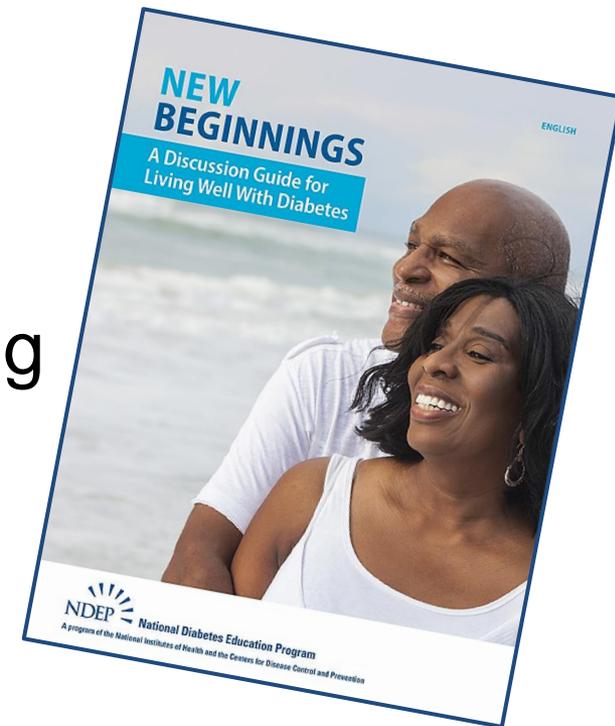


Getting Your Patients Ready for Effective Health Care Communications: A New Beginning in Diabetes Management





National Diabetes Education Program

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

Introduction



Janet Brown-Friday, RN, MSN, MPH

Clinical Trials Manager
Einstein Diabetes Clinical Trials Unit
Albert Einstein College of Medicine



Webinar Objectives:

- Discuss the importance of quality patient-provider communication.
- Describe approaches for patient engagement in effective communication.
- Name at least two strategies for teaching patient-provider communication skills to people with diabetes.



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Today's Presenters



**Linda Siminerio, RN, Ph.D.,
CDE**

Professor of Medicine
Executive Director
University of Pittsburgh Diabetes
Institute



**Alexis Williams, MPH, MS,
CHES**

Public Health Advisor
Division of Diabetes Translation
Centers for Disease Control and
Prevention



**Margaret B Thearle, RN, BSN,
CDE**

Diabetes Educator
University of Pittsburgh Medical Center-
Physician Operations



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Linda Siminerio, RN, Ph.D., CDE

EFFECTIVE PATIENT-PROVIDER COMMUNICATION



What we hear in clinical practice – sound familiar?

- My patients are non-compliant.
- Our patient population is different/unique.
- Standardized approaches inhibit critical thinking and individualized care.
- I know what is best for my patients based on my experience.



What we know about patient-provider communication:

- Directive approach is not always effective.
- Improving knowledge does not always translate to improved behavior.
- Health literacy is a problem.
- Health care providers do not always communicate with each other.



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Traditional Decision Making Model: Paternalism at its Peak



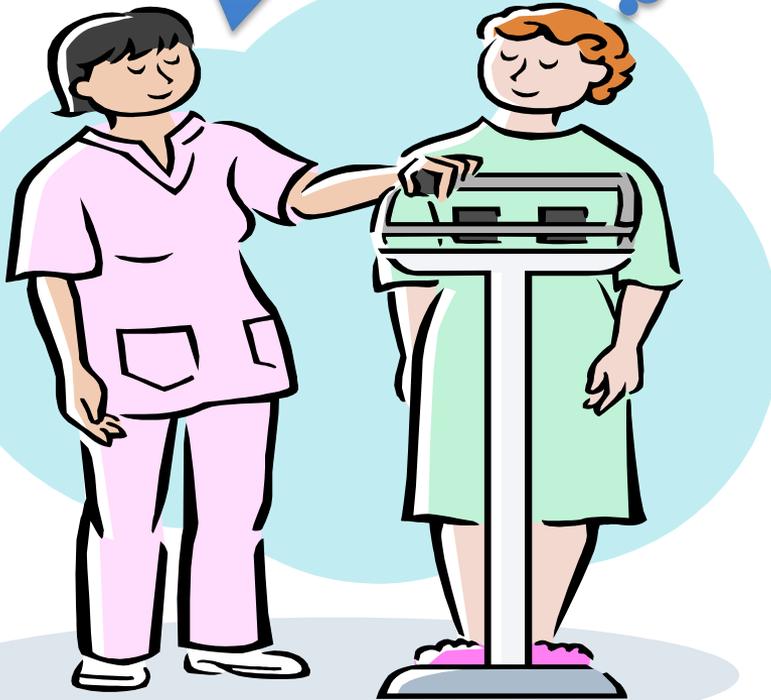


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A lot of patients
I meet have
problems with
grazing.

Does she
think I eat or
look like a
cow?



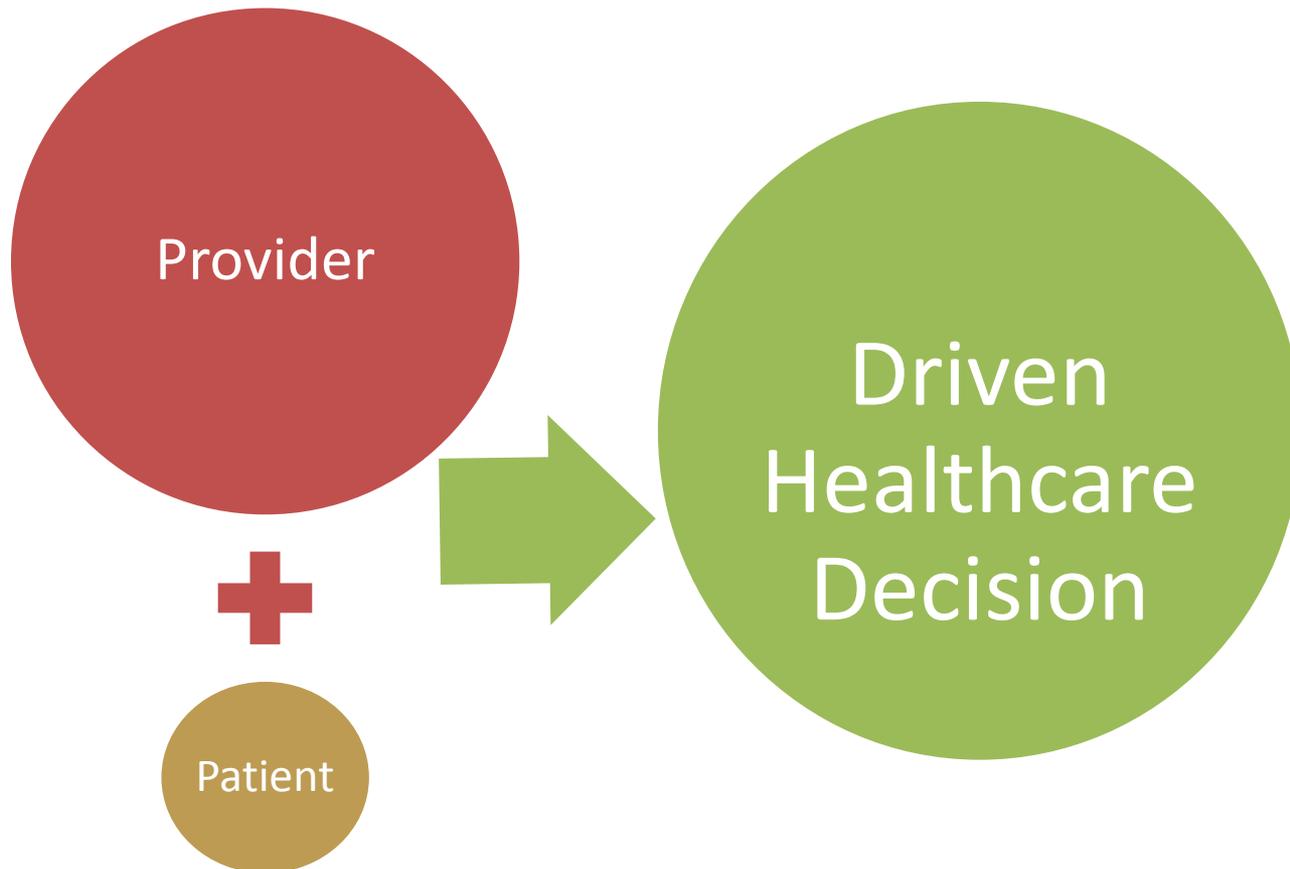
Do we understand each other?



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Traditional Healthcare Decision Making: Unequal Partnership





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What do studies tell us about patient/provider communication?



Are we empathetic?

- Study aimed to describe relationship between patient Body Mass Index (BMI) and physician communication behaviors.
- Primary Care Physicians (PCPs) demonstrated less emotional rapport with overweight and obese patients than for normal weight patients.
- Findings raised concern that low levels of emotional rapport may weaken the patient/provider relationship, diminish patient adherence and the effectiveness of counseling.



How satisfied are patients?



- 52% in ratings of care satisfaction was accounted for by physicians' levels of warmth and respect.
- Dietitians' empathic engagement predictive of patient satisfaction and successful consultations.
- Empathy was the most important quality for being considered a "good physician".
- Patients who don't have decision support more often blame their practitioner for bad outcomes.

Kenny DT. *Determinants of Patient Satisfaction with the Medical Consultation*. Psychol Health. 1995.

Goodchild CE, et al. *The Value of Empathy in Dietetic Consultation: A Pilot Study to Investigate its Effect on Satisfaction, Autonomy, and Agreement*. J Hum Nutr Diet. 2005.



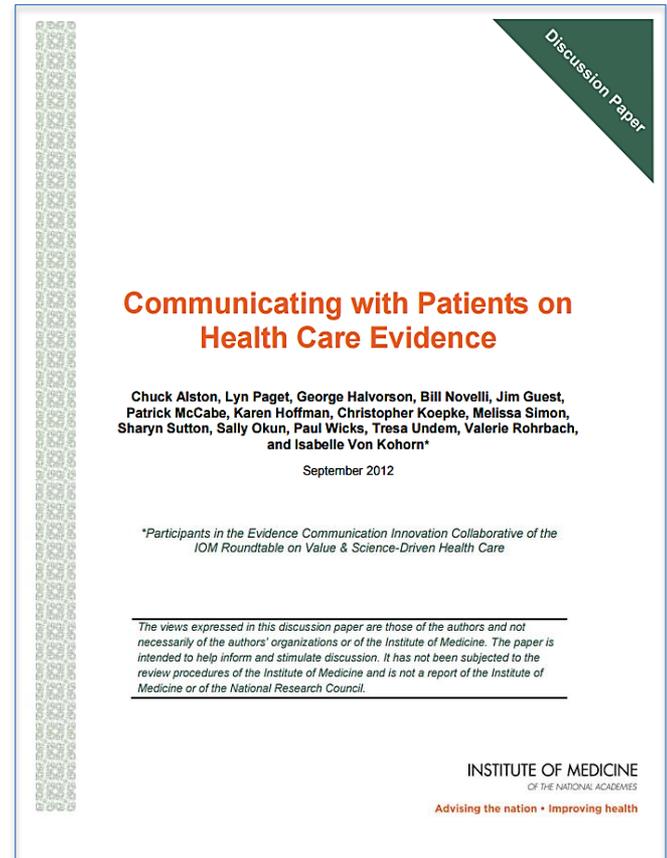
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Institute of Medicine

Communicating with Patients on Health Care Evidence.

Discussion Paper, Institute of Medicine, Washington, DC.



<https://nam.edu/wp-content/uploads/2015/06/VSRT-Evidence.pdf>



Gap between what people want and what they get regarding engagement in health care:

- 8 in 10 people want their health care provider to listen to them, but just 6 in 10 say it actually happens.
- Less than half of people say their provider asks about their goals and concerns for their health.
- 9 in 10 people want their providers to work together as a team, but just 4 in 10 say it actually happens.

Alston, C., L. et al. 2012. *Communicating with Patients on Health Care Evidence*. Discussion Paper, Institute of Medicine, Washington, DC.

<https://nam.edu/wp-content/uploads/2015/06/VSRT-Evidence.pdf>



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What can we do?



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Shared decision making (SDM):

Collaborative process that allows 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.





Cochrane review of 86 clinical trials found that patient use of decision aids led to:

- improved knowledge of options;
- more accurate expectations of possible benefits and harms;
- greater participation in decision making;
- higher satisfaction; and
- choices resulting in lower costs and better health outcomes.



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CCDTR CHICAGO CENTER FOR
DIABETES TRANSLATION RESEARCH

Monica E. Peek, MD, MPH

USING SHARED DECISION MAKING TO EMPOWER UNDERSERVED POPULATIONS WITH DIABETES



Background: Patient Empowerment

- Self-management at home.
- SDM with providers.
- Diabetes self-management interventions effective in minority populations.
- No prior work: SDM + culturally-tailored patient education.
- SDM → improved health outcomes.



Shared Decision Making Domains





Background: SDM and Diabetes

- SDM is central to the chronic care model.
- SDM correlates with positive health indicators:
 - Better diagnostic accuracy, informed consent;
 - Improved glucose control, lowered BP, shorter hospitalizations; and
 - More efficient visits, fewer malpractice claims, less doctor-swapping.
- Implications for the Patient Centered Medical Home
 - Average physician has 160,000 patient interviews.



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Getting the most for our health

Shared decision-making

Getting the right care at the right time is essential to ensuring that we are getting the most for our health where there is a choice between more than one clinically appropriate course of treatment, patients and physicians work together to choose the treatment option that best reflects both medical evidence and patients work together to choose the treatment option that best reflects both medical evidence and patient priorities and goals for his or her care. The aim of using formal shared decision-making tools is to improve value by better incorporating patient preferences into decisions about how health care is delivered.

The AMA recognizes that a formal shared decision-making process should include core elements: shared decision-making partners in their health care and that the application of shared decision-making processes should be based on the concept of strengthening the patient-physician relationship.

American College of Physicians Endorses Shared Decision Making Approach for Prostate Cancer Screening

Posted on April 9, 2013 by IMDFoundation



In a [guidance statement](#) published Tuesday in the Annals of Internal Medicine, the American College of Physicians (ACP) joined the heated discussion on PSA testing by endorsing a shared decision making approach for prostate cancer screening. The ACP Clinical Guidelines Committee developed this guidance statement after reviewing current guidelines for prostate cancer screening in the U.S.

"The new ACP guidance statement on PSA screening acknowledges the potential benefits and significant harms of screening for prostate cancer. The American College of Physicians joins the Informed Medical Decisions Foundation. "The importance of considering the preferences of informed patients and their families should not screen for prostate cancer in patients who are not at high risk for prostate cancer."

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Shared Decision Making: The Patient as Expert

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Partnering with Patients to Drive Shared Decisions, Better Value, and Care Improvement



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Peek ME, Wilson SC, Gorawara-Bhat R, Odoms-Young A, Quinn MT, Chin MH. *Barriers and Facilitators to Shared Decision-making Among African-Americans with Diabetes*. Journal of General Internal Medicine. 2009; 24(10):1135-9.

JGIM

BRIEF REPORT

Barriers and Facilitators to Shared Decision-making Among African-Americans with Diabetes

Monica E. Peek, MD, MPH^{1,2,3,4}, Shannon C. Wilson, MPH^{1,2}, Rita Gorawara-Bhat, PhD^{2,5}, Angela Odoms-Young, PhD^{2,6}, Michael T. Quinn, PhD^{1,2,3}, and Marshall H. Chin, MD, MPH^{1,2,3}

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INTRODUCTION: Shared decision-making (SDM) between patients and their physicians is associated with improved diabetes health outcomes. African-Americans have less SDM than Whites, which may contribute to diabetes racial disparities. To date, there has been little research on SDM among African-Americans.

OBJECTIVE: We explored the barriers and facilitators to SDM among African-Americans with diabetes.

METHODS: Qualitative research design with a phenomenological methodology using in-depth interviews (n=24) and five focus groups (n=27). Each interview/focus group was audio-taped and transcribed verbatim, and coding was conducted using an iterative process. **Participants:** We utilized a purposeful sample of African-American adult patients with diabetes. All patients had insurance and received their care at an academic medical center.

RESULTS: Patients identified multiple SDM barriers/facilitators, including the patient/provider power imbalance that was perceived to be exacerbated by race. Patient-related factors included health literacy, fear/denial, family experiences and self-efficacy. Reported physician-related barriers/facilitators include patient education, validating patient experiences, medical knowledge, accessibility and availability, and interpersonal skills.

DISCUSSION: Barriers/facilitators of SDM exist among African-Americans with diabetes, which can be effectively addressed in the outpatient setting. Primary care physicians, particularly academic internists, may be uniquely situated to address these barriers/facilitators and train future physicians to do so as well.

KEY WORDS: shared decision-making; patient-provider communication; diabetes; African-Americans.
J Gen Intern Med 24(10):1135-9
DOI: 10.1007/s11606-009-1047-0
© Society of General Internal Medicine 2009

INTRODUCTION

Shared decision-making (SDM) has been defined as a process where both patients and physicians share information, express treatment preferences and agree on a treatment plan¹. SDM has been promoted in a wide variety of settings, including primary care²⁻³, and is associated with important primary care outcomes such as improved control of diabetes and hypertension, and enhanced preventive care utilization⁴⁻⁵.

Although SDM is understudied in African-Americans, disparities exist in several related concepts, suggesting that there may be less SDM in this population. For example, African-Americans experience less physician responsiveness and listening than White patients and describe their physicians as less participatory during clinic visits⁶⁻⁷. Communication disparities may be an important contributor to racial health disparities⁸, particularly concerning chronic diseases (e.g., diabetes) where effective communication is important to optimal disease management. Addressing such disparities will involve understanding the barriers and facilitators to SDM among African-Americans. To date, however, there has been little research in this area⁹⁻¹¹.

METHODS

The methods have been described in detail elsewhere¹¹. This study utilized a qualitative research design, specifically, a



SDM Barriers:

- Power imbalance
- Limited health literacy
- Self-efficacy
- Trust
- Fear/denial
- Normative beliefs
- Appointment length/provider time limitations



SDM Facilitators:

- Patient engagement/invitation
- Interpersonal relationships
- Validating health concerns
- Accessibility/availability



SDM and Treatment Non-adherence

- “[The doctor] told me I need to go to the dermatologist... Now the lady up there at the check out desk- I told her that I didn’t want to go. That if this [skin growth] goes down, then I don’t see a reason to [operate]. So, I’ll have think about that... 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. ”
- “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 can.”



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Diabetes Empowerment Program

- 10-week program
- Culturally tailored diabetes education
- Shared decision-making





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Diabetes Empowerment Program

- 10-week program
- **Culturally tailored diabetes education:**
 - BASICS curriculum.
 - Adult learning, health literacy.





Diabetes Empowerment Program

- 10-week program
- Culturally tailored diabetes education:
 - BASICS curriculum.
 - Adult learning, health literacy.
- **Shared decision making:**
 - Asking more questions.
 - Giving more information.
 - Clarifying physician information.
 - Communicating healthcare preferences.





SDM Domains: The 3Ds

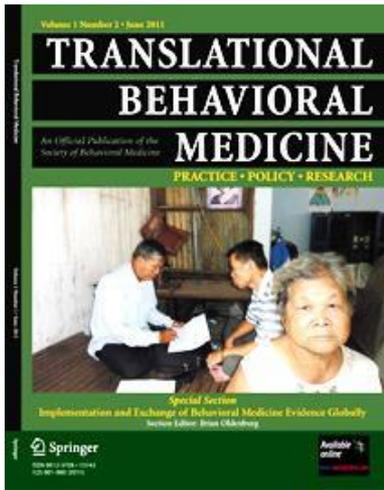




Diabetes Empowerment Program

- 10-week program
- Culturally tailored diabetes education:
 - BASICS curriculum.
 - Adult learning, health literacy.
- Shared decision making:
 - Asking more questions.
 - Giving more information.
 - Clarifying physician information.
 - Communicating healthcare preferences.
- **Support groups**





Peek ME, Harmon SA, Scott SJ, Eder M, Roberson TS, Tang H, Chin MH.
Culturally Tailoring Patient Education and Communication Skills Training to Empower African-Americans with Diabetes.
Translational Behavioral Medicine. 2012; 2(3):296-308.

TBM

ORIGINAL RESEARCH

Culturally tailoring patient education and communication skills training to empower African-Americans with diabetes

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doi: 10.1007/s13142-012-0125-8

ABSTRACT

New translational strategies are needed to improve diabetes outcomes among low-income African-Americans. Our goal was to develop/pilot test a patient intervention combining culturally tailored diabetes education with shared decision-making training. This was an observational cohort study. Surveys and clinical data were collected at baseline, program completion, and 3 and 6 months. There were 21 participants; the mean age was 61 years. Eighty-six percent of participants attended >70 % of classes. There were improvements in diabetes self-efficacy, self-care behaviors (i.e., following a "healthful eating plan" (mean score at baseline 3.4 vs. 5.2 at program's end; $p=0.002$), self glucose monitoring (mean score at baseline 4.3 vs. 6.2 at program's end; $p=0.04$), and foot care (mean score at baseline 4.1 vs. 6.0 at program's end; $p=0.001$), hemoglobin A1c (8.24 at baseline vs. 7.33 at 3-month follow-up, $p=0.02$), and HDL cholesterol (51.2 at baseline vs. 61.8 at 6-month follow-up, $p=0.01$). Combining tailored education with shared decision-making may be a promising strategy for empowering low-income African-Americans and improving health outcomes.

Implications

Research: Culturally -tailored diabetes empowerment programs can improve self-efficacy, behaviors, and clinical outcomes among African-Americans. However, more work is needed to identify effective strategies to enhance shared decision-making among this population. Our findings may have relevance for other racial/ethnic minorities and vulnerable populations with diabetes health disparities, and this research should be extended to other populations (e.g., Hispanics) to assess its feasibility and potential effectiveness.

Practice: African-Americans patients with diabetes often want to be more active in their diabetes care, both in self-care activities and in shared decision-making (SDM). While dynamic classroom instruction may be sufficient to change self-care behaviors, patients may likely need encouragement and support from their health care providers in order to enhance SDM within clinical encounters.

Policy: Sustaining behavioral change and ultimately reducing diabetes disparities among African-Americans will require a comprehensive



SDM: Role of Narrative

“It changed how I interact with the doctor... by me seeing the video, I did have the presence of mind to at least ask, ‘What is this [medication] for? How often should I take it?’” [Film]

“They kind of built me up... we’d be like we’re at a doctor’s session ... and then she would say things that she know 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 just speak up? ... sometimes you don’t be wanting to question your doctor and it be kind of hard, especially if you really like them and stuff. So, she was just like building us up so that you’ve got to be able whether you like the doctor or not.” [Role play]





Building an SDM Foundation

- Empower patients (Pt/MD relationship):
 - Let them know you value their opinion (and why).
 - Tell them about the “3Ds” (Discuss, Debate, Decide).
 - Increase their expectations about involvement in care (partners).
 - Continue SDM: multiple micro-decisions to revisit over time.
- Address uncomfortable barriers:
 - Trust.
 - Perceived discrimination.
 - Cultural differences.
- Involve support staff (organizational culture):
 - Staff meetings.
 - Resources in waiting room (SDM video, posters/flyers).
 - Pre-visit coaching by LPN, Medical Assistant (goals for discussion, 2 key questions).
 - Diabetes/health educator; incorporate SDM messages/skills.



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Alexis M. Williams, MPH, MS, CHES

**THE *NEW BEGINNINGS* DISCUSSION GUIDE:
APPROACHES TO TEACHING PSYCHOSOCIAL AND
INTERPERSONAL SKILLS**



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Participants are bad cooks:

- Teach them how to cook.

“I forget where I am while I'm at where I'm going.”



“I forget where I am while I'm at where I'm going.”

Participants are not bad cooks:

- Scared.
- Low self-efficacy.
- Trouble communicating.
- Stressed.
- Disorganized.
- Lack cooking skills.

Motivated to change their behavior.



Diabetes self-management is not just about the “hollandaise sauce.”

- Address self-management behaviors.
- Address interpersonal skills.
- Support motivation and self-efficacy.



We need tools that help us address psychosocial and interpersonal issues, as well as knowledge transfer.

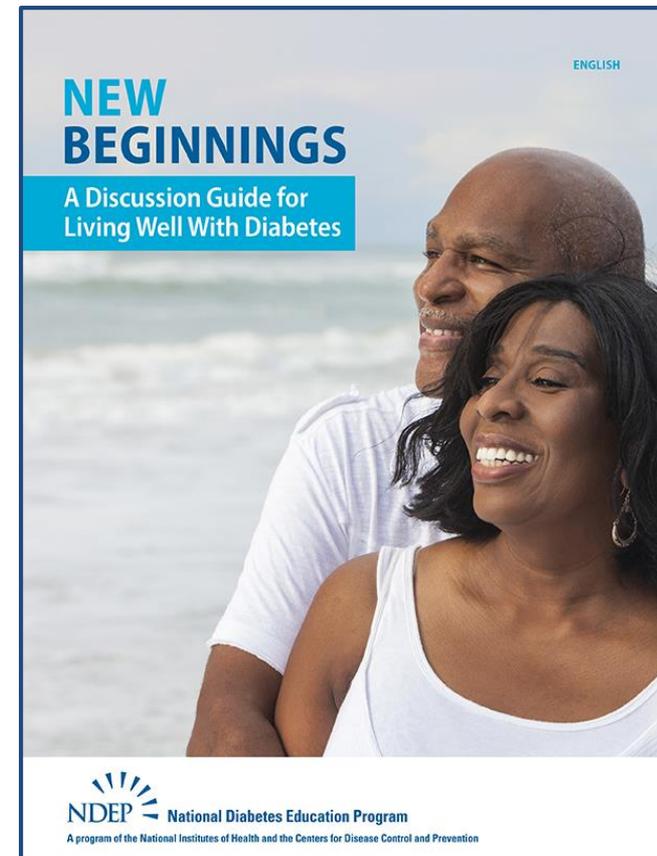


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New Beginnings: A Discussion Guide for Living Well with Diabetes

- **Manage the emotional impact of living with diabetes:**
 - Manage the impact on the family;
 - Develop meaningful social support; and
 - Improve communication with providers, caregivers, and loved ones.





New Beginnings Modules

Module	Topics Covered
Module 1. Overview: Living Well With Diabetes	<ul style="list-style-type: none">• Diabetes ABCs• Managing diabetes• Supporting a loved one with diabetes
Module 2. Know Your ABCs	<ul style="list-style-type: none">• Diabetes ABCs• Managing diabetes• Goal setting
Module 3. Healthy Coping	<ul style="list-style-type: none">• Emotional coping• Depression• Providing emotional support
Module 4. Overcoming Self-Doubt	<ul style="list-style-type: none">• Building self-confidence and reducing self-doubt• Goal setting
Module 5. Managing Stress	<ul style="list-style-type: none">• Stress management
Module 6. Problem Solving and Emergency Preparedness	<ul style="list-style-type: none">• Problem solving• Emergency preparedness
Module 7. Children and Family: How Can They Understand?	<ul style="list-style-type: none">• Communicating with children and family members• Building social support
Module 8. Working With Your Doctor	<ul style="list-style-type: none">• Preparing for health care visits• Roles for family caretakers



Storytelling in *New Beginnings*:

- Support communication.
- Model behaviors.
- Overcome barriers to discussing personal information.
- Bridge cultural divides.



Guiding Principles of *New Beginnings*:

- Adult learning theory.
- Self-efficacy.
- Motivational interviewing.

The stories and discussions are driven by these concepts.



Core Concepts:

- Principles of adult learning.
- Self-efficacy.
- Motivational interviewing.



- Involve participants in where and how the discussion goes.
- Focus on relevance and impact on participants' lives.
- Draw on their experiences.
- Include hands-on problem solving.



Core Concepts:

- Principles of adult learning.
- Self-efficacy.
- Motivational interviewing.



- Social modeling.
- Mastery experiences.
- Encouragement to overcome self-doubt.
- Stress management and developing positive coping skills.



Core Concepts:

- Principles of adult learning.
- Self-efficacy.
- Motivational interviewing.



- Open questions.
- Change talk.
- Normalizing challenges.



Improving Patient-Provider Communication

- Partnering with your diabetes care team:
 - Building self-efficacy in the patient-provider encounter.
 - Preparing for your visit.
- Partnering with your caregivers/family:
 - Identifying helpful social support for health care visits.
 - Reinforcing patient progress.
 - Supporting behavioral goals.



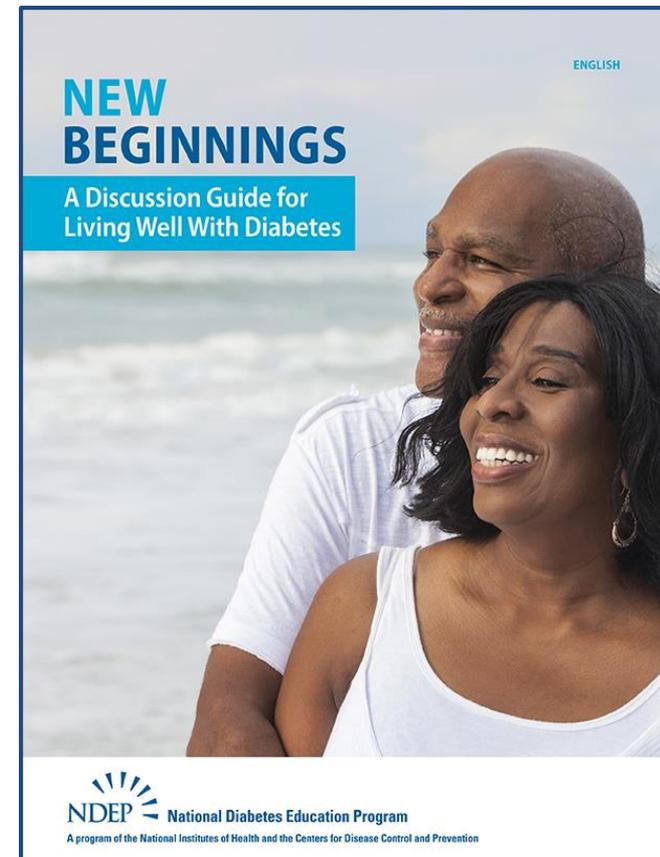
New Beginnings Sessions as a Model for Effective Patient-Provider Communication:

- Mutual respect.
- Mutual understanding.
- Common agreement on goals.
- A supportive environment.
- The right information.
- Transparency and full disclosure.
- Regular feedback on progress.
 - Assessment and course correction as needed.



Approaches to Teaching Psychosocial and Interpersonal Skills

- **Approaches to learning:**
 - Basic skills.
 - Interpersonal and psychosocial skills.
 - Motivation and self-efficacy.
- **Resources:**
 - Adult learning principles.
 - Storytelling.
 - Learner-centered techniques.





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Margaret Thearle RN, BSN, CDE

USING *NEW BEGINNINGS* TO TEACH PATIENT-CENTERED COMMUNICATION SKILLS



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Recruitment Flyer

You don't need to be a **SUPERHERO** to manage your diabetes.

You need to control your **ABCs**.

If you have diabetes, you are at high risk for heart attack and stroke. *But you can fight back.* You can control the ABCs of diabetes and live a long and healthy life. Ask your health care provider what your **A**1C, **B**lood pressure, and **C**holesterol numbers are and ask what they *should* be. Then talk about the steps you can take to reach your ABC goals. You have the power to help prevent heart attack and stroke. Control your ABCs.

Talk to your health care provider today.





Recruitment Messages

New Beginnings Participants...

- Learn planning, stress management and communication skills.
- Learn how to cope with the ups and downs of managing your diabetes.
- Learn how to get the support they need from health care providers, friends and family. Family members can also participate and learn about diabetes management and the best ways to support you.
- Learn in a fun, supportive group setting that every day is a new chance to do a little better, and live well with diabetes.

New Beginnings is coming to your community – at no cost to you!

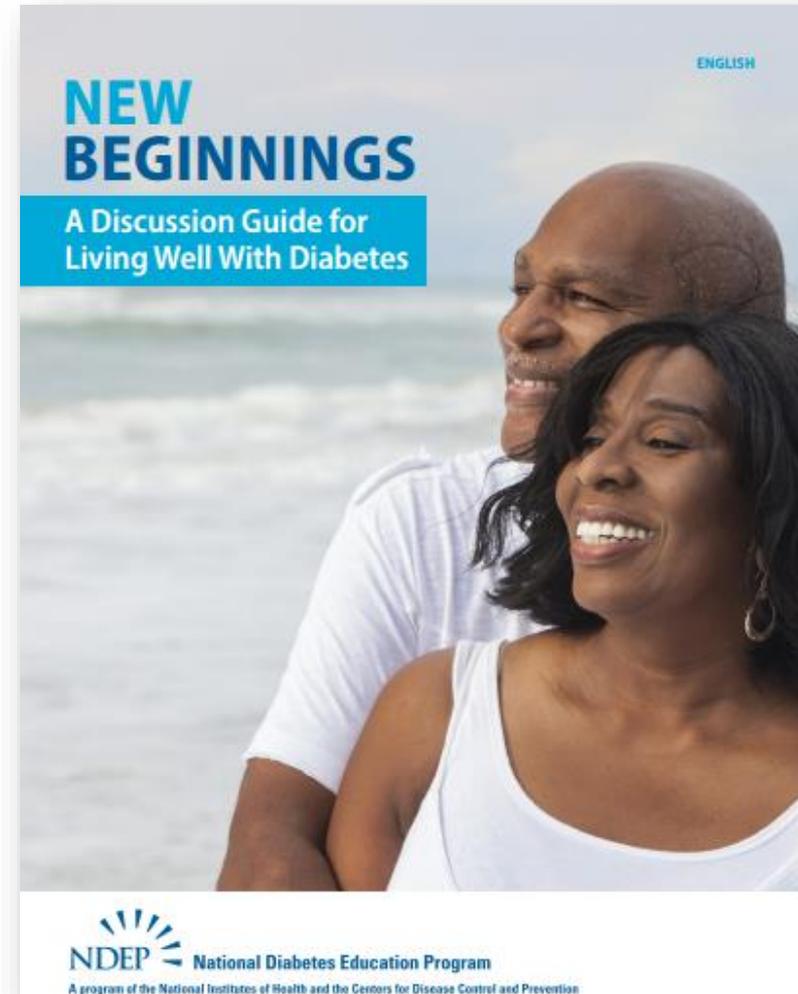
Call to save a slot for yourself, or just show up.

Each session will include a healthy lunch, laughter, and information to help you live well with diabetes.



Session Topics

- **Session 1:** Living well with Diabetes, Introduction to ABC's of Diabetes Care
- **Session 2:** Coping with Emotions, Self-doubt, and Stress
- **Session 3:** Making a SMART Plan, Problem Solving, Handling the “ups and downs”, Emergency Preparedness
- **Session 4:** Developing a Support Network, Working with your Doctor





New Beginnings for HCP/Educators

- Incorporate the discussions and activities into groups that are already meeting.
- Make the activities and discussions longer or shorter based on the needs of your group.
- Turn the stories into role plays by giving the participants the plot and asking them to act it out.
- Develop stories or adapt them to include recognizable things from your community (i.e., local parks, sports teams, activities).





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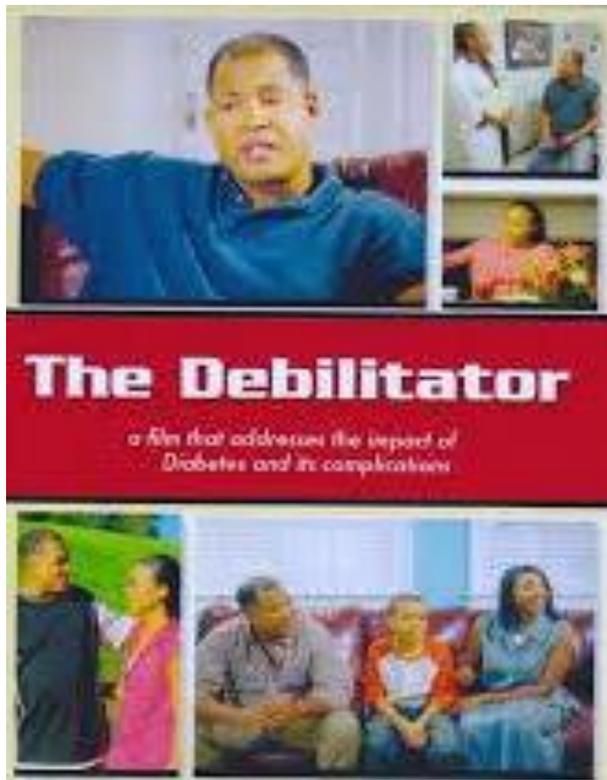
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Resources





Storytelling Videos



Managing Type 2 Diabetes: Sorcy's Story Video



Sorcy has changed her family's eating and activity habits to help manage her diabetes—and to

[Managing Type 2 Diabetes Subtitle](#)

[Managing Type 2 Diabetes Transcript](#)

[Managing Type 2 Diabetes Video \(MP4\)](#)

Keywords: [self-management](#), [behavior change](#), [National Diabetes Month](#), [story](#)



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Videos Promote Discussion

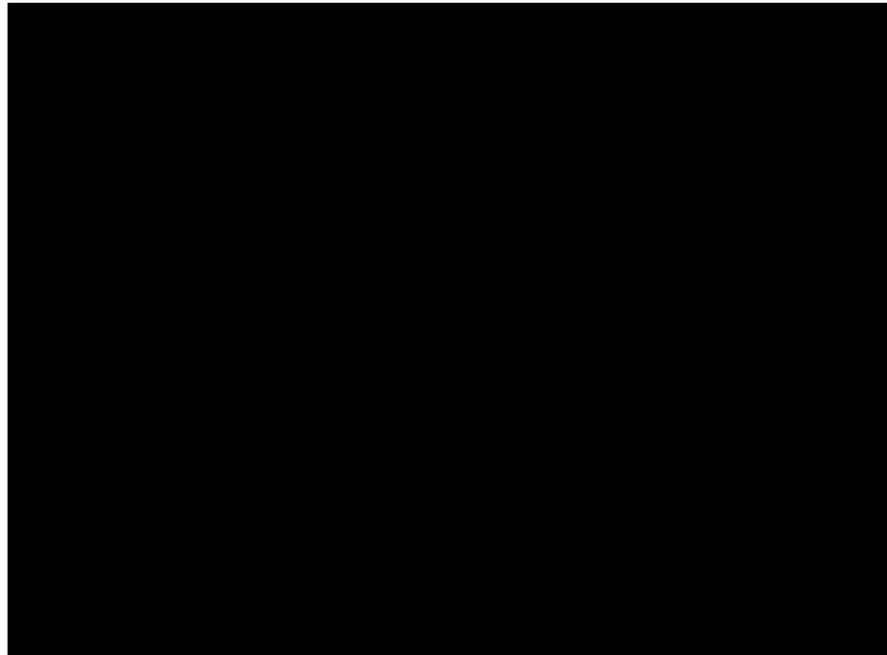




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Grandma Visits the Doctor





New Beginnings

- Talking Points and Discussion Questions.

After video discussion

Group Leader Instructions	Talking Points and Discussion Questions
<p><i>When the video or audio clip is over, see if any participants look ready to talk. If so, let them comment on what they heard. If not, move on to the first question (Option 1) or the Think-Pair-Share exercise (Option 2). In all cases, wait for open, voluntary responses.</i></p>	
<p>Option 1</p> <p><i>Note: Call on people who look as if they have something to say. When necessary probe for the following emotions: fear, sadness, and hope. Allow each participant about 3 minutes to express his or her feelings and then move to the next person.</i></p>	<p>That story had a lot of key messages for the main character and his/her family. Tell me how this story made you feel and why.</p>
<p>Option 2</p> <p><i>Conduct the Managing Diabetes Think-Pair-Share exercise on page 30. Participants who do not know each other or who are not comfortable speaking in front of the entire group may prefer this exercise to warm up to the group discussion.</i></p>	



Role Play



A Guide to Changing Habits

Top Story: Setting Goals Helps You Take Charge of Diabetes

Diabetes can turn your life upside down. Suddenly, there's a lot more to do. Taking care of diabetes is a whole new thing to fit into your daily life. All the changes can be too much. But don't give up! Change is all about working toward a goal. And to reach your goal, you need a plan.



- Decide what your goals are. What changes do you want to make?
- Review your goals with your health care team. Choose one goal to work on first.
- Decide what steps will help you reach your goal.
- Pick one step to try this week.

You can get there from here—one step at a time!

Special Message

Making changes in your life is a matter of trying and learning. First, you try something, and then you see what works and what doesn't. Not every idea will work. You may run into some problems along the way. That's OK. Sometimes when things go wrong, you learn a better way to reach your goal.

Diabetes Matters

The talk show about diabetes, featuring diabetes educator Fran Tate, CDE, and her guests.

Changing Your Habits

Fran: Good morning, everyone. Today we're talking to Carrie and Tom Kingbird about changing habits.

Carrie: When I got type 2 diabetes, I was told to lose weight, check my blood sugar, be more active, and take my pills. And all at once! I felt overwhelmed. For me, even thinking the word "diabetes" was hard. And Tom started nagging me.

Fran: What did you nag about, Tom?

Continued inside...



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New Beginnings Line Dance





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“Take away Messages- Inspire”

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 NDEP is a partnership of the National Institutes of Health, the Centers for Disease Control and Prevention, and more than 200 public and private organizations.

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I Have Diabetes Am I at Risk? Health Care Professionals, Businesses & Schools Partners & Community Organizations

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Diabetes Topics:
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Podcasts

Listen to stories of real people who manage their diabetes everyday in this weekly podcast produced by the Diabetes Education Program.

Managing Diabetes Podcast - Episode 1
 Listen to David discuss the “rules of the game” and his strategies for managing diabetes.
 David and his wife, Kay
 Fishers, IN

00:00/00:00

[Download audio file](#)
[Download transcript](#)

Managing Diabetes Podcast - Episode 2
 Haywood tells us what he does to manages his diabetes.
 Haywood and his wife, Ellen
 Midlothian, VA

00:00/00:00

[Download audio file](#)
[Download transcript](#)

<http://www.resources.nid.nih.gov/podcasthelp.htm>



New Beginnings Mini-Lesson:

- This lesson focuses on helping participants make the most of visits with health care professionals.
- Many people find it hard to get the information they need to manage their diabetes during their visit.
- One strategy to improve patient-provider partnership is to prepare for their health care visit.
- The lesson will help participants learn how to get ready for a visit.





Partnering with Your Diabetes Care Team



National Institute of Diabetes and Digestive and Kidney Diseases

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Contact Us

Health Information Center

- Phone: 1-800-860-8747
- TTY: 1-866-569-1162
- Email: healthinfo@niddk.nih.gov
- Hours: 8:30 a.m. to 5 p.m. eastern time, M-F

Partnering with Your Diabetes Care Team Video

Your health care team is a resource to help you manage your diabetes. Find ways to work with your team so you can successfully manage your disease.





New Beginnings

- Patients prepare for a health care visit.
- Talking points and discussion questions.

Group Discussion

This discussion will focus on making the most of your visits with health care professionals. In this discussion, “health care professional” includes any professional who provides treatment and support to the person with diabetes. This can include doctors, nurses, physician assistants, diabetes educators, pharmacists, dentists, podiatrists, dietitians, and any other specialists.

Partnering With Your Diabetes Care Team Discussion

Group Leader Instructions	Talking Points and Discussion Questions
<i>Show Getting Ready for Your Diabetes Care Visit or Partnering with Your Diabetes Care Team.</i>	
Ask:	<p>What did you think when Dr. Gavin said you are in charge of managing your diabetes and you are getting advice from a team you have engaged to help you?</p> <p>What do you think doctor visits are like when a person with diabetes has a relationship like this with their health care team?</p> <p>Do you feel like you are in charge of managing your diabetes and are getting advice from your health care team? Why or why not?</p> <p>How do you think you can get the most out of your visits to your health care providers?</p> <p>Would you feel comfortable doing this? Why or why not?</p>



Think-Pair-Share Exercise

Goal: Participants prepare questions they would like to ask at their next visit to a health care professional.

- Participants will review handouts:
 - Think about questions they would like to ask their health care provider.
- Circle the issues they would like to discuss or write down their questions:
 - Diabetes care record.
 - Action plan handout.
- Participants will pair up with another group member:
 - Share the questions they have decided to ask at their next appointment.
- One person from each group will share questions they identified.





Partner with Your Diabetes Care Team: Summarize

- YOU are the most important member of your health care team.
- YOU can make the most of your visits with your care team by getting ready ahead of time.
- YOU think about questions and concerns you would like to discuss and write them down.
- YOU be sure to bring a list of your medications and your diabetes self-care records.





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CONCLUSIONS



CONCLUSIONS

Your Motivations:

- There is a gap between what people want and what they get regarding engagement in their health care.
- Problems in patient-provider communication have been reported.
- Shared decision making approaches have been shown to be effective.
- Efforts to improve communication are being explored.

Your Practice:

- When teaching communication skills, look for resources that address psychosocial issues like self-efficacy and stress.
- Model shared decision making and effective patient-provider communication in education sessions.
- *New Beginnings* is a resource that can be used to teach effective communication skills, along with other important skills for managing the emotional side of living with diabetes.



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Q&A



Continuing Education

- This program has been approved for CNE, CEU, CECH, and CPH credit.
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The information, views, and opinions contained on this presentation do not necessarily reflect the views and opinions of the Centers for Disease Control and Prevention, the National Diabetes Education Program, or its partners.

Visit CDC NDEP's New Website

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

National Diabetes Education Program



▶ Diabetes at Work

Protect the productivity and health of your workforce with these free resources.



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



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Learn more from the National Diabetes Education Program

National Diabetes Education Program

Call 1-800-CDC-INFO (800-232-4636)

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

To order resources, visit https://nccd.cdc.gov/DDT_DPR/.

Claim Your Continuing Education Credits

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

WC2607-062116 - (Webcast) National Diabetes Education Program Webinar Series - June 21, 2016

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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 **July 25, 2016** 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.

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Thank you!