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

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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.
Today’s Presenters

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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.
Traditional Decision Making Model: Paternalism at its Peak

“When we want your opinion, we’ll give it to you”
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?
Traditional Healthcare Decision Making: Unequal Partnership

Provider

+ 

Patient

Driven Healthcare Decision
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.


Institute of Medicine

Communicating with Patients on Health Care Evidence.
Discussion Paper, Institute of Medicine, Washington, DC.

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.

What can we do?
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.

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

Information Sharing → Deliberation → Decision Making/Implementation
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.
Getting the most for our health: Shared decision-making

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 Institute of Medicine, under the guidance of the National Academies, has published a comprehensive report that includes considerations for decision-making processes, patient preferences, and informed consent. The ACP encourages patients and healthcare providers to discuss these factors in order to make informed decisions about prostate cancer screening.

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

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.

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

METHODS: The methods have been described in detail elsewhere. 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.”
Diabetes Empowerment Program

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

- DISCUSS
  - Information Sharing
- DEBATE
  - Deliberation
- DECIDE
  - Decision Making/Implementation
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
Culturally tailoring patient education and communication skills training to empower African-Americans with diabetes.

Monica E. Peek, MD, MPH,1,2,3,4 Sheila A. Harmon, MSN, APN/CNS, CDE,5 Shelley J. Scott, RD, LDN,5 Milton Eder, PhD,5 Tonya S. Roberson, BA, DT,1,2 Hui Tang, MS, MS,5,6 Marshall H. Chin, MD, MPH1,2,3

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 comprehensive strategies that empower patients and providers and extend beyond the clinical encounter.
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.
Alexis M. Williams, MPH, MS, CHES

THE NEW BEGINNINGS DISCUSSION GUIDE:
APPROACHES TO TEACHING PSYCHOSOCIAL AND INTERPERSONAL SKILLS
Participants are bad cooks:
• Teach them how to cook.

“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.

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

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.
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

<table>
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<th>Module</th>
<th>Topics Covered</th>
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<td>Module 1. Overview: Living Well With Diabetes</td>
<td>• Diabetes ABCs&lt;br&gt;• Managing diabetes&lt;br&gt;• Supporting a loved one with diabetes</td>
</tr>
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<td>Module 2. Know Your ABCs</td>
<td>• Diabetes ABCs&lt;br&gt;• Managing diabetes&lt;br&gt;• Goal setting</td>
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<td>Module 3. Healthy Coping</td>
<td>• Emotional coping&lt;br&gt;• Depression&lt;br&gt;• Providing emotional support</td>
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<tr>
<td>Module 4. Overcoming Self-Doubt</td>
<td>• Building self-confidence and reducing self-doubt&lt;br&gt;• Goal setting</td>
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<td>Module 5. Managing Stress</td>
<td>• Stress management</td>
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<td>Module 6. Problem Solving and Emergency Preparedness</td>
<td>• Problem solving&lt;br&gt;• Emergency preparedness</td>
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<tr>
<td>Module 7. Children and Family: How Can They Understand?</td>
<td>• Communicating with children and family members&lt;br&gt;• Building social support</td>
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<tr>
<td>Module 8. Working With Your Doctor</td>
<td>• Preparing for health care visits&lt;br&gt;• Roles for family caretakers</td>
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</table>
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.
Margaret Thearle RN, BSN, CDE

USING NEW BEGINNINGS TO TEACH PATIENT-CENTERED COMMUNICATION SKILLS
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 **A1C**, blood pressure, and **cholesterol** 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).
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 help her parents. You can listen to her story and learn more at the [Managing Type 2 Diabetes Subtitle](#), [Managing Type 2 Diabetes Transcript](#), or watch the [Managing Type 2 Diabetes Video (MP4)](#).

Keywords: self-management, behavior change, National Diabetes Month, story
Videos Promote Discussion
Grandma Visits the Doctor
New Beginnings

- Talking Points and Discussion Questions.

<table>
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<tr>
<th>Group Leader Instructions</th>
<th>Talking Points and Discussion Questions</th>
</tr>
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<tr>
<td><strong>Option 1</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Note:</strong> 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.</td>
<td></td>
</tr>
<tr>
<td><strong>Option 2</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
Role Play

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.
New Beginnings Line Dance
"Take away Messages - Inspire"
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

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.
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.
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.
Continuing Education

• This program has been approved for CNE, CEU, CECH, and CPH credit.

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Visit CDC NDEP’s New Website
http://www.cdc.gov/diabetes/ndep

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

- AMERICAN INDIANS & ALASKA NATIVES
- AFRICAN AMERICANS & AFRICAN ANCESTRY
- HISPANIC & LATINO AMERICANS
- ASIAN AMERICANS, NATIVE HAWAIIAN & PACIFIC ISLANDERS
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Learn more from the National Diabetes Education Program

National Diabetes Education Program
Call 1-800-CDC-INFO (800-232-4636)
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To order resources, visit https://nccd.cdc.gov/DDT_DPR/.
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- 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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1-800-41-TRAIN
Thank you!