

Personal Health Engagement™ Model and *Conversation Map*® Programs – Enabling Effective Behavior Change to Impact Health

Healthy Interactions Inc.

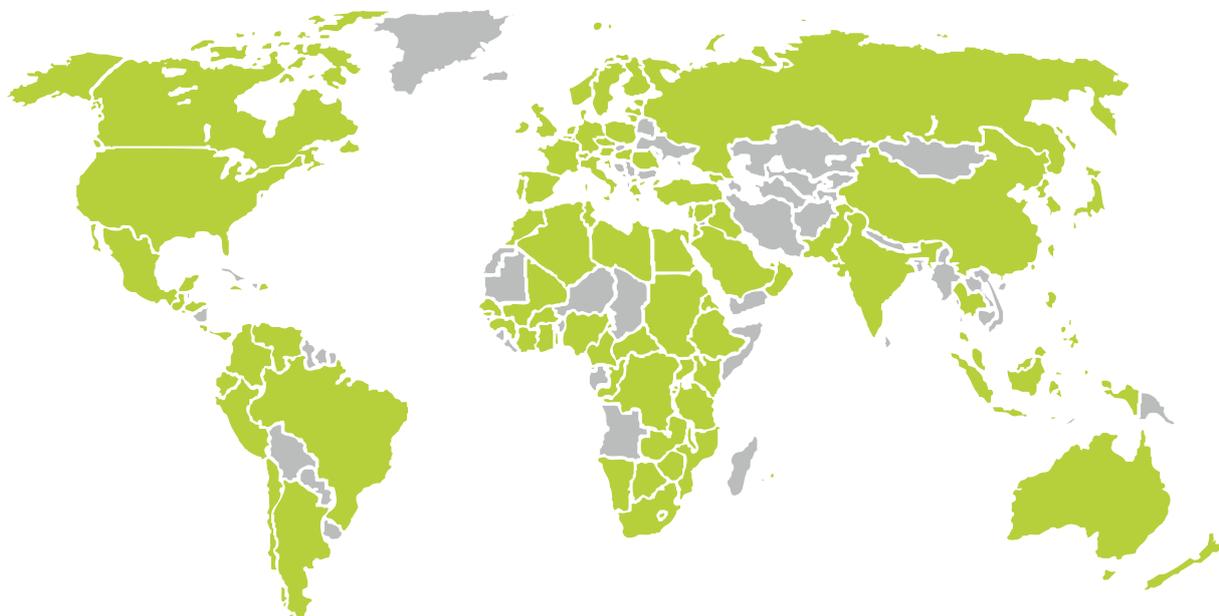
Introduction

Healthy Interactions is transforming health care education throughout the world by engaging people in meaningful conversations about their health. Our mission is to become the global standard for health education and to improve decision-making, behaviors, and actions by transforming the way people experience, internalize, and respond to health-related information.

Personal Health Engagement (PHE) programs, developed by Healthy Interactions, are built on the philosophy that people respond better when they are involved, empowered, and come to their own conclusions as to why they need to change behaviors that will ultimately have an impact on their health.

The *Conversation Map* education tools are one of the vehicles used within PHE programs. *Conversation Map* experiences allow for information sharing, peer support and the clinical intervention needed to prepare a person for optimal self-management and care.

Healthy Interactions' *Conversation Map* tools have been utilized in over 100 countries by thousands of health care professionals and millions of people with chronic conditions. The tools are making a difference in the way health care professionals deliver self-management education and the way people manage their medical conditions.



This paper examines what it takes to change behaviors needed to improve health outcomes, the principles of learner-centered intervention methods, and what it takes to put Personal Health Engagement model in practice.

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1. Behavior Change Related to Improving Health and Care

A. What does it take?

“If you can not explain it simply, you do not understand it well enough”- Albert Einstein. The solutions to behavior change needed to improve health outcomes are within the person who needs to implement them. The person with the chronic medical condition is responsible for his own self-care management and care. It takes an empowered, well-prepared and supported patient to do what needs to be done to effectively manage his condition. The way to accomplish this is via a productive communication between the health care professionals and patients.

For chronic conditions, behavior change is a critical element of the therapy. The person with the medical condition is directly responsible for manipulating daily routines and tasks needed to achieve the desirable metabolic markers. Consequently, effective self-care management (taking medications, monitoring symptoms, controlling pain, preventing or minimizing negative side effects and just feeling well) involves some form of behavior change.

Any change requires work to modify the existing environment and circumstances – this is not always easy. We have created routines that make us feel in control or good given the circumstances. To change a usual way of behaving we need to examine our intrinsic and extrinsic values and circumstances and weigh the cost and benefits of the change.

Despite a medical indication for the need to change, many people do not change. There are many reasons why people do not change. Some simply do not want to change, some do not feel confident to make the change, some feel limited by their environmental circumstances, some feel like giving up after one or more failures, some do not feel enough pain yet, some do not know how and what to change, and some do not want it change (or its resulting perceived benefits) enough to work through the difficulties of getting there - as big changes might require a lot of little changes that require time and work.

Many people are resistant to change even though they know that the change is good for them. They almost need to evaluate what they are giving up before examining their willingness to make a change. Other people might not be able to know how it can possibly feel when they achieve something that they have never experienced before. They can't yet fathom how good things might get if they have never felt that kind of good before.

As it relates to health and managing a chronic condition, people need the knowledge and skills to perform self-care on a day-to-day basis. Each person has to evaluate their existing situation, willingness, readiness, ability, and confidence to make the needed changes that will result in better health. It is a very individual process that requires an individual to internalize their own position on the situation and what they can do about it. The decision-making is ultimately done by the person with the medical condition not the health care professional who is telling the person he needs to change. The ownership of the decision-making and taking the responsibility for it allows a person to feel in control. People who feel in control over their destiny are more likely to do something about it.

The patient and health care professional (HCP) process of learning is a two way street. A patient is "teaching" an HCP about his circumstances and condition and an HCP is "teaching" what can be done about it. However, teaching what to do about the medical condition does not guarantee that a person will do something about it. Knowledge on what to do and how to do it does not always result in people doing those things.

People want simple solutions to complex problems. In many cases, people will listen intently to what health care professionals have to say and agree with the given recommendations, but they ultimately will act on their own conclusions. These conclusions and actions are often not consistent with the HCP's recommendations.

Many times people just need to think about things or change the way they think about those things before they can change. "The world we created is a product of our thinking; it cannot be changed without changing our thinking." (Albert Einstein) Some people overthink issues, see things in black and white, worry too much about what others will think, overgeneralize, become over consumed with negativism, are dependent on their comfort zone, self victimize, think that this moment and the current thinking is the reality, compare themselves to others or think they already know how things are and will be.

Health behavior change approaches have been evolving over years and transforming to be more patient-centred. Engaged patients, confident health care professionals (HCPs) and good information flow within the system can support productive behavior change.

B. What works and what does not work?

Knowledge transfer does not occur via osmosis; it is not considered a communicable disease. Teaching people what needs to be done and how to do it does not always produce desirable results when it comes to behavior change. Health care professional-patient communication and teaching style can have both a direct and indirect impact on health outcomes. These might include knowledge, agreement on diagnosis and treatment, therapeutic alliance for coordinating patient care and involving a patient in that care, helping to manage any negative emotions, family/social support, quality medical decisions, and self efficacy such as empowerment and enablement.

Over the last few decades there has been a large volume of research focusing on compliance and adherence that has exposed a multitude of factors affecting it. A better understanding of the factors affecting compliance, including the health care professional (HCP)-patient relationship has led to the evolution of a patient-centered education model. Patient-centred behavioural interventions involve: concordance instead of compliance, patient participation instead of adherence, planning with patients instead of for them, empowerment instead of behaviour change, active patient instead of passive patient, independence instead of dependence on HCPs, and the patient defining needs instead of the HCP determining them.

Learning occurs when we incorporate knowledge, attitude and behavioral components in the intervention process. A person needs to know what and how to do it, be willing to do it and have an ability to do it. A health care professional utilizes different skills supporting each domain of learning. Increasing learner's knowledge requires that the educator has competencies in a subject matter and its intervention methods. Adjusting learner's attitude requires that the educator possesses effective counseling skills. The behavioral intervention allows for the effective transition of knowledge into action.

The evidence for self-management education that is needed to produce behavior modification indicates that education is effective for improving clinical outcomes and quality of life, at least in the short-term. Self-management education has evolved primarily from didactic presentations to more theoretically based empowerment models. Ongoing support is critical to sustain progress made with the initial education. Behavioral goal setting supports self-management behaviors. Using behavioral and psychosocial strategies also improves outcomes.

Chronic disease-self management programs improve care outcomes. The available evidence indicates that self-management education (SME) has a beneficial effect on physical and emotional outcomes, and health related quality of life. Effective self-management education can produce reductions in health care expenditures like fewer emergency room visits, fewer hospitalizations, fewer days in a hospital, and reductions in outpatient visits. SME results in more appropriate utilization of health care resources, addressing health care needs in outpatient settings rather than ER and hospital visits.

Self-management programs focused on high prevalence chronic conditions have been supported by decades of federal research. They are effective across a variety of chronic illnesses, effective across socioeconomic and education levels, and enable participants to manage progressive and debilitating illnesses. The health benefits of self-management programs are shown to persist over time.

C. Learner-centered education: what does it take to deliver it?

Education has evolved from being teacher-centered and content-driven to more learner-centered and learning process-driven. The learner's role has also changed from that of being a passive recipient of information to that of an engaged learner and active agent in the learning process. The instructor's role expands from that of someone who is knowledge-laden that professes truths and disseminates factual information, to that of being a learning mediator or facilitator who assumes the role of an educational architect (designing learning tasks and creating environment that is conducive to participation), educational consultant or facilitator (serving as coach working with the learning process), and educational assessor (evaluating impact and outcomes and using this information as feedback to improve the learning process).

A learner-centered approach produces positive outcomes, including deep learning, intrinsic motivation, and retention. There are four elements that create a synergistic impact on the learning experience in learner-centered education:

- active involvement when learning becomes deeper and more durable and participants become actively engaged in the learning process
- social integration when learning is strengthened through participants educator and participant-participant (peer) interaction and collaboration
- self-reflection when learning is deepened by participants reflecting on how they are learning and what they are learning, transforming it into a form that makes sense or has personal meaning to them, which enables them to build relevant conceptual connections between what they are trying to learn and what they already know
- personal validation when learning enables participants to feel personally significant, when they are recognized as individuals and sense that they matter to their instructor and other participants, their peers

The responsibility of the learner in a learner-centered education model is to identify the information he already knows and practices, and what he wants to learn more about. The educator is responsible for listening to the learner and determining what he already knows, practices, and what he might still need to learn. The educator is able to facilitate a dialogue and tailor the session to the learner's needs. The educator acknowledges that the learner needs to be the decision-maker. The learner decides if he will learn, what he will learn, and ultimately what he will do with that information. The educator cannot make these decisions for the learner.

Evaluating learning in a learner-centered education model is more complex than in a teacher-centered education model. In a learner-centered education model, learners participate in the evaluation of their learning and are involved in deciding how to demonstrate their learning. Using an assessment that evaluates learning and motivation is instrumental in measuring the success of learner-centered approaches. An evaluation can include satisfaction with care, change in behaviors or clinical care outcomes.

In a health care environment learner-centered education has an added component of "healing". Learning what to do, how to do it and doing it is part of the clinical intervention. The term therapeutic patient education (TPE) implies that educating a patient to be empowered has a positive therapeutic effect on the health of the patient.

Providing therapeutic patient education has driven the need for the health care professional to be caring, empathetic, responsive to patient's concerns as well as other socio-emotional positioning. A professional acknowledges patients' views and perspectives, and provides supportive communication via reassurance, praise and comforting.

Part of therapeutic patient education is to alleviate anxiety or create hope. The anxiety is often rooted in some levels of uncertainty with what will happen with health related outcomes. Managing uncertainty involves the realization that uncertainty is experienced with disease management. It explores the challenges of divergence, ambiguity, ambivalence, and impossibility.

Enabling patient self-management involves competence, autonomy, and relatedness. Behavior change is a continuum and is a function of attitudes, social norms, self-efficacy that emanate from behavioral, normative and control beliefs. The steps to patient education include empowerment, self-efficacy, control and behavioral actualization.

D. Group vs. one-on-one education: can individually tailored interventions be provided in a group setting?

One-on-one education allows for the health care professional to tailor and individualize the education to meet the unique needs of the learner. Learner-centered group education can also provide the individual effective education but with the added benefit of peer-to-peer support. Group education allows participants to learn from one another, recognize that they are not alone, validate each other's views, and explore strategies that others like themselves have found to be successful.

The success of learner-centered group education depends on the skills of the health care professional and the methodology used to deliver it. Effectively delivered group education is meant to be either as effective as the one delivered via an individual setting or superior based on the appropriate utilization of peer-to-peer support.

The utilization of effective counseling skills is instrumental for effective patient education. Group education also dictates a need for group dynamics management skills.

An example of a group dynamic management strategy is Tucker's model for group formation. There are four steps in creating an appropriate environment for peer-to-peer support and effective learning: forming, storming, norming and performing.

During the forming stage participants (in this case patients) meet for the first time, verbalize their situation, share their needs and agree on goals and objectives of the session. The facilitator (in this case a health care professional) makes sure that each participant can introduce himself and his agenda or needs. Participants need to be heard and need to feel that they are vital component of the learning process.

During the storming stage participants share what they have done in the past, what has worked for them and what hasn't. They identify the obstacles that might have prevented them to act on the desirable tasks. They might express their frustrations with situations that they feel they have little control over. Participants continue to establish their roles within the group and start to develop personal friendships. The facilitator still continues to coach and allow people to express how they are feeling freely.

During the norming stage participants start to work cohesively on summarizing commonalities, generating solutions, support each other; agree on team values and rules. The consensus on views and realities gets participants to feel validated. The motivation to do something about their circumstances increases. The facilitator's role is to help the participants to assess what motivates them and elevate the need to do something about it.

During the performing stage participants strategize and generate solutions that best fit into their circumstances. The participants assist each other in formulating plans to deliver on their disease management goals and personal circumstances. The facilitator provides minimal guidance to participants on what to do and how to do it. The participants independently can identify what is important to them, what needs to be done about it and how they will go about doing it.

An optimal group education is facilitated by a health care professional that has content expertise in the subject matter, counseling skills and skills in a group dynamic management. Each participant in a group needs to feel that their individual educational needs have been met, and feel supported by the facilitator and their peers.

2. Personal Health Engagement

A. Definition

Personal Health Engagement (PHE) is the continuum of individual involvement and empowerment in health and wellness. The health engagement process is intended to generate self-fulfillment in daily living and ultimately an improvement in quality of life and health outcomes.

B. Process

The Personal Health Engagement process starts with effective communication between an individual and his or her health care providers. A productive exchange of ideas and strategies leads to personal accountability and involvement in decision-making that is followed by improvement in clinical care outcomes.

C. Measurement

The Personal Health Engagement Scale has seven dimensions:

- 1. Health ownership:** a person's belief in his own competence in self-care management. Health status perceptions and health belief systems impact the level of responsibility for self-care.
- 2. Motivated to change behavior:** a level of being ready and willing to change certain behaviors in order to improve health status. It is also an attitude towards change and related emotions.
- 3. Actionable:** being prepared to act on the self-managements tasks. Determining the specific actions and ability to implement short and long-term goals of self-care management.
- 4. Utilize support network:** the ability to solicit support from HCPs, peers and family.

- 5. Knowledgeable:** the level of knowledge it takes to know what to do about health related behaviors and how to go about it. The ability to assess the risk of health related repercussions.
- 6. Resourceful:** the willingness to solicit information related to self-care from various media channels.
- 7. Adaptable/Responsive:** willingness to change actions in response to health status changes or changes in psychological or social circumstances.

D. Personal Health Engagement programs

Personal Health Engagement (PHE) programs activate, prepare, empower and support individuals to act on the desirable behaviors to positively influence outcomes.

PHE programs are designed to simplify the process of behavior change for both the patients and the health care professionals involved. The realities of daily living are put in strategic focus allowing an individual to embrace change and enjoy the process of making the changes in their lives.

PHE programs are inclusive in all aspects of behavior change needed to promote improvement in care. PHE helps in prioritizing on actionable behaviors like healthy eating, physical activity, taking medications, dealing with family, friends, co-workers, health care systems, and decision making for daily tasks. PHE also monitors progress in self-care, relapses and adjusts for changes in psychosocial circumstances.

The PHE scale assesses behavior change capacities. The scale is assessing all of the dimensions of behavior change identifying what to focus on at the right time. The results of the PHE assessment generate behavioral self-care diagnosis and its progress.

The Personal Health Engagement (PHE) methodology is designed to improve patient care outcomes, improve the delivery of care, help the patient and help the health care professional. Appropriately trained and equipped professionals use the PHE programs either as stand alone curriculums for disease self-management or as complement to existing programs.

3. Conversation Map Education Tools

A. Methodology

Conversation Map education tools are a main component of a Personal Health Engagement program.

Healthy Interactions, creator of the *Conversation Map* methodology, believes in facilitated, small-group, self-discovery, and visual stimulation learning. These principles, integrated with an engaging Socratic approach (questions that elicit dialogue and conclusions) are a dramatically more effective technique to creating Personal Health Engagement than traditional didactic approaches.

The *Conversation Map* content is based on a reliable and evidence-based practice in applicable interventions. *Conversation Map* sessions allow participants with different agendas and needs to identify strategies that are individually relevant and enable them to accelerate their progression toward behavior change.

The *Conversation Map* tools align with the following learning principles: information is simple and practical, directed by participant interests, leveraging participant experiences and focusing on application. The Map tools also consider and address cognition, emotions and environmental factors that impact knowledge level, skill acquisition and views.

B. Evident theories and support

The biopsychosocial model (BPS) of health and illness regulation has been considered for many years the cornerstone of good patient outcomes. The BPS posits that health care is optimized when health care professionals seek to understand the individual's unique combination of biological, psychological, and social factors, which influence his health functioning. Multiple well-grounded and well-tested models and theories of health behavior pertaining to the three components of the BPS are integrated into the *Conversation Map* experience. The behavior change theories put in action in the *Conversation Map* session maximize learning, interest in self-care and willingness to take actions. *Conversation Map* sessions are a safe and supportive environment to facilitate effective discussion of topics, validate the participants' perspectives, learn new strategies, take ownership of self-care, and create actions for change.

Self-Efficacy Theory

Self-efficacy refers to a person's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives. Self-efficacy beliefs are the foundation for human motivation and a strong predictor of behavior, influencing the choices people make and the courses of action they pursue, partially determining how much effort, perseverance and resilience people will use on an activity, and fostering psychological well-being (both positive and negative).

Self-efficacy theory suggests that the beliefs people hold about their capabilities, in concert with other socio-cognitive factors are more predictive of behavior than actual capability. Self-efficacy theory provides the foundation for much of the *Conversation Map* approach as it allows participants to explore what is personally meaningful through identification of short-term and long-term goals and support mechanisms. Self-efficacy theory, was used to develop the active group dialogue in *Conversation Map* sessions, where participants are encouraged to consider their individual performance capacity by reflecting on their past experiences in self-care, changes in attitudes, and overcoming environmental and psychosocial barriers. Through active conversation, participants can define their progress, hear other perspectives, identify what is meaningful to them, anticipate changes, learn how to get help and celebrate their successes.

Health Belief Model

The Health Belief Model (HBM) identifies the role knowledge and perceptions play in personal responsibility. There are six core constructs to the HBM: perceived susceptibility and perceived severity (collectively a belief about a health threat), perceived barriers to behavior change, perceived benefits of adopting behavior, perceived self-efficacy and cues to action (external influences promoting the desired behavior). In *Conversation Map* sessions participants are asked to consider these six concepts and explore personal feelings, perceptions, attitudes and beliefs related to a condition and its self-care management. These aspects are internalized through normalization and peer validation that is inherently part of the facilitated dialogue.

Common-Sense Model of Health and Illness Self-Regulation

According to the Common Sense Model (also known as the Illness Perceptions Model, the Illness Representations Model, the Self-Regulatory Model, the Parallel Process Model, or Leventhal's model), the belief about a health threat (one component of the HBM) is explained by subjective illness representations integrating with existing schemata to make sense of symptoms. Representations are cumulative, formed and develop based upon information receipt and experiences. These representations will guide behavior regarding coping procedures, action plans and outcomes. Participants in *Conversation Map* sessions are encouraged to discuss and acknowledge health threats as they perceive them, and their individual motives for making changes in their self-care behavior. By identifying their motives, they can proactively respond to potential consequences of the condition. By accurately perceiving threats to their health, a person can improve their self-care by responding to their symptoms and situation to minimize adverse outcomes.

Social Learning Theory

Similar to the HBM, the Social Learning Theory (SLT) posits that the likelihood of a behavior occurring is a function of expectancies and values. Behavior will take place if a reward or reinforcement is anticipated and if that reward is valued. It further suggests that a combination of environmental (social) and psychological factors influence these expectancies and values. Remembering certain health behaviors (retention), perceiving oneself able to reproduce them (self-efficacy), and having good reason to want to adopt the behavior (motivation) are all necessary for behavior change to occur. Participants in *Conversation Map* sessions compare their experiences, knowledge and approaches, discuss best practices for completing tasks, and accept responsibility for their daily self-care. Situational problem solving strategies are discussed through group dialogue.

Transtheoretical Model

The Transtheoretical (Stages of Change) Model illustrates the five stages in a continuum of behavior change: pre-contemplation, contemplation, preparation, action, maintenance and relapse. Each stage plays an important role in supporting an evolutionary process whereby learners recognize the need for change, act, evaluate, and react. As a 2-1 hour group intervention with active and sustained participation, a *Conversation Map* session supports the stages associated with recognizing the need for change, enables personally-determined strategies for adopting change, and provides the action plan for implementing change and recovering from potential self-management mis-steps. Participants self-assess their willingness and ability to self-manage their condition effectively and discuss personal journeys through each stage of self-care and their adaptation to changing needs.

Dual Processing Theory

Dual Process Theory distinguishes between heuristic processing (where patients are passive in listening to HCPs) and systematic processing (where patients are actively involved in the learning process). The theory emphasizes the importance of systematic processing by proposing the provision of the least possible information from which to learn and encouraging dialogue to enhance knowledge and understanding. Participants in *Conversation Map* sessions practice situational problem solving, guided by the facilitator, but with dialogue led and determined by participants' interests. Some of the activities focus on un-learning unhealthy behaviors and instilling belief among the participants that they can embrace change and self-discovery.

C. What does it takes to deliver a successful *Conversation Map* session?

There are six components of a *Conversation Map* experience:

- 1. Large Visual** – The Map visual is a 3' by 5' illustration that depicts several issues and the relationships between those issues.
- 2. Information** – Facts are used to focus the group's discussion on the realities of the issues being explored.

- 3. Conversation Questions** – The pace and direction of the group’s conversation is guided by a series of questions that the group is asked to discuss and answer.
- 4. Group Interaction** – An open and trusting environment where real dialogue can take place is created. It’s through the process of discussing facts with peers that people are able to change what they believe to be true.
- 5. Facilitator** – Each session of 10-3 participants is facilitated by a health care professional. The facilitator is responsible for managing the group dynamics and “depth” of the group’s conversation.
- 6. Action Plan** – Exercises are designed to help participants think about and articulate what it is they are going to do different. Post session follow-up activities are discussed and reinforced.

4. Diffusion of the Personal Health Engagement (PHE) Model

A. Why do we need PHE innovation to successfully drive behavior change?

Where there is a need there is a way: Personal Health Engagement programming has been developed based on existing need for effective approaches to drive behavior change.

The PHE innovation is to renew and improve the way people self-manage their medical condition(s) and the way health care professionals function to assist them.

The solution for what appears to be a complex challenge of changing the way a patient cares for himself in order to produce a desirable health outcome has been there all the time. The solution is within each patient, ready to outline and put in action what is needed if just given a chance to do so. The problem is, that while we have been developing elaborate treatment strategies to treat the medical conditions we have neglected to involve a patient and his capacity to implement the treatment strategies.

Human behavior and actions can be very unpredictable. The health-related behaviors are affected by individual factors or interpersonal factors, institutional or organizational factors, community factors, and public policy factors. Each individual has their own reality and a way to do things. Personal Health Engagement model allows for the behavior change to be more predictable as the decisions to modify it comes from the patient himself. Patient can explore his own realities, internalize what he needs to do and if he can or want to do it. Ultimately, this process allows for a better accuracy in strategies to behavior change.

William Butler Yeats said, “Education is not the filling of a pail, but the lighting of a fire.” Personal Health Engagement lights the fire within an individual to effectively self-manage his health.

B. What does it take to implement and put Personal Health Engagement in practice?

“Simplicity is the ultimate sophistication”- Leonardo Da Vinci. The PHE model is simple and inclusive and on its way to becoming the norm in health care education.

The first step in making a difference in driving effective behavior change is to provide people with the right tools. It is almost like building a house. The architect provide a blueprint and builders build the house. In this case, Healthy Interactions has created a *Conversation Map* tools for over 100 countries and local health care professionals utilize them to help people manage their medial conditions.

C. How do we measure progress?

“Health is a state of complete physical, psychological, and social well-being and not simply the absence of disease or infirmity.” (World Health Organization, 1948)

The Personal Health Engagement model provides the framework for behavior change. The needs of the communities, health care systems, health care professionals and people they care for are unique and varied across geographies. The PHE model utilizes a continuous quality assurance process appropriate and meaningful for the systems in place.

The progress of the PHE model and its programing is measured by the level of its integration and functional markers of success meaningful to its users.

Works Consulted:

1. Epstein RM, Street RL. The values and value of patient-centered care. *Ann Fam Med*. 2011;9(2):100-103.
2. Position Paper: Healthy Interactions *Conversation Map* Education Tools: Creating the Foundation for *Personal Health Engagement* and Self-Management Education. Available at: HealthyInteractions.com.
3. Mensing C, Eichorst B. Educating the Patient with Diabetes. In Holt RI, Cockram C, Flyvbjerg A et al. ed. *Textbook of Diabetes*. 4th ed. Wiley-Blackwell; 2010.
4. *Conversation Map*® Programs: A Quantitative and Qualitative Analysis of Usage and Outcomes. Available at: HealthyInteractions.com
5. Powers MA, Bardsley J, Cypress M, et al. Diabetes Self-management Education and Support in Type 2 Diabetes: A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics. *Diabetes Care*. 2015;38(7):1372-1382.
6. Morris J, Marzano M, Dandy N, O'Brien L. Theories and models of behaviour and behaviour change. Forest Research Web site. [http://www.forestry.gov.uk/pdf/behaviour_review_theory.pdf/\\$FILE/behaviour_review_theory.pdf](http://www.forestry.gov.uk/pdf/behaviour_review_theory.pdf/$FILE/behaviour_review_theory.pdf)
7. Therapeutic Patient Education, Continuing Education Programmes for Health Care Providers in the Field of Prevention of Chronic Diseases : Report of a WHO Working Group. 1998.
8. Scannell MJ. *Coaching for Behavior Change, A Practical, Easy to Use 5-Step Method*. iUniverse; 2008.
9. Barlow DH, Nock M, Hersen M. *Single Case Experimental Designs, Strategies for Studying Behavior for Change*. Allyn & Bacon; 2009.
10. Robinson PJ, Gould DA, Ph.D. KD. *Real Behavior Change in Primary Care, Improving Patient Outcomes and Increasing Job Satisfaction*. New Harbinger Publications Incorporated; 2011.
11. Glanz K, Rimer BK, Viswanath K. *Health Behavior and Health Education, Theory, Research, and Practice*. Jossey-Bass; 2008.