

# **Physical Activity for a Lifetime of Success (PALS): A Community Based Referral and Support Program to Increase Physical Activity Among Elderly Individuals with Diabetes (USA-Research-based)**

## **Section I: Summary**

Physical Activity for a Lifetime of Success (PALS) is a program modeled after the Active Choices program, a 6-month phone intervention program led by community agencies that helps individuals engage in physical activity. The Active Choices model has been shown to increase activity/caloric expenditure in non-elderly adults but it has not been implemented with a diverse or low-income population of older adults with diabetes. The goal of PALS was to partner with community clinics to translate a variation of the Active Choices program to older, low-income, ethnically diverse people with diabetes to increase physical activity levels. While the program encountered a number of barriers to success, it can provide 'lessons learned' for future programs.

## **Section II: Statement of Purpose**

Many older individuals are not sufficiently physically active, and for older individuals with diabetes, this can pose additional challenges to managing the illness. The PALS program was a senior center-based motivational support program delivered by older adult volunteers over the telephone. The program was a modification of the Active Choices program, a 6-month program that has shown some success in increasing activity levels among young and middle-aged adults.

The PALS program was introduced in an ethnically diverse, low income, predominantly elderly neighborhood in the city of Seattle, Washington in the United States. Earlier research showed that the neighborhood had enough resources to support physical activity for older adults (e.g. exercise facilities, fitness programs, etc.) but nevertheless the demand for such activities was low. At the same time, the nearby University of Washington's Health Promotion Research Center had been engaging in various activities to promote physical activity by older adults and reduce existing barriers. To build on these efforts, the PALS program was developed in collaboration with the university Health Promotion Research Center, two community clinics, the neighborhood senior center, and a community social services provider. Primary care providers (PCP) at the community clinics provided referrals to the program and the clinics also had other diabetes management resources available, including a collaborative care model to monitor diabetic patients, an electronic registry to provide reminders and make notes on physical activity, and the Seattle Rapid Assessment of Physical Activity (RAPA) program to assess physical activity levels for all older patients with diabetes.

With some exceptions, most patients aged 65 and older who had visited one of the community clinics in the previous 18 months were eligible to participate in the program through a referral from their PCP. After filling out a RAPA questionnaire, the PCP and patient would develop a "prescription" for physical activity. PCPs would offer patients the opportunity to be contacted by the PALS program, and a PALS coordinator would schedule an intake interview with interested individuals. In addition, all clinic patients received information and handouts on physical activity resources and exercise tips regardless of whether they participated in the PALS program.

PALS was a telephone-based motivational support program based on behavioral principles of self-efficacy and tailoring support to an individual's readiness to change. Participants were offered ongoing telephone support from older volunteers who were already participating in physical activity programs at the senior center. Participants were encouraged to participate for at least 6 months and could choose how and where they would carry out their physical activity plan (e.g. home versus community-based program). The program also attempted to reduce barriers to participation by waiving fees to certain community-based group exercise classes and providing transportation to group walking sites. Also, a half-time staff project coordinator was employed by the senior center to manage the program.

Two different groups were studied – one group of patients was offered the PALS program immediately (immediate intervention group) and one group was offered the program one year later (delayed intervention group/control).

### **Section III: Outcomes**

The PALS program focused on two measurable outcomes: level of physical activity as measured by the RAPA questionnaire and, secondarily, average hemoglobin A1c (hbA1c) which was measured at the beginning of the program and at 6-month and later followup visits to the clinic.

It is important to note that the program experienced significant challenges to enrollment. Of 135 individuals considered for the program, 70 were not offered the program. Several factors played a role in a patient not being offered the program, including lack of an interpreter services for non-English speakers and exclusion of some patients for medical reasons. Time constraints of the PCPs in clinic visits may have also been a barrier to PCPs offering the program, especially if a more immediate medical condition required attention during the appointment. The remainder (65) were referred by their PCP to the program in the immediate intervention group. One-third of those declined to participate outright for a number of reasons including "lack of interest, feeling at an age for rest rather than physical activity, feeling already active enough, perceived ill health and consequent inability to be more active, depression, unfamiliarity with the senior center, and uneasiness about having a telephone call from a stranger." Among those who

agreed to be contacted by the program, 44% subsequently declined enrollment or were unreachable by the support center. Patients cited a number of reasons for declining after initially agreeing to participate, including "lack of interest, too busy, other issues of higher priority, and difficulty comprehending English." Therefore, only 21% of those offered referral actually enrolled in the program (14 total participants).

For actual participants, activity levels did increase so that a higher percentage of them were sufficiently active at the end of the program than at enrollment. However, there was not a significant difference in this measure. There was also no significant change in mean hemoglobin A1c for the intervention group compared to the control group.

Attempts were made to identify and address barriers to enrollment in the PALS program. The clinical setting did not seem to be an effective environment to engage and interest patients in the program, therefore recruitment was discontinued during clinic visits. Instead, the health educator at the community clinic began contacting patients with diabetes to invite them to enroll in the program. The eligible age to participate was also lowered from 65 years to 50 years. Data was not available to assess how these changes impacted program enrollment and outcomes.

It is clear that many challenges exist to implementing a community-based physical activity program to a population of ethnically diverse, low-income, elderly adults with diabetes. Even when some barriers were addressed, such as waiving fees for exercise classes and providing transportation to walking activities, other issues prevented patients from gaining interest in the program. Further study with a larger group of participants is needed to shed light on the motivations and barriers for both the patients and the referring PCPs, as well as explore how the PALS program could be better marketed to a population with complex characteristics.

#### **Section IV: Additional Resources**

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Batik O, Phelan EA, Walwick JA, Wang G, LoGerfo JP, Translating a community-based, motivational support program to increase physical activity among older adults with diabetes at community clinics: a pilot study of Physical Activity for a Lifetime of Success (PALS), *Preventing Chronic Disease* 2008, Volume 5(1), [http://www.cdc.gov/pcd/issues/2008/jan/07\\_0142.htm](http://www.cdc.gov/pcd/issues/2008/jan/07_0142.htm).