Written Tests
• Standardized patient cases
• Training certificate
Differences

Differences: Outcomes

- Empowerment-based facilitation skills
- Developing a SMART plan
- Self-efficacy
Differences: Approaches

• Video vignettes
• Peer assessment

Lessons Learned
Lessons learned

- Test specific skills
  - 5-step, goal-setting, I-SMART action plan, and problem-solving
- Graduation certification
- Use an observational method to assess competency
- Formative evaluation to assess diabetes-related knowledge
Role Play Scenarios for CHA Certification

Scenario 1.

Age: 62 years

Medical History: Diabetes for 14 years, hypertensive

Social History: Married, for 40 years

2 adult children that live in Birmingham

Spouse has many medical conditions and your client is the primary caregiver

Their faith is very important to them and they will believe God will provide

Psych history: Sometimes feels somewhat depressed and hopeless

Health Behavior: Does not always take medication as should – forgetful and also worried about side effects

No time for physical activity

Diet is pretty good, they enjoy cooking healthy meals

Relationship w/ physician: Very good

Barriers: Self care seems selfish

Does not always know how best to take care of their diabetes

Doesn’t believe they have an extra time to take care of their health
Scenario 2.

Age: 38

Medical History: Diagnosed with diabetes 1 year ago, no other medical comobidities

Social History: Single

3 small children at home, 3, 8, 11

Unemployed and looking for work

Psych history: In good spirits. Sometimes is anxious about making ends meet.

Health Behavior: Smokes 8 cigarettes a day – helps cope with the stress of being a single parent and unemployed

Exercises once a week for 10 minutes, figures she does enough exercise running after kids

Thinks healthy food is unappetizing……

Is not on medication yet for diabetes, and is not interested in taking any

Relationship w/physician: Poor: Feels nervous about asking questions and expressing concerns

Barriers: High level of stress interferes with health behaviors

Doesn’t think diabetes is that much of a problem (or a serious disease)

Little social support
Peer Supporter Certification: Observed Role Play

Date: _________________________________
Peer: _________________________________
Observer: _____________________________

Part 1: Ability to help participant set SMART goals

1. Did the Peer ask participant to identify some of her own goals?
   a. Yes
   b. No
   c. Not sure (explain) _____________________________

2. Did the peer help guide the participant in setting a goal that was specific?
   a. Yes
   b. No
   c. Not sure (explain): _____________________________

3. Did the peer help guide the participant in setting a goal that was measurable (quantifiable)?
   a. Yes
   b. No
   c. Not sure (explain): _____________________________

4. Did the peer explore whether the participant thought the identified goal was realistic and achievable?
   d. Yes
   e. No
   f. Not sure (explain): _____________________________

5. Did the peer ask the participant to think about potential barriers to achieving their goal?
   a. Yes
   b. No
   c. Not sure (explain): _____________________________

6. Did the peer encourage the participant to problem solve around anticipated barriers?
   a. Yes
   b. No
   c. Not sure (explain)
7. Did the peer encourage the participant to set a start date to begin working on their goal?
   a. Yes
   b. No
   c. Not sure (explain): _____________________________

Part 2: Rapport building and approach

For the following statements, please indicate the extent to which you agree with the statement:

8. The peer developed a good rapport with the participant

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree/disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

9. The peer was somewhat confrontational with participant

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree/disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Items</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Neutral</td>
<td>Disagree</td>
</tr>
<tr>
<td>-------</td>
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</tr>
<tr>
<td>a. Is not distracted during the conversation</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>b. Is not off-hand, hurried or dismissive</td>
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<td>4</td>
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<tr>
<td>c. Listens attentively</td>
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<td>d. Gives patient time and space to present the problem</td>
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</tr>
<tr>
<td>f. Uses open-ended questions</td>
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<td>2</td>
</tr>
<tr>
<td>g. Expresses understanding verbally and non-verbally</td>
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<td>4</td>
<td>3</td>
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<tr>
<td>h. Makes an effort to state back understanding of what the other is communicating</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>i. Avoids giving advice or expressing judgments</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>j. Thoroughly explores and identifies all aspects of the problem</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>
### Empowerment-based facilitation skills rating form

<table>
<thead>
<tr>
<th>RATING</th>
<th>GOAL</th>
<th>EXAMPLES OF QUESTIONS</th>
</tr>
</thead>
</table>
| **Focusing on Feelings or the Problem (+2)** | Focusing on the participant’s feelings | • How do you feel about that?  
• It sounds like you are feeling overwhelmed. |
| | Exploratory questions to clarify the meaning | • Tell me more about that  
• Why is this a problem for you?  
• Can you give me some examples?  
• How would you like things to be different? |
| | Making reflections | • So, it is a nuisance to have to remember to check your blood sugar 2 hours after eating. |
| **Focusing on goals (+1)** | Eliciting patient commitment | • What are you willing to do?  
• Are you reading to make a change? |
| | Eliciting options and goals | • What do you want to accomplish?  
• What are the steps you can take? |
| **Miscellaneous (0)** | Asking and answering technical questions (i.e., simply gathering factual data) | • How long have you had diabetes?  
• What medication did your provider prescribe? |
| | Miscellaneous | • Any statement that doesn’t fit the other four scoring categories. |
| **Solving problems for the person (-1)** | Giving advice | • A better way to handle that situation would be  
• Why don’t you try to do it this way? |
| | Offering to solve-problems for the patient. | • I think you should talk to your wife about that.  
• I would be glad to call your sister and talk to her about her nagging you. |
| **Judging the person (-2)** | Blaming the patient | • You need more willpower.  
• That’s doesn’t seem like the best solution. |
| | Forgiving the patient | • Nobody could follow a diet on vacation.  
• That’s not really your fault you couldn’t help yourself. |
| | Invalidating the patient | • Your situation does not seem as bad as other people’s.  
• You shouldn’t feel angry about that. |
Peer Leader Evaluation Packet
(1) Please indicate how confident you feel in performing the following skills.  
(2) Circle two skills that you would like to improve.

<table>
<thead>
<tr>
<th>I feel confident that I can...</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ask open-ended questions.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>2. reflect back what</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>participants tell me.</td>
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<tr>
<td>3. use the 5-step behavioral</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
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<tr>
<td>goal setting model with</td>
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<tr>
<td>participants.</td>
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<tr>
<td>4. help participants make</td>
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<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>an I-SMART action plan.</td>
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<tr>
<td>5. avoid offering advice.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>6. address negative feelings</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>and/or concerns voiced by</td>
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<tr>
<td>participants.</td>
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<tr>
<td>7. defer to a health care</td>
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<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
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<td>professional when</td>
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<td>participants ask clinical</td>
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<td>questions that I don’t know.</td>
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<tr>
<td>8. facilitate the weekly</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>support groups.</td>
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</tr>
</tbody>
</table>
(1) Please indicate how confident you feel in performing the following skills.

(2) Please circle two skills that you would like to improve.

<table>
<thead>
<tr>
<th>I feel confident that I can...</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. deal with participants when they are expressing resistance.</td>
<td>☐ 1</td>
<td>☐ 3</td>
<td>☐ 5</td>
<td>☐ 7</td>
<td>☐ 7</td>
</tr>
<tr>
<td>2. help participants clarify the personal values and attributes that are important to them.</td>
<td>☐ 1</td>
<td>☐ 3</td>
<td>☐ 5</td>
<td>☐ 7</td>
<td>☐ 7</td>
</tr>
<tr>
<td>3. help participants identify their own motivation to make changes.</td>
<td>☐ 1</td>
<td>☐ 3</td>
<td>☐ 5</td>
<td>☐ 7</td>
<td>☐ 7</td>
</tr>
<tr>
<td>4. help participants prepare for a physician visit (i.e., diabetes concerns assessment).</td>
<td>☐ 1</td>
<td>☐ 3</td>
<td>☐ 5</td>
<td>☐ 7</td>
<td>☐ 7</td>
</tr>
<tr>
<td>5. help participants set goals in the group sessions.</td>
<td>☐ 1</td>
<td>☐ 3</td>
<td>☐ 5</td>
<td>☐ 7</td>
<td>☐ 7</td>
</tr>
<tr>
<td>6. handle difficult/sensitive topics in the group sessions.</td>
<td>☐ 1</td>
<td>☐ 3</td>
<td>☐ 5</td>
<td>☐ 7</td>
<td>☐ 7</td>
</tr>
<tr>
<td>7. address situations when participants do not follow the ground rules.</td>
<td>☐ 1</td>
<td>☐ 3</td>
<td>☐ 5</td>
<td>☐ 7</td>
<td>☐ 7</td>
</tr>
</tbody>
</table>
## Training Program Satisfaction

<table>
<thead>
<tr>
<th>Items</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Feedback and suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The length of the training program was just right.</td>
<td>□1</td>
<td>□2</td>
<td>□3</td>
<td>□4</td>
<td>□5</td>
<td></td>
</tr>
<tr>
<td>2. The length of the training sessions was just right.</td>
<td>□1</td>
<td>□2</td>
<td>□3</td>
<td>□4</td>
<td>□5</td>
<td></td>
</tr>
<tr>
<td>3. The balance between diabetes education content &amp; skills development was just right.</td>
<td>□1</td>
<td>□2</td>
<td>□3</td>
<td>□4</td>
<td>□5</td>
<td></td>
</tr>
<tr>
<td>4. I feel prepared to co-facilitate a support group.</td>
<td>□1</td>
<td>□2</td>
<td>□3</td>
<td>□4</td>
<td>□5</td>
<td></td>
</tr>
<tr>
<td>5. I feel prepared to work one-on-one with participants.</td>
<td>□1</td>
<td>□2</td>
<td>□3</td>
<td>□4</td>
<td>□5</td>
<td></td>
</tr>
</tbody>
</table>
**Instructions:** Please indicate how effective the following teaching activities were in preparing you to become a Peer Leader.

<table>
<thead>
<tr>
<th>Teaching activities</th>
<th>Not effective</th>
<th>Somewhat effective</th>
<th>Moderately effective</th>
<th>Very effective</th>
<th>Extremely effective</th>
<th>Feedback and suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Quizzes</td>
<td></td>
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<tr>
<td>7. Lecturetes</td>
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<tr>
<td>8. Individual peer leader simulations</td>
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<tr>
<td>9. Group brainstorming</td>
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<tr>
<td>10. Group sharing</td>
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<tr>
<td>11. Role-plays</td>
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<tr>
<td>12. PAIRED-peer leader simulations</td>
<td></td>
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<tr>
<td>13. Reading assignments</td>
<td></td>
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</tr>
</tbody>
</table>
14. What was most effective about the training program?

15. What was least effective about the training program?

16. Do you have any suggestions to improve the training program?
Peer Assessment

Peer assessment is a process that helps fellow peer leaders improve their skills. Please provide constructive feedback for the participants below as well as for yourself. THESE COMMENTS WILL REMAIN ANONYMOUS AND CONFIDENTIAL.

<table>
<thead>
<tr>
<th></th>
<th>Joyce Fitch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengths:</td>
<td></td>
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<tr>
<td>Areas for improvement:</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Marti Cothern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengths:</td>
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<tr>
<td>Areas for improvement:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Al Robinson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengths:</td>
<td></td>
</tr>
<tr>
<td>Areas for improvement:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Nate Hill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strength:</td>
<td></td>
</tr>
<tr>
<td>Areas for improvement:</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Strengths:</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Genell Ryce</td>
<td></td>
</tr>
<tr>
<td>Clinten Campbell</td>
<td></td>
</tr>
<tr>
<td>Arlivia Chambers</td>
<td></td>
</tr>
<tr>
<td>Betty Ellerson</td>
<td></td>
</tr>
</tbody>
</table>
### Case Name
Ms. Grayson

### Age/Gender
38

### Presenting Situation
You are working with a peer as part of this project. Your primary goal for joining the program is weight loss and support.

### Symptoms
- None, other than tired all the time

### Medication
On metformin to treat diabetes, plus a blood pressure and cholesterol lowering medicine.

### Past Medical History
- Diagnosed 12 months ago with Type 2 diabetes
- Was told if you lost weight you would be able to go off the diabetes medication.

### Cultural Issues
- You want very much to stop taking so many medications. For you, medications are unnatural, full of chemicals and bad for your body.
- You are afraid that the complications are inevitable because of your inability to lose weight.

### Family History
Both of your parents had diabetes and your father died from kidney failure related to diabetes about 10 years ago. You don’t want what happened to them to happen to you.

### Social History
Busy elementary school teacher with 2 children who have many after-school activities. You feel these are important to keep them busy and out of trouble. Because you are a teacher, you feel strongly that you need to be involved with your children’s homework so that they do well. Most of the responsibility for the children and the household fall to you as your husband is very busy at work and frequently works late. He is the primary breadwinner, while your income is supplemental. This school year has been especially difficult because the principal is new and insisting on many changes and you have several children with learning and behavioral problems in your classroom. Because of cutbacks, you have less time to prepare your lesson plans at school so do much of that work in the evening.

### Psychosocial History
Stressful, busy days with every minute spent caring for the needs of work, family and spouse. Feels tired and stressed all of the time. Your main goal is weight loss and while you do well during the day, suppers and evenings are your downfall. You are disappointed with yourself and feel that weight loss is “hopeless” for you. Dinner is usually rushed with little time for preparation and everyone in a hurry to get to homework etc. You have lost weight in the past with high protein diets, but when the diet ended the weight came back. Looks to husband, a close friend at work, sister who lives in town and church for support, but recognizes that eating is your main way of coping with stress.

### Demeanor
Evidence of sadness, frustration, guilt and anger directed at yourself and situation. Much of this stems from the fear you feel about the
| Objectives | You want to create a plan that will work for not eating in the evening. You have tried eating healthy snacks while your family eats as usual in the evening and cooking on weekends, but found those strategies problematic. Carrots and celery just weren't the same as chips and ice cream and you were too tired and too busy with soccer games, lesson plans etc. to cook on weekends. |
Peer Leader Assessment Questionnaire

Name: __________________________________________
Date: __________________________________________

IRBMED # HUM00027165
Please answer every question by filling in the blank(s), circling the correct answer, or checking the correct box(s).

1. What is your age? □ □ □ years old

2. What is your birth date? □ □ □ / □ □ / □ □ □
   Month  Day  Year

3. What is your sex: □1 Male  □2 Female

4. What year were you first told you had diabetes? (Please enter the year) □ □ □ □ □ □ □ □

5. How much schooling have you had? (Years of formal schooling completed)
   □1 8 grades or less
   □2 Some high school
   □3 High school graduate or GED
   □4 Some college or technical school
   □5 College graduate or higher

6. What is your occupation? ____________________________________________
   (If you are retired, what type of work did you do?)
   ____________________________________________

Please check the best answer to each question.

1. The diabetes diet is:
   □1 the way most American people eat
   □2 a healthy diet for most people
   □3 too high in carbohydrate for most people
   □4 too high in protein for most people

2. Which of the following is highest in carbohydrate?
   □1 baked chicken
   □2 swiss cheese
   □3 baked potato
   □4 peanut butter
3. Which of the following is highest in fat?
   □ 1  low fat milk
   □ 2  orange juice
   □ 3  corn
   □ 4  honey

4. Which of the following is a “free food”?
   □ 1  any unsweetened food
   □ 2  any dietetic food
   □ 3  any food that says “sugar free” on the label
   □ 4  any food that has less than 20 calories per serving

5. A1c is a test that is a measure of your average blood sugar level for the past:
   □ 1  day
   □ 2  week
   □ 3  3 months
   □ 4  6 months

6. Which is the best method for testing blood sugar?
   □ 1  urine testing
   □ 2  blood testing
   □ 3  both are equally good

7. What effect does unsweetened fruit juice have on blood sugar?
   □ 1  lowers it
   □ 2  raises it
   □ 3  has no effect

8. Which should not be used to treat low blood sugar?
   □ 1  3 hard candies
   □ 2  1/2 cup orange juice
   □ 3  1 cup diet soft drink
   □ 4  1 cup skim milk

9. For a person in good control, what effect does exercise have on blood sugar?
   □ 1  lowers it
   □ 2  raises it
   □ 3  has no effect
10. Infection is likely to cause:
   □_1 an increase in blood sugar
   □_2 a decrease in blood sugar
   □_3 no change in blood sugar

11. The best way to take care of your feet is to:
   □_1 look at and wash them each day
   □_2 massage them with alcohol each day
   □_3 soak them for one hour each day
   □_4 buy shoes a size larger than usual

12. Eating foods lower in fat decreases your risk for:
   □_1 nerve disease
   □_2 kidney disease
   □_3 heart disease
   □_4 eye disease

13. Numbness and tingling may be symptoms of:
   □_1 kidney disease
   □_2 nerve disease
   □_3 eye disease
   □_4 liver disease

14. Which of the following is usually not associated with diabetes:
   □_1 vision problems
   □_2 kidney problems
   □_3 nerve problems
   □_4 lung problems

Please answer true or false for each of following questions.

15. Eating too much sugar and other sweet foods is the cause of diabetes.
    □_1 True □_2 False □_3 Don't Know

16. The usual cause of diabetes is lack of effective insulin in the body.
    □_1 True □_2 False □_3 Don't Know
17. Diabetes is caused by failure of the kidneys to keep sugar out of the urine.
   □1 True □2 False □3 Don't Know

18. Kidneys produce insulin.
   □1 True □2 False □3 Don't Know

19. In untreated diabetes, the amount of sugar in the blood usually increases.
   □1 True □2 False □3 Don't Know

20. If I am a person with diabetes, my children have a higher chance of getting diabetes.
   □1 True □2 False □3 Don't Know

21. Diabetes can be cured.
   □1 True □2 False □3 Don't Know

22. A fasting blood sugar level of 210 is too high.
   □1 True □2 False □3 Don't Know

23. The best way to check my diabetes is by testing my urine.
   □1 True □2 False □3 Don't Know

24. Regular exercise will increase the need for insulin or other diabetes medication.
   □1 True □2 False □3 Don't Know
25. There are two main types of diabetes: type 1 (insulin-dependent) and type 2 (non-insulin dependent).

☐1 True       ☐2 False       ☐3 Don't Know

26. An insulin reaction is caused by too much food.

☐1 True       ☐2 False       ☐3 Don't Know

27. Medication is more important than diet and exercise to control my diabetes.

☐1 True       ☐2 False       ☐3 Don't Know


☐1 True       ☐2 False       ☐3 Don't Know

29. Cuts and abrasions on people with diabetes heal more slowly.

☐1 True       ☐2 False       ☐3 Don't Know

30. People with diabetes should take extra care when cutting their toenails.

☐1 True       ☐2 False       ☐3 Don't Know

31. A person with diabetes should cleanse a cut with iodine and alcohol.

☐1 True       ☐2 False       ☐3 Don't Know

32. The way I prepare my food is as important as the foods I eat.

☐1 True       ☐2 False       ☐3 Don't Know

33. Diabetes can damage my kidneys.

☐1 True       ☐2 False       ☐3 Don't Know
34. Diabetes can cause loss of feeling in my hands, fingers, and feet.
   □₁ True   □₂ False   □₃ Don’t Know

35. Shaking and sweating are signs of high blood sugar.
   □₁ True   □₂ False   □₃ Don’t Know

36. Frequent urination and thirst are signs of low blood sugar.
   □₁ True   □₂ False   □₃ Don’t Know

37. Tight elastic hose or socks are not bad for people with diabetes.
   □₁ True   □₂ False   □₃ Don’t Know

38. A diabetic diet consists mostly of special foods.
   □₁ True   □₂ False   □₃ Don’t Know
How do you rate your understanding of:

<table>
<thead>
<tr>
<th>Question</th>
<th>Poor</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>39. Overall diabetes care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>40. Coping with stress.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>41. Diet and blood sugar control.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>42. The role of exercise in diabetes care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>43. Medications you are taking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>44. How to use the results of blood sugar monitoring.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45. How diet, exercise, and medicines affect blood sugar levels.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46. Prevention and treatment of high blood sugar.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>47. Prevention and treatment of low blood sugar.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>48. Prevention of long-term complications of diabetes.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>49. Foot care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>50. Benefits of improving blood sugar control.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Judgment Scenarios

Scenario 1:

While you are in the middle of a small group session, you notice that one of the members is more listless and begins to slump over. You call her name, and she does not respond but looks slightly confused. Please outline the steps you would take next.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Scenario 2:

When calling a group member to touch base after not having seen him at group sessions for three weeks, he mentions that he has been feeling very depressed. After asking him more questions, he says, "Everything just seems hopeless. I have to say I'm feeling tempted to just throw in the towel." Please outline what your next steps would be.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Scenario 3:

In a group discussion, one of the members begins to talk about a natural medicine for cholesterol that she ordered online. She says that she heard it was much better than a statin and with no side effects. Another member turns to you and says, “Wow. That sounds great. Maybe I’ll try it. What do you think?” What would you say?


Scenario 4:

In a group discussion, one member interrupts others and dominates the discussion. Please list some of the things you could do to address this problem.


Empowerment-based Vignettes

Please write a 1-2 sentence response to each person’s statement.

1. Al – Video Clip 1

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

2. Dorothy – Video Clip 2

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

3. Lois – Video Clip 3

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

4. Ayana – Video Clip 4

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
5. Nate – Video Clip 5

6. Arlivia – Video Clip 6
A. VOLUNTEER EXPERIENCE

This part of the survey looks at your volunteer experience.

1. Have you done any kind of volunteer work? Check one box only.
   - Yes – If yes, please answer question 2 below.
   - No – If no, please skip to Section B.

2. If yes, please list what volunteer work you have done, for what organization, and use numbers to specify how long you served and the average number of hours per week you did it. An example appears on the first line.

<table>
<thead>
<tr>
<th>Type of work</th>
<th>Organization</th>
<th>For how long? (in yrs/mos)</th>
<th>Hours/week</th>
<th>Presently Serving?</th>
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</thead>
<tbody>
<tr>
<td>Troop leader</td>
<td>Girl Scouts</td>
<td>2 years 3 months</td>
<td>5</td>
<td>Yes ☑ No ☐</td>
</tr>
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</table>

B. MOTIVATIONS FOR VOLUNTEERING AS A LEADER

Please respond to these items by thinking about your motivations for being a volunteer leader. How important are each of the 30 motivations for doing volunteer work? Check only one box per motivation.

1. Volunteering can help me to get my foot in the door at a place where I would like to work.
   - Not at all important ☐ A little important ☐ Somewhat important ☐ Neutral ☐ Moderately important ☐ Very important ☐ Extremely important ☐

   - Not at all important ☐ A little important ☐ Somewhat important ☐ Neutral ☐ Moderately important ☐ Very important ☐ Extremely important ☐

3. I am concerned about those less fortunate than myself.
   - Not at all important ☐ A little important ☐ Somewhat important ☐ Neutral ☐ Moderately important ☐ Very important ☐ Extremely important ☐
4. People I'm close to want me to volunteer.

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Neutral</th>
<th>Moderately</th>
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<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Important_1</td>
<td>Important_2</td>
<td>Important_3</td>
<td>Neutral_4</td>
<td>Moderately_5</td>
<td>Very_6</td>
<td>Extremely_7</td>
</tr>
</tbody>
</table>

5. Volunteering makes me feel important.

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Neutral</th>
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<tbody>
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<td>Moderately_5</td>
<td>Very_6</td>
<td>Extremely_7</td>
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</table>

6. People I know share an interest in community service.

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<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
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<td>Moderately_5</td>
<td>Very_6</td>
<td>Extremely_7</td>
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</tbody>
</table>

7. No matter how bad I've been feeling, volunteering helps me to forget about it.

<table>
<thead>
<tr>
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<td>Very_6</td>
<td>Extremely_7</td>
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</table>

8. I am genuinely concerned about the particular group I am serving.

<table>
<thead>
<tr>
<th>Not at all</th>
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<td>Very_6</td>
<td>Extremely_7</td>
</tr>
</tbody>
</table>

9. By volunteering I feel less lonely.

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
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<th>Extremely</th>
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<td>Very_6</td>
<td>Extremely_7</td>
</tr>
</tbody>
</table>

10. I can make new contacts that might help my business or career.

<table>
<thead>
<tr>
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<th>A little</th>
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<th>Neutral</th>
<th>Moderately</th>
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<th>Extremely</th>
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<td>Moderately_5</td>
<td>Very_6</td>
<td>Extremely_7</td>
</tr>
</tbody>
</table>

11. Doing volunteer work relieves me of some of the guilt over being more fortunate than others.

<table>
<thead>
<tr>
<th>Not at all</th>
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</tbody>
</table>

12. I can learn more about the cause for which I am working.

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Neutral</th>
<th>Moderately</th>
<th>Very</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Important_1</td>
<td>Important_2</td>
<td>Important_3</td>
<td>Neutral_4</td>
<td>Moderately_5</td>
<td>Very_6</td>
<td>Extremely_7</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Neutral</th>
<th>Moderately</th>
<th>Very</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Important_1</td>
<td>Important_2</td>
<td>Important_3</td>
<td>Neutral_4</td>
<td>Moderately_5</td>
<td>Very_6</td>
<td>Extremely_7</td>
</tr>
</tbody>
</table>
14. Volunteering allows me to gain a new perspective on things.

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Neutral</th>
<th>Moderately</th>
<th>Very</th>
<th>Extremely</th>
</tr>
</thead>
</table>

15. Volunteering allows me to explore different career options.

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Neutral</th>
<th>Moderately</th>
<th>Very</th>
<th>Extremely</th>
</tr>
</thead>
</table>

16. I feel compassionate toward people in need.

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Neutral</th>
<th>Moderately</th>
<th>Very</th>
<th>Extremely</th>
</tr>
</thead>
</table>

17. Others with whom I am close place a high value on community service.

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Neutral</th>
<th>Moderately</th>
<th>Very</th>
<th>Extremely</th>
</tr>
</thead>
</table>

18. Volunteering lets me learn things through direct, hands on experience.

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Neutral</th>
<th>Moderately</th>
<th>Very</th>
<th>Extremely</th>
</tr>
</thead>
</table>

19. I feel it is important to help others.

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Neutral</th>
<th>Moderately</th>
<th>Very</th>
<th>Extremely</th>
</tr>
</thead>
</table>

20. Volunteering helps me work through my own personal problems.

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Neutral</th>
<th>Moderately</th>
<th>Very</th>
<th>Extremely</th>
</tr>
</thead>
</table>

21. Volunteering will help me to succeed in my chosen profession.

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Neutral</th>
<th>Moderately</th>
<th>Very</th>
<th>Extremely</th>
</tr>
</thead>
</table>

22. I can do something for a cause that is important to me.

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Neutral</th>
<th>Moderately</th>
<th>Very</th>
<th>Extremely</th>
</tr>
</thead>
</table>

23. Volunteering is a good escape from my own troubles.

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Neutral</th>
<th>Moderately</th>
<th>Very</th>
<th>Extremely</th>
</tr>
</thead>
</table>
24. Volunteering is an important activity to the people I know best.

Not at all important, A little important, Somewhat important, Neutral, Moderately important, Very important, Extremely important

25. I can learn how to deal with a variety of people.

Not at all important, A little important, Somewhat important, Neutral, Moderately important, Very important, Extremely important

26. Volunteering makes me feel needed.

Not at all important, A little important, Somewhat important, Neutral, Moderately important, Very important, Extremely important

27. Volunteering makes me feel better about myself.

Not at all important, A little important, Somewhat important, Neutral, Moderately important, Very important, Extremely important

28. Volunteering experience will look good on my resume.

Not at all important, A little important, Somewhat important, Neutral, Moderately important, Very important, Extremely important

29. Volunteering is a way to make new friends.

Not at all important, A little important, Somewhat important, Neutral, Moderately important, Very important, Extremely important

30. I can explore my own strengths through volunteering.

Not at all important, A little important, Somewhat important, Neutral, Moderately important, Very important, Extremely important

C. DIABETES KNOWLEDGE

For each of the following statements, please indicate whether you think they are true or false and circle your answer.

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eating too much sugar and other sweet foods is a cause of diabetes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The usual cause of diabetes is lack of effective insulin in the body.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Diabetes is caused by failure of the kidneys to keep sugar out of the urine.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Kidneys produce insulin.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. In untreated diabetes, the amount of sugar in the blood usually increases.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. If I am diabetic, my children have a higher chance of being diabetic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Diabetes can be cured.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>8. A fasting blood sugar level of 210 is too high.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. The best way to check diabetes is by testing urine.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Regular exercise will increase the need for insulin or other diabetic medication.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. There are two main types of diabetes: Type 1 (insulin-dependent) and Type 2 (non-insulin-dependent).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. An insulin reaction is caused by too much food.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Medication is more important than diet and exercise to control diabetes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Cuts and abrasions on diabetics heal more slowly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Diabetics should take extra care when cutting their toenails.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. A person with diabetes should cleanse a cut with iodine and alcohol.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. The way a person prepares food is as important as the foods that he/she eats.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Diabetes can damage kidneys.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Diabetes can cause loss of feeling in hands, fingers, and feet.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Shaking and sweating are signs of high blood sugar.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Frequent urination and thirst are signs of low blood sugar.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Tight elastic hose or socks are not bad for diabetics.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**D. YOUR DIABETES AND YOUR HEALTH CARE**

*Important note: If you do not have diabetes, please go to Question 4.*

1. At what age were you diagnosed with diabetes? ............................................. __ __ years old

2. What type of diabetes do you have? ................................................................. Type 1 diabetes □
   Type 2 diabetes □
   Gestational diabetes □
   Pre-diabetes □
   Not sure what type of diabetes I have □
3. What medications did you take for your diabetes in the past seven days? Please include alternative medicines, as well as medicines purchased in Mexico for your diabetes. For each medication you list, please answer each of the following questions in the boxes below.

<table>
<thead>
<tr>
<th>a. Medication name and dose</th>
<th>b. How many days did you take it in the past 7 days?</th>
<th>c. How many times per day did you take it?</th>
<th>d. How many pills or injections did you take each time?</th>
<th>e. How well does this medicine control your symptoms or treat your illness?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td>☐ Works well</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td>☐ Works well</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td>☐ Works well</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td>☐ Works well</td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td>☐ Works well</td>
</tr>
</tbody>
</table>

4. What other medications did you take in the past seven days? Please include alternative medicines, as well as medicines purchased in Mexico for other health conditions. For each medication you list, please answer each of the following questions in the boxes below.

<table>
<thead>
<tr>
<th>a. Medication name and dose</th>
<th>b. How many days did you take it in the past 7 days?</th>
<th>c. How many times per day did you take it?</th>
<th>d. How many pills or injections did you take each time?</th>
<th>e. How well does this medicine control your symptoms or treat your illness?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td>☐ Works well</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td>☐ Works well</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td>☐ Works well</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td>☐ Works well</td>
</tr>
</tbody>
</table>

These next questions are also about your medicine. Circle one answer.

5. Do you ever forget to take your diabetes medicine?.................................Yes, No, or No diabetes

6. Are you careless (forgetful, absent-minded) at times about taking your diabetes medicine? Yes, No, or No diabetes

7. When you feel better, do you sometimes stop taking your diabetes medicine?.................Yes, No, or No diabetes

8. Sometimes if you feel worse when you take the diabetes medicine, do you stop taking it? Yes, No, or No diabetes

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These next questions are about your health insurance and health care costs.

9. What type of medical insurance do you have? Check one box.
   - Private insurance □
   - Medicaid/Medi-Cal □
   - County medical services/CMSP □
   - Medicare □
   - No insurance □

10. Do you have one person you think of as your personal doctor or health care provider? Yes or No

11. Was there a time in the past 6 months when you needed to see a doctor but could not because of cost? Yes or No

12. How much do you spend per month on diabetes medications? $

   Check here if you do not have diabetes

13. How much does it cost you to see a doctor (e.g., co-payment or sliding scale fee)? $

14. During the past 6 months and considering all costs (medication, visits, travel, etc) approximately how much did you spend to take care of your diabetes? $

   Check here if you do not have diabetes

促使 Important note: If you do not have diabetes, please go to Question 23. These next questions are about your health care visits.

15. When was your last visit to Clínicas de Salud del Pueblo, Inc. for diabetes treatment? ___/___/___ (month/day/year)

16. When was your last HbA1c test completed by CDSDP? ___/___/___ (month/day/year)

17. In the past 6 months, how many planned health care visits did you have related to your diabetes? ___ Number of visits

18. In the past 6 months, how many planned health care visits did you have for other reasons? ___ Number of visits

19. In the past 6 months, how many unplanned health care visits did you have related to your diabetes? ___ Number of visits

20. In the past 6 months, how many visits did you have to seek emergency/acute care related to your diabetes? ___ Number of visits

21. In the past 6 months, on how many nights did you have to stay in the hospital overnight related to your diabetes? ___ Number of nights

22. In the past 6 months, how many days did you miss work because of your diabetes? ___ Number of days

When you visit your health care provider, how often do you…

23. Prepare a list of questions for your doctor. Never □
   - Almost never □
   - Sometimes □
   - Fairly often □
   - Very often □
   - Always □
24. Ask questions about things you want to know and things you don’t understand about your treatment..............................................Never □ 0
Almost never □ 1
Sometimes □ 2
Fairly often □ 3
Very often □ 4
Always □ 5

25. Discuss any personal problems that may be related to your diabetes...............................Never □ 0
Almost never □ 1
Sometimes □ 2
Fairly often □ 3
Very often □ 4
Always □ 5

🎉 Important note: If you do not have diabetes, please go to Question 32.
These next questions are about your diabetes self care behaviors.

26. On how many of the last seven days did you eat five or more servings of fruit and vegetables? A serving of fruit is ½ cup; a serving of vegetables is ½ to 1 cup.

0 None 1 2 3 4 5 6 7

27. On how many of the last seven days did you eat high-fat foods, such as red meat or full-fat dairy products?

0 None 1 2 3 4 5 6 7

28. On how many of the last seven days did you participate in at least 30 minutes total of physical activity?

0 None 1 2 3 4 5 6 7

29. On how many of the last seven days did you test your blood sugar?

0 None 1 2 3 4 5 6 7

30. On how many of the last seven days did you check your feet?

0 None 1 2 3 4 5 6 7

31. Have you smoked a cigarette, even a puff, in the past 7 days?.................................Yes □ 1 or No □ 0
31a. If Yes, how many cigarettes did you smoke on an average day? ...................... # of cigarettes
31b. If No, have you smoked a cigarette, even a puff, in the past 30 days? ......................Yes □ 1 or No □ 0

32. Would you say that in general your health is...? ..................................................Excellent □ 1
Very good □ 2
Good □ 3
Fair □ 4
Poor □ 5

🎉 Important note: If you do not have diabetes, please go to Question 35.
These next questions are about the support you receive from friends and family for your diabetes.

33. How much support do you get for dealing with your diabetes?...............................No support □ 1
A little support □ 2
Some support □ 3
Often get support □ 4
A great deal of support □ 5
34. How satisfied are you with the support you get for dealing with your diabetes?...
Not at all satisfied □ 1
A little satisfied □ 2
Somewhat satisfied □ 3
Satisfied □ 4
Extremely satisfied □ 5

These next questions are about understanding information.
35. How often do you have someone like a family member, clinic worker or caregiver help you read clinic materials?...
Never □ 1
Rarely □ 2
Sometimes □ 3
Often □ 4
Always □ 5

36. How often do you have problems learning about medical conditions because of difficulty understanding written information?...
Never □ 1
Rarely □ 2
Sometimes □ 3
Often □ 4
Always □ 5

37. How confident are you filling out health care forms for yourself?...
Not at all □ 1
A little □ 2
Somewhat □ 3
Quite a bit □ 4
Extremely □ 5

---

E. QUALITY OF LIFE AND DEPRESSION

Please indicate which statements best describe your own health today.

1. When it comes to your mobility...You have no problems walking about. □ 1
   You have some problems in walking about. □ 2
   You are confined to bed. □ 3

2. When it comes to your self-care...You have no problems with self care. □ 1
   You have some problems washing or dressing yourself. □ 2
   You are unable to wash and dress yourself. □ 3

3. When you do your usual activities (e.g., work study, housework, family, or leisure activities)...You have no problems with performing your usual activities. □ 1
   You have some problems with performing your usual activities. □ 2
   You are unable to perform your usual activities. □ 3

4. In regards to your pain or discomfort...You have no pain or discomfort. □ 1
   You have moderate pain or discomfort. □ 2
   You have extreme pain or discomfort. □ 3

5. In regards to your anxiety or depression...You have not anxious or depressed. □ 1
   You are moderately anxious or depressed. □ 2
   You are extremely anxious or depressed. □ 3
Important note: If you do not have diabetes, please go to Question 10.

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. Listed below are four potential problem areas that people with diabetes may experience. Consider the degree to which each of the four items may have distressed or bothered you during the past month and choose the appropriate number. 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 check “1.” If it is very bothersome to you, you would check “6.”

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Feeling that I am often failing with my diabetes routine.</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>8. Not feeling motivated to keep up with my diabetes self-management</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>9. Feeling angry, scared and/or depressed when I think about living with diabetes.</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</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>10. Little interest or pleasure in doing things.</th>
<th>Nearly Everyday</th>
<th>More than half the days</th>
<th>Several days</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Feeling down, depressed, or hopeless.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>12. Trouble falling or staying asleep, or sleeping too much.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>13. Feeling tired or having little energy.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>14. Poor appetite or overeating.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>15. Feeling bad about yourself, feeling that you are a failure or feeling that have let yourself or your family down.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>16. Trouble concentrating on things, such as reading the newspaper or watching television.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>17. 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.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
Important note: If you do not have diabetes, please go to Section G.

The following questions ask about a variety of different resources that people may use to manage their diabetes. For each item, select the number that best indicates your experience over the last 3 months.

<table>
<thead>
<tr>
<th>How often in the last 3 months…</th>
<th>None of the time</th>
<th>A little bit of the time</th>
<th>Sometimes</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did your doctor or other health care provider involve you in making decisions about your diabetes?</td>
<td>□₁</td>
<td>□₂</td>
<td>□₃</td>
<td>□₄</td>
<td>□₅</td>
</tr>
<tr>
<td>2. Did your doctor or other health care provider listen to what you had to say about your diabetes?</td>
<td>□₁</td>
<td>□₂</td>
<td>□₃</td>
<td>□₄</td>
<td>□₅</td>
</tr>
<tr>
<td>3. Did your doctor or other health care provider tell you the results of any tests in a way you could understand (e.g. HbA1c, cholesterol, blood pressure or other laboratory tests)?</td>
<td>□₁</td>
<td>□₂</td>
<td>□₃</td>
<td>□₄</td>
<td>□₅</td>
</tr>
<tr>
<td>4. Did your family or friends exercise with you?</td>
<td>□₁</td>
<td>□₂</td>
<td>□₃</td>
<td>□₄</td>
<td>□₅</td>
</tr>
<tr>
<td>5. Did you share healthy low-fat recipes with friends or family members?</td>
<td>□₁</td>
<td>□₂</td>
<td>□₃</td>
<td>□₄</td>
<td>□₅</td>
</tr>
<tr>
<td>6. Did your family or friends make food for you that was healthy?</td>
<td>□₁</td>
<td>□₂</td>
<td>□₃</td>
<td>□₄</td>
<td>□₅</td>
</tr>
<tr>
<td>7. Did you think about good things you did to take care of your diabetes?</td>
<td>□₁</td>
<td>□₂</td>
<td>□₃</td>
<td>□₄</td>
<td>□₅</td>
</tr>
<tr>
<td>8. Did you think about the goals you set for yourself to take care of your diabetes?</td>
<td>□₁</td>
<td>□₂</td>
<td>□₃</td>
<td>□₄</td>
<td>□₅</td>
</tr>
<tr>
<td>9. Did you make time to take care of your diabetes?</td>
<td>□₁</td>
<td>□₂</td>
<td>□₃</td>
<td>□₄</td>
<td>□₅</td>
</tr>
<tr>
<td>10. Did you walk or exercise outdoors in your neighborhood?</td>
<td>□₁</td>
<td>□₂</td>
<td>□₃</td>
<td>□₄</td>
<td>□₅</td>
</tr>
<tr>
<td>11. Did you walk or exercise with your neighbors?</td>
<td>□₁</td>
<td>□₂</td>
<td>□₃</td>
<td>□₄</td>
<td>□₅</td>
</tr>
<tr>
<td>12. Did you eat at a restaurant that had low-fat food choices?</td>
<td>□₁</td>
<td>□₂</td>
<td>□₃</td>
<td>□₄</td>
<td>□₅</td>
</tr>
<tr>
<td>13. Did you go to parks for picnics, walks or other outings?</td>
<td>□₁</td>
<td>□₂</td>
<td>□₃</td>
<td>□₄</td>
<td>□₅</td>
</tr>
<tr>
<td>14. Did you read articles in newspapers or magazines about taking care of your diabetes?</td>
<td>□₁</td>
<td>□₂</td>
<td>□₃</td>
<td>□₄</td>
<td>□₅</td>
</tr>
<tr>
<td>15. Did you have health insurance that covered most of the costs of your medical care and medicines?</td>
<td>□₁</td>
<td>□₂</td>
<td>□₃</td>
<td>□₄</td>
<td>□₅</td>
</tr>
<tr>
<td>16. Have you seen ads about not smoking, eating low-fat foods or getting regular exercise?</td>
<td>□₁</td>
<td>□₂</td>
<td>□₃</td>
<td>□₄</td>
<td>□₅</td>
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</tbody>
</table>
G. OTHER HEALTH BEHAVIORS

1. During the past 30 days, how many days per month did you have at least one drink of any alcoholic beverage? .................................................................____ days per month

2. One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average? Note: A 40 ounce beer would count as 3 drinks, or a cocktail drink with 2 shots would count as 2 drinks. .................................................................____ Number of drinks

3. Considering all types of alcoholic beverages, how many times during the past 30 days did you have [say “5” if man; say “4” if woman] or more drinks on an occasion (for example, at a friend's house or a get-together)? .................................................................____ times in past 30 days

4. During the past 30 days, how many hours of actual sleep did you get at night on a typical night? This may be different from the number of hours you spent in bed. .........................____ hours in a typical night

5. During the past 30 days, how many times in a typical week did you eat fast food for breakfast, lunch, or dinner? Fast food includes restaurants like McDonalds and Pizza Hut, but also food sold from lunch wagons and vending machines. .................................................................____ times in a typical week
7. During the past 30 days, about how many cups of FRUIT (including 100% pure fruit juice) do you eat or drink in a typical day? ...........................................................

1 cup is equal to...
- 1 small apple
- 1 large banana
- 1 large orange
- 8 large strawberries
- 1 medium pear
- 2 large plums
- 32 seedless grapes
- 1 cup (8 oz.) of 100% juice
- ½ cup of dried fruit
- 1 small wedge of watermelon (1 inch thick)

None □ 0
½ cup or less □ 1
More than ½ a cup to 1 cup □ 2
More than 1 cup to 2 cups □ 3
More than 2 cups to 3 cups □ 4
More than 3 cups to 4 cups □ 5
4 or more cups □ 6

7. During the past 30 days, about how many cups of VEGETABLES (including 100% vegetable juice) do you eat or drink in a typical day? ...........................................................

1 cup is equal to...
- 3 broccoli spears, 5 in. long
- 1 cup of cooked leafy greens
- 2 cups of lettuce or raw greens
- 12 baby carrots
- 1 medium potato
- 1 large sweet potato
- 1 large ear of corn
- 1 large raw tomato
- 2 large celery stalks
- 1 cup of cooked beans

None □ 0
½ cup or less □ 1
More than ½ a cup to 1 cup □ 2
More than 1 cup to 2 cups □ 3
More than 2 cups to 3 cups □ 4
More than 3 cups to 4 cups □ 5
4 or more cups □ 6

H. MASTERY

These questions are about how much control you feel over things in your life.

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have little control over the things that happen to me.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>2. What happens to me in the future mostly depends on me.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>3. There is little I can do to change many of the important things in my life.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>4. There is really no way I can solve some of the problems I have.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>5. I can do just about anything I really set my mind to do.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>6. Sometimes I feel that I’m being pushed around in life.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>7. I often feel helpless in dealing with the problems of life.</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
</tbody>
</table>
1. Do you think of yourself as being Latino, Hispanic, Mexican/Mexican American, or of Spanish origin? ................................................................. Yes1 or No0

2. Which one or more of the following would you say is your race? ........................................ White □
   Black or African-American □
   Asian or Asian-American □
   Native Hawaiian or Other Pacific Islander □
   American Indian or Alaska Native □
   Other □

3. Were you born in the U.S. or in another country? ...................................................... United States □
   Mexico □
   Central America □
   South America □
   Other country □

4. **If born in another country**, at what age did you first come to the U.S. to live? ..........______age
   Check here if you were born in the U.S.□

5. **If born in another country**, from the time you first moved to the U.S. until today, how many years have you lived in the U.S.? ................................................................. ____ yrs in U.S.
   Check here if you were born in the U.S.□

6. In the past month, how often did you cross the border into Mexico?.........................
   Every day □
   4-5 times a week □
   2-3 times a week □
   1 time a week □
   Every two weeks (or twice in the past month) □
   Once in the past month □
   I did not cross the border in the past month □

7. Where were your parents born? **Check all that apply**. ..............................................
   Born in U.S. □
   Born in Mexico □
   Born in Central America □
   Born in South America □
   Born in another country □

8. Where were your grandparents born? **Check all that apply**.................................
   Born in U.S. □
   Born in Mexico □
   Born in Central America □
   Born in South America □
   Born in another country □
9. This set of questions concerns your use of different languages and your ethnic identification.

<table>
<thead>
<tr>
<th></th>
<th>Almost always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Almost never</th>
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</thead>
<tbody>
<tr>
<td>a. How often do you speak English?</td>
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<tr>
<td>b. How often do you speak English with your friends?</td>
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<tr>
<td>c. How often do you speak in Spanish?</td>
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<tr>
<td>d. How often do you speak Spanish with your friends?</td>
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<tr>
<td>e. How well do you speak English?</td>
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<tr>
<td>f. How well do you read in English?</td>
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<tr>
<td>g. How well do you understand TV programs in English?</td>
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<tr>
<td>h. How well do you understand radio programs in English?</td>
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<tr>
<td>i. How well do you write in English?</td>
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<td></td>
<td></td>
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<tr>
<td>j. How well do you understand music in English?</td>
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<tr>
<td>k. How well do you speak Spanish?</td>
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<tr>
<td>l. How well do you read in Spanish?</td>
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<tr>
<td>m. How well do you understand TV programs in Spanish?</td>
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<tr>
<td>n. How well do you understand radio programs in Spanish?</td>
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<tr>
<td>o. How well do you write in Spanish?</td>
<td></td>
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<td></td>
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<tr>
<td>p. How well do you understand music in Spanish?</td>
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<tr>
<td>q. How often do you watch TV programs in English?</td>
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<tr>
<td>r. How often do you listen to radio programs in English?</td>
<td></td>
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<td></td>
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<tr>
<td>s. How often do you listen to music in English?</td>
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<tr>
<td>t. How often do you search the internet in English?</td>
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<td></td>
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<tr>
<td>u. How often do you watch TV programs in Spanish?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>v. How often do you listen to radio programs in Spanish?</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>w. How often do you listen to music in Spanish?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>x. How often do you search the Internet in Spanish?</td>
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</tbody>
</table>
This section asks some personal questions about you.

1. What is your age? ................................................................. __ __ years old

2. What is your birthdate? ............................................................ ___ / ___ / ___
   (month/day/year)

3. Are you...? ..............................................................................
   Female □ 1
   Male □ 2

4. What is your marital status? ......................................................
   Married, living with spouse □ 1
   Married, not living with spouse □ 2
   Living as married □ 3
   Divorced □ 4
   Widowed □ 5
   Separated □ 6
   Single or never married □ 7

5. Are you currently...? ..............................................................
   Employed for wages full-time □ 1
   Employed for wages part-time □ 2
   Self-employed □ 3
   Employed in seasonal labor (farmworker) □ 4
   Out of work for more than one year □ 5
   A homemaker □ 6
   A student □ 7
   Retired □ 8
   Do not work or unable to work □ 9

6. How many hours per week do you usually work? ..................... ___ ___ hours per week
   Check here if you are not currently working. □

7. What is your occupation? ......................................................

8. Of the following, which best describes your occupation...? ...........
   Professional or Technical □ 0
   Manager, Official or Proprietor □ 1
   Clerical □ 2
   Sales worker □ 3
   Craftsman, Foreman or Skills Manual Worker (aka Master Craftsman) □ 4
   Semi-skilled Operative (Journeyman) □ 5
   Service Worker (Apprentice) □ 6
   Laborer or Farmworker (unskilled labor) □ 7
   Do not work □ 88
9. What is the highest grade or year of school you have completed? Did not go to school  
   1st grade 
   2nd grade 
   3rd grade 
   4th grade 
   5th grade 
   6th grade 
   7th grade/first year of secundaria 
   8th grade/second year of secundaria 
   9th grade/third year of secundaria 
   10th grade/first year of preparatoria 
   11th grade/second year of preparatoria 
   12th grade/GED/third year of preparatoria 
   1+ years of college but no degree (including any technical college) 
   Associate degree 
   Bachelor’s degree 
   Master’s degree 
   Doctoral degree 
   Professional degree (MD, JD) 

10. Where did you complete most of your education? In the United States  
    In your country of origin  
    In another country 

11. Which range best describes your household’s monthly income from all sources?  
    less than $500  
    $500 to $999  
    $1,000 to $1,499  
    $1,500 to $1,999  
    $2,000 to $2,499  
    $2,500 to $2,999  
    $3,000 to $3,499  
    $3,500 to $3,999  
    $4,000 to $4,499  
    $4,500 to $4,999  
    $5,000 to $5,499  
    $5,500 to $5,999  
    $6,000 to $6,499  
    $6,500 to $6,999  
    $7,000 to $7,499  
    $7,500 or more 

12. How many people does this income support? Number of people 

13. What is your current living situation? Own a home, live with my family  
    Rent an apartment/house, live with my family  
    Rent an apartment/house, share it with non-family members 

14. How long have you lived in your present location? Number of years or months 

15. How many working motor vehicles do you have in your home? Number of working vehicles 

16. Do you have internet access at home? Yes or No
17. Compared to other people you know, would you say your family is financially better off or worse off than other families?
   - Much worse off □
   - Somewhat worse off □
   - About the same □
   - Better off □
   - Much better off □

18. How many children under 18 years of age live in your household? ........... ___ Number of children

19. How many adults (18 years of age or older) live in your household including yourself? ................................................................. ___ Number of adults
A. VOLUNTEER EXPERIENCE

J. PROCESS EVALUATION

1. What does it mean to be a Puentes líder?

2. Is the Puentes program meeting your expectations? If it is meeting your expectations, tell us why. If it is not meeting your expectations, tell us why.

3. What challenges have you confronted as a Líder?

4. What did you do to overcome these challenges?

5. How effective was the training you received to become a Líder? 
   - Not very effective; □
   - A little effective; □
   - Somewhat effective; □
   - Very effective; □

6. What did you like most about the training?

7. What did you like least about the training?

8. How confident are you in your abilities to serve as a Líder?
   - Not at all confident; □
   - A little confident; □
   - Somewhat confident; □
   - Very confident; □
9. During the past six months, about how many hours per week did you spend on Puentes activities? ........................................... __________________ hours per week

10. How interested are you in continuing to serve as a Líder? Not at all interested; □
                                A little interested; □
                                Somewhat interested; □
                                Very interested; □

11. What new skills did you acquire as part of the Puentes program? ________________________________

12. Have the skills and knowledge you obtained as a Líder helped you in other parts of your life? Yes; □
                                No; □
                                a. If yes, in which other parts of your life? Check all that apply ........................................... Job; □
                                Family; □
                                Community; □
                                Other______________

13. How successful do you think the Puentes program is in helping Clinicas’ patients control their diabetes? Not at all successful; □
                                A little successful; □
                                Somewhat successful; □
                                Very successful; □

14. What support are you getting as a Líder in the Puentes program? ________________________________

15. Thinking about all forms of support, how much support do you get from the Puentes program? No support; □
                                A little support; □
                                Some support; □
                                A lot of support; □

16. In what ways can the Puentes program improve its support to Líderes? ________________________________

17. What aspects of the Puentes program do you like most? ________________________________

18. What aspects of the Puentes program do you like least? ________________________________
Conocimientos de Entrenamiento

1. ¿Cuáles son los síntomas de un nivel alto de azúcar en la sangre? En otras palabras, ¿cómo se siente una persona cuando su azúcar en la sangre está alta?

2. ¿Cuáles son los síntomas de un nivel bajo de azúcar en la sangre? En otras palabras, ¿cómo se siente una persona cuando su azúcar en la sangre está baja?

3. ¿Qué debe hacer una persona si su azúcar está demasiado baja?

4. ¿Con qué frecuencia debe una persona con diabetes revisarse los pies? ¿Debe ser una vez al día, una vez por semana o una vez al mes?

5. ¿Por qué son importantes los exámenes de los pies para alguien con diabetes? ¿Qué es lo que está buscando al verlos?

6. ¿Con qué frecuencia debe una persona con diabetes ver un oculista y por qué es importante hacerlo?

7. Cuando la persona se levanta por la mañana y lo primero que hace es revisar su nivel de azúcar en la sangre antes de comer o tomar medicamentos, ¿qué nivel de azúcar debe tener?
8. ¿Cuál es un nivel normal de HbA1c (hemoglobina A1C) o “prueba de nivel promedio de azúcar en la sangre”?

Para cada uno de los siguientes enunciados, por favor indique si usted cree que sea Verdadero o Falso y encierre en un círculo su respuesta.

<table>
<thead>
<tr>
<th>Enunciado</th>
<th>Verdadero</th>
<th>Falso</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. La causa común de la diabetes es la falta de insulina efectiva en el cuerpo.</td>
<td></td>
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<tr>
<td>11. La diabetes es causada porque los riñones no pueden mantener el azúcar fuera de la orina.</td>
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<tr>
<td>12. Los riñones producen insulina.</td>
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<tr>
<td>13. En la diabetes que no se está tratando, la cantidad de azúcar en la sangre usualmente sube.</td>
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<tr>
<td>14. Si yo soy diabético, mis hijos tendrán más riesgo de ser diabéticos.</td>
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<tr>
<td>15. La diabetes se puede curar.</td>
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<tr>
<td>16. Un nivel de azúcar de 210 en prueba de sangre hecha en ayunas es muy alto.</td>
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<tr>
<td>17. La mejor manera de revisar la diabetes es haciéndose pruebas de orina.</td>
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<tr>
<td>18. El ejercicio regular aumentará la necesidad de insulina u otro medicamento para la diabetes.</td>
<td></td>
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</tr>
<tr>
<td>19. Hay dos tipos principales de diabetes: Tipo 1 (dependiente de insulina) y Tipo 2 (no-dependiente de insulina).</td>
<td></td>
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<tr>
<td>20. Una reacción a la insulina es causada por demasiada comida.</td>
<td></td>
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<tr>
<td>21. Los medicamentos son más importante que la dieta y el ejercicio para controlar la diabetes.</td>
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<tr>
<td>22. La diabetes frecuentemente causa mala circulación.</td>
<td></td>
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<tr>
<td>23. Las cortaduras y raspones cicatrizan más despacio en los diabéticos.</td>
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<tr>
<td>24. Los diabéticos deberían poner cuidado extra al cortarse las uñas de los pies.</td>
<td></td>
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<tr>
<td>25. Una persona con diabetes debería limpiar una cortadura primero con yodo y alcohol.</td>
<td></td>
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<tr>
<td>26. La manera en que se prepara la comida es igual de importante que las comidas que se comen.</td>
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<tr>
<td>27. La diabetes puede dañar los riñones.</td>
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</tr>
<tr>
<td>28. La diabetes puede causar pérdida de sensibilidad en las manos, dedos y pies.</td>
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<tr>
<td>29. El temblar y sudar son señales de azúcar alta en la sangre.</td>
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</tbody>
</table>
| 30. El orinar frecuentemente y tener sed son señales de azúcar baja en la sangre. | Verdadero  
Falso |
| 31. Los calcetines y las medias elásticas apretadas no son malos para los diabéticos. | Verdadero  
Falso |
| 32. Una dieta diabética consiste principalmente de comidas especiales. | Verdadero  
Falso |

33. Cómo mínimo, ¿cuántas veces se debía reunir con sus compañeros durante los primeros seis meses?

34. ¿Cuáles son los tres entornos en que Ud. debe ayudar a sus compañeros manejar y porque es importante cada entorno?

35. ¿Cuáles son los tres tipos de apoyo que se pueden ofrecer a sus compañeros?

36. ¿Qué significa R-MESA?

37. Dibuje el contenido del plato de “T”.

3 of 4
38. ¿Qué significa FITT? Fije una meta de actividad física usando el concepto de FITT.

39. Identifique 3 síntomas de la depresión.

40. Identifique 3 maneras de mantener la salud emocional en buena forma.

41. ¿Qué significa el acrónimo AMAR y porque es importante enfatizarlo a las familias durante las visitas familiares?

42. Cómo mínimo, ¿cuántas visitas se recomiendan de llevarse a cabo en la clínica y por qué es importante que sus compañeros mejorar el uso de los servicios de atención médica?

43. Cómo mínimo, su formulario que registra su contacto con sus compañeros, ¿debe de incluir cuál información?

44. ¿Cuáles son ejemplos de información confidencial? ¿Cómo puede Ud. proteger la información personal de sus compañeros?
Part 4: Tracking
Tracking peer activities:
Where do I start?

Step 1: Develop a clear understanding of what you need and want to track.
• Type of contact?
• Amount of contact?
• What was discussed?
• Others involved?
• Action steps?
• Were peer leader skills used?

……Fidelity!!
Tracking peer activities:
Where do I start?

**Step 2:** Develop a tracking guide AND system to meet your needs AND train how to use

- Paper and pencil or electronic?
- Frequency of turning in documentation?
- Who supervises completion?
- How much training is needed?
Tracking Peer Advisor Activities

- Number of contacts
- Call content & duration
  - Including goals set and barriers identified by clients
- Adherence to principles of motivational interviewing
  - Collaborative, client centered approach

Tracking forms

- All Forms
  - N=2410, range 0-58, median, 12
- Categories for first goals set
  - Diet, Exercise, or Diet & exercise, 49.7%
  - Weight loss, 36.2%
  - Stress management, 7.9%
  - Medication Adherence, 2.8%
  - Doctor’s Visit, 1.7%
  - Other, 1.7%
  (monitor blood sugar, quit smoking, eye care)
Coaching approach

• Assessed at 6 months via questionnaire
• Assessed using video tool

Video Assessment
Tracking Peer Leader Activities

• Intervention
  – 12 group-based sessions
  – 2 one-on-one
  – 1 telephone support

• Skills
  – 5-step goal-setting, iSMART
  – Active listening, problem-solving

• Encounters
  – Frequency and length
  – Type and issues discussed
ENCOUNTER #1: IN PERSON
Feb. 1-Feb. 13
VALUES CLARIFICATION

Peer Leader: “Taking care of diabetes can be a lot of work. There are different reasons people want to make changes in their self-management. Sometimes it is helpful to think about what is important to you and what kind of person you are or want to be. The list (see Values Clarification Form) contains values, traits, and goals that can be important to some people. Looking at this list, what is important for you? Why is it important to you?

Evaluating values vs. self-management practices
After helping the participant identify the values and attributes that are important to him/her, help the participant think about whether their current self-management practices reflect their personal values.

Peer Leader: Now that we’ve explored the values that are important to you, think about the way you manage your diabetes.

Does your self-management relate to your values and goals?
Are they consistent with one another or do they conflict?
How will these values change the way you take care of your diabetes?

Clarifying values and their relationship to self-management
By exploring the link between self-management behavior and core values, you have laid the groundwork for achieving change. Next, your participant will explore his/her internal motivation to make improvements or changes as you lead him/her through the following questions:

Peer Leader: Choose a behavior you wish to change.
1. On a scale of 0 to 10 (10 being the highest), how motivated or interested are you in changing this behavior?
2. Assuming you want to change, on a scale of 0-10, how confident are you that you could change this behavior?
3. For questions 1 and 2, why did you not choose a lower number, like a 1 or 2? (To elicit positive motivational statements)
4. Why did you not choose a higher number? What would it take to get you to a 9 or 10? (To elicit barriers)

Peer Leaders: Please remember to fill out Encounter Note #1 and to update the Encounter Log.
Peer Leader: _________________________ Participant: ______________________

**ENCOUNTER NOTE #1: IN PERSON**
Feb. 1-Feb. 13

<table>
<thead>
<tr>
<th>Date:</th>
<th>Start Time:</th>
<th>End Time:</th>
</tr>
</thead>
</table>

What 3 values did your participant choose? Please also briefly describe why he/she felt these were important.

1. 

2. 

3. 

**Core Education Areas**

Reflect on the discussion you just had. What do you think your participant's main goal was for this encounter? Circle the core education area that describes his/her goal.

- Healthy Eating
- Healthy Coping
- Reducing Risks
- Problem Solving
- Being Physically Active
- Monitoring
- Taking Medication
- Other__________

Peer Leaders: Please remember to update the Encounter Log.

---

**Encounter one: Active listening**

[Image of a digital recorder]
ENCOUNTER #2: IN PERSON
Feb. 14-Feb. 27
5-STEP BEHAVIORAL GOAL-SETTING MODEL

Peer Leader: _________________________
Participant: _______________________

Step 1: Define the problem
What is the hardest thing about living with diabetes for you?
Please tell me more about that.
Are there some specific examples you can give me?

Step 2: Recognize your feelings
What are your feelings or thoughts about this?
Why do you think you feel this way?
Are you feeling _______ because _______?

Step 3: Choose a goal
What do you want to accomplish?
How would this situation be different for you to feel better about it?
What are your options?
What would happen if you do not do anything about it?

Step 4: Make a plan to reach your goal
Peer Leader: As you work on a plan together: have your participant fill out his/her copy
along with you while you fill out the Peer Leader Copy.

Let’s develop a plan using the I-SMART experiential form.

Looking Ahead to Encounter 4 > Step 5: Experience and evaluate the plan

How did it go?
What did you learn?
What barriers did you encounter?
What, if anything, would you do differently next time?
What will you do when you leave here today?

I-SMART Experiment notes: (possible topics to address: What goal was chosen? What about this process was challenging to your participant? What came naturally to them? Do you think they felt sufficiently motivated? Confident? Etc.)

Core Education Areas
Reflect on the goal your participant chose to work on. What core education area does it fall under? Circle the core education area that best describes his/her goal.

<table>
<thead>
<tr>
<th>Healthy Eating</th>
<th>Healthy Coping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing Risks</td>
<td>Problem Solving</td>
</tr>
<tr>
<td>Being Physically Active</td>
<td>Monitoring</td>
</tr>
<tr>
<td>Taking Medication</td>
<td>Other</td>
</tr>
</tbody>
</table>

Peer Leaders: Please remember to fill out Encounter Note #2 and to update the Encounter Log.

www.peersforprogress.org
My I-SMART 
Diabetes Action Plan 
Inspiring - Specific Measurable Achievable Relevant Time-specific 

Inspiring:  ... 

Time-specific: How long will you do this experiment? 

   _______________________________________________________

Specific: What will you do? Where will you do it? When will you do it? 

   _______________________________________________________

Measurable: How much will you do? How often will you do it? 

   _______________________________________________________

Achievable: What barriers, if any, do you expect to face? How will you overcome these barriers? 

   _______________________________________________________

Relevant: How will this step help you achieve your overall goal? 

   _______________________________________________________

www.peersforprogress.org
ENCOUNTER LOG

Weeks 3-4 (Feb. 14th-Feb. 27th): Personal Encounter

<table>
<thead>
<tr>
<th>Participant</th>
<th>Date</th>
<th>Length of conversation</th>
<th>CDE Notes</th>
</tr>
</thead>
</table>

---

ENCOUNTER NOTE #3: BY PHONE

Date: __________________________
Start Time: _____________________
End Time: _______________________

Please note some of the things you discussed with your participant. How are they doing with their goal? Have they revised it?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Core Education Areas

Reflect on the discussion you just had. What do you think your participant’s main goal was for this encounter? Circle the core education area that best describes his/her goal.

Healthy Eating
Healthy Coping
Reducing Risks
Problem Solving
Being Physically Active
Monitoring
Taking Medication
Other_________________

www.peersforprogress.org

Peer Leaders: Please remember to update the Encounter Log.
Tracking peer leader activities

- Determine intervention fidelity
  - 8 contacts during first 6 months

- Exploratory:
  - Frequency and amount of contact
  - Type of contact
  - Initiation of contact
  - How peer felt
  - Topics discussed
  - Others present
First attempt
Leaders completed forms and turned them into coordinator at biweekly meeting.

+ Opportunity to discuss with coordinator.
- Perceived as burdensome.

Second attempt
Calls made by a trained staff member to each leader. Notes were reviewed with coordinator during biweekly meetings.

+ Reduce burden on leader.
- No support provided by caller.
Third & final attempt
Leaders complete forms and turn into coordinator at biweekly meeting.

+ Opportunity to discuss with coordinator.
+ Acknowledges attempts made.
+ Less burdensome because closed-ended
Similarities

• Tracking forms completed by peers and submitted for review

• Tracking different types of encounters (group, one-on-one, telephone)

• Tracking details of encounter
  – Frequency and duration
  – Content and topics discussed

Differences
Differences

• Approaches to tracking
  – Audiotaping (Michigan)
  – Direct observation and feedback by CDE (Michigan)

• Skills tracked
  – Motivational interviewing (Alabama)
  – Active listening (Michigan)

Lessons Learned
Lessons learned

• Provide sufficient training on how to and importance of tracking

• Volunteer time - intervention activities or documentation?

• Track attempted contacts

• Original number and type of encounters too ambitious
  – 3 one-on-one; 3 telephone contacts (original)
  – 2 one-on-one; 1 telephone contact (revised)

• Audiotaping logistically difficult and burdensome

www.peersforprogress.org
Treatment Fidelity: Group session # ___

Peer Leader: ___________________ Date/Time: ___________________

On a scale of 1-5 with 1= strongly disagree and 5 = strong agree, rate peer leader’s performance in evaluating behavioral experiments and helping participants make an I-SMART behavioral experiment.

Evaluating participant’s behavioral experiment

1. Gives participant time and space to describe their experience _____
2. Avoids “success” and “failure” descriptions _____
3. Uses questions and reflects to clearly identify barriers _____
4. Responds to “feeling words” used by the participant or asks participant to identify feelings _____
5. Expresses understanding verbally and non-verbally _____
6. Helps participant identify lessons learned from the experience _____
7. Engages group participants in problem-solving _____

Goal-setting/I-SMART action plan

1. Helps participant identify an INSPIRING goal _____
2. Helps participant select a SPECIFIC behavioral experiment _____
3. Helps participant make the behavioral experiment MEASURABLE _____
4. Helps participant assess how ACHIEVABLE experiment is _____
5. Helps participant assess if experiment is RELEVANT to goal _____
6. Helps participant establish a specific TIME FRAME for experiment _____
ENCOUNTER NOTE #1: IN PERSON

Feb. 1-Feb. 13

Date: ______________ Start Time: ______________ End Time: ______________

What 3 values did your participant choose? Please also briefly describe why he/she felt these were important.

1. _______________________________________________________
   __________________________________________________________________

2. _______________________________________________________
   __________________________________________________________________

3. _______________________________________________________
   __________________________________________________________________

Core Education Areas

Reflect on the discussion you just had. What do you think your participant’s main goal was for this encounter? Circle the core education area that describes his/her goal.

- Healthy Eating
- Reducing Risks
- Being Physically Active
- Taking Medication
- Healthy Coping
- Problem Solving
- Monitoring
- Other__________________

Peer Leaders: Please remember to update the Encounter Log.
ENCOUNTER NOTE #3: BY PHONE

Feb. 28-March 13

Date: _______________ Start Time: _______________ End Time: _______________

What was your participant most concerned about? Is this related to the goals he/she has been setting? Tell us anything you wish about this encounter.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Core Education Areas

Reflect on the discussion you just had. What do you think your participant’s main goal was for this encounter? Circle the core education area that best describes this goal.

- Healthy Eating
- Healthy Coping
- Reducing Risks
- Problem Solving
- Being Physically Active
- Monitoring
- Taking Medication
- Other __________________

Peer Leaders: Please remember to update the Encounter Log.
One-on-One visit form
[Use this form for every contact with your peers]

Name of leader: ___________________ ID number of peer: ______________________

Date: _______________ Start time: _______________ End time: _______________

Type of contact:
☐ Home visit
☐ Visit to the clinic
☐ By telephone
☐ By regular mail or email
☐ Other ________________________________

Who initiated the contact?
☐ The leader
☐ The peer
☐ Another person or organization__________________

City: __________________________ Location: _______________________________

Topics discussed:
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

What support or resources did you give the peer? (listened to him/her, gave materials
or information about services)
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Were other people present during visit?  No or Yes → If yes, who?
(if contact was by telephone, write ‘not applicable’ here)
_____________________________________________________________________
_____________________________________________________________________

Topics/issues to review for next time:
_____________________________________________________________________
_____________________________________________________________________

How did your peer feel?
Circle one.

N=Don’t know

Happy? Nervous? Not Interested? Sad?

(revised 11.18.10; green)
Número del líder / leader ID number

Notes

__________________________________________________________________________

__________________________________________________________________________

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Formulario de visita personalizada

[Use esta forma para cada contacto con su compañero(a)]

Número del líder: ________________
Número del compañero: ________________

Fecha: ____________
Hora que inicia: ____________
Hora que termina: ____________

Tipo de contacto:
☐ Visita familiar
☐ Visita a la clínica
☐ Llamada por teléfono
☐ Por correo ordinario o electrónico
☐ Otro ________________

¿Quién inició el contacto?:
☐ El líder
☐ El compañero
☐ Otra persona u organización ________________

Ciudad: ________________
Lugar: ________________

Temas presentados:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

¿Qué apoyo o recursos le dio al compañero? (le escucho, le dio materiales o información sobre servicios)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

¿Hubo otras personas presentes durante la visita? Sí o No. En caso afirmativo, quién(es)?
(sí su contacto fue por teléfono, escribe "no aplique")
________________________________________________________________________
________________________________________________________________________

Temas/asuntos a repasar para la próxima vez:
________________________________________________________________________
________________________________________________________________________

¿Cómo se sintió su compañero? Encierre en un círculo su respuesta.

☐ ¿Alegre?
☐ ¿Nervioso?
☐ ¿No interesado?
☐ ¿Triste?

Número del compañero / participant ID number

(revised 11.18.10; green)
Notas
Group sign-in sheet
[Use this form for every group with your peers]

Leader name: ________________

Date: ___________  Start time: _______________  End time: __________________

Session:  1  2  3  4  5  6  7  8  #________

City: __________________________  Location: ______________________________

Topic of session:________________________________________________________

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<th>Name</th>
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</table>

C=Companion/Peer  
F=Family member  
O=Other  
N=Don’t know

(revised 11.18.10; yellow)
# Hoja de asistencia del grupo

[Use esta forma para cada grupo con sus compañeros(as)]

Nombre del líder: ________________

Fecha: __________ Hora que inicia: __________ Hora que termina: __________

Sesión:  1  2  3  4  5  6  7  8  #_____ 

Ciudad: ___________________________ Lugar: _____________________________

Tema de la sesión:________________________________________________________

<table>
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<tr>
<th>Nombre</th>
<th>(para uso del líder solamente)</th>
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</table>

C=Compañero  
F=Familiar  
O=Otro  
N=No sé

(revised 11.18.10; yellow)
Número del líder/ leader ID

Notas

(revised 11.18.10; yellow)
Líder: M. JACÓ  
Fecha: 04/25/11  
Ciudad: CALEXIUDA

2-012  
**CONSIDÍMO** MI COMPAÑERA Y YO EN EL MERCADO POR MOTIVOS PERSONALES. DESDE SU ANTERIOR DOMICILIO, SU #TEL: 9601455-0430, DON. CLEVELAND 2225, CALEXIUDA. ESTO BIEN DE SALVO Y NO HUA. HECHAS UNA CITAS CON EL DOCTOR.

2-027  
LE MARQUE A MI COMPAÑERA, NO ESTABA QUE REGRESÓ EN LA NOCHE 04/25/11 HONQ 6:25. LLENO LE MARQUE A MI COMPAÑERA EL 04/23/11, A LAS 4:35, NO ESTABA ME DIO SU HIDA QUE LE HACER POR LA MONTAÑA.

2-035  
TÉLEF DE COMUNICACIÓN, SIN EVIDENCIA HONQ 6:25-010 04/25/11

**LOCALICE** A MI COMPAÑERA AL 6:35, ESTE MIERCO, EL LUNES 25 TUVO CITAS CON EL DOCTOR. HORA: 4:17  FECHA: 04/27/11

2-036  
DÍA: 04/25/11, HORA: 6:35, TUVO CITAS CON EL DOCTOR, HICE LIC. MIERCO, 00, 02 ABRIL Y SU PROGRAMA CITAS 21 DE MAYO.

2-006  
PLATIQUE CON MI COMPAÑERA, ABRIL-26, HORA: 6:35, ME DICE QUE TODO BIEN. EL 4/20/11 TUVO CITAS CON EL DOCTOR Y SU PROGRAMA CITAS 05/21/11, LE COMENZÓ SU MEDICINAS Y MEDICAMENTOS PREVIO.

2-010  LE MARQUE A MI COMPAÑERA 04/25/11, SIN ÉXITO, DEJO MENSAJE.

Notas
Successful Contacts

[If you did not have a successful contact with your compañero(a), please make a note of the attempt on the back of this page]

Answer questions 1 to 3 for all contacts. 

*If the contact was one-on-one, also answer questions 4 to 6.*

<table>
<thead>
<tr>
<th>Day of the Week</th>
<th>Date</th>
<th>Start time</th>
<th>End time</th>
<th>HbA1c</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon</td>
<td>Tue</td>
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<td>Thur</td>
<td>Fri</td>
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</tbody>
</table>

(1) Who initiated the contact? *(select one)*

- [ ] The líder
- [ ] The compañero
- [ ] Another person or organization: ______________________________________

(2) What topics were discussed? *(select all that apply)*

- [ ] Control of diabetes
- [ ] Glucose exam
- [ ] HbA1c
- [ ] Diet/nutrition
- [ ] Exercise
- [ ] Emotional support
- [ ] Depression or stress
- [ ] Reference to services/aid
- [ ] Other: __________________________

(3) How did your compañero feel during the visit? *(select one)*

- [ ] Happy?
- [ ] Nervous?
- [ ] Sad?
- [ ] Not interested?

If the contact was by telephone, STOP here.

If the contact was one-on-one, continue with questions 4, 5, and 6.

(4) City:

- [ ] Brawley
- [ ] Calexico
- [ ] El Centro
- [ ] Other: __________________________

(5) Location:

- [ ] Home
- [ ] Clinic
- [ ] In the community _______________________
- [ ] Other: __________________________

(6) Were there other people present during the visit?

- [ ] Spouse
- [ ] Child
- [ ] Parent
- [ ] Other family member: __________________
- [ ] Other: __________________________

Notes

(Revised 05.06.11; green)
**Attempted Contacts**

[Until you have a successful contact with your compañero, please make note of attempted contacts on this page.]

<table>
<thead>
<tr>
<th>Day of the Week</th>
<th>Date</th>
<th>Time</th>
<th>Contact Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon Tue Wed Thur Fri Sat Sun</td>
<td>Mo. / Day / Year</td>
<td>: AM/PM</td>
<td>Telephone call</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>One-on-one visit</td>
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<tr>
<td>Notes</td>
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</tbody>
</table>

(Revised 05.06.11; green)
<table>
<thead>
<tr>
<th>Día de la semana</th>
<th>Fecha</th>
<th>Hora que inició</th>
<th>Hora que terminó</th>
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(1) ¿Qué temas se hablaron? *(selecciona todos los que aplican)*
- Control de la diabetes
- Examen de glucosa en ayunas
- HbA1c
- Dieta/nutrición
- Ejercicio
- Apoyo Emocional
- Depresión o estrés
- Referencia a servicios/ayuda
- Otro(s):

(3) Ciudad:
- Brawley
- Calexico
- El Centro
- Otro: _______________________________

(4) Lugar:
- Casa
- Clínica
- En la comunidad ______________________
- Otro: _______________________________

<table>
<thead>
<tr>
<th>Número del compañero</th>
<th>¿Cómo se sintió su compañero durante la visita?</th>
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<tbody>
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(Revised 05.06.11; green)
Número del líder(es): _______________

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Notas