INSTRUCTIONAL DESIGN AND ASSESSMENT

An Elective Course to Train Student Pharmacists to Deliver a Community-based Group Diabetes Prevention Program

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Objective. To develop and assess the impact of an elective course aimed at improving student knowledge of and confidence in delivering a group diabetes prevention program.

Design. Two colleges of pharmacy collaborated to develop a 2-credit elective course using didactic and active-learning strategies to prepare students to serve as lifestyle coaches offering a proven group diabetes prevention program.

Assessment. Students' confidence in their ability to deliver a group diabetes prevention program increased as a result of the class. However, their knowledge of diabetes prevention facts was unchanged from baseline.

Conclusion. A diabetes prevention elective course improved students' confidence in their ability to teach a diabetes prevention program.

Keywords: diabetes prevention, health promotion, active learning

INTRODUCTION

Diabetes affects over 29.1 million citizens—9.3% of the population—in the United States.¹ Diabetes is the leading cause of kidney failure, nontraumatic lower-limb amputation, and new onset blindness in American adults, and it is a major cause of heart disease and stroke. As such, diabetes is the seventh leading cause of death in the United States.² The estimated diabetes-related costs nationwide in 2012 exceeded \$245 billion, with the average health care costs for a person living with diabetes exceeding \$13 700 per year as opposed to \$5800 for a person without diabetes.³ In addition, 35% of adults over age 20 and half of all adults over age 65 years have prediabetes.⁴ Without changes in lifestyle and improvement in health, 15-30% of these people will develop type 2 diabetes mellitus in the next five years.⁴ This high proportion of people at risk for diabetes, and the costs of treating diabetes-related conditions, presents a potential health care crisis related to personal and societal costs, if these trends continue and progression to diabetes is complete.

Pharmacists are highly accessible and effective health care professionals for people living in urban,

suburban, and rural locations.⁵ Pharmacists are uniquely positioned to provide services related to diabetes prevention for several reasons: convenient location of pharmacies, accessibility of pharmacists for questions and counseling (eg, appointments not usually required), strong rapport that pharmacists and their staff develop with patients and their families, and frequent contact pharmacists have with health care providers in their community. Although the public image of pharmacy is often related to the task of dispensing, a primary focus for pharmacists is on the appropriate, safe, and effective use of medications and, importantly, health promotion to prevent illness. Core training in pharmacy education includes motivational interviewing, basic nutrition, behavior modification, and health promotion strategies to prevent conditions like diabetes. In fact, currently published educational outcomes and accreditation standards emphasize that pharmacy curricula include training for students in how to design prevention, intervention, and educational strategies that manage chronic disease and improve health and wellness.^{6,7}

Numerous controlled trials demonstrate that pharmacists make a significant impact on improving control of conditions related to diabetes including lipid, blood pressure, and glucose levels, as well as promoting smoking cessation among patients.⁸⁻¹⁶ Additionally, pharmacies are effective sites for patient screening and education

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about diabetes risks.¹⁷ Preparing practicing and student pharmacists to deliver diabetes prevention services in their accessible, community-based pharmacies leverages great potential for reaching citizens and impacting the diabetes epidemic.

The Diabetes Prevention Program (DPP), an intervention using lifestyle modification, has successfully reduced the development of diabetes in individuals with prediabetes by 58% over a 3-year period.^{18,19} The long term follow-up study reported that participants in the DPP continue to benefit from the program even 10 years later, with diabetes incidence reduced by 34% in the lifestyle modification group compared to placebo.²⁰ Since 2002, the DPP curriculum has been modified into a group delivery model and provided in a variety of urban, semi-urban, and rural settings using nurses, health educators, volunteer health professionals, nutritionists, dietitians, exercise physiologists, and fitness specialists as coaches.²¹ The most widely implemented diabetes prevention program has been delivered through the Young Men's Christian Association.²² Yet, few reports have been published about pharmacists offering such services.^{23,24}

Reports on teaching student pharmacists to provide lifestyle change intervention and education have been published.²⁵⁻³³ In these experiences, student pharmacists learned about health and wellness services in the classroom, provided individuals with lifestyle interventions, or participated in wellness programs themselves. However, none of these courses or curricula trained student pharmacists to instruct groups of patients in lifestyle interventions as part of a formal curriculum specifically proven to be effective in diabetes prevention. Therefore, an elective course was developed and offered to student pharmacists at Washington State University (WSU) and University of Washington (UW) preparing them to be Lifestyle Coaches for the Diabetes Prevention Program Group Lifestyle Balance (DPP GLB). The DPP GLB is an adaptation of the DPP developed by The University of Pittsburgh Diabetes Prevention Support Center (DPSC). The DPSC is managed by faculty members at the University of Pittsburgh who were members of the original DPP Research Group. The DPP GLB is designed to be delivered as a group-based program taught by health professionals. This report shares the results of this diabetes prevention elective course and describes its impact on students' knowledge and confidence in their ability to teach diabetes prevention as a formal service.

DESIGN

The Diabetes Prevention class is a 2-credit, elective course offered to third-year students at WSU and UW. This report highlights the experience offering the course

three times over two academic years at the two institutions – twice at WSU (with class sizes of 10 each) and once at UW (with a class size of 29). All students initially enrolling in the elective course completed it. The course was patterned after the DPP GLB Coaches training completed by the course instructors at the DPSC in May 2011. The course was designed to prepare students with the knowledge of prediabetes risks and evidence-based interventions and skills in communication and behavior modification to serve as DPP GLB Lifestyle Coaches offering a recognized and reimbursable diabetes prevention program and to promote health and wellness in their communities.

Using Bloom's Taxonomy,³⁴ curricular goals and learning objectives for the elective course were focused in the areas of communication, professionalism, and health promotion. Specific learning goals for the class were to: (1) apply principles of communication and behavior modification skills for positive promotion of healthy lifestyles; (2) demonstrate comprehension of cultural competence principles; (3) respect the values and perspectives of others and modify self-attitudes and behaviors as necessary for optimal interactions with patients and other health care providers; and (4) apply the principles of the health and wellness practices and nonpharmacologic therapies to promote public health.

To achieve these learning goals, the following learning objectives were included for student achievement: (1) summarize the current burden of diabetes in the United States; (2) evaluate the scientific evidence for the value of the DPP in preventing diabetes; (3) discuss the role of weight management and physical activity to prevent diabetes; (4) lead a DPP GLB course. The DPP GLB Coaches training is a 2-day workshop with 12.5 contact hours delivered primarily in a didactic format. All content from the workshop was included in the course with additional active-learning activities incorporated.

The course began with instructors delivering lectures covering the background, rationale, goals, and translation of the original DPP to group instruction. The remaining weeks consisted of the instructor training on how to teach a session followed by an assigned student (alone or in pairs) teaching the lesson the instructor taught the previous week. Learning format for the course was approximately one-third didactic and two-thirds active learning. See Appendix 1 for a sample course schedule.

During each student-led session, other students roleplayed as DPP GLB participants and would ask questions that a participant might ask during a lesson. This allowed each student leader the opportunity to practice skills on leading an effective group. At the conclusion of each session, the student leader gathered and reviewed

Keeping Track Booklets (University of Pittsburgh, Pittsburgh, PA) completed weekly to record food intake and activity. The student leader was encouraged to use the “sandwich method” for making comments in the booklet (ie, highlighting a positive change, making a suggestion, highlighting a positive change).

Each week of the course, students were required to simulate the life of a DPP GLB participant. The two main goals of the DPP GLB are to lose 7% of body weight through healthy eating and accumulate 150 minutes of moderate physical activity weekly. A key tool to achieve these goals is daily tracking of food and physical activity. The students participated in these goals by writing down everything they ate, tracking fat grams and calories and tracking the number of minutes of physical activity each day in the Keeping Track Booklets. Students were not required to lose weight during the class; however, they were expected to track food and activity. The second year the course was offered at WSU, students were also expected to observe a DPP GLB session delivered to participants at a local community pharmacy. The community sessions were led by fourth-year students during advanced pharmacy practice experience (APPEs), who had completed the diabetes prevention elective course the previous year.

Prior to the class, students were given the DPP GLB’s website link (diabetesprevention.pitt.edu), where students could download the DPP GLB Manual of Operations, participant handouts, and the leader’s guide. Students were required to purchase a pedometer and The CalorieKing Calorie Fat and Carbohydrate Counter (Family Health Publications, Costa Mesa, CA). Additionally, students were required to record food intake and activity in a Keeping Track Booklet each week. Alternatively, students were allowed to use smart phone apps of their choosing to track food and activity. Students using the latter method printed out their logs each week.

Students reflected on their experiences using weekly journaling, focus group discussions, and an end-of-term reflection assignment. These assignments allowed them to identify and reflect upon key defining learning achievements, most impactful learning opportunities, and how the experience might impact future practice.

Student grades were based on class participation, leading group instruction, and individual reflection assignments. Students were given knowledge examination and student confidence surveys on the first and last days of class, which were not included in the grade assessment. The knowledge examination was used to determine change in knowledge of facts regarding prediabetes and role of lifestyle intervention to prevent diabetes development. The student confidence survey was used to assess students’ confidence in 15 different areas related to assisting participants in making lifestyle changes. A 5-point Likert scale ranging from disagree strongly to agree strongly was used. The knowledge examination and student confidence survey were developed by course faculty members based on key learning outcomes for the DPP GLB Lifestyle Coaches training program. The Institutional review boards at Washington State University and the University of Washington approved this project as exempt.

EVALUATION AND ASSESSMENT

Student knowledge about diabetes prevention and confidence in ability to instruct the DPP GLB course were evaluated using a paired, pre/posttest design. The assessment included 12 multiple-choice questions covering key content objectives and 15 confidence statements about ability to facilitate DPP GLB group sessions as a Lifestyle Coach. Knowledge quiz scores were compared at baseline and after completion of the course using a paired *t* test. Confidence was assessed using a 15-item questionnaire (5-point Likert scale, 1=strongly disagree I am confident, 5=strongly agree I am confident). Change in confidence was assessed using the Wilcoxon signed-rank test based on the paired nature of the data. See Appendix 2 for the assessment tool.

Knowledge and confidence scores were pooled for the two universities (*n*=49). Mean knowledge assessment scores were 7 out of 12 (58%) at baseline as compared to 7.28 out of 12 (61%) at course completion (*p*=0.6). Confidence scores improved from a mean of 2.2 at baseline to 4.2 after completing the course (*p*<0.001, Wilcoxon signed-rank test). There was no association between pre/post score change between universities (*p*=0.08). See Table 1 for results.

Table 1. Student Confidence in Diabetes Prevention Ability Before and After the Elective Course

	Mean (SD)		<i>p</i> value
	Precourse	Postcourse	
Overall	2.2 (0.5)	4.2 (0.4)	<i>p</i> <0.001
WSU* (n=20)	2.2 (0.5)	4.3 (0.4)	* <i>p</i> =0.08
UW* (n=29)	2.2 (0.5)	4.2 (0.4)	(between university comparison)

WSU=Washington State University; UW=University of Washington

Qualitative assessment of the course was completed using three methods. Washington State University students were asked to select a course outcome from the syllabus they felt they had been able to achieve in the course. They were then asked to reflect on their experiences in the course and how they were able to meet the outcome. Nineteen of 20 students who completed the course completed this assignment, with 16 students selecting the outcomes related to communication and promotion of health and wellness, and three selecting the outcomes focused on cultural competence and respect for others. The 16 students identifying improved communication and health promotion skills highlighted the experience teaching a lesson as a key learning opportunity for them. They reported that this experiential component of the course enhanced their skills to use their knowledge to create impactful learning opportunities for class participants. The three students identifying cultural competence and respect for others as key learning outcomes highlighted the experiences they had attending community DPP GLB classes. They reported that the opportunity to interact with people experiencing real-life challenges of making behavior changes, as well as playing the role of DPP GLB participants over the course of the term allowed them to better appreciate the struggles individuals face in making lifestyle changes.

At UW, a qualitative mixed-methods approach blending thematic content analysis from written student feedback about the course, weekly debriefs, and a student focus group was used to identify key areas of strength and opportunities for course improvement. Additionally, instructor field notes regarding the need for correction of misinformation and opportunities for course improvements were used to guide this assessment and weekly in-class debriefs. Weekly reflections queried students about key personal learning and further learning needs. These reflections were also used to provide “just-in-time” course adjustments and to guide development.

Thematic analysis was conducted by two investigators to independently identify emergent themes in course effectiveness and needs for improvement. Once identified,

themes were adjudicated between the investigators to achieve agreement and coding for analysis. A guided inquiry approach based on themes identified during the weekly course debriefs and the emergent themes was used to guide input from the student focus group (n=19). Key qualitative themes identified are presented in the Table 2.

DISCUSSION

Performance on the knowledge examination was poor at baseline and did not improve. Although disappointing, this lack of improvement in knowledge likely reflected a difference in course content delivered vs what was assessed. The initial course didactic content focused on the DPP research design and results. However, this content was not revisited throughout the course with the intention to ensure student retention of key concepts. Following that, the weekly course sessions were primarily oriented on developing lifestyle coaching skills and strategies in behavior modification to deliver the DPP intervention. We identified the importance of students having more depth of knowledge about the DPP and plan to augment this component of the course in the future. Moving forward, the skill building sessions each week will include discussion of key knowledge points regarding diabetes risk factors and prevention interventions.

An important finding from our study was that the course improved student confidence in acting as a lifestyle coach. This was demonstrated by the improvement we observed in self-reported confidence at the end of the course, in weekly debriefings about each session, and in end-of-course reflection statements and focus group input. In the pre-assessment, overall student confidence was low, with the exception of average confidence reported regarding the ability to explain the burden of diabetes and healthy food choices. Students at both universities had exposure to the overall burden of diabetes in their respective curricula, during previous or concurrent therapeutics, counseling, and elective diabetes management courses, which may explain why baseline confidence in this area was higher than other areas. However, these courses addressed diabetes management rather than prevention.

Table 2. Student Focus Group Qualitative Themes for University of Washington Cohort

Evaluation Question	Qualitative Themes (% respondents, n)
What portions of the course stretched your learning?	Learning to facilitate small groups (53, 10) Learning how to prevent diabetes (21, 4)
What contributed most to your learning?	Teaching a small group session (68, 13)
What detracted most from your learning?	Weekly reflection assignments (26, 5)
What suggestions do you have for course improvement?	Teach the majority of the information at the beginning of the course and allow students to facilitate small groups weekly (58, 11)

Our data indicated high student confidence at baseline in areas such as nutrition. However, using field notes and weekly student debriefing, we identified throughout the course that this may have been overconfidence. The gap in reported vs actual confidence was clear early on during weekly student teach-backs and evolved throughout the course. The experience of becoming self-aware of learning needs and competency gaps likely fostered a more powerful educational experience. In future sessions, we will continue to use the confidence assessment tool as a baseline and, based on this assessment, we will ask students to identify individual competency development priorities so instructors can more directly mentor development and knowledge as lifestyle coaches.

In general, students found the course to be intellectually stimulating and to stretch their thinking. The majority of students felt that teaching and facilitating a diabetes prevention education session contributed most to their learning. Students' perspectives on the weekly reflections were mixed. Some felt the reflections detracted from their learning while others felt it was valuable to contemplate key information learned and knowledge gaps. Student feedback on the Keeping Track Booklets was also mixed. Some students found logging their diet and activity to be cumbersome and too time consuming for the duration of the course. Students struggled with the same challenges experienced by DPP GLB participants at risk for diabetes as they were not always successful in tracking all their food and activity choices. In addition, students were challenged to incorporate behavioral changes in nutrition or activity level into their lifestyles. Other students enjoyed the experience of the weekly Keeping Track Booklets as it gave them a real-life perspective of the challenges faced by individuals enrolled in the DPP GLB program. Faculty members reported feeling these course components were valuable and they have been retained in subsequent courses.

In 2010, Smith and Olin proposed a curricular approach for integrating wellness promotion and education in pharmacy curricula.³⁵ However, few have implemented such an integrated curricular plan. When followed up by an APPE in community pharmacy where students gain experience in diabetes prevention with actual patients, this course offering could form the basis for an integrated curriculum that would produce graduates with competency in such services.

Course instructors are now certified as DPP master trainers, and students can earn Lifestyle Coach certificates on completion of the course. In fact, students at both institutions have the opportunity to put their skills to work teaching the program at community pharmacies during APPEs.

Accreditation Council for Pharmacy Education, and accreditation bodies for other professional groups, call for inclusion of interprofessional education (IPE) as a key component of health profession student training.^{7,36} The knowledge and skills taught in this course cross many disciplines, which gives it potential to be offered in multiple schools and programs as an IPE course. Since completion of this study, WSU has progressed toward offering it as an IPE course that includes nutrition and exercise physiology and occupational therapy students.

There are several limitations to this study. Instructors worked together in course design, patterning it after the DPP GLB Lifestyle Coaches training. As the course was developed at two universities with different instructors over the course of two years, differences in instructional delivery emerged, resulting in some shift in course delivery between institutions and between years 1 and 2. In addition, qualitative assessment methods differed at the two universities. With these limitations and the small cohort, the ability to draw broader conclusions is limited.

SUMMARY

A diabetes prevention course can improve student confidence in the ability to teach the DPP GLB curriculum. Future opportunities for expanding this ability exist as this course is increasingly developed as an interprofessional elective course and community classes with trained professionals are further developed that reach into the community to impact the diabetes epidemic.

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Appendix 1. Sample Course Schedule

Week	Content/Topic
1	Course introduction Diabetes Prevention Program: background, rationale, goals
2	DPP/GLB translating into practice Leading effective groups Instruction on Leading Session 1 – Welcome to the Program
3	Practice Leading Session 1 Instruction on Leading Session 2 – Be a Fat and Calorie Detective
4	Practice Leading Session 2 Instruction on Leading Session 3 – Healthy Eating
5	Practice Leading Session 3 Instruction on Leading Session 4 – Move Those Muscles
6	Practice Leading Session 4 Instruction on Leading Session 5 – Tip the Calorie Balance, 6 – Take Charge of What’s Around You, 7 – Problem Solving
7	Practice Leading Session 5 Practice Leading Session 6
8	Practice Leading Session 7 Instruction on Leading Session 8 – Four Keys to Healthy Eating Out, 9 – Slippery Slope of Lifestyle Change, 11 – Make Social Cues Work for You
9	Practice Leading Session 8 Instruction on Leading Session 10 – Jump Start Your Activity Plan
10	Practice Leading Session 9 Practice Leading Session 10
11	Practice Leading Session 11 Instruction on Leading Session 12 – Ways to Stay Motivated, Post Core 1 – Behavioral Support
12	Practice Leading Session 12 Instruction on Leading Post Core 2 – Dietary Support, 3 – Physical Activity Support
13	Practice Leading a Post Core Session Practice Leading Post Core Session
14	Practice Leading a Post Core Session Practice Leading a Post Core Session
15	Practice Leading a Post Core Session Implementing Group Lifestyle Balance

Appendix 2. Assessment Tool

You are being asked to complete a survey which will collect information of your knowledge about prediabetes and metabolic syndrome, and your confidence in caring for patients with prediabetes and metabolic syndrome. Your participation is important to the advancement of successful teaching methods in health sciences education. Responses are confidential, and individual responses will never be shared with anyone outside the research team. Participation is completely voluntary and will have no bearing on your grade for this course. By submitting a survey, you are consenting to aggregate your data with that from other respondents. The aggregated data may be presented at professional meetings and included in professional publications. This survey has been reviewed by the institutional review board at Washington State University and determined to be exempt.

1. Which of the following statements accurately summarizes the diabetes burden in the United States?
 - a. Diabetes reduces the life expectancy by 10 years.
 - b. 1.9 million adults were diagnosed with diabetes in 2010.
 - c. Diabetes is one of the leading causes of chronic kidney disease.
 - d. Diabetes increases the risk of heart attack and stroke by 2-4 times.
 - e. All of the above.
2. An individual is at an increased risk for diabetes (prediabetes) based on which of the following criterion by the American Diabetes Association?
 - a. Oral glucose tolerance test (OGTT) range <140 mg/dL
 - b. Fasting plasma glucose (FPG) range 100-125 mg/dL
 - c. Casual plasma glucose range ≥ 200 mg/dL
 - d. A1C range 4.6%-5.6%
3. According to the Diabetes Prevention Program (DPP), all the following are modifiable risk factors for Type 2 diabetes *except* ____.
 - a. Body fat distribution
 - b. Obesity
 - c. Physical inactivity
 - d. Elevated fasting blood glucose
 - e. Hispanic ethnicity
 - f. All of the above are modifiable risk factors.
4. The National Cholesterol Education Program (NCEP) defines metabolic syndrome as 3 out of the 5 risk factors. Which of the following statements has 3 of the “categorical cut points” for metabolic syndrome for a woman?
 - a. HDL<50 mg/dL in women, waist circumference ≥ 88 cm, SBP ≥ 130 mmHg
 - b. TG ≥ 150 mg/dL, LDL ≥ 160 mg/dL, waist circumference ≥ 88 cm
 - c. BMI ≥ 25 kg/m², SBP ≥ 130 mm Hg, TC ≥ 200 mg/dL
 - d. TG ≥ 150 mg/dL, LDL ≥ 160 mg/dL, FPG ≥ 100 mg/dL
5. The original DPP research demonstrated that ____.
 - a. Lifestyle interventions reduced the incidence of metabolic syndrome more than metformin
 - b. Placebo group reduced the incidence of metabolic syndrome more than metformin
 - c. Intensive lifestyle intervention was statistically more effective in women than men
 - d. All of the above were results from the study.
6. A key component of encouraging safety during the physical activity lifestyle intervention is ____.
 - a. Having participants sign a release of liability prior to participation
 - b. Providing immediate recommendations about medical issues
 - c. Reviewing the handout on signs and symptoms of when to stop exercising with participants
 - d. Having the participant exercise for only half the time when running a low grade fever

7. What was the top approach used by the DPP coaches to improve weight loss?
 - a. Provide healthy recipes
 - b. Review behavior and action plan to aid in problem solving
 - c. Provide a new self-monitoring technique
 - d. Recommend a lower fat or calorie goal
8. What was the top approach used by the DPP coaches to improve physical activity?
 - a. Coach exercise with participants
 - b. Review behavior and action plans to aid in problem solving
 - c. Schedule extra visits or phone class
 - d. Give a pedometer
9. Setting group expectations at the first session is an important technique when trying to develop an effective group. According to Group Lifestyle Balance (GLB), which of these is *not* an important expectation for the group?
 - a. Group members commit to regular attendance.
 - b. Group members plan on actively participating in discussions.
 - c. Group members demonstrate respect for other participants' comments and opinions.
 - d. Group members will commit to an extended session when the topic seems important.
 - e. All of the above are important expectations for the group.
10. The intensive lifestyle interventions included all the following goals *except* ____.
 - a. Reduction of fat intake to 25% of total caloric intake
 - b. Reduction of calorie intake to 1200-2000
 - c. Increase physical activity to 300 minutes/week
 - d. Lose and maintain a weight loss of at least 7% of body weight
11. The main difference(s) between DPP and GLB is ____.
 - a. The DPP was translated for use in a group setting
 - b. The focus on fat %
 - c. The focus on healthy food selection
 - d. The use of pedometers
 - e. a and d only
12. Prior to facilitating a group discussion, you must learn strategies when participants ____.
 - a. Monopolize the conversation
 - b. Won't talk
 - c. Comments are negative
 - d. Act like a "know it all"
 - e. Only a, c, & d
 - f. All of the above

Directions: Mark your response with a check that best represents your belief about each statement at the present moment
[Original survey contained boxes. Answer choices included: disagree strongly; disagree; neutral; agree; agree strongly]

1. I feel confident that I can explain the original research design and results of the Diabetes Prevention Program.
2. I feel confident that I can explain the burden of diabetes in the United States.
3. I feel confident that I can explain the lifestyle intervention goals of the Group Lifestyle Balance (GLB) program.
4. I feel confident that I can facilitate an effective group session in an hour.
5. I feel confident in my ability to teach the sessions on making healthy food choices.
6. I feel confident in my ability to teach the sessions on meal planning.
7. I feel confident in my ability to determine the fat intake percent goal for each GLB participant.
8. I feel confident in my ability to determine the caloric goal for each GLB participant.
9. I feel confident in my ability to instruct the GLB participants on how to fill out the self-monitor record each day for calories and fat.
10. I feel confident in my ability to review GLB participants' self-monitoring records and make appropriate comments to enhance participants' goals for lifestyle change.

11. I feel confident in my ability to motivate GLB participants to achieve and maintain a weight loss of 7% of their initial body weight.
12. I feel confident in my ability to evaluate and safely progress each GLB participant to reach the physical activity goal.
13. I feel confident in my ability to motivate GLB participants to achieve and maintain the energy expenditure goal of 700 kilocalories (150 minutes) per week through moderate physical activity.
14. I feel confident in my ability to tailor the GLB program's goals based on the participants' goals, ethnic heritage, or personal social factors.
15. I feel confident in my ability to assist the GLB participants in problem solving or in developing an action plan if there is evidence of a barrier.