

# NDEP Webinar Series



## Community Collaboration to Prevent and Manage Diabetes

 **NDEP** National Diabetes Education Program

A program of the National Institutes of Health and the Centers for Disease Control and Prevention





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# Welcome



**Pamela Allweiss MD, MPH**

Medical Officer  
Centers for Disease Control and  
Prevention  
Division of Diabetes Translation



## Continuing Education

- This program has been approved for CNE, CEU, CECH, and CPH credit.
- To receive credit:
  - Complete the activity.
  - Complete the evaluation at [www.cdc.gov/TCEOnline](http://www.cdc.gov/TCEOnline).
  - Pass the posttest with 60% at [www.cdc.gov/TCEOnline](http://www.cdc.gov/TCEOnline).
- No fees are charged for CDC's CE activities.
- For more information, please see the TCEO Instructions handout.



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## Today's Presenters



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# Introduction



**Lisa Carr, MSW**

Senior Advisor

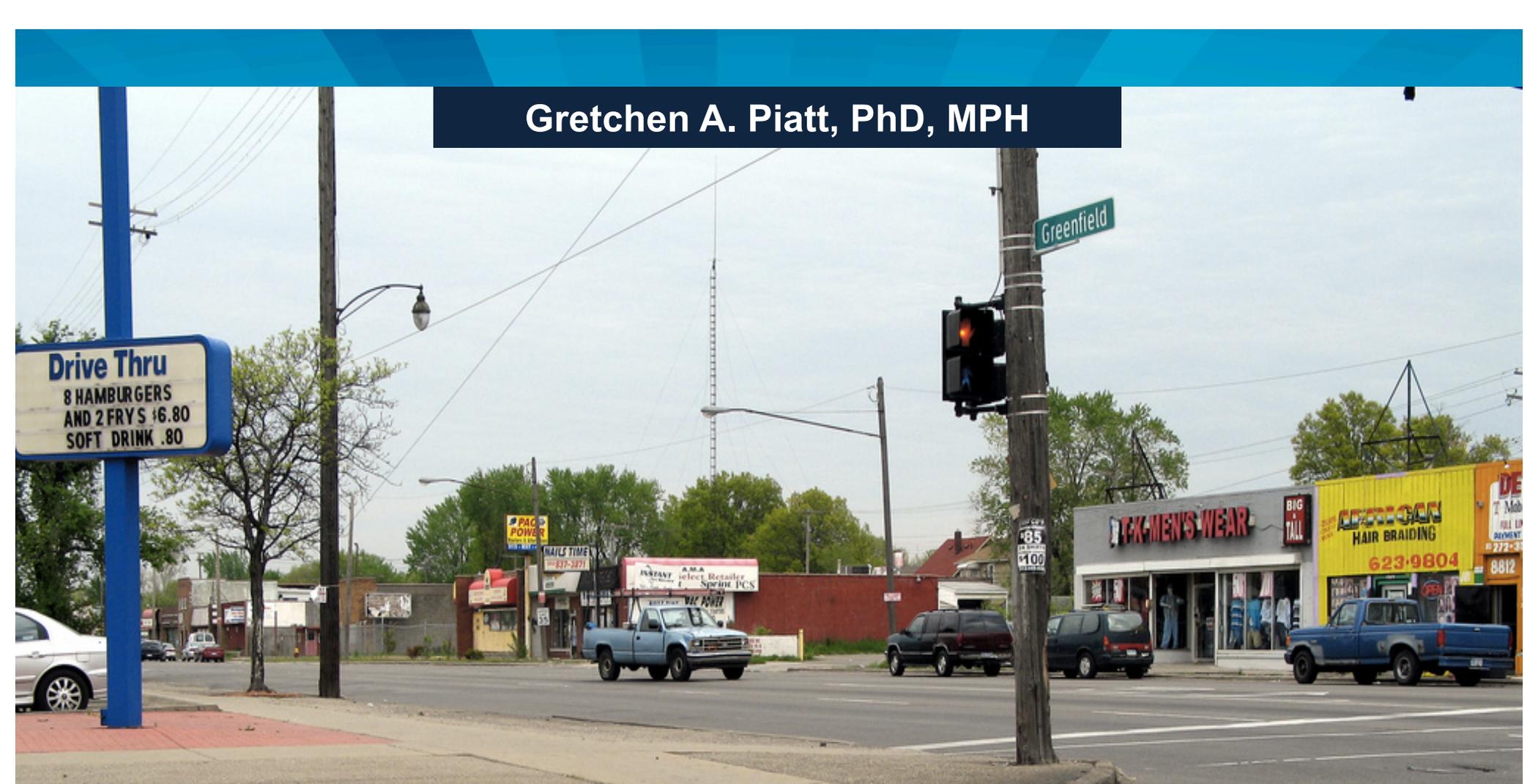
Centers for Medicare and Medicaid Services



## Learning Objectives

- Analyze the challenges and opportunities unique to their setting.
- Identify potential diabetes prevention or management education partners within their setting.
- Articulate the basic steps in planning for collaboration.
- Name at least two strategies to fund diabetes prevention and management education.
- Share strategies used by other organizations to evaluate the impact of community collaboration to achieve diabetes prevention and management education goal.

Gretchen A. Piatt, PhD, MPH



**Challenges and Pitfalls to Diabetes Self-Management in Low Resource Settings**



## Objectives

1. Highlight issues that are often not considered when planning interventions and diabetes care for underserved populations.
2. Provide examples of effective interventions, in underserved populations, that considered the aforementioned issues prior to implementation.



## Despite Everyone's Best Efforts...

- Disparities still exist in quality of diabetes care in racial and ethnic minority populations in the United States compared with their non-Hispanic white counterparts. Why?
- Two silent but dangerous assumptions:
  - If an intervention has been proven to be efficacious and effective, its implementation in any setting would decrease the quality gap.
  - “Adaptations happen” when an intervention is transposed from one setting to another.



## Mrs. Pierce

- Is 63 years old.
- Has type 2 diabetes, high blood pressure, and hypothyroidism.
- Has latest A1c = 9.8%.
- Works full time.
- Has husband with heart disease and chronic obstructive pulmonary disease.
- Has adult daughter who lost her job and moved into their home with her two school-aged children.
- Prepares meals that grandchildren like to eat.
- Sees her primary care provider twice per year.
- Attends church regularly.





## How Do We Help Mrs. Pierce?

- We help by determining the most
  - *Effective*
  - *Practical*
  - *Sustainable*

approaches to provide ongoing diabetes self-management support in the context of the community in which Mrs. Pierce lives.

- In the African American community, the church plays a central role in community life and can serve as a powerful channel to deliver health promotion programs.





## Didactic Teaching Style



- Lectures used to convey information.
- Passive.
- Adult attention span = 15 minutes.
- Overused because easy.
- Not effective for psychosocial or behavior change support.



## Behavior Change



- Behavioral strategy:  
**“You should!”**



**“What is important  
to you?”**



## Lack of Attention to Health Literacy and Numeracy



- 90 million people in the United States have difficulty understanding and using health information.
- Health literacy and numeracy are stronger predictors of a person's health than age, income, employment status, education level, and race.”



## No Cultural Tailoring



- Lack of cultural tailoring → reductions in the uptake and effectiveness of interventions.
- Few interventions tailored to:
  - Low income groups
  - Racial or ethnic minorities
  - Other vulnerable populations



## Paternalistic Care



- Care shows lack of focus on the patient-provider interaction.
- Care is defined by the provider.
- “I know everything about my patients and their care” (provider).
- **“What’s the matter?” → “What matters?”**



## Short-Sighted Outcomes



- Focus remains on clinical outcomes, largely because of reimbursement.
- Largest and most significant improvements occur in behavioral and psychosocial outcomes:
  - Depression symptoms.
  - Self-efficacy.
  - Quality of life.
  - Self-care behaviors.



## Lack of Social Support



### **Social Support:**

- Affects mental and physical health through its influence on emotions, cognition, and behavior.
- Plays a role in the risk for, progression of, and recovery from physical illness.



## Lack of Infrastructure Focus



- Current system is not designed to support long-term self-management.
- Efforts have shifted towards community resources.
- Low-cost interventions that build on available resources and existing infrastructures.



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## No Sustainability Plan

**#CONTROLMESELF**





## Diabetes Self-Management Education (DSME)

- Ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care
  - Using evidence-based standards.
  - Making DSME a covered benefit in the some health systems.
  - Improving outcomes in the short-term (6 months).
  - Providing a certified diabetes educator in a hospital or outpatient setting.
  - Continuing follow up and support to sustain outcomes.
  - Being essential but not sufficient.



## Diabetes Self-Management Support

- Activities that help a patient implement and **sustain** the ongoing behaviors needed to manage their diabetes
  - Can be behavioral, educational, psychosocial, or clinical.
  - Respond to questions or issues based on patient concerns.
  - Focus on feelings, decisionmaking, roles vs. responsibilities, and costs vs. benefits.
- Lack of sound evidence.



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## *Who* Should Provide Self-Management Support?

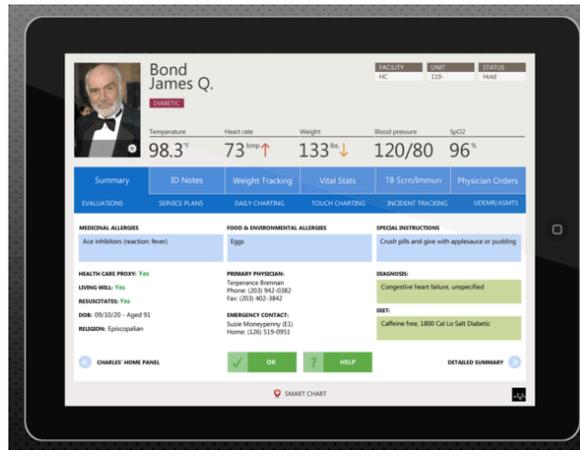




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## Where to Provide Self-Management Support?





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## *When* to Provide Self-Management Support?





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## *How* to Provide Self-Management Support?





## What Do The Questions Mentioned Above Mean?

- Lack of evidence → limited access and availability of diabetes self-management support (DSMS) programs.
- Particularly in high risk or high burden populations.
- Critical need to:
  - Develop.
  - Evaluate.
  - Understand effective DSMS models that are:
    - Ongoing.
    - Patient-driven.
    - Embedded in the community.



## Are Peer Support Models the Answer?

- **Four key functions of a peer leader:**
  1. Assisting in self management assistance.
  2. Emotional and social support.
  3. Linkage to clinical care.
  4. Ongoing support.
- **Peer support helps to:**
  - ↓ Lower problematic health behaviors.
  - ↓ Lower depression.
  - ↑ Raise diabetes management behaviors.
- Peers may effectively and economically fill the need for patient *support* in maintaining lifestyle changes.





## Who Are Peer Leaders?



- Live and work in the study communities.
- Often have diabetes.
- Respected.
- Willing to be trained.
- Empathetic.
- “Good” patient less effective than those who have struggled.



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*The Strength of Individuals  
The Power of Community*

Gretchen A. Piatt, PhD, MPH

Marti Funnell, RN, MSN., CDE

Michele Heisler, MD, MPA

Mary Janevic, PhD

Wen Ye, PhD

Diana Hall, MPH

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Kate Kloss, RD

Nik Koscielniak, BS



## Diabetes Self-Management Support in Church-Based Settings



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## Project Goals and Summary

- Determine the relative effectiveness of parish nurse + peer leader-led DSMS and peer leader-led DSMS compared with enhanced usual care within the context of the church-based setting.
- Implement DSMS in a feasible, scalable, and sustainable manner.



## Methods

- Fifteen-month, cluster randomized, practical behavioral trial.
- Nine African American churches in metro-Detroit in three parallel study groups.
- Unit of randomization the church.

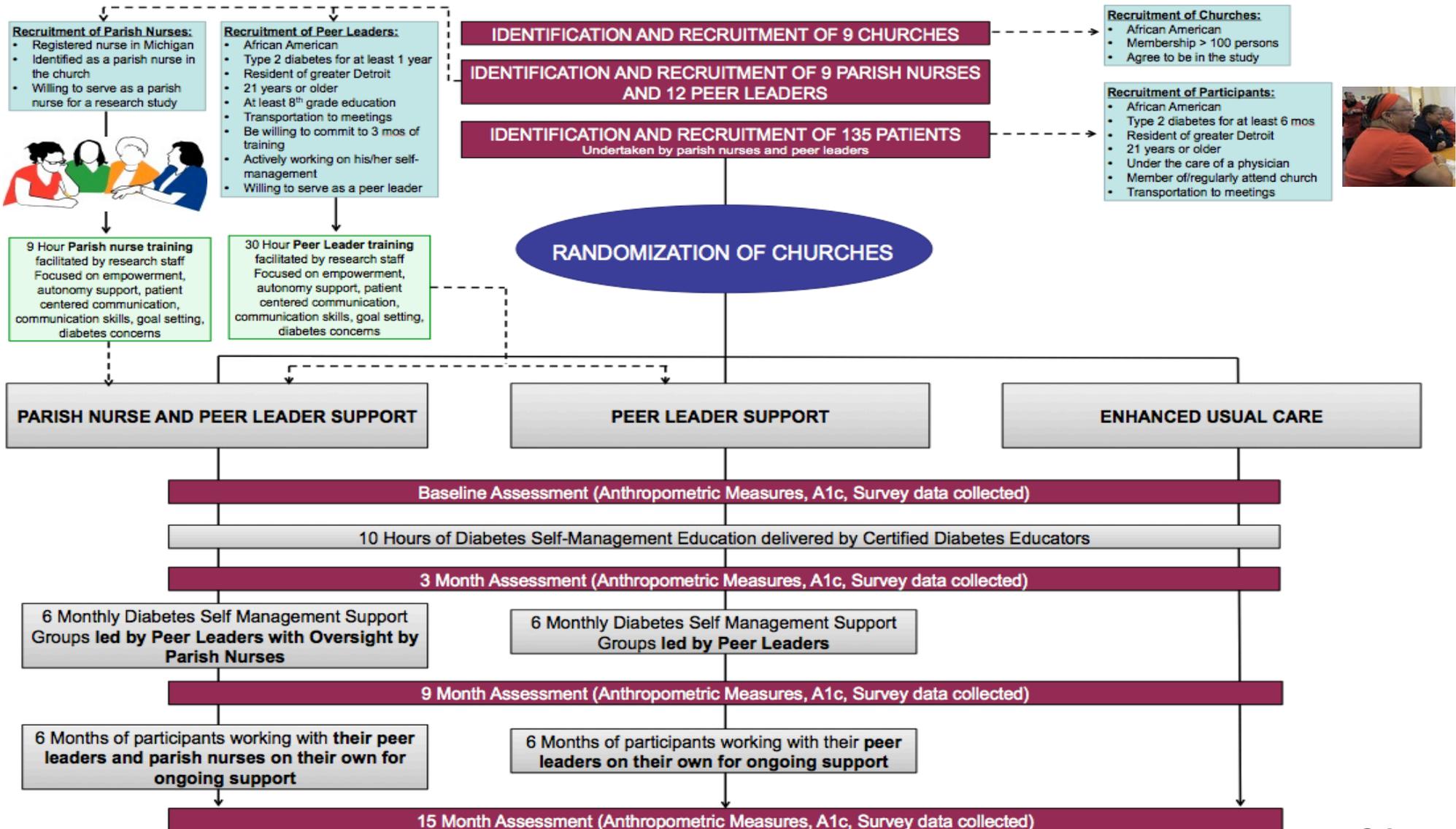
## Community Partner

- **Detroit Parish Nurse Network (DPNN) of Southeast Michigan:**
  - Assist in recruitment of parish nurses.
  - Support staff and assist in the development of project materials.
  - Oversee the coordination of peer support with parish nurses.
  - Participate in all-project team.
  - Assist with dissemination and sustainability efforts.



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## Qualitative Results

- Three key DSMS processes:
  - 1. Goal-setting
  - 2. Group problem-solving
  - 3. Sharing experiences and information
  - All in a context of mutual support, camaraderie, and a sense of safety that were enabled, in part, by everyone belonging to the same church.
- Group processes (e.g., goal-setting) and dynamics (e.g., support) linked to **improvements in motivation and self-management goals.**



## Qualitative Results (Continued)

- Participants found that discussion of nonevidence-based diabetes treatments (e.g., cinnamon) was beneficial.
- Challenges for peer leaders included using open-ended questioning techniques and motivating attendance.
- Peer-led DSMS in African American churches can motivate positive self-management behaviors, in part via positive group dynamics that are facilitated by the faith community setting.



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## Fostering Sustainability of Diabetes Self-Management Support in Church-Based Settings



## Project Goals and Summary

- To examine the relative effectiveness of three approaches to address DSMS compared with enhanced usual care within the context of the church-based setting.
- To implement a 33-month cluster randomized, practical behavioral trial with three parallel DSMS approaches: **(1) Parish Nurse + Peer Leader DSMS, (2) Parish Nurse DSMS, and (3) Peer Leader DSMS.**

# Study Design

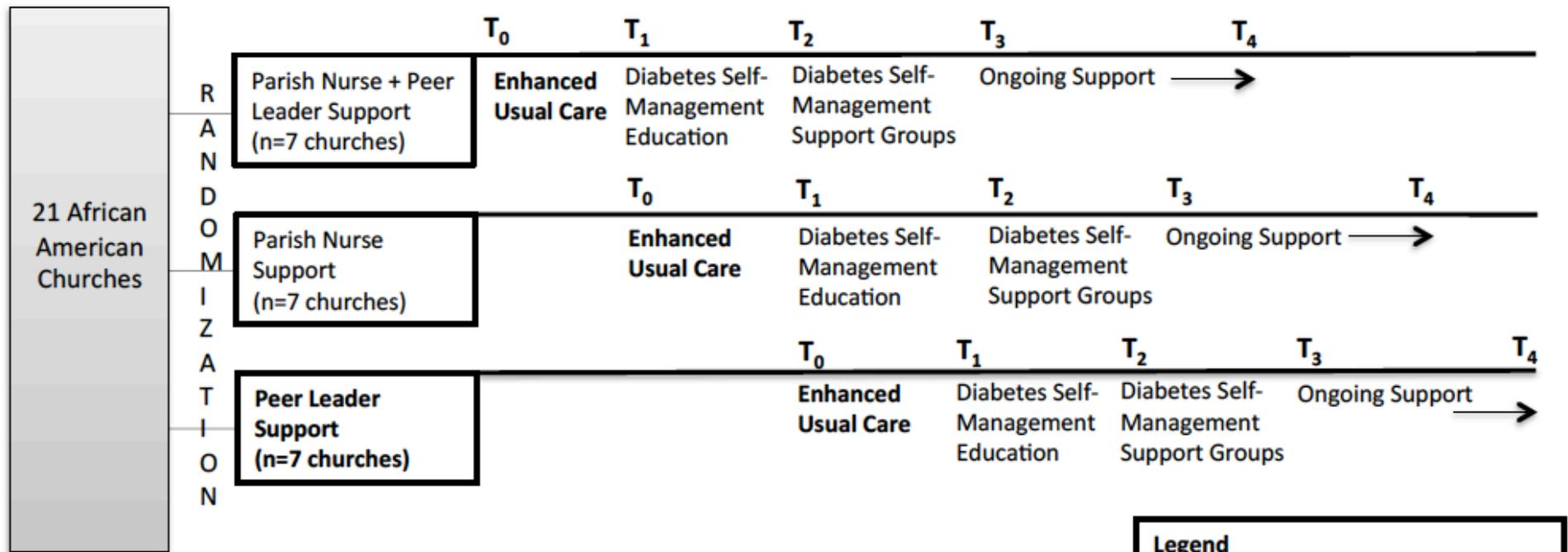


Figure 1. Study Diagram

| Legend                               |
|--------------------------------------|
| T <sub>0</sub> : Baseline            |
| T <sub>1</sub> : 6 Month Assessment  |
| T <sub>2</sub> : 9 Month Assessment  |
| T <sub>3</sub> : 21 Month Assessment |
| T <sub>4</sub> : 33 Month Assessment |



- **Five-year** study to examine the relative effectiveness of three approaches to address DSMS compared with enhanced usual care within the context of the church-based setting.
- **Thirty-three month** cluster-randomized, practical behavioral trial with three parallel approaches: **(1) Parish Nurse + Peer Leader DSMS, (2) Parish Nurse DSMS, and (3) Peer Leader DSMS.**
- **Twenty-one** African American churches in Detroit, Michigan; Flint, Michigan; Toledo, Ohio.
- **Fourteen** parish nurses who are volunteers at the churches, and **28** peer leaders to be trained to deliver diabetes self-management support.





## Church Recruitment

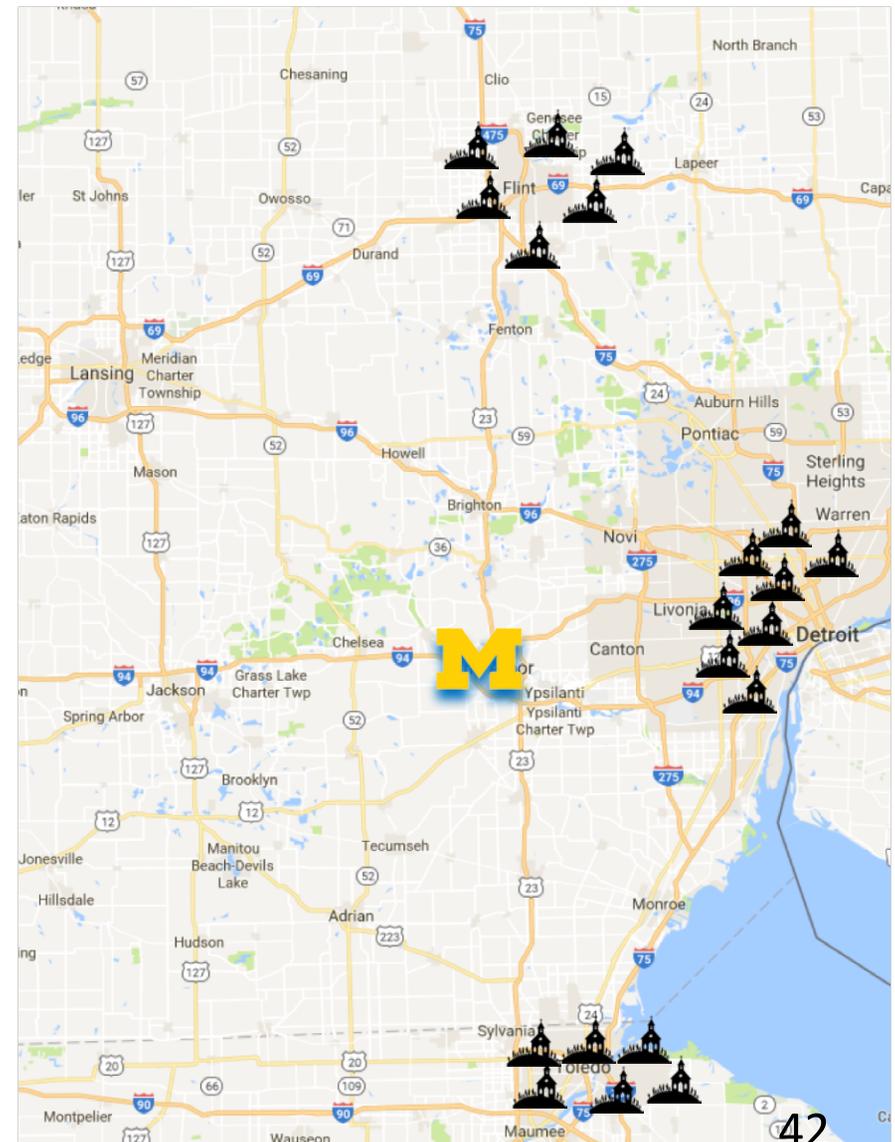
- Baseline knowledge of churches in Detroit, Toledo, and Flint.
- Referrals from churches, individuals, organizations, etc.
- Internet searches
  - Google, Facebook, Yellow Pages, etc.
- Developing relationships with churches
  - Announcements during church services, attending health fairs.





## Church Recruitment

- Goal = 21
- All churches recruited.
  - Detroit... 9
  - Toledo... 6
  - Flint ..... 6
- Various denominations included.





## **Sustainability Strategies**

- **Dissemination of findings and tools**
  - Participants, African American churches, community organizations, policy makers, the national Church Health Center, the American Nursing Association, and academic and public audiences.
  - Toolkit includes (1) curriculum and manuals, (2) data collection instruments to allow for program evaluation, and (3) information on the functions staff members need to sustain improved outcomes.
- **Organizational infrastructure**
  - Identify, procure, and facilitate communication with community partner organizations, including churches.



## **Sustainability Strategies (continued)**

- **Integration into health care systems**
  - Currently, DPNN integrated into four large health systems.
  - Peer leaders as members of the health care team through the Chronic Health Home.
- **Program recognition and billing potential**
  - American Diabetes Association (ADA) or American Association of Diabetes Educators (AADE) program recognition can be obtained.
  - Each congregation would fall under a health system that has recognition; thus offering DSMS as a stand alone service and the possibility of future billing.



## Pitfalls

Didactic education

“You should”

Adherence or compliance

No health literacy focus

Non-tailored interventions

Paternalistic care

Lack of social support

Not taking existing infrastructure into consideration

No sustainability plan



## Successes

Focus on patients’ wants or needs

“What do you want to work on?”

Empowerment

Health literacy and numeracy tailoring

Cultural tailoring

Patient-centered care

Peer leaders or buddies

Leveraging existing infrastructure already in place

Studies that examine HOW to achieve sustainability

# Addressing Diabetes in the Context of Food Insecurity





## What Is “Food Security?”

- Food security = access by all people at all times to *enough* food for an *active, healthy* life
- **Food insecurity (FI)** = the household-level economic and social condition of limited or uncertain access to adequate food
- Hunger = individual physiological sensation; the uneasy or painful sensation caused by a lack of food

More information: USDA Economic Research Service, **Food Security Status of U.S. Households in 2014**. <http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us.aspx>



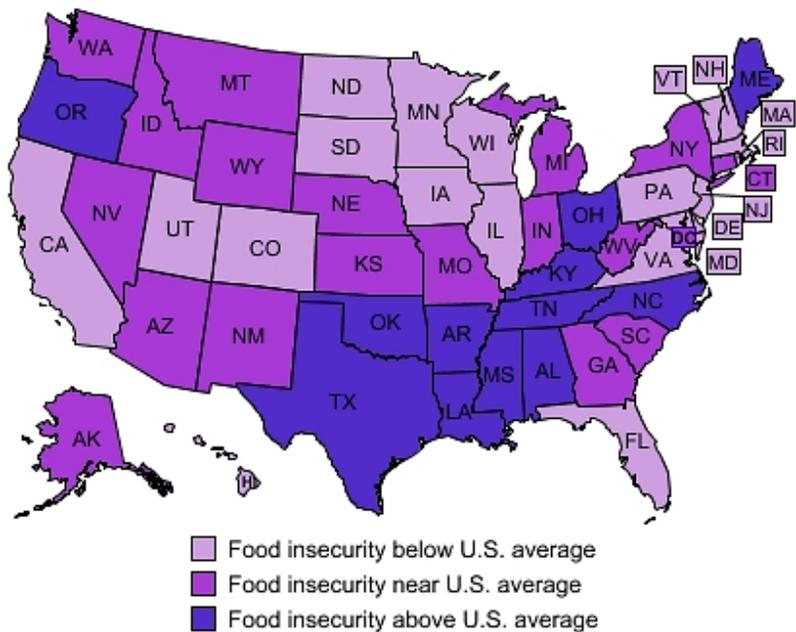
## The Numbers

- **12.7%** of US households (HH) are FI (2015):
  - 7.7%: low food security
    - Impact on quality and food access strategies.
  - 5.0%: very low food security
    - Disrupted eating and reduced intake.
  - 15.8 million HH, **42.2 million people**
    - 6.4 million children.
  - Elevated rates of food insecurity
    - HH with children, single-parent (HH), (AA) or Hispanic (HH).

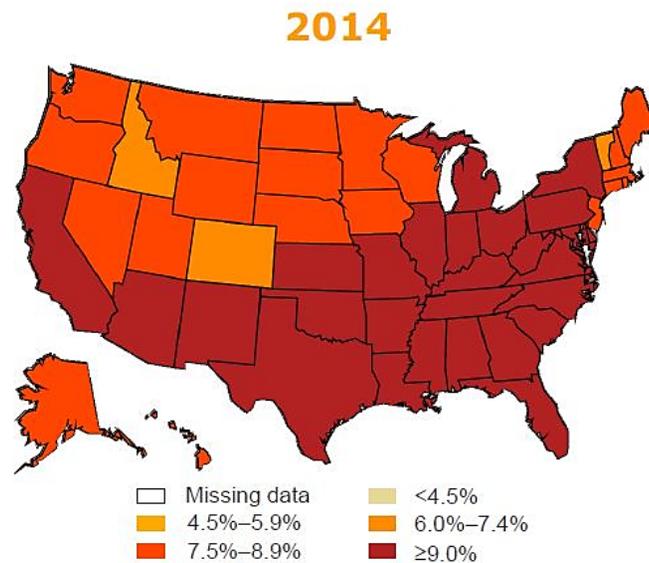


# Prevalence of Food Insecurity and Diabetes in the United States.

Prevalence of food insecurity, average 2013-15



Age-Adjusted Prevalence of Diagnosed Diabetes Among US Adults



Source: Calculated by ERS, USDA, using data from the December 2013, 2014, and 2015 Current Population Survey Food Security Supplements.



CDC's Division of Diabetes Translation. United States Diabetes Surveillance System available at <http://www.cdc.gov/diabetes/data>

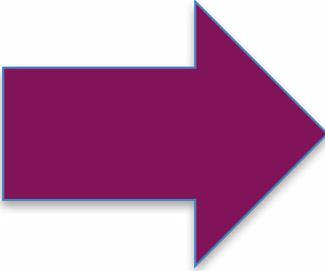


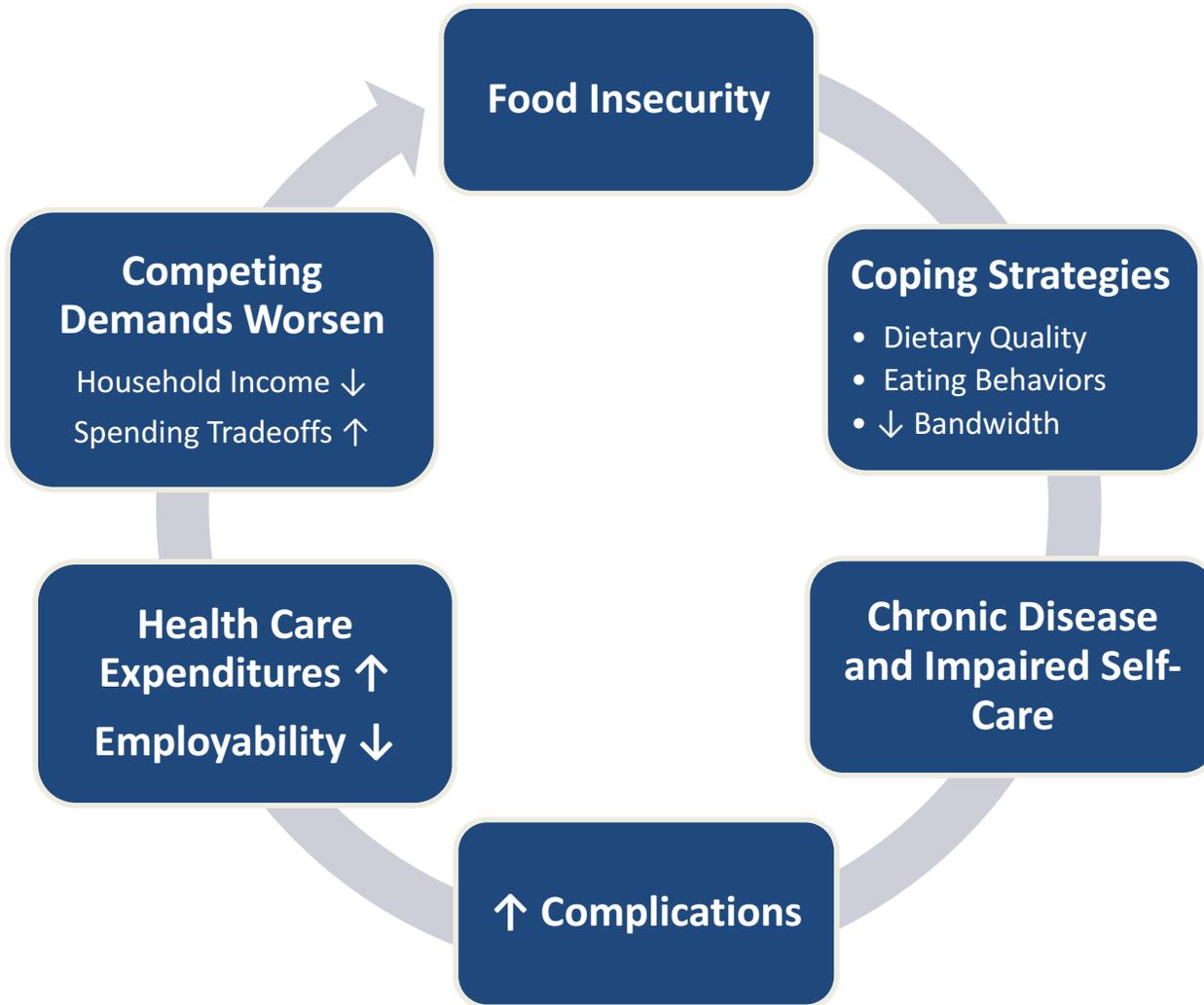
<https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics/>

[https://www.cdc.gov/diabetes/statistics/slides/maps\\_diabetes\\_trends.pdf](https://www.cdc.gov/diabetes/statistics/slides/maps_diabetes_trends.pdf)



## Coping Strategies to Avoid Hunger

- Eating low-cost foods
    - Fewer fruits or vegetables.
    - More fats or carbs
  - Eating highly filling foods.
  - Eating small variety of foods.
  - Avoiding food waste.
  - Binging when food is available.
- 
- Increased risk for obesity, prediabetes, type 2 diabetes.
  - Reduced ability and capacity to effectively manage disease once you have it.



# The Cycle of Food Insecurity and Diet-Sensitive Chronic Disease

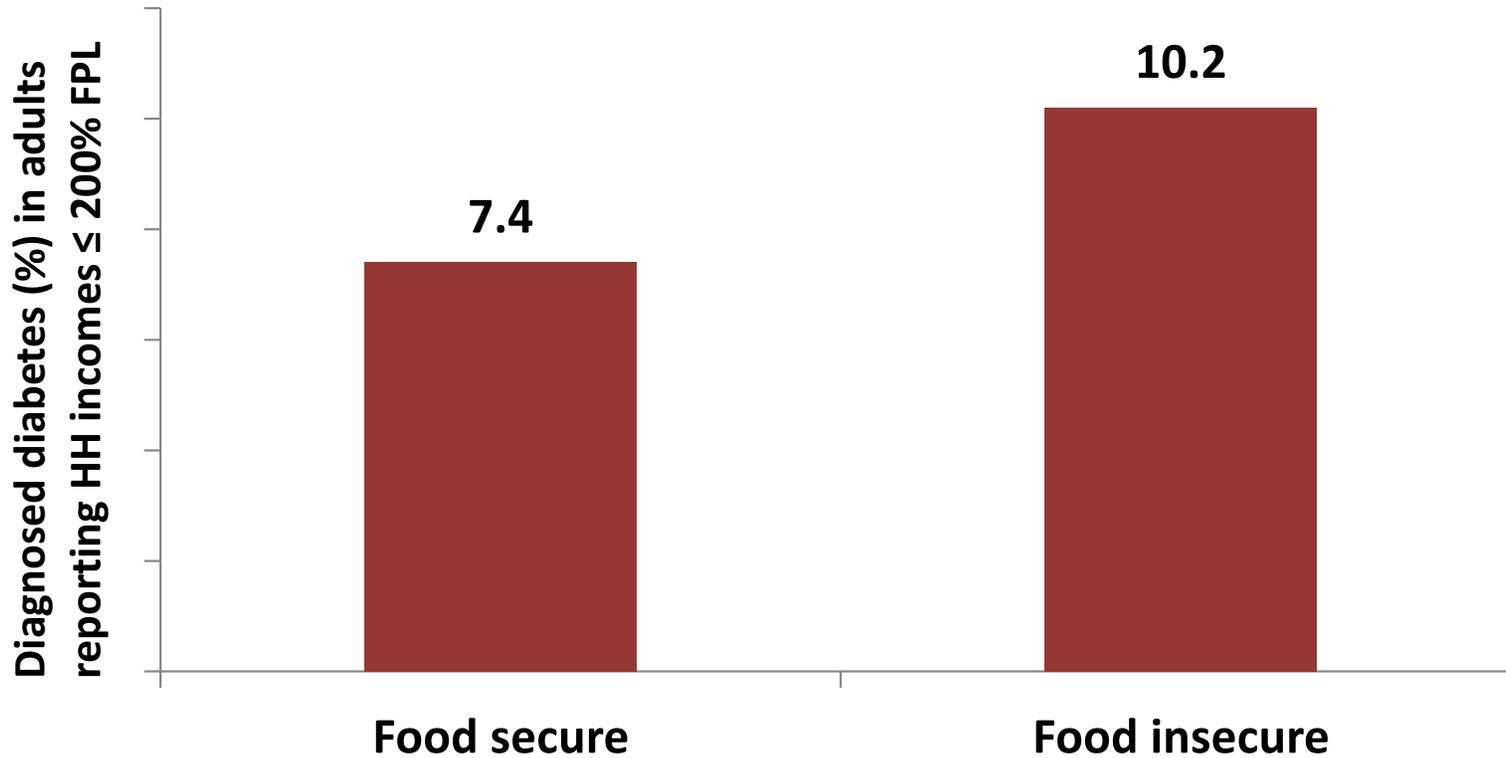
Seligman HK, Schillinger D. The cycle of food insecurity and diet sensitive chronic disease. N Engl J Med 2010;363:6-9.



The NEW ENGLAND JOURNAL OF MEDICINE



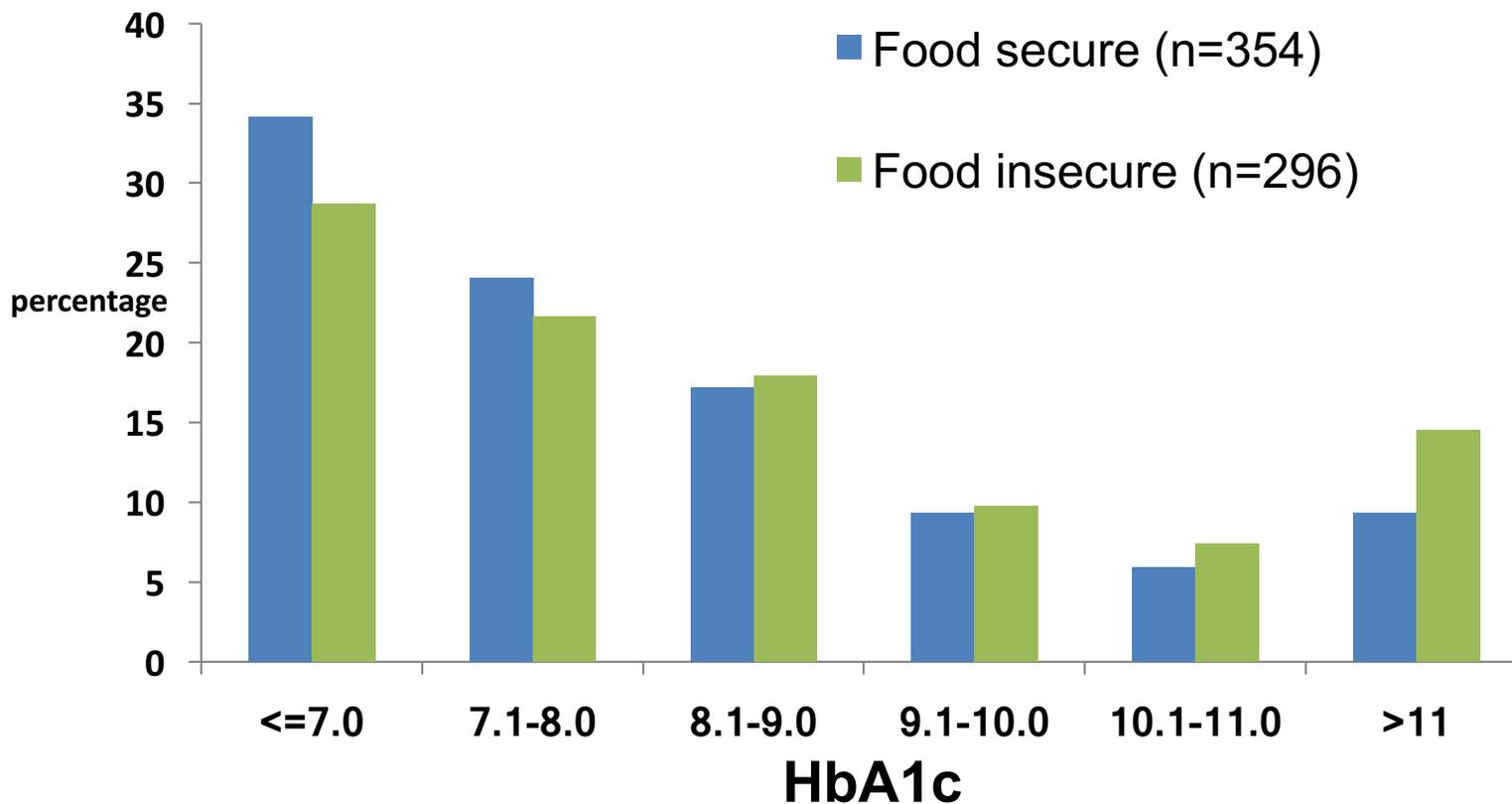
# Food Insecurity and Diabetes (U.S. Low-Income Population, NHANES 1999-2004)



95% CI, 1.51 (1.04–2.19)



# Food Insecure Adults With Diabetes Have Higher Average Blood Sugars



Association between HbA1c and food security status among patients with diabetes receiving care in safety net clinics



## Hunger in America 2014



**58%**  
OF HOUSEHOLDS HAVE A  
MEMBER WITH HIGH  
BLOOD PRESSURE



**33%**  
OF HOUSEHOLDS  
HAVE A MEMBER  
WITH DIABETES

**47%** of food pantry clients responded they are in **fair or poor health**

**29%** of households all members have **no health insurance\***

**55%** of households report some **medical debt**

Source: Feeding America. *Hunger in America 2014 – Executive Summary*.  
Accessed at: <http://www.feedingamerica.org/hunger-in-america/our-research/hunger-in-america/> . Accessed 4/20/2017

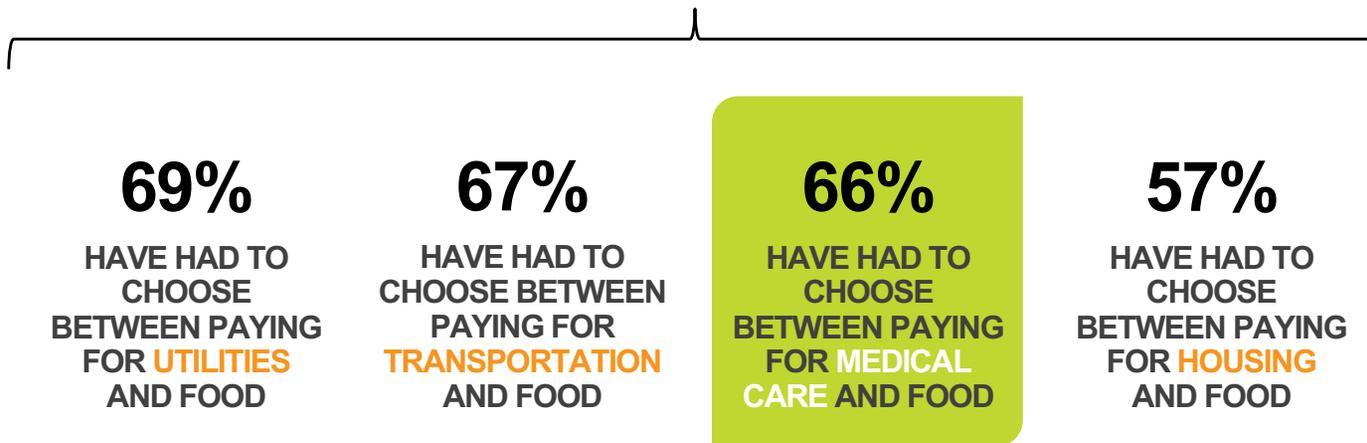
\*The Affordable Care Act went into effect after the fielding period of this survey.



## Difficult Choices



Feeding America's clients report that their household income is inadequate to cover their basic household expenses.



Sources: Feeding America, Map the Meal Gap (2014) and Hunger in America (2014).  
<http://www.feedingamerica.org/hunger-in-america/our-research/>



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## Feeding America Network



**MISSION:** To feed America's hungry through a nationwide network of member food banks and engage our country in the fight to end hunger.



## Diabetes Interventions

- FA/[BMSF](#) Diabetes Pilot
  - Three sites (California, Texas, Ohio)
- FAITH-DM (*Feeding America Intervention Trial for Health—Diabetes Mellitus*).
  - Three sites (Michigan, Texas, California).
- Intervention components.
  - Blood glucose and HbA1c testing at food pantries.
  - Monthly healthy food packages.
  - DSME and self-management support.
  - Referrals to primary health care providers.
- Food bank diabetes programs.





## Tailoring DSME for Food Insecurity

- American Diabetes Association 2016 guidelines.
- Literacy, numeracy, and cultural relevance.
- Connect patients to resources (e.g., Supplemental Nutrition Assistance Program, food banks, 211, mental health and social support).
- Food affordability.
- Realistic glucose self-monitoring plans.
- “Low or no food days”: medication adjustments.
- Peer support and coping (high rates of depression and distress in populations with DM and FI).
- Preventative care and risk reduction.



## Diabetes Prevention Work

- Identification of at-risk adults.
- Supplemental healthy foods.
- Referrals to community-based providers of DPP.
- Referrals to clinical care.
- AmeriCares partnership.
- Feeding America DPP.





## Health Care Partnership Work

- Food insecurity screening and referrals.
  - Two-item screener.
  - Roll into clinic flow (electronic medical records).
  - Universal: normalization with patient - providing resources.

1. “We worried whether our food would run out before we got money to buy more.” Was that **often** true, **sometimes** true, or **never** true for your household in the last 12 months?
2. “The food that we bought just didn’t last, and we didn’t have money to get more.” Was that **often**, **sometimes**, or **never** true for your household in the last 12 months?



## Health Care Partnership Work (continued)

- Collaborations
  - Partner agencies and community organizations (e.g., nonprofit, faith-based, social services).
  - Community clinics (Federally Qualified Health Centers, free clinics).
  - Hospital systems (Humana).
  - Coalitions.
  - Americares, YMCA.
  - AADE, ADA.
  - Academic Partners.
  - Urban Institute.



## Challenges and Opportunities

- Health care and CB-DPP buy-in capacity.
- Funding.
  - Grants, foundation support, fundraising, and general operating expenses.
- Translation.
  - Pilot projects → 200 food banks.
- Operationalization of healthy food distributions.
  - Food system strengths and weaknesses.
- Uncertainty in the health care environment.



## Evaluation and Outcomes

- Diabetes pilot
  - Feasibility study, UCSF CVP
  - Seligman et. al., [A Pilot Food Bank Intervention Featuring Diabetes-Appropriate Food Improved Glycemic Control Among Clients In Three States](#). 2015, *Health Affairs*, 34(11):1956-1963.
  - ↓ **0.48% HbA1c**; ↑ **F&V**, ↓ **distress**, ↓ **food & DM tradeoffs**, ↑ **self-efficacy (for all:  $p < 0.001$ )**
  
- FAITH-DM
  - RCT ending October 2017, UCSF CVP.
  - <https://clinicaltrials.gov/ct2/show/NCT02569060>
  
- Diabetes prevention
  - FA Diabetes Prevention Pilot Project (2017-2019); UPITT.
  - Americares/FA DPP (2017–2018); Loyola.
  
- Effect on participants



## Next Steps and Vision

- Continuing to build evidence and expanding across network.
- Ending hunger work: root causes.
- Improving nutrition across network.
- Expanding health care partnerships.
  - FI screening and referrals with Healthcare Partners.
- Cost impact and utilization data.
  - Funding and sustainability.



## What YOU Can Do

- Connect with your local food bank.
  - <http://www.feedingamerica.org/find-your-local-foodbank/>
- Visit Hunger and Health website.
  - <https://hungerandhealth.feedingamerica.org/>
- Get food insecurity screening and referring.
  - <http://childrenshealthwatch.org/public-policy/hunger-vital-sign/>
- Tailor DSME and health education for food insecurity.
- Advocate!



Barbara Gordon, MA

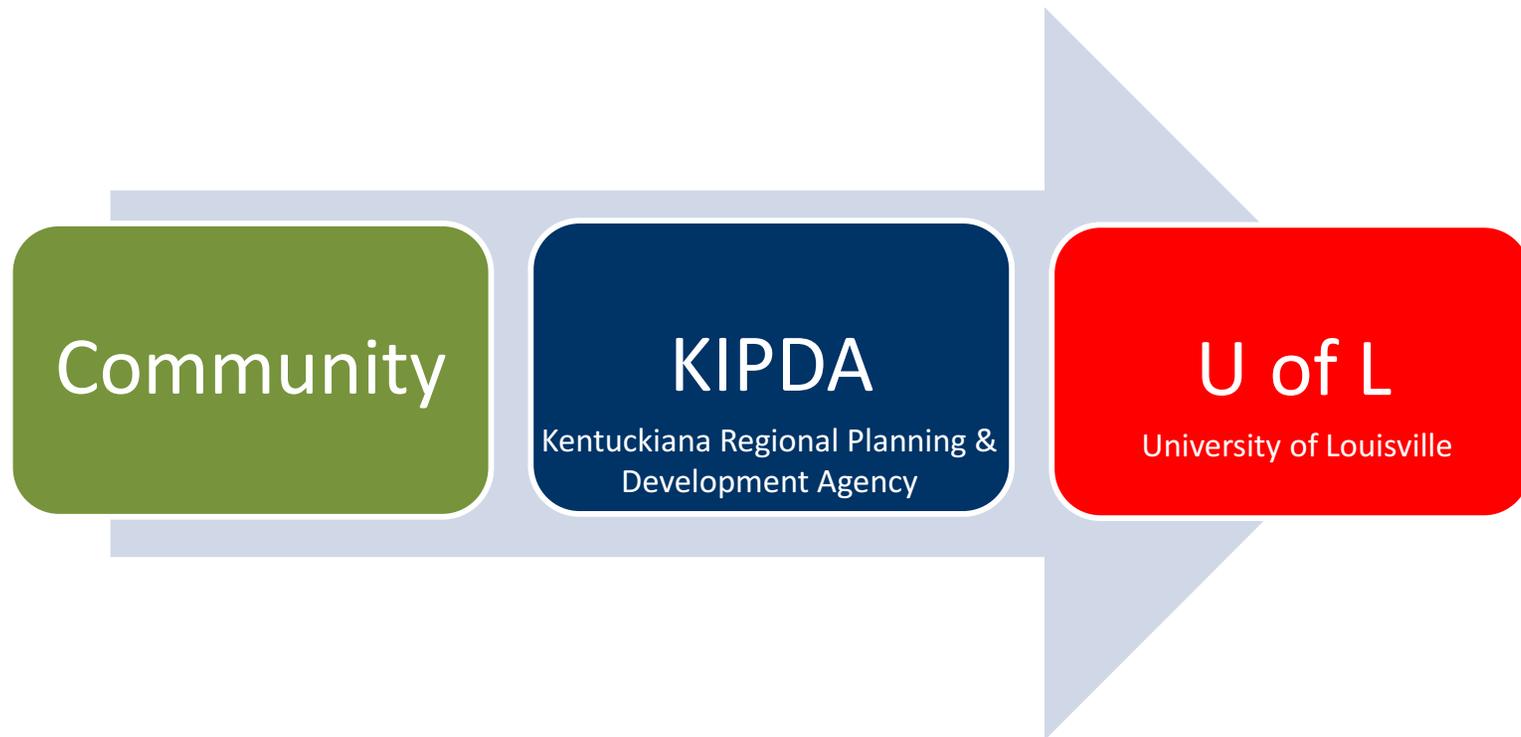
**Impacting Community Change for  
Older Adults With Type 2 Diabetes:  
The Journey**



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# Facilitating and Impacting Change: It Is a Facilitated Journey



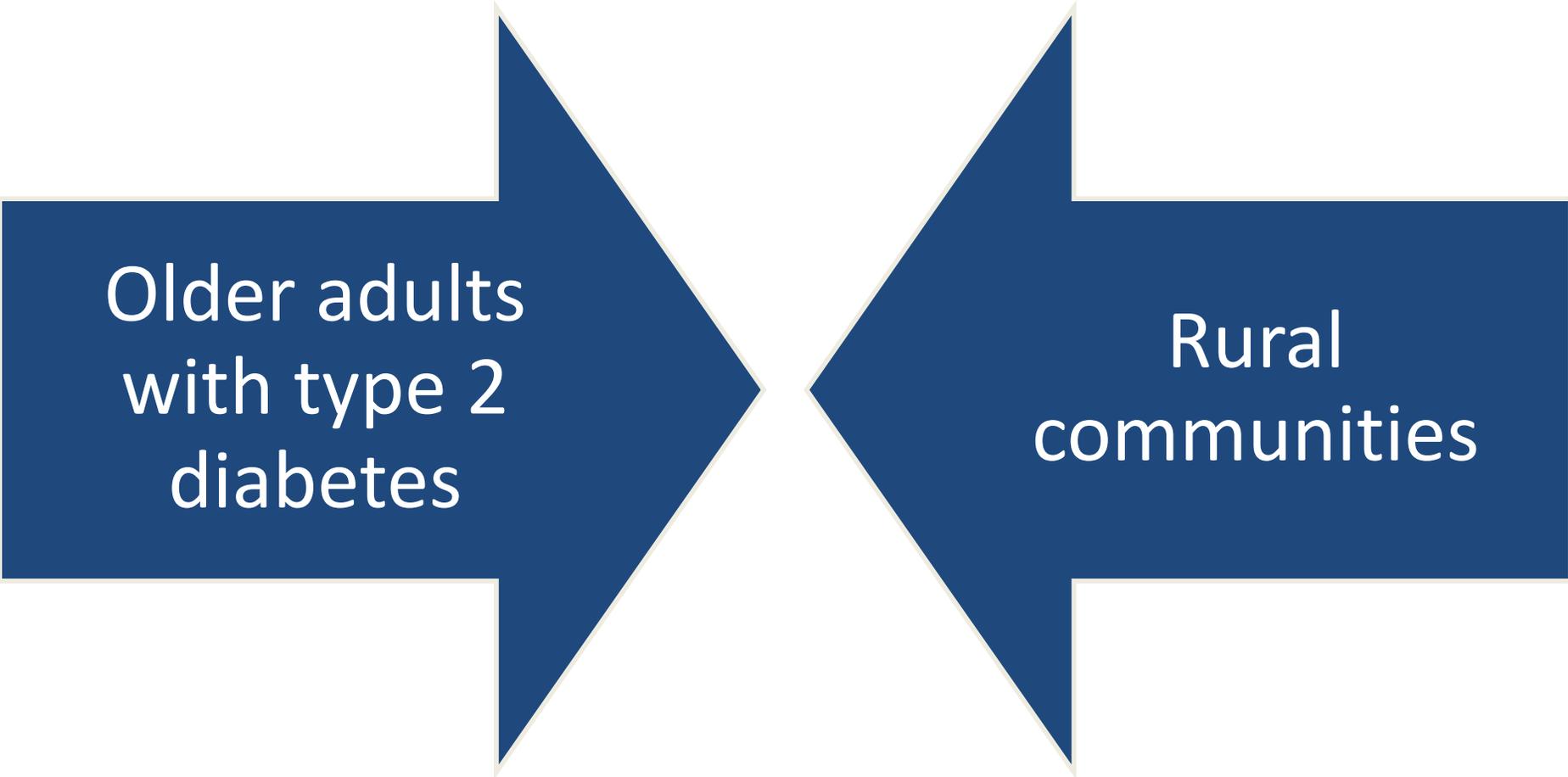


# Every Journey Requires a Guide





## Travelers on This Journey: The Community

Two large, dark blue arrows point towards each other from the left and right sides of the slide, meeting at a central point. The left arrow points right, and the right arrow points left. The text 'Older adults with type 2 diabetes' is centered within the left arrow, and 'Rural communities' is centered within the right arrow.

Older adults  
with type 2  
diabetes

Rural  
communities



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## Our Coalition



KIPDA Rural Diabetes Coalition  
*Diabetes has no boundaries*

In collaboration with the University of Louisville  
Funding provided by the Centers for Disease Control and Prevention





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# Our Model







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# Travelers on This Journey: The Community

## COALITION PARTNERS





# The Many Challenges and Opportunities Along This Journey

## Challenges

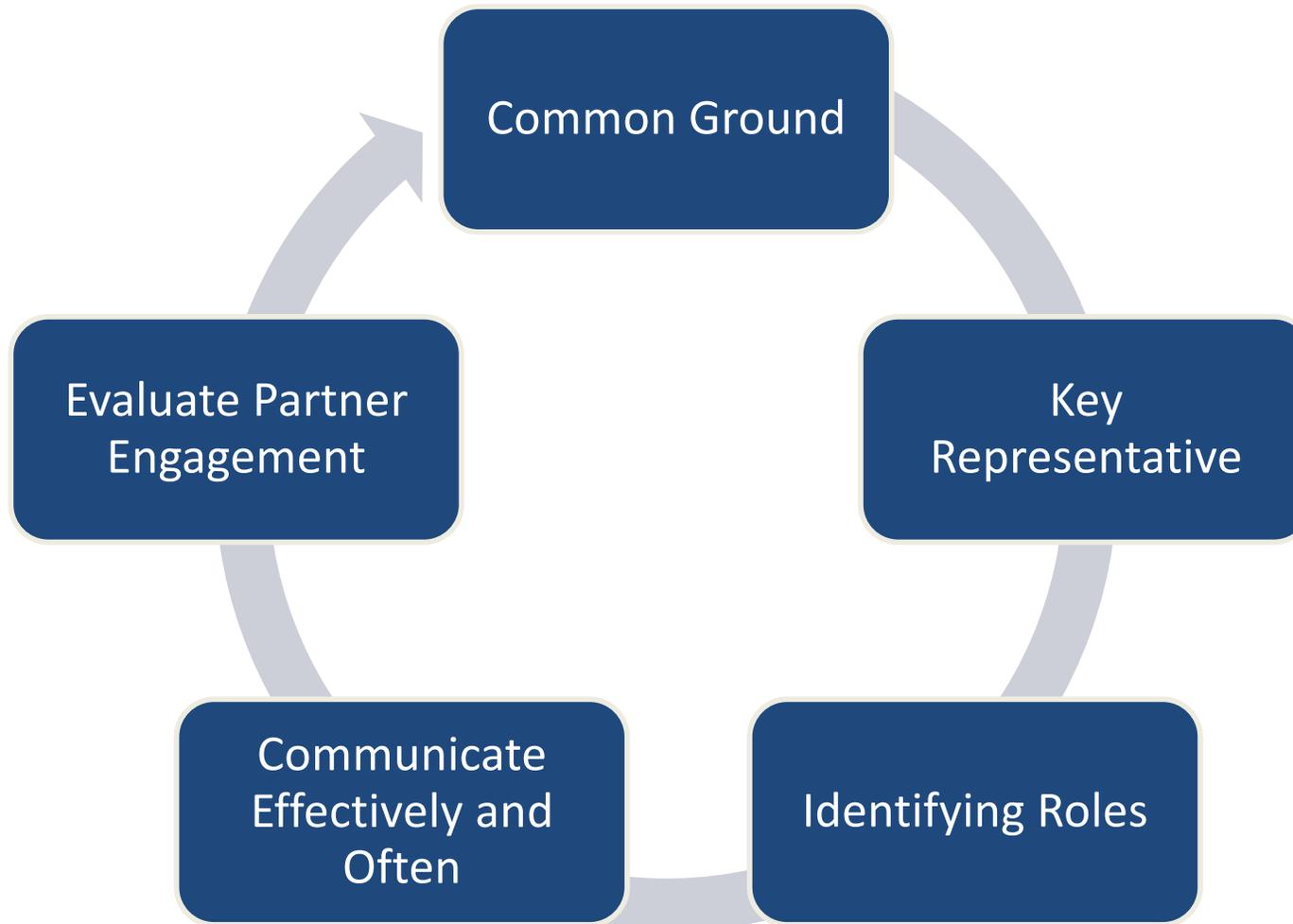
- To establish a strategic focus.
- To foster and anchor collaboration.
- To develop and implement a strategic plan.
- To deal with conflict and emotions.
- To sustain the movement.

## Opportunities

- Engage and mobilize community members.
- Work with many community partners towards common goals.
- Assist communities learn about health care, health systems, and more.
- Impact change in policies, systems, and the community for health.

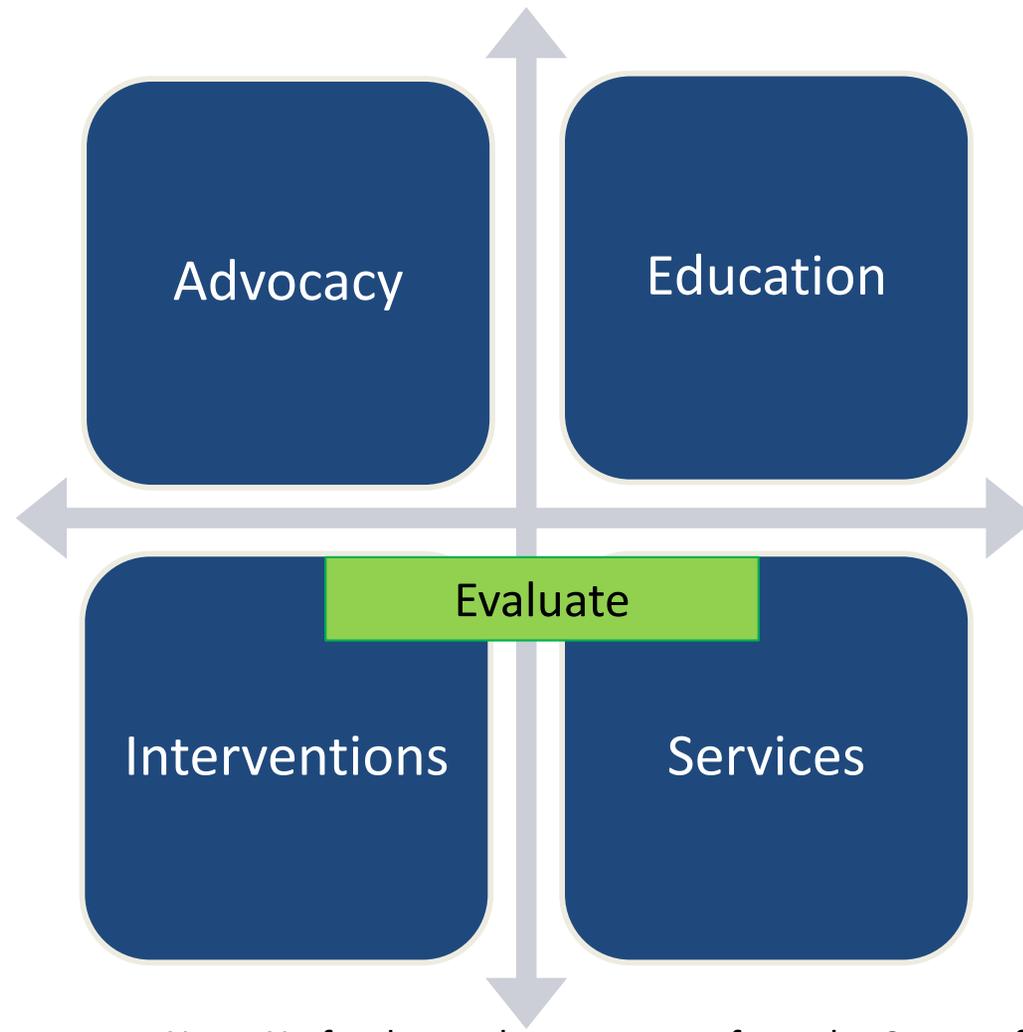


## Partner Engagement Is a Journey





# Mobilizing for Change: The Journey



Note: No funds or other resources from the Centers for Disease Control and Prevention were used for this advocacy work.



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# Continuing The Journey



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**Our Vision:**

Optimal Health for all of Kentucky

**Our Mission:**

To improve the health of all people by:

Promoting access to health care

Encouraging people to live and model healthy behaviors

Supporting an environment with no barriers to health

Creating collaborative communities of health



## Journeying for Change: Healthy Communities

- Diabetes is a **PERSONAL** diagnosis.
- Diabetes is a **FAMILY** diagnosis.
- Diabetes is a **COMMUNITY** diagnosis.
- Health is **PERSONAL**.
- Health is **FAMILY**.
- Health is **COMMUNITY**.



## Presenters' Information

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# Q&A

# Visit CDC NDEP Website

<http://www.cdc.gov/diabetes/ndep>

 Centers for Disease Control and Prevention  
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## National Diabetes Education Program



### ► Faith Leaders Toolkit

Bring information about type 2 diabetes prevention and management to your congregation and others



The National Diabetes Education Program (NDEP) works with partners to reduce the burden of diabetes and prediabetes by facilitating the adoption of proven approaches to prevent or delay the onset of type 2 diabetes and the complications of diabetes. NDEP is a joint program of the Centers for Disease Control and Prevention and the National Institutes of Health.

#### PARTNERING WITH NDEP

Learn about NDEP and find partnership resources.

#### WORKING IN COMMUNITIES

Find tools to help implement community programs.

#### WORKING IN HEALTH SETTINGS

Find resources to support team care.

#### TRAINING & TECHNICAL ASSISTANCE

Find webinars and courses to build your capacity.

#### FOR PEOPLE AT RISK FOR DIABETES

Find information on preventing type 2 diabetes.

#### FOR PEOPLE WITH DIABETES

Find information on managing diabetes.

#### FIND RESOURCES FOR SPECIFIC GROUPS



AMERICAN INDIANS & ALASKA  
NATIVES



AFRICAN AMERICANS & AFRICAN  
ANCESTRY



HISPANIC & LATINO AMERICANS



ASIAN AMERICANS, NATIVE  
HAWAIIAN & PACIFIC ISLANDERS

# Claim Your Continuing Education Credits

## <http://www.cdc.gov/tceonline/>

### WC2607-052517 - (Webcast) National Diabetes Education Program Webinar Series - May 25, 2017

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#### How to Obtain Continuing Education

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Continuing Education for this course is only available through the *CDC Training and Continuing Education Online* system (CDC TCEO). Please follow the instructions provided below. You must complete the online evaluation by **June 26, 2017** to receive your Continuing Education or your certificate of completion.

#### To complete online evaluation:

- Go to *CDC TCEO* at <http://www.cdc.gov/tceonline/>. Select **Participant Login** to login. If you are new to TCEO, select **New Participant** to create a user ID and password.
- Once logged on to *CDC TCEO*, the **Participant Services** page will display. Select the **Search and Register** link. Select a search method to locate the course and click on **View**.
- Click on the course name, and the course information page will display. Scroll down to **Register Here**. Select the type of CE that you would like to receive and then select **Submit**.
- The next page requests demographic information. New participants are required to answer the demographic questions. Returning participants please verify this information and select **Submit**.
- A message will display thanking you for registering for the course. If you have already completed the course you may select the option to take the evaluation.
- If you have not completed the course, you will be directed back to **Participant Services**. Under **Evaluations and Tests** you may access the course detail page, the course link, or the evaluation and/or posttest after completing the course.
- Complete the evaluation and **Submit**. If a posttest is required it will follow the evaluation. A record of your course completion and your CE certificate will be posted in the **Transcript and Certificate** section, located on the **Participant Services** page.

If you have any questions or problems, please use the link below to contact:

*CDC/ATSDR Training and Continuing Education Online*  
Contact TCEO or <https://www2a.cdc.gov/TCEOnline/comments.asp>



**National Diabetes Education Program**

A program of the National Institutes of Health and the Centers for Disease Control and Prevention

# Thank You!



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For more information call 1-800-CDC-INFO (800-232-4636)

TTY 1-(888) 232-6348 or visit [www.cdc.gov/info](http://www.cdc.gov/info).

To order resources, visit [www.cdc.gov/diabetes/ndep](http://www.cdc.gov/diabetes/ndep).

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