

**CDC/National Diabetes Education Program
Getting Your Patients Ready for Effective Health Care Communications:
A New Beginning in Diabetes Management**

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TRANSCRIPT

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Janet Brown-Friday: Welcome, everyone, to today's webinar from the National Diabetes Education Program, *Getting Your Patients Ready for Effective Health Care Communications: A New Beginning in Diabetes Management*.

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My name is Janet Brown-Friday. I am the clinical trials manager at the Albert Einstein College of Medicine in Bronx, New York. We are very excited about today's program.

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We have an excellent panel of experts, which I will introduce

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before...before their presentations. We will begin today with someone that needs no introduction, Dr. Linda Siminerio

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who is a professor of medicine and executive director at the University of Pittsburgh Diabetes Institute. Dr. Siminerio has led a career in diabetes research and education. She is a nationally recognized expert on self-management education and care delivery models in both pediatric and adult populations, and she serves as the principal investigator on numerous studies related to diabetes prevention and treatment.

Dr. Siminerio served as president of health care and education for the American Diabetes Association and as senior vice president for the International Diabetes Federation. She is currently chair of NDEP. Linda, take it away.

Linda Siminerio: Thank you, Janet, for that nice introduction. I'm going to start today's webinar by talking about effective patient-provider communication and give you some background.

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So, these are some things that we often hear whenever we are working in our practices or clinic, and the defenses and the rationalizations go up. See if these sound familiar: My patients are noncompliant. Our patient population is different, very unique. When you use these standardized approaches, it inhibits my critical thinking and limits the ability to individualize my care, and I really do know what is best for my patient. I know what's best for my patient, based on my experience and...ah...the traditional role of the experienced, more knowledgeable advisor.

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What we know about patient-provider communication is that, well, we know that patient communication (we've learned a lot over the years); we know that a directed, paternalistic approach is not effective, and improving knowledge alone doesn't necessarily translate to improved behavior. Literacy, health literacy, numeracy—these are all problems. And health care providers do not always communicate with each other.

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For years, we were trained to believe that what we said mattered, and when we spoke, patients understood and accepted our direction. And if people didn't do and accept, they were classified as noncompliant. I'm guessing this sounds familiar.

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An example of a communication challenge that I heard recently is depicted in this cartoon. I was the diabetes educator, partnering with the diabetes specialist on a telemedicine visit. The visits were done remotely to provide access to our patients with diabetes in remote rural communities.

When our rural patient is having problems with weight and following a meal plan, she snacks throughout the day. Our very kind and well-meaning

endocrinologist said, “We have lots of patients who have problems with grazing.” Our confused and somewhat disgruntled patient looked at me, “Does that doctor think I eat or look like a cow?” As someone who grew up and lives on a farm, that’s how she interpreted the word “grazing.”

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This cartoon depicts the long-accepted relationship of the traditional health care decision making. The provider, in the red balloon, can be one of us—the physician, the nurse, the educator, the dietitian, the pharmacist—and the other green bubble is the patient. Of course, this pathway in the large green bubble leads to a provider-driven decision.

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So, what does the literature tell us about patient–provider communication?

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First, let’s ask ourselves: Are we empathetic? So, what do we know? Studies published in obesity are just one example. Physicians, we know or have learned, build less rapport with people who are overweight or obese, and this leads to some interesting insight on empathy.

This particular study was aimed to describe the relationship between patients’ BMI and physician communication behavior. They used audio-recorded encounters from 39 urban PCPs and 208 of their patients.

The researchers examined the frequency of communication behaviors between the doctor and the patient. What they found was patients...the PCPs demonstrated less emotional rapport with overweight patients than for their normal weight patients. And for those of us working in diabetes, this certainly offers big opportunities

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for gaps in communication in caring. What about patient satisfaction? In this particular study, they looked at, are patients satisfied? Fifty-two percent of the variance in ratings of patient satisfaction with medical care was accounted for by the physician’s level of interpersonal warmth and respect.

A study involving diabetes patients found dietitians' empathetic engagement with patients with diabetes to be a predictor of patient satisfaction and successful consultation.

Another study found that empathy is the most important quality for being considered a good physician. Interestingly, patients who don't have decision support blamed their practitioner for bad outcomes 19% more often as compared to a physician who they feel is empathetic and respectful.

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The Institute of Medicine gathered a team of experts who worked to develop strategies to guide evidence communications about providers and patients, the communication that...this communication that holds the potential to yield better care.

And what they found from this expert committee is that this seeks to improve the public's understanding of the discussion of the nature and use of evidence to guide clinical choices. This collaborative was very inclusive of participants, communication experts, physician scientists, patient advocates, health system leaders, health care providers, and more.

The work took place in a number of distinct cities across the United States and scanned and surveyed and found interesting information on people's attitudes and their beliefs. And I direct you to this website because there's a plethora of information based on what this consultative group found in their surveys and their environmental scan.

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One of the interesting things that I noticed in reading information from this particular documentation is that there was a gap between what people want and what they get regarding engagement in health care. Interestingly, 8 in 10 people with chronic disease want their health care provider to listen to them, but only 6 in 10 say it actually happens.

Less than half of people say their provider asked them about their goals and concerns for their health. And 9 in 10 people want their providers to work together as a team, but only 4 in 10 say it actually happens.

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What can we do?

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Well, one of the processes that has gained a great deal of attention is shared decision making. And shared decision making is defined as a collaborative process of patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patients' values and preferences, and doing this in a collaborative way.

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There was a Cochrane review of 86 clinical trials of those patients who use shared decision-making aids. And what they found within this meta-analysis was there was improved knowledge of options; there were more accurate expectations of possible benefits and harms; there was greater participation in the decision-making process; higher satisfaction, which all of us are challenged through all of our health care systems to demonstrate; and choices resulting in lower costs and better health outcomes when decisions were made collaboratively.

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I'd like to direct this next part of the conversation to some work of a friend and colleague, who I consider to be an expert in exploring the use of shared decision making to empower underserved people with diabetes.

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And Dr. Monica Peek, who has done her work at the University of Chicago, has really used the patient empowerment model as a theoretical philosophy, a groundwork, for her work, because she realized that self-management is key to diabetes care, and most of that self-management happens during the person's daily life, 24/7, outside of the physician's office or the dietitian's office or weight management educator.

The shared decision making needs to happen with providers, and providers need to be educated and empowered to also perform shared decision making. She also realized that diabetes self-management interventions are accepted in minority populations, and she based a lot of her work on all of the literature that's available on this.

But what she did realize is that there was no prior work looking at shared decision making with culturally tailored patient education, and she wanted to determine if shared decision making improves outcomes.

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So, to walk through the domain of the shared decision-making process, the first piece of shared decision making is about information sharing. So, information is important, but again, all of these processes need to lead to behavior change, so it's giving information. This is what an A1C is. This is why an A1C is important.

The next step in the domain is deliberation. Why is this important for me? How often do I need to get it tested? What does it mean if the number is high or within a range that is supposed to be a target range for me? And then make a decision together and implement it.

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Well, she also realized, Dr. Peek, is that shared decision making is central to the chronic care model. And this is the model that's being used throughout the country as the formation through what many of us refer to as patient-centered medical homes.

And the chronic care model has been used in many, many primary care practices, in health care community settings, because it contains elements that we weren't paying attention to for many years: self-management, population-based management, and community care.

Shared decision making does correlate with positive health indicators. It gives better diagnostic accuracy. It helps informed consent. It has been shown to improve glucose control, lowers blood pressure, shorter hospitalization.

And even though some folks will argue that it takes more time, actually it's been shown that it provides more efficient and effective visits; fewer, interestingly enough, malpractice claims; and less doctor swapping, because the patients are engaged with their physicians.

And it has very big implications for processes that are involved with patient-centered medical homes. When you think about it, an average physician has over 160,000 patient interviews that they participate in.

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This is just an example of, and you can refer to this slide, of many, many organizations that are jumping on board who appreciate that we need to start using these kinds of approaches with communication

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with our patients. And I refer to you to another slide that has the publication that Dr. Peek first prepared that reviewed the barriers and the facilitators to shared decision making among the population that she worked with in Chicago, African Americans with diabetes, but many of the lessons learned by Dr. Peek are applicable to the patients that we work with in our own communities.

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What she found in her work—and these are just some key nuggets that I pulled out—is that there is often a power imbalance. We many...almost all of our cultures still have that hierarchical feeling.

This is the doctor. I'm the...the...eager patient here. This is where we need to empower our patients that we're equal partners. They're the ones that are in charge of their own health.

She also recognized that one of the barriers was health literacy; limited self-efficacy; trust; some fears and denials; and, of course, challenges with normative beliefs; and providers fearing that the length of the process would take longer when these kinds of communications occurred when the evidence tells us

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that's not the case. Some of the facilitators [inaudible] shared the decision making process is patient engagement and an invitation for open communication and transparency, improved interpersonal relationships, validating the person's health concerns, and accessibility and availability to have that open, transparent conversation.

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This slide has the things that Dr. Peek had heard and were quoted from some of the studies that she has done using her model. These may sound familiar.

"The doctor told me I need to go to the dermatologist. Now, the lady up there at the desk, I told her that I don't want to go." So again, the patient felt more comfortable with the person at the desk, and often as educators, many times, they'll tell us [audio not clear] patients will tell us things that they don't feel comfortable sharing with their provider.

The patient said that "If this skin growth goes down, then I don't see a reason to operate. So, I'll have to think about it. Well, I didn't tell my doctor about my preference for not messing with it. I just told her that I would go through with it."

Another finding. A quote: "Some African Americans still don't believe in everything the doctors say. I have a neighbor and she goes to the doctor, and when she gets medication, she throws it in the garbage." Happens with many, many

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of our populations. Some elements of Dr. Peek's program that you may find applicable to use in your own work or applicable to use in the New

Beginnings Program: First, it's a 10-week program; it is culturally structured. It included, of course, diabetes education that is intended to culture that used

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shared decision making, and you're going to see some actual videos on shared decision making. It included the basic curriculum, get to the key points of what we need to communicate about good health care, used adult-learning principles, and was very, very attentive to health literacy.

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The shared decision-making steps: Ask more questions; give more information, evidence-based information; clarify physician information, make sure the patient understands, repeats, can speak back to you what you've communicated; and communicate health care preferences. Although the physicians, our educators, our dietitians, nurses, etcetera, can advise the patients willing, only those willing, to do what they are able to accept as a plan as a priority

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in their care. Again, information sharing, deliberation, and decision making to be implemented by the patient.

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Another thing that Dr. Peek found is very important; we know that any intervention that we do that involves self-management needs ongoing support and she used

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support groups. This is a summary of the findings from her study—and again, you can refer to this on the slides that will be available

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to you on the NDEP site. And these are just some summarizing quotes on how people felt after the program: "It changed how I interact with my doctor. By me seeing the video," that you're going to be seeing, "I did have the presence of mind to ask."

“They kind of built me up in the program—we’d be like we were at a doctor’s session and then my doctor would say things that she knew is not right either, but then she wants to know, are we going to catch on to it and just let it go or will we speak up?”

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So, in summary, building a shared decision making foundation, again, one strategy posted in the literature, empowers patients. Let them know they have value, that their opinions are valuable and why.

Tell them about the three Ds: discuss, debate, decide; increase expectations about involvement in care; continue shared decision making throughout the visit; address uncomfortable barriers, like trust, perceived discrimination, cultural differences; and involve the staff so they understand the process with meetings, resources in the waiting room, precoaching visits with other staff, and of course, interaction and integration with other health members of the team like diabetes

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educators. Thank you, and I would like to move on to a colleague and friend, Alexis Williams, who’s going to talk about the New Beginnings Discussion Guide: Approaches to Teaching Psychosocial and Interpersonal Skills. Welcome, Alexis.

Janet Brown-Friday: Thank you, Linda.

Lots of insights. As you were talking, a couple of questions came through the chat box. So, I wanted to ask you one of the questions if you don’t mind.

Janet Brown-Friday: This question came in from Leah Anne Miyagawa and says, “Did Dr. Peek use motivational interviewing with SDM? How are these concepts similar and/or different?”

Linda Siminerio: You know, I think all of those techniques are similar. I think there’s just nuances in maybe some of the strategies, but I would have to say that that’s

the thread that's similar is that empowering the patient's thread that runs through all of those conversations.

And I think the other key thing that happens to every one of the strategies, the shared decision making, empowerment approaches, and motivational interviewing is taking the time to listen, really listen to what our patients are telling us and being able to demonstrate that we are willing to listen and willing to act on what they're telling us. Thank you.

Janet Brown-Friday: Thank you again, Linda. That's great. Now, we will continue our program with our dear colleague, Alexis Williams, who is a public health adviser at NDEP. Ms. Williams develops and delivers training and technical assistance for NDEP, working with CDC-funded programs, partners and community-based organizations to help strengthen their capacity to deliver effective diabetes prevention and control programs.

A certified health education specialist, she holds a bachelor's degree in sociology from Mills College and a master's of public health and behavioral science and health education from Emory University in Atlanta.

Alexis, the floor is yours.

Alexis Williams: Thanks, Janet. Hi, everybody. Welcome to our webinar today.

I'm so glad to have so many of you on to talk about this really important topic. And thanks, Linda, for really setting the stage for what we're going to talk about in the rest of the webinar today, which is actually how we begin to apply some of the concepts when we're teaching, when we're providing health education or patient education.

What I'm going to do is talk about some of the frameworks that we use in New Beginnings and really the kind of frameworks that you can use when you're approaching any kind of instruction around psychosocial or interpersonal skills like communication. So, I really am enjoying watching this show called

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the Worst Cooks in America. And I think this is a really good example of the traditional kind of education that Linda was talking about in her presentation.

The idea of the show is that people are bad cooks, the participants in the show are bad cooks, and so the solution is we're going to teach them how to cook, and we're going to have them watch a subject matter expert cook something like Hollandaise sauce.

They're going to take notes, and then they're going to go back to their workstations and replicate the dish, and whoever does the best wins, and people who can't improve or don't improve or don't have the best dish end up leaving the show.

And the people who are the best at the end, end up winning the whole show. And I think this is really how we have tended to approach education—health education.

A knowledge problem requires a knowledge solution from a subject matter expertise...from a subject matter expert. So, maybe there are some other things that we need to address, maybe it's not just about knowledge. Take a look at the participant from last season here.

This is Donna. Donna is trying to make her Hollandaise sauce. She's wearing two pairs of glasses, and she's saying, "I forget where I am, while I'm at where I'm going." What do you think might be going on with Donna besides the fact that she doesn't know how to cook Hollandaise sauce?

If you think there are any issues with her besides a lack of skills for cooking? [READING AUDIENCE RESPONSES FROM CHAT BOX] Thinking ahead too much, overwhelmed, stressed, anxiety. She's juggling a lot; she's overwhelmed, overwhelmed, poor memory. She sounds flustered, maybe she needs a checkup on her eyes, memory problem. Multitasking, focusing on too much, vision problems, anxiety, stressed, disorganized, lacking confidence.

Poor Donna has a lot going on besides the fact that she doesn't know how to cook Hollandaise sauce.

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I would propose that the participants on the show are not bad cooks, but they have other issues going on with them that are impacting their ability to learn cooking skills. They're scared. They have failed at cooking so many times before that they are scared that they are going to continue to fail.

They have low self-efficacy. They don't have any confidence in their ability to cook. They don't think they can cook. They don't think they'll ever be able to cook, and the people around them have told them that they can't cook and have made fun of them, and the stories of their bad cooking are legendary.

Which means they have trouble communicating. They have trouble communicating with their family about how this makes them feel. They have trouble communicating with the subject matter expert. They have trouble understanding the recipe.

They are stressed—not just on the show, not just being on TV, but when they start to talk about their lives and what has brought them to the TV show, you realize they're stressed in their personal life, as well. They're disorganized, and they lack cooking skills. They can't cook.

But maybe at the heart of the issue, it's not just the cooking skill. They are also highly motivated to change their behavior, not just by the prize money, but they all talk about the reasons that they came on the show is that they have linked this, their ability to cook, to some core value like being a good parent, being a good partner. To their health, the fact that they can't cook means they eat out all the time, and it's having a negative impact on their health. And so their need to learn how to cook has driven them to go on the show. It's not much about the money but that they have linked their poor cooking skills to some core values that's motivated them to come on board.

Does this sound like any patients or participants or clients that you might have? I think that we all, when we're teaching, run into people who it's not

just about the knowledge, it's not just about the skills, but they have a lot of other things going on. And we actually have trouble getting to the skills, getting to how you make the Hollandaise sauce, because we need to address all of these other issues.

The fact is that most of the people on the show, all of the people on the show learn how to cook. The ones who win are the ones who have the greatest increases in self-efficacy and the greatest increases in learning how to manage their stress.

So, they start to win; they win one or two cooking dishes, and they start to think, "Oh, I can cook." And they learn how to organize their cook stations and those are the people who go on to win.

Everybody on the show learns to cook something, but the people who win are the ones who have the biggest increases in self-efficacy and stress management.

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So, diabetes management, the point of this story, is that diabetes management is not just about Hollandaise sauce. I mean, when we go to teach people any skills about their health, it is not just about here are the basic skills for healthy eating and physical activity and monitoring and all the other things we try to teach people, but we also have to address important core interpersonal skills. We have to find ways to support motivation; we have to find ways to support self-efficacy.

We have to find that link to personal core values that are really going to motivate people to want to change their behavior and start to build up the interpersonal skills that they need in order to address these issues, as we need to do all of that on top of the knowledge transfer.

So, what is useful...what will be useful to us is to have the kinds of tools that support these kind of interactions and these kinds of instructional approaches.

So, not just, here are the things that you need to teach people about the food plate or about what counts as moderate physical activity, but tools that will actually help us to begin to support a person's self-efficacy or a person's communication skills or a person's ability to be more organized and less stressed.

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This is really at the heart of New Beginnings, which is *A Discussion Guide for Living Well With Diabetes*. It's a resource for diabetes educators, community health workers, health educators, anybody who provides education to people who have diabetes and their family members.

This does not replace diabetes self-management education, but it's intended as an add-on, and it's really focused on managing the emotional side of living with diabetes. So, how do you deal with the impacts on your own feelings, your own self-worth? How do you manage the impact on your family? How do you develop meaningful social support structures and improve communication with providers, caregivers, and loved ones?

The New Beginnings Guide has been tailored for African Americans. We'll talk a little bit about how we do that. The primary way is through stories of African Americans with diabetes. One of the things that we recognize is that in talking about that all populations, all groups have issues when it comes to discussing new kinds of interpersonal and psychosocial and emotional issues.

And what we need to do is find ways to bridge those communication gaps, to make it easier for people to talk about what's going on with them and to talk about things that are frankly considered somewhat taboo to talk with people outside of your community or outside of your family.

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New Beginnings has eight modules, and they cover a variety of topics around emotional coping, self-efficacy, stress management, problem solving, and communication.

We're going to focus on Module 8, which is "Working With Your Health Care Provider, Working With Your Doctor, and Improving Your Communication Skills." But the...

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the sort of psychosocial approach to teaching these is carried throughout all eight modules, and they're very flexible and adaptable modules.

You don't have to do a whole New Beginnings eight-week course. You can adapt with the need, whatever your needs are, you can pull out one exercise and do one exercise in the program you're already running. There are a lot of ways to use New Beginnings, which Peg will talk about later.

At the heart of New Beginnings is storytelling. So, all of the exercises, all of the modules are linked to a particular story of a person who is trying to or family member who is trying to help someone with diabetes, or a person who's trying to live with diabetes, and then we have a discussion and activities that are built around the story.

And the reason we use storytelling is because it really supports communication. It helps people overcome that personal barrier to talking about that emotional thing that I'm not supposed to talk to other people about, because they can talk about the character in the story; they can talk about what's going on with them without having to disclose personal information about themselves. It really helps to break down some of those communication barriers.

The stories also help to model behaviors so people can see someone who's either doing something really well or struggling with something, and people can see how someone else deals with that and start to think about how they can cope with that in their own lives.

And it can also help bridge cultural divides when there are differences between the educator or the group leader and the people in the group or the patient that this story becomes a shared experience that can help break down some of those communication divides that...that sometimes arise.

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So, the guiding principles of New Beginnings, what we really want to talk about and getting back to some of the things that Linda talked about and some of these core concepts that we want to keep in mind are around adult learning theory, promoting self-efficacy, and motivational interviewing.

The stories and the discussions in New Beginnings are driven by these concepts. And you don't have to go out and take a training on motivational interviewing; we have built these concepts into the lessons. So, if you follow the lesson plan, you will begin to start using some of these skills and applying some of these skills

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with the people in your group. So, in terms of the core concepts and the principles that are used in New Beginnings, adult learning theory and the principles of adult learning recognizes that adults come to the table having already learned a lot, having already advanced a lot, and we need to respect that.

So, the New Beginnings discussions really involve the participants in deciding where these discussions go and how the discussions go.

So, you show the story, and you don't tell people what the story is supposed to mean or what the moral of the story is. It's not that kind of approach; it's now let's talk about what happened.

And in talking about what happens, people will pull out the message that's most relevant to them, to the story. And it helps them begin to be more self-directed in terms of the areas they want to explore, the areas they want to talk about, and how that discussion goes.

New Beginnings focuses on the relevance and the impact of the skills that we're trying to teach on the participants' lives.

So, it's not sort of unrelated skills that you think I need to learn as a health educator. So, what skills are important for you? What's going to help you when you leave here today to do a better job or to have better communication with your family members or to have better communication with your...your health care provider.

It draws on the experiences people already have. It draws on the successes and tries to build on any successes that they already experienced, and every New Beginnings module includes hands-on problem solving.

It's really important for people and adult learners and for certain cultural groups—for men, for African Americans, for Hispanics/Latinos, for some other cultural groups—for things to be really concrete and hands-on and not, sort of, we don't want to sit around and talk about our feelings—that's not what we do. But, here are some specific skills, some things that you can take away and that you can apply today.

So, that's really some...some really important concepts that we draw on

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from adult learning theory. We also really have a big emphasis on building self-efficacy in New Beginnings. If you don't believe that you can accomplish a skill, that you can make a change, then it's not going to happen.

It's just my belief, as a health educator, that self-efficacy lies at the heart of almost all of the changes that we're asking people to make is that they have to believe that not only is it important to make this change but that they are capable of making this change.

So, in New Beginnings, we use social modeling through the story to build self-efficacy, so you see people like you making these kinds of changes. We encourage mastery experiences, and mastery experiences are quick wins to help people build their confidence.

So, you start to take small steps and see you can do it, and that's just one step to a bigger success, and we try to reinforce those quick wins.

We do the discussion, we do the activity. The participants are able to break down a new behavior into manageable steps that they can...that they can practice.

As...know what we said about the Worst Cooks in America show—the people who win are the ones who have these quick wins, and they start to build...those wins build upon themselves until you finally feel like you can be successful with something.

People are encouraged to overcome their self-doubt, the stories and discussions are really there to help people work through that negative self-talk and replace it with positive self-talk. To be a good friend to yourself and to encourage yourself and to build yourself up and to not be beat down by minor setbacks—that's all they are.

Every day is a new beginning. That's our motto for the program, and you get another chance to try again, and next time will be better. And we also focus on stress management and developing positive coping skills.

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The third sort of core principle that...that's a part of New Beginnings is motivational interviewing.

And without training our facilitators to go out and become experts in motivational interviewing, what we have tried to do is to build some of these concepts from motivational interviewing into the discussion guide.

So, motivational interviewing is—for...for people who are not familiar with that...that approach—is a participant-centered communication technique that's designed to build internal motivation and self-efficacy for behavior change.

It's really to help people overcome their ambivalence to change—that "I'm feeling two ways about something," that "I know I need to walk more, but...." And it's to help people overcome that...that "but" and to sort of lose all of

those reasons why they can't do something. And to start to talk about the reasons why they can do something and why they will do something.

So, we do this in New Beginnings by using open questions. So, those are questions that can't be answered with a yes or no. That helps participants do most of the talking and drive the discussion. It's really important for people to be driving the discussion and not the facilitators.

And it also helps participants start to tell their own story, and this can help support change talk. Change talk is when a participant starts to state what they should change, why they should change—instead of the facilitator.

So, it's not me, as the health educator, coming in and saying, "OK, now you are going to learn to read food labels and be able to count how many calories."

If that's not important to you, then you're not really going to be that interested in it. What change talk is, is a participant saying, "Well, what would really be helpful is if I did a better job of reading the food labels before I bought something."

We want the participant to state a change they're going to make, and so the stories and the discussions are really designed to elicit that change talk.

And we also try to normalize challenges. So, the stories help normalize that it's...it's difficult to learn to manage diabetes. It's stressful and it's okay. That is normal, and it's expected that from time to time for you to feel overwhelmed, for you to feel stressed, for you to feel angry or sad or frustrated.

Those are all normal, and you can work through them. And so what the stories and the discussion really help to do is normalize what the participants are going through. They see people who are facing similar challenges. Change is hard for everyone, and normalizing helps participants move away from blaming themselves to more...taking more constructive actions.

In terms of how this is applied in improving patient–provider communications, the Session 8 focuses on two key concepts: partnering with your diabetes care team and partnering with your caregiver or your family.

So, in terms of partnering with your care team, we focus on building the participant’s self-efficacy and the patient–provider encounter. You are the person in charge of that encounter, and by being prepared, you can come in and get what you need to get out of that meeting with the provider. And so, we help participants prepare for their visits with their health care providers.

We also help participants learn to partner with their caregivers and families. And this is important for helping them to get more social support for their health care visits so that if they need someone to provide moral support or someone to come with them to help them understand, to help them communicate with the health care provider, they are able to communicate that in a way—with their family or their caregiver—in a way that they can get what they need.

It’s also designed to help reinforce patient progress so that family members are focused on the right thing and the helpful things and the useful things to help build up the person’s self-efficacy and to help support the person in meeting their behavioral goals that they have worked to set with their

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health care provider. And recognizing that patient–provider communication is not a one-way street—that it’s not just on...on the patient to improve that...that communication relationship, but it is also on the provider.

We also try to set up some expectations for what those encounters look like in the New Beginnings sessions. So, you can teach people skills, improve communication skills, but you can also model how a facilitator or an educator or a provider who is practicing those communication skills, what that looks like as well. And set some expectations of what those kinds of relationships are like.

So, we reinforce in New Beginnings that it's mutual respect, that the participants and the facilitators are all there working together, and so you create an air of mutual respect.

We come to mutual understanding. Facilitators make an effort to understand their...their participants and where they're coming from, and the stories really help to build up that mutual understanding.

You come to common agreement on goals. Participants set their own goals—it's not someone else setting goals for them. And you may talk back and forth about tweaking those goals or making those goals relevant, making those goals meaningful, impactful, and achievable.

You provide a supportive environment. You provide the right information at the right time—not all of the information, but the information that participants need at the time to address the issues they are having.

We reinforce the importance of transparency and full disclosure in New Beginnings sessions, and we also set up the sessions so that people have regular feedback on their progress and the progress of the course. So, how am I doing as a facilitator and are you getting what you need, so that we can make assessment and course correction as needed in that session.

And so that the participants leave having this kind of relationship with the facilitator that they would hopefully expect to see in a relationship with

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their providers, their health care providers. So, just to summarize, the way that we approach patients' psychosocial skills in New Beginnings is not just basic skills but interpersonal and psychosocial skills as well, with a big emphasis on motivation and self-efficacy. And we base this on adult learning principles through the use of storytelling and learner-centered techniques.

Thank you.

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Janet Brown-Friday: Alexis, I want to thank you...

Alexis Williams: Thank you!

Janet Brown-Friday: I want to thank you very much for that great presentation. I'm sorry. You can talk. What's going on?

Alexis Williams: Well...and I just thought...and I think I didn't clarify—and I meant to go back and clarify—that the basic framework for New Beginnings can be used with a lot of different populations. We're actually in the process of adapting it for other populations.

The stories feature African Americans, and they feature, sort of, language and family interactions and attitudes and beliefs about health care and managing your health and how you are supposed to deal with emotions from an African American perspective.

And so that's why we say that New Beginnings is tailored for African Americans, because it's been culturally adapted to the way that we, African Americans, tend to think about things like stress and how you're supposed to cope with stress and how you're not supposed to talk to people about how you feel.

And so, it's been designed...and these are not issues that are unique to African Americans, we recognize that.

And what some other facilitators do is they use stories that are meaningful to the population they're working with. So, we have people in American Indian communities and Hispanic/Latino communities, and they have adapted the stories or chosen their own stories to reflect the cultures of the population that they work with.

We had some rural communities as well who have done some stories that are...are unique to rural communities. And so that would be the way that you would adapt this, these stories to meet the needs of your population.

Janet Brown-Friday: Alexis, thank you again.

I have one question from Rebecca Sutherland, which is, “Are there parallel evidence-based programs designed for preventing early onset diabetes? Is this program effective at preventing early onset diabetes among family members, caregivers who participate with program participants?”

Alexis Williams: Those are some really great questions. So, the National Diabetes Prevention Program, which you can find more information about on CDC website, cdc.gov/diabetes, the curriculum—the approved curriculum—for that program includes things like stress management that is a diabetes prevention program for people with prediabetes and that includes things like stress management, self-efficacy, communication, organization, and problem solving.

So, those kinds of psychosocial issues are built into that evidence-based...and that...that prevention program is evidence based. So, you can find more information about that on the website.

New Beginnings also encourages people to bring their family members, and so, within the guide, we have added some resources for people who might be concerned about prevention among...among their family members.

So, encouraging their family to start to take steps to reduce their risk for type 2 diabetes—that is included in the New Beginnings discussion guide. Although the focus is not specifically on diabetes—that type 2 diabetes prevention—we do try to provide some...some resources for people who have an interest in that. Thank you.

Janet Brown-Friday: Thanks again, Alexis. Now, I would like to introduce the last presenter of the day, Margaret B. Thearle. Ms. Thearle is a certified diabetes educator at the University of Pittsburgh Center...Medical Center Physician Operations. She’s been working in adult diabetes care for 15 years.

In her current role, she consults and collaborates on projects that include professional staff training, member self-management education, community outreach, and quality initiatives for population management.

So, without further ado, Peg, please go ahead.

Margaret Thearle: Thank you. Thank you for giving me the opportunity to share my experiences using the New Beginnings discussion guide.

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I'm very passionate about talking about diabetes. I had a great opportunity in the fall of 2014 to partner with UPMC Health Plan and the University of Pittsburgh Diabetes Institute and local community health centers on a diabetes outreach project.

Here you see the recruitment flyer that we used, and the flyer comes...it was adapted from some of the promotional resources that were available in the New Beginnings guide information, and we were advertising that you don't need to be a superhero to manage your diabetes.

We...we're trying to reach out to people living around poor urban community centers in the Greater Pittsburgh area, and the program was open to anyone interested in learning about living with diabetes. The program was free, and it included a healthy lunch, which was coordinated by Janine Jones, one of our dietitians, and CDEs from the health plan.

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As you can see from the flyer information, some of our goals were to help participants learn skills for planning, managing stress, and communicating, as well as coping with the ups and downs of managing diabetes.

We also wanted them to learn about getting that support that they need from health care providers, as well as family and friends. And we really wanted the participants to know that this would be a fun and supportive group setting.

Our overarching theme was that every day was a New Beginning and a chance to do a little bit better to live with diabetes. So, we really did embrace a lot of the themes from the New Beginning concept.

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We kind of modified the *New Beginning Discussion Guide for Living Well With Diabetes* as a model for our program. We—unlike what Alexis mentioned in the eight sessions—we had to modify that to a four-session program. So, we adjusted a little bit, and the New Beginnings program could be very adaptable. We modified that to four-session program. We used four sessions of 90 minutes, and our key objectives were taken from the guide.

We consolidated that for major content areas, and the program focused on the emotional aspect of managing diabetes that involved both the persons with diabetes and their loved ones.

And accurate information about current diabetes management was incorporated at every session, as well as building those skills for developing action plans.

So, at each session, you can see the session topics here, as you can see listed on the flyer information. Session 1 was focusing on living with diabetes, living well, and we introduced the concept of the ABCs of diabetes care. And in Session 2, we were talking about coping with emotions, self-doubt, and stress, much of which Alexis spoke about.

Session 3, we were talking about making those smart plans, and we've...we practiced that—problem solving, handling those ups and downs. And we talked a little bit about emergency preparedness.

We also, in Session 4, we talked about developing those support networks in working with your doctor. It was very important to build that trust and maintaining that privacy, creating a nonthreatening, supportive environment. That was a crucial part of the program. And actually, it was a part of a guide...a recommendation from the guidebook.

And the participants on the first session set up ground rules, which they themselves were very instrumental in doing, and some of the things that they agreed upon was that everyone was entitled to their opinion, their own beliefs, and that all the participants would be nonjudgmental; they would not criticize or offer unsolicited advice.

In the program, attendance was open. Participants were not required to attend all four sessions.

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The New Beginnings, for those of you who are diabetes educators, this was not intended to replace traditional diabetes self-management education program.

For our purposes, however, we did not solicit to do that. But as a diabetes educator, I found that this New Beginnings guide was a very useful tool, which...which I feel could be used for diabetes self-management education, as I have a lot of experience in providing that kind of program...program use.

As a matter of fact, I feel it could be used for any group that's already meeting. It was very adaptable. It had a lot of the activities, and discussions could be used for any group. It was easy. The guide itself had...all the homework was done for you. Their...the programming was very, very easy to follow. The access for the resources was already included. It was easily...to modify to whatever content or curriculum you already had. All the worksheets, discussion guides, and exercises that you need to implement for the program are included in the guidebook.

And the guidebook is available as a PDF; it's available as a...as a booklet. There's a lot of hyperlinks embedded, so by going to the website, you can get whatever information you needed.

Actually, we did a lot of turning the stories into role plays, which gave the participants an opportunity to act out situations. And with a little bit of creativity, we were able to personalize some of the themes by adding some, you know, local events, sports themes, holidays—keeping the stories real.

We, here in Pittsburgh, can really relate to any story that has anything to do with our cherished sports teams such as our recent Stanley Cup Champion Pittsburgh Penguins.

We...

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made available Terri DeFazio, who's our program manager for our program, was very diligent in trying to provide a lot of resources throughout the sessions.

And we made a lot of resources available so that participants could choose whatever they found helpful or useful for them or their family members. A lot of resources available out there from the NDEP site, including a lot of literature, which is available to be downloaded.

There were a lot of resources that we chose from our own national local public health departments, including some information about free clinic availability, community support programs, information from our local American Diabetes Association. We felt it was important to help connect them to resources that they may need at their avail and contacts for how to find a diabetes educator or diabetes program.

And also, because we were working with the health plan, we wanted to make them aware of what programs were available for diabetes information related to diabetes prevention and health coaching and disease management programs through the health plan itself.

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Storytelling was really, really an integral part of the program. And I'll tell you, as an old dog, it really taught me some new tricks.

After observing the storytelling videos, at each session, participants were open to sharing their feelings. As an educator, it was a sit-back moment. Discussing characters, thoughts, and feelings in the third person was really less intimidating for the participants.

These interactive discussions created an open, nonthreatening environment for vetting feelings and for them to talk about obstacles and barriers. Participants could often relate to the characters. They could share their situations, their

challenges, their family dynamics. The video characters often demonstrated positive behavior changes. And this provided some realistic role models.

For instance, the character on the right, the woman on the right, her name is Sorcy. She's actually a Hispanic woman. She tells a story of discovering that she had type 2 diabetes only...she only found out she had type 2 diabetes after she developed multiple diabetes complications.

She was a staunch advocate for engaging her entire family in lifestyle changes. She wanted to prevent her daughters from developing diabetes health problems. In this picture, you see her playing with her family using a Wii Fit Boxing Program.

Building on these observed behaviors really helped the participants to begin to talk about and internalize and develop strategies for personal action plans.

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In this picture, these participants are watching a clip from a video called "The Debilitator," which is obtained from Millennium Filmworks.

In a dream segment, the character, Calvin, he dreams about his early death from diabetes complications and the impact that this has on his family. The emotional interaction between Calvin and his family had a powerful influence on the follow-up group discussion about feelings and personal interaction.

And this was a great lead-in to talking about developing support networks. After that discussion, many of the participants were moved to share their own personal experiences related to health disparities and some of their concerns for their risks and concerns for their loved ones with diabetes.

These emotional interplays were often a major catalyst for developing personal behavior change talk.

It was really moving for me to begin to see the people in the class, in their environment, begin to actually move toward a discussion about their need to start to make changes in their diabetes care.

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I want to share with you that we had brief evaluations after each session, and of all the sessions across the board in all four centers, Session 4, Developing a Support Network and Working With Your Doctor, had the most impact.

After the session, 100% of the participants reported improved confidence in working with their health care team. I want to take a moment to share with you a video that we used to start the session. And I'd like to thank Dr. Monica Peek from the University of Chicago for allowing us to use this video, which is a part of her work.

[Audio of video begins]

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Doctor: Hello Mrs. Robinson, how are you doing today?

Mrs. Robinson: I'm fine, thank you and you?

Doctor: I'm well, thanks. How have you been?

Mrs. Robinson: I've been pretty good.

Doctor: Good, good. Have you noticed anything unusual or different about how you've been feeling?

Mrs. Robinson: No, everything's about the same.

Doctor: And have you been taking your medication and checking your diet?

Mrs. Robinson: Well, yes. I've been pretty good. I've been eating all my vegetables because I know you said that was important and I've been taking all my medications too every day.

Doctor: Okay, that's great. That's really important Mrs. Robinson. Are you experiencing any fatigue or other symptoms?

Mrs. Robinson: No sir, I feel about the same.

Doctor: OK. If everything's the same, let's keep you in your current medications and you can come back and see me in three months.

Granddaughter: Grandma, did you tell him about your sore in your foot?

Mrs. Robinson: It's just a little sore; I don't think there's anything to worry about.

Granddaughter: She has a sore in her foot Dr. Woods. She says it hurts and she's tired all the time.

Doctor: You have a sore in your foot?

Mrs. Robinson: Uhumm.

Doctor: Well, have you been wearing proper shoes and checking your feet every day?

Mrs. Robinson: Yes I have.

Doctor: Alright, then, let's take a look, OK?

Mrs. Robinson: Well, it's just a little sore. It don't even hurt that much. It's on my right foot.

Doctor: Well, I do see some redness and some signs of infection. I believe that's a result of your diabetic condition. Now the infection is still in the early stages but it's important we address it because some serious problems could occur as a result.

Mrs. Robinson: OK doctor, I understand.

Doctor: There are two ways to handle the problem with your foot. I can give you some antibiotics, which should clear the problem, or you should see a foot specialist. You know I think I'm going to have you see a foot specialist.

Mrs. Robinson: Whatever you think is best doctor Woods.

Doctor: I've got a referral slip for you to see a foot specialist. Call his office, make an appointment and they should take care of you.

Mrs. Robinson: Oh, I can't see the foot specialist today? I have to make an appointment?

Doctor: Yes. I'm afraid so.

Mrs. Robinson: But I have to work all week and I don't think I can take off another day so soon.

Doctor: Mrs. Robinson, I'm sorry for the inconvenience but we don't have a podiatrist in this office so you are going to make an appointment to call.

Mrs. Robinson: Okay, I will call as soon as I get home.

Doctor: Great. Glad to hear that. You know is also a time for your flu shot. So I'm going to send the nurse in and she can take care of that for you.

Mrs. Robinson: Okay doctor, thank you. You have a nice day.

Nurse: Mrs. Robinson?

Granddaughter: Grandma never made that appointment.

[Faint audio of Monica Peeks video]

What happened in that Mrs. Robinson video?

Is...Mrs. Robinson goes to the doctor with her granddaughter, and during the visit, the doctor asked her, "How's everything going," and she says, "Everything's just fine." "Any changes?" "No, everything is the same."

In fact, the doctor said, "Fine. Everything is the same. Keep doing everything you're doing." And then the small granddaughter says, "Grandma is tired all the time, and she has a sore on her leg." And, of course, the grandmother frowns at the little girl.

And the doctor looks at the sore on her leg and says, probably speaking at a higher literacy than grandma's used to, "I think this sore is coming from your diabetes condition. And we could do two things. We could treat you with antibiotics, or I could send you to a specialist." And without consulting her said, "No, I think I have decided. I'm going to send you to the specialist."

And then without discussion says, you know, "Here's the referral. You'll have to go to see the specialist." And the woman says, "I don't think I can take time off work to do that." And he frowns at her and says, "You need to take this seriously."

And then he says, you know, "Here's the referral. Contact the doctor. Call and make an appointment. You need to take these kinds of things seriously. And by the way, while you're here, we need to give you your flu shot." So, at the end of the discussion, you can see the nurse walks in. Mrs. Robinson has left the office.

At the end of that discussion, or at the end of that video, that video had a major impact on a lot of the participants. It was kind of an example of not shared decision making. Mrs. Robinson was really not being listened to by her doctor. There was a one-way conversation going on there, and really, we cannot assume what was going on. She had...wasn't her health care needs being met.

In our program, we opened up the discussion afterwards with prompts like, "This story had a lot of key messages; tell me how this made you feel." Wow, that opened up a lot of discussion in our program.

We didn't tell people what was going on. We later opened up some discussion with, "How do you think Mrs. Robinson felt?" And later some things such as, "What do you think happened next in the story with Mrs. Robinson?"

Allowing the participants the opportunity to share their feelings, their comments, then to talk about the character, the patient–doctor relationship, was very important.

Many identified with the character and expressed their own feelings of inadequacy when it came to talking about health care providers. The discussion guide provided talking points and open-ended discussion questions, making the useful...making it a useful tool for both experienced or inexperienced facilitators.

Following the discussions, we had participants work together in small groups to explore and practice talking with your doctor. Later in the program, Alexis will share with you an exercise to take with you, because practicing the stepwise process was an effective way to enhance the participants' skills and increase their confidence.

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We did a lot of role playing, and in role playing—here you see one of the participants...two of our participants actually doing a role play where they were acting out the...a part of two sisters, one the nagger and the other one the overwhelmed patient.

By acting out these kinds of situations in a nonthreatening third-person characters, they were often able to talk about situations and develop action plans. By practicing these action plans, they could later develop their own sets of action plans.

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This is another picture of them actually learning to take action plans and incorporate them into their own active living styles. Several participants created their own New Beginning line dance from the resources we gave

them. There was a CD, New Beginning CD, that they developed their own line dance and taught to the others in the group. This was real empowerment in action, and it was lots of fun.

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As an educator, I learned a lot, and I began to see that they were beginning...they were beginning to support and encourage each other.

After one of the breakout sessions, a member of the group was practicing healthier Thanksgiving meal plans, and one of them was overheard saying that she was going to explain to her family that this year Thanksgiving was going to have some new traditions for health. They were beginning to practice that change talk and how were they were going to talk to their families.

As an educator, I have a new beginning. Every day is a chance for me to transform my interactions to an empowerment model. My job is never to tell people what to do but to help them become more confident in living with diabetes.

I promise I will never show another slide of a pancreas to a group of people living with diabetes when they can learn so much more from Sorcy, Calvin, Mrs. Robinson, and each other.

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At the end of each session, we would give them a small clip from the NDEP HealthSense website. It was very inspired by the people. And I learned that New Beginning outreach program—the people there help to inspire me. Every day, I am still inspired and honored by the people that I work with.

I've learned that people will never forget, as Maya Angelou said, that people will never forget what you did, but people may forget what you did, but they will never forget how you made them feel.

We all need to move toward a new model and a new beginning.

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Alexis is going to talk a little bit about a mini-lesson.

Alexis Williams: Thanks, Peg. I just wanted to let everyone know that for participating in today's webinar, you will receive the New Beginnings Mini-Lesson on Partnering with Your Diabetes Care Team.

This is straight from the New Beginnings discussion guide, but we've adapted it into a

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short, 10-minute lesson that you can incorporate into whatever kinds of education you're doing.

It's based on the video from NDEP, Partnering with Your Diabetes Care Team, which is appropriate for all audiences. And it has some discussions and some exercises, short exercises that people can do, as well as some handouts, and those will be included in the mini-lesson that you get after the webinar...after today's webinar. And as a bonus, you will also get infographics that you can use to promote or print out posters or handouts to promote patient-provider communication, and those will be available in English and in Spanish.

New Beginnings is not available in Spanish, but we have made that infographic and those patient handouts available in both English and Spanish.

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[Slide skipped]

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And I think we'll give it back to Janet.

Janet Brown-Friday: Thank you both,

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Alexis and Peg,

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for your presentations. And I just want to just take a little, some time...again, if you have additional questions, please do...please do present them in the chat box.

I think we answered a couple of questions already—about the audiences that New Beginnings is geared to—but I have one that’s from Robin, —and I guess you all can decide who wants to answer these questions— Robin, “Is the New Beginnings”...Robin says, “Is the New Beginnings Guide available to...for educators?”

Alexis Williams: Yes, it is available. The...the New Beginnings discussion guide is available on our website, and we will provide the link to that in the...in the e-mail that you receive after the webinar.

Janet Brown-Friday: OK. And then Leah asks...Leah Anne Miyagawa again is asking, “Did all your participants speak English?”

Margaret Thearle: This is Peg. Yes, in my situation in the program that we had, yes. In the Pittsburgh area, all of the participants in our program did speak English.

Janet Brown-Friday: OK. Anybody else want to answer that question?

Linda Siminerio: Well, I just want to add that a lot of materials are in Spanish, and the other thing that I wanted to mention—I think this is really important—is, you know, we use the word “educator” a lot in throughout, you know, all of our presentations, and yes, this is all, you know, a user-friendly program that educators can use, but also want to, you know, remember to think about all of you community workers that are out there, working with folks in the community, and when we talk about, you know, making sure that folks are supported and continue to have ongoing support for education.

I mean all of these programs are, I think, created in your interest. And so I just wanted to make that clarification that I think these programs are available and should be used by all of us who are providing services to people with diabetes.

Janet Brown-Friday: OK. Thank you.

We have another question from Hannah Parks, and I think this is a great question: “If you had only one session with the patient, i.e., no promise that they’d come back for another education visit, what kind of activities would you incorporate in a 45-minute, one-on-one session?”

Margaret Thearle: So, I guess that you’re asking me since I’m the CDE.

Janet Brown-Friday: Yes.

Margaret Thearle: After looking as if I were using the whole New Beginnings program—and New Beginnings is not DSME, so it doesn’t really necessarily meet that—I would probably base it on what the patient is looking for. So, I would listen very carefully to what the patient needed, but I would say probably the one that says, you know, if the patient is demonstrating some diabetes distress, I would use the program that talks about stress. If it’s a new patient and they’re looking for the basic, you know, the ABCs of what is diabetes, that’s a really good segment on, you know, what is diabetes, living well with diabetes, and the ABCs that comes from the NDEP, you know, the four things you need to manage diabetes, so a lot of those resources are there to help. But the one about, you know, developing the support network and how to talk to your doctor and developing that, it was...it was actually invaluable. So, if I had to pick one, I would listen to the patient to see what their need is, and I would individualize that to whatever the specific need was.

Janet Brown-Friday: OK. Thank you very much, Peg.

Next question is from Ann Currens, and I think that we may...Ann Currens...I think we may have answered this one: “Are there videos available?”

Alexis Williams: So, the videos are...there are links to all of the videos. There are also some audio podcasts and some print stories available as well. All of the videos are in the public domain, so you can feel free to show them. And they are all online, and you’ll find the links to those online.

“The Debilitator” is a privately produced film. That’s the only one that’s not available online, and there’s information about how to get that video in the New Beginnings discussion guide, which you can get that directly from the filmmaker and your...you have permission to use that for education—not just for New Beginnings, but any kind of education program you’re having.

The New Beginnings discussion guide is only available as a download from our website, and if you have problems, we know some people have bandwidth problems downloading, so just shoot me an e-mail if you have those kinds of problems, because we can either provide all of the materials on a disk or we can provide a printout for you, but we can’t do that for everyone, so that’s just for people who have trouble...have Internet connection problems.

Janet Brown-Friday: OK. Alexis, it sounds as though you answered the question about the hard copy for New Beginnings just now, right?

Alexis Williams: Yes.

Janet Brown-Friday: That it’s only available for download, right. OK. Thank you. Betsy Rodriguez is asking, “How is behavior change measured?”

Alexis Williams: Well, I’ll say for specific for New Beginnings, there are behavioral objectives in each module that you can use to measure behavior change, but Linda and Peg, you can talk about your own experience measuring behavior change.

Linda Siminerio: Yes, and I...this is...I guess an answer with New Beginnings, but may be broader. I think there are a lot of great validated measures that are really quick and easy to use.

One of the ones that we use, because I really believe that we need to empower patients, is the empowerment form, the short form, and it’s just a few questions, and it’s really helped our educators guide them to see how they have empowered patients.

Another great measure is the Diabetes Distress Scale. You know, people are so burdened with all the complex things they need to do, so that's another measure that I think is very useful. And there's also some self-care measures.

And I think if you Google any of those—the empowerment short form; the Diabetes Distress Scale; or any of the self-care measures, there's pediatric and adult ones—I think that...I happen to think that using validated measures is very, very important, because if you collect that information, you know, it really helps to determine how your patients are doing and how effective you are at your job.

Janet Brown-Friday: Thank you, Linda. I have...I think we have time for a couple more questions.

We have a question from Theresa Cumberland: "Is the New..." Sorry, let me go back...I'm sorry, I made...yes, Theresa Cumberland, "Is the New Beginnings program designed for group sessions or individual visits?"

Alexis Williams: It's designed for group sessions, but people have adapted it for individual or very small group sessions. So, it is really designed to be flexible and to be adapted to whatever situation that you find yourself in.

Janet Brown-Friday: OK. Thank you, Alexis.

Danny Sarbot asks, "Are you planning on getting these materials for this program in Spanish in the future?"

Alexis Williams: Yes. We are looking at adapting New Beginnings right now for Hispanic/Latino, American Indian, and rural communities, and we've also had requests for Asian/Pacific Islander.

So, I think everybody would like their own version of New Beginnings, and so what we'd like to do is just in addition to collecting new story...stories that reflect the culture, but also adjust some of the specific psychosocial and cultural issues around emotional well-being in those...in those communities,

so, it's a process, but yes, that is underway. That is, I can't give you a date for when that will be available, but we will let you know when they are.

Janet Brown-Friday: OK. And then I think we have our last question, which is from Kelly Coughlin, which is, "Is there material being developed for East African communities?"

Alexis Williams: Wow! That's a great question. No, we haven't had a request for East African. I think, you know, one of the things to think about is how do we help people adapt the guide, how do we help people collect stories and make the questions relevant to the communities in which they work.

And so, maybe in addition to different cultural adaptations, there is a need for, OK, how you go out and collect your own stories to help support not just New Beginnings, but any kind of diabetes education, prevention, or self-management education you're doing. So, we will make a note of that question because that's a really...that's a great question.

Janet Brown-Friday: I'm sorry. I'm going to pull up this one last question. I thought it was a pretty good one, which is, "Do you..." and I think this is...will be the last question, "Do you do a traveling road show and bring this information to groups who may be interested?"

Alexis Williams: I wish I did.

Multiple speakers: (Laughter)

Margaret Thearle: I'll get you some dancers, Alexis.

Multiple speakers: (Laughter)

Alexis Williams: Like the New Beginnings line dance and...

Janet Brown-Friday: Yes, I'll get you some...

Alexis Williams: ...that go out on the road. Unfortunately, we're not able to travel and provide training, but if you contact us, we can discuss what options are available to provide additional training on New Beginnings.

So, we can't always do in-person training but contact us, because we can talk about what options are available.

Janet Brown-Friday: OK. And is that, I'm sorry that question came from Karen Christopherson. And what I'd like to say is...thank you very much to all our presenters today for the time and for answering all the questions.

I invite everyone to go to visit the newly redesigned NDEP website

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at www.cdc.gov/diabetes/ndep and to check the many resources that could help you in your diabetes education, prevention, and control classes.

Feel free to Linda...to e-mail Linda, Alexis, or Peg,

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and they'll be more than happy, Margaret Thearle, they'll be more than happy to answer any questions you may have.

Don't forget that continuing education credits will be provided through the CDC training

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and continuing education online system. A handout will be provided once we close this webinar, with specific instructions on how to obtain CEUs or a certificate of completion.

For those who joined our webinar today, you'll also receive a New Beginnings Mini-Lesson, with patient handouts in English and Spanish.

We hope that you use this lesson on your patient-provider communications. And once again, I want to

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thank you, everyone, and good-bye.

END