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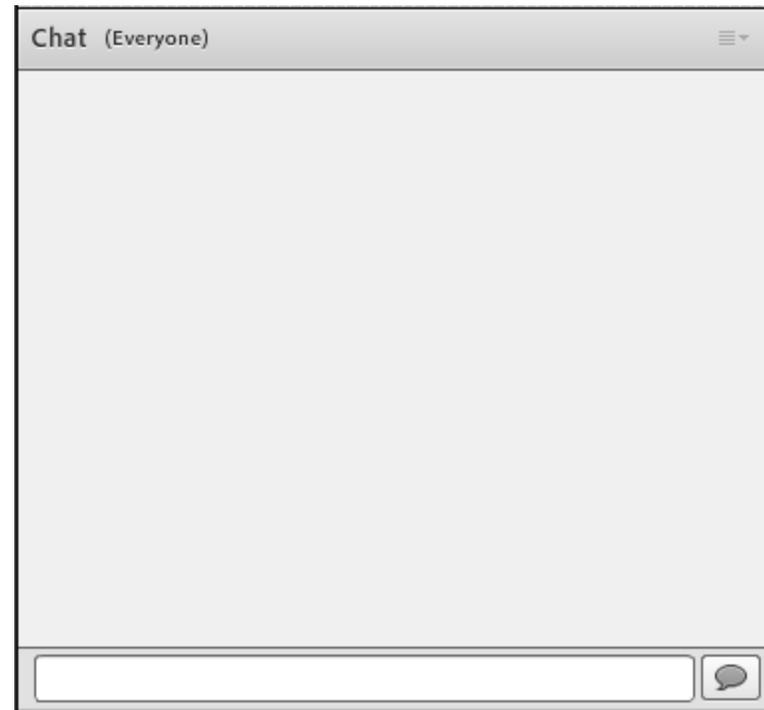
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Division of Diabetes Translation

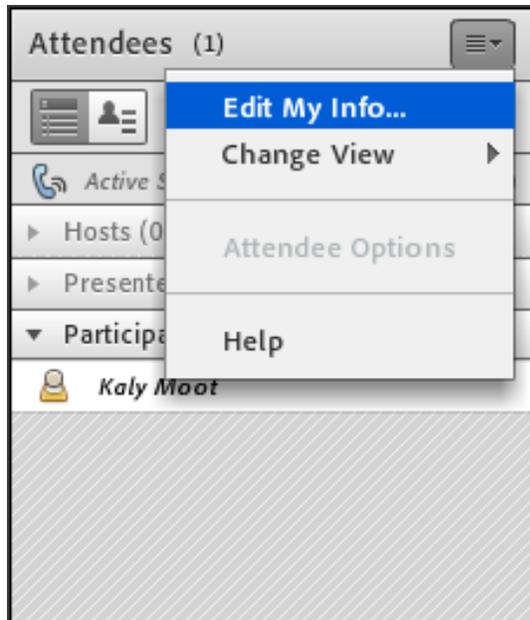


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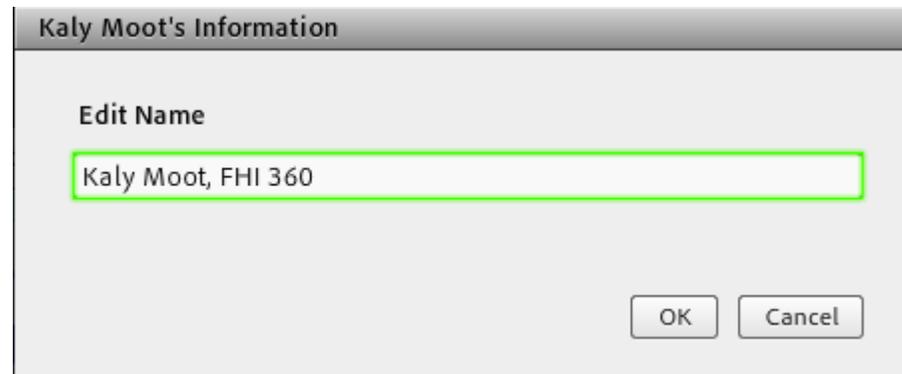
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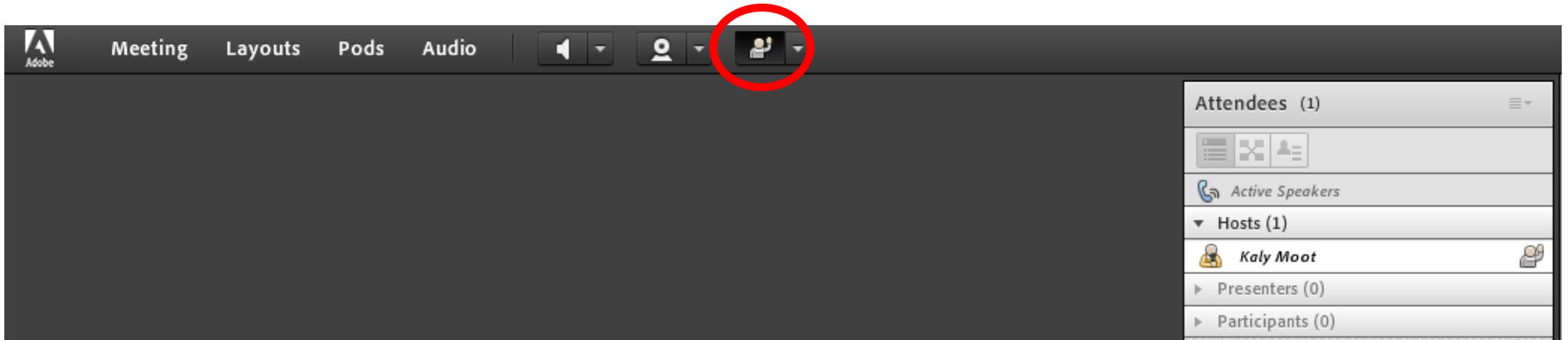
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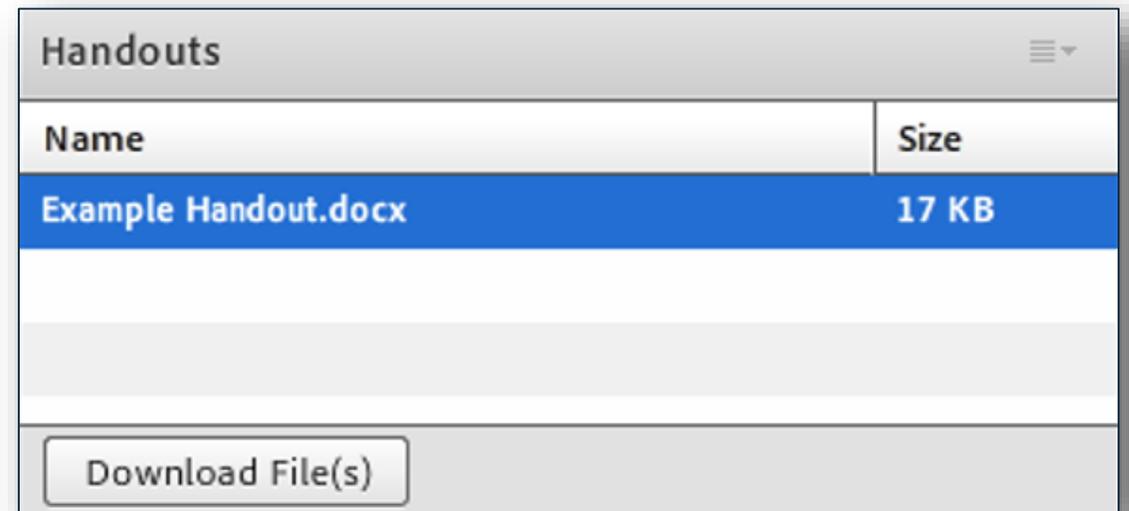
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A screenshot of a web interface titled "Handouts". It features a table with two columns: "Name" and "Size". The table contains one row with the text "Example Handout.docx" and "17 KB". Below the table is a button labeled "Download File(s)".

Name	Size
Example Handout.docx	17 KB

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- Speaking the Language of Diabetes: New Language Guidance for Diabetes-related Research, Education, and Publications <https://www.diabeteseducator.org/practice/educator-tools/diabetes-language-paper>
- The Use of Language in Diabetes Care and Education
<http://care.diabetesjournals.org/content/40/12/1790>
- Learn, Connect, Engage: Peer Support Tip Sheet
- References
- Don't Blame Me webinar slides

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“DON’T BLAME ME!”

HELPING HEALTH CARE PROVIDERS AND PEOPLE WITH DIABETES
WORK TOGETHER TO OVERCOME CHALLENGES FOR BEHAVIOR CHANGE

Featuring Guest Panelists:

Christina Roberto, PhD

Nicole Bereolos, PhD, MPH, CDE

Marie Brown, MD

Moderated by:

Michelle Owens-Gary, PhD

Nancy Silver, MS

Centers for Disease Control and Prevention

Division of Diabetes Translation

Division of Diabetes Translation (DDT)
September 19, 2018





Michelle Owens-Gary, PhD

Behavioral Scientist

CDC Division of Diabetes Translation (DDT)

- Licensed clinical psychologist
- Behavioral scientist with DDT more than 17 years
- Leads the diabetes and mental health efforts of the division
- Assists with the development of health education tools related to:
 - Diabetes and depression
 - Lifestyle change programs
 - Women's health issues

Nancy L. Silver, MS
Health Communication Specialist
CDC Division of Diabetes Translation (DDT)

- Health communications specialist with DDT since 2003
- Works on a wide array of health communication projects
 - Diabetes retention tool
 - Webinars
 - Product research
 - Infographics
 - Plain language documents & web content
- Serves as the liaison for graphics and translation materials for DDT



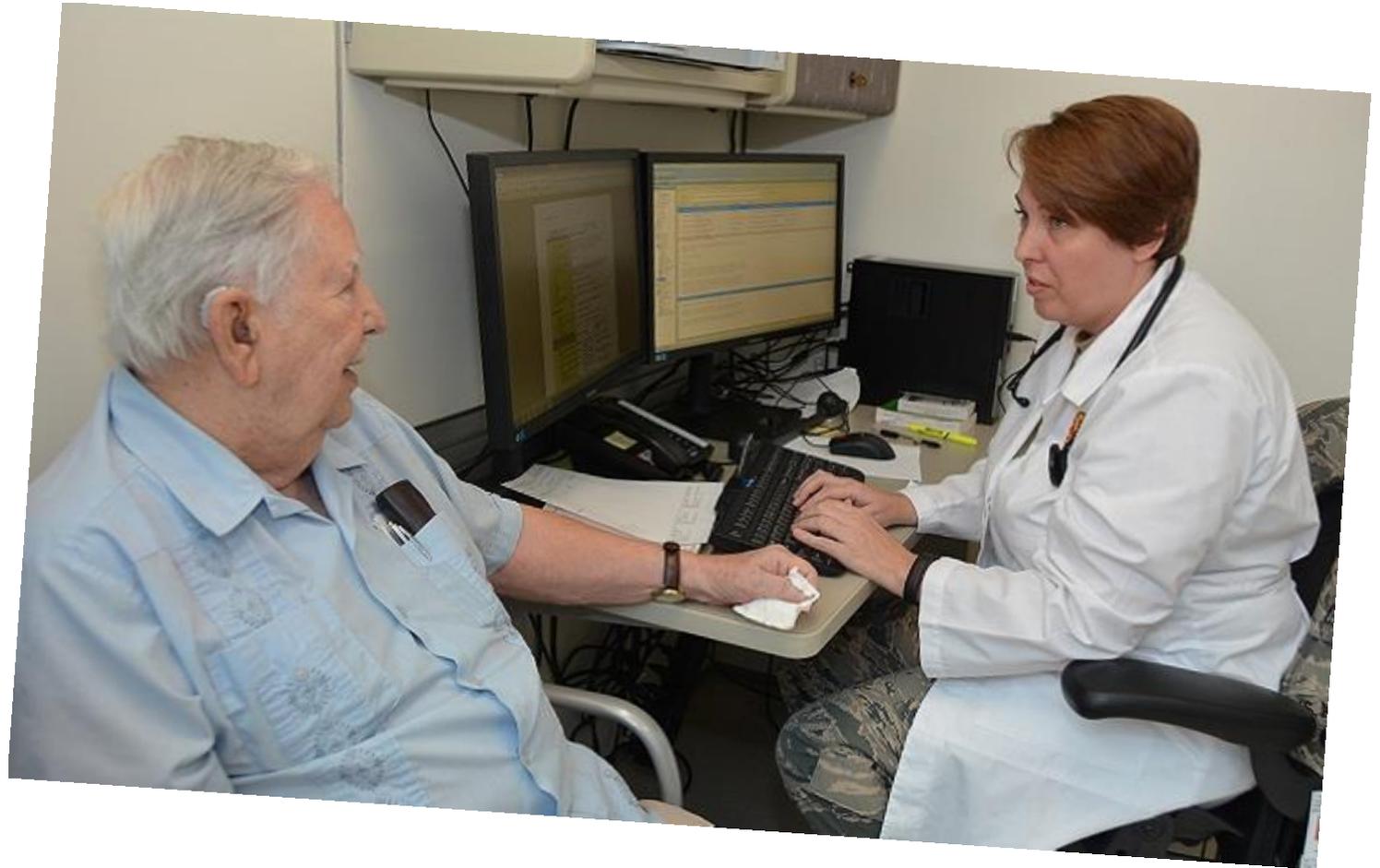
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Managing diabetes can be challenging.

Both people with diabetes and providers who care for them can be frustrated by setbacks.





Christina A. Roberto, Ph.D.

Assistant Professor of Medical Ethics & Health Policy
Perelman School of Medicine, University of Pennsylvania

- Psychologist and epidemiologist
- Works to identify and understand factors that promote unhealthy eating behaviors and design interventions to improve eating habits
- Director of the **Psychology of Eating And Consumer Health** lab, or **PEACH** lab

HELPING PATIENTS WITH DIABETES MAKE HEALTHY CHOICES

CHRISTINA A. ROBERTO, PHD

ASSISTANT PROFESSOR OF MEDICAL ETHICS AND HEALTH POLICY, UNIVERSITY OF PENNSYLVANIA

NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION



**2013-2020 GLOBAL ACTION PLAN
NON-COMMUNICABLE DISEASE TARGET**

**No increase in
obesity
prevalence from
2010-2015**



**World Health
Organization**

WHO OR WHAT IS RESPONSIBLE FOR WEIGHT GAIN & DIABETES?



BIOLOGICAL VULNERABILITIES

**Salt
Sugar
Fat**

**Addictive
potential**

**Sweet
preferences**



SOCIAL & ECONOMIC VULNERABILITIES



**Cost of
food**

**Targeted
marketing**

Stress

PSYCHOLOGICAL VULNERABILITIES

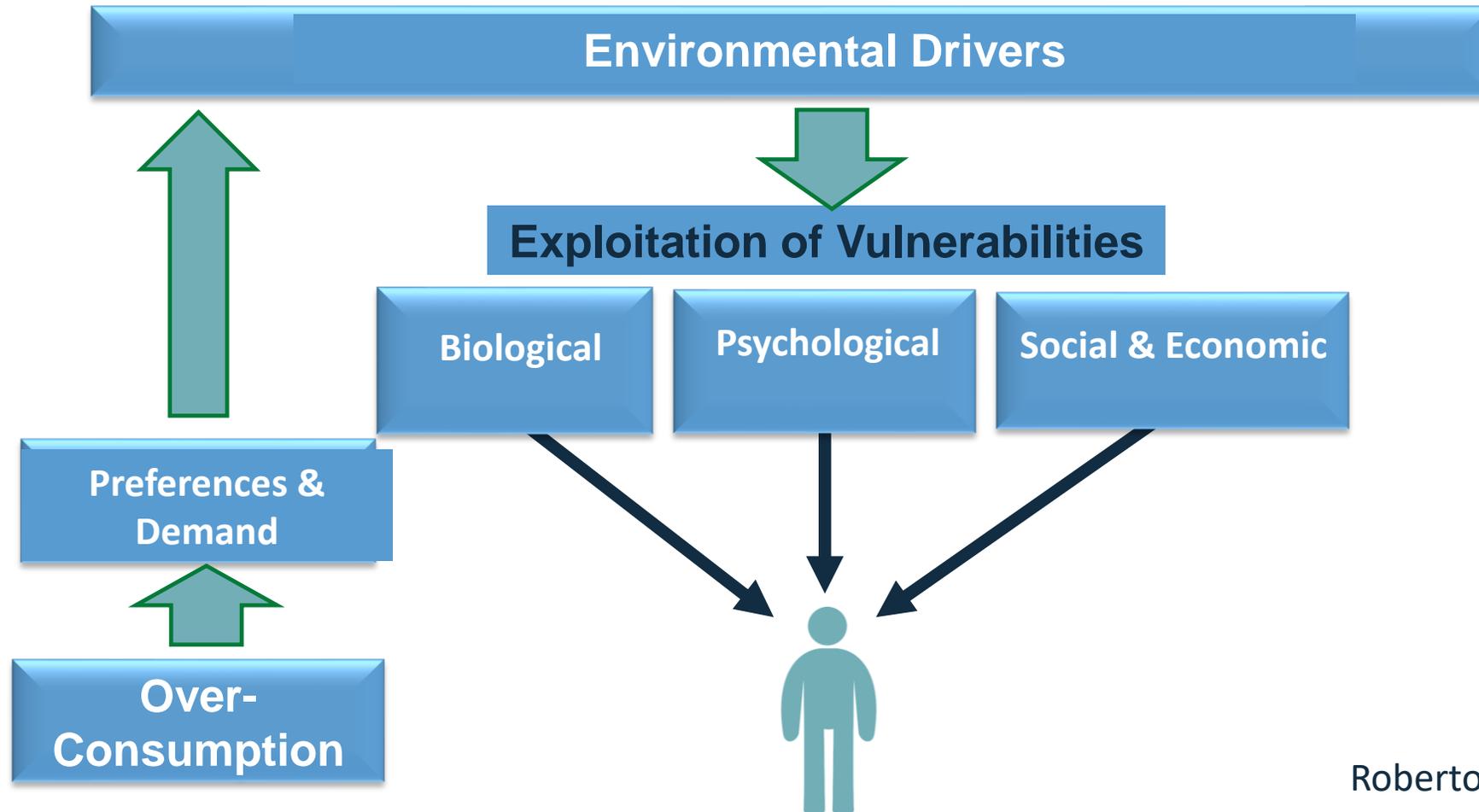


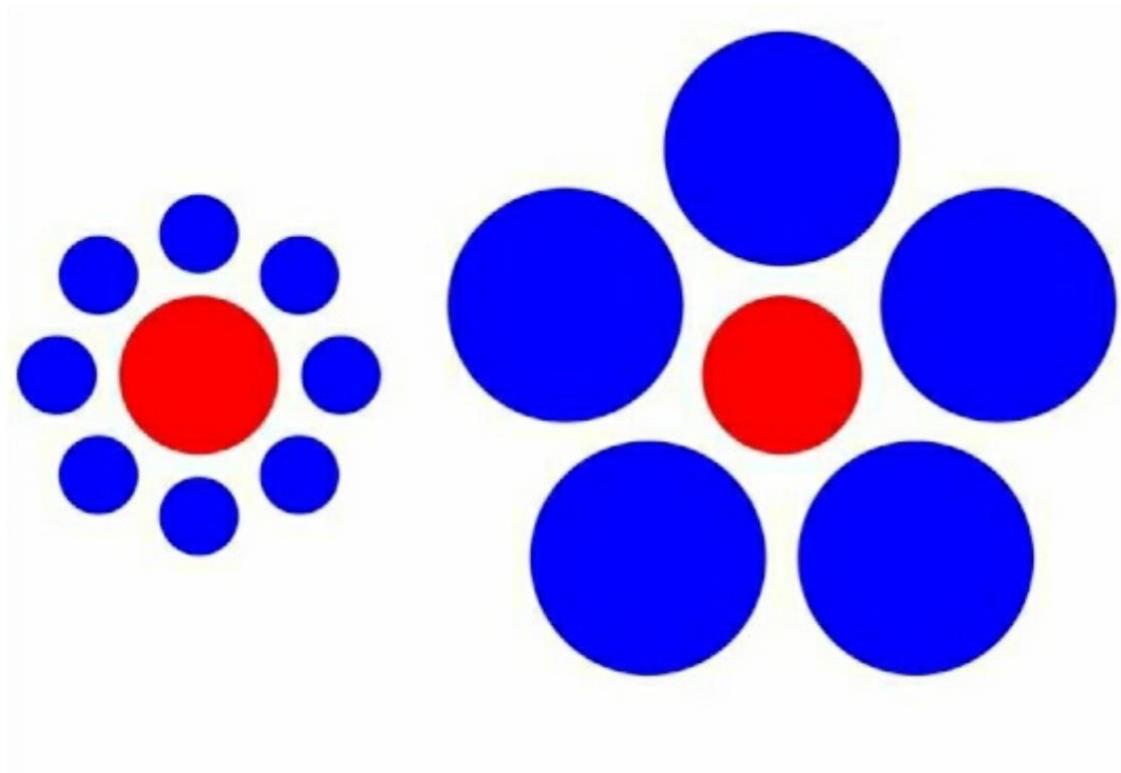
**Present-
biased
preferences**

**Status
quo bias**

**Mindless
eating**

VICIOUS CYCLE





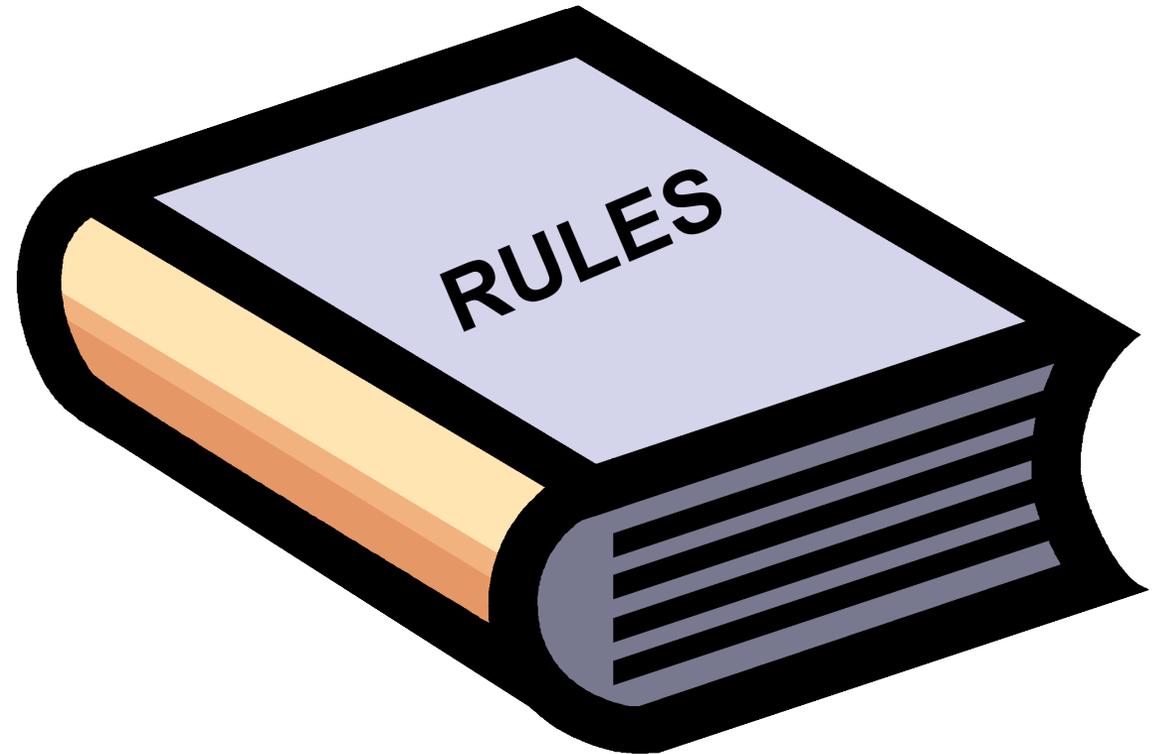


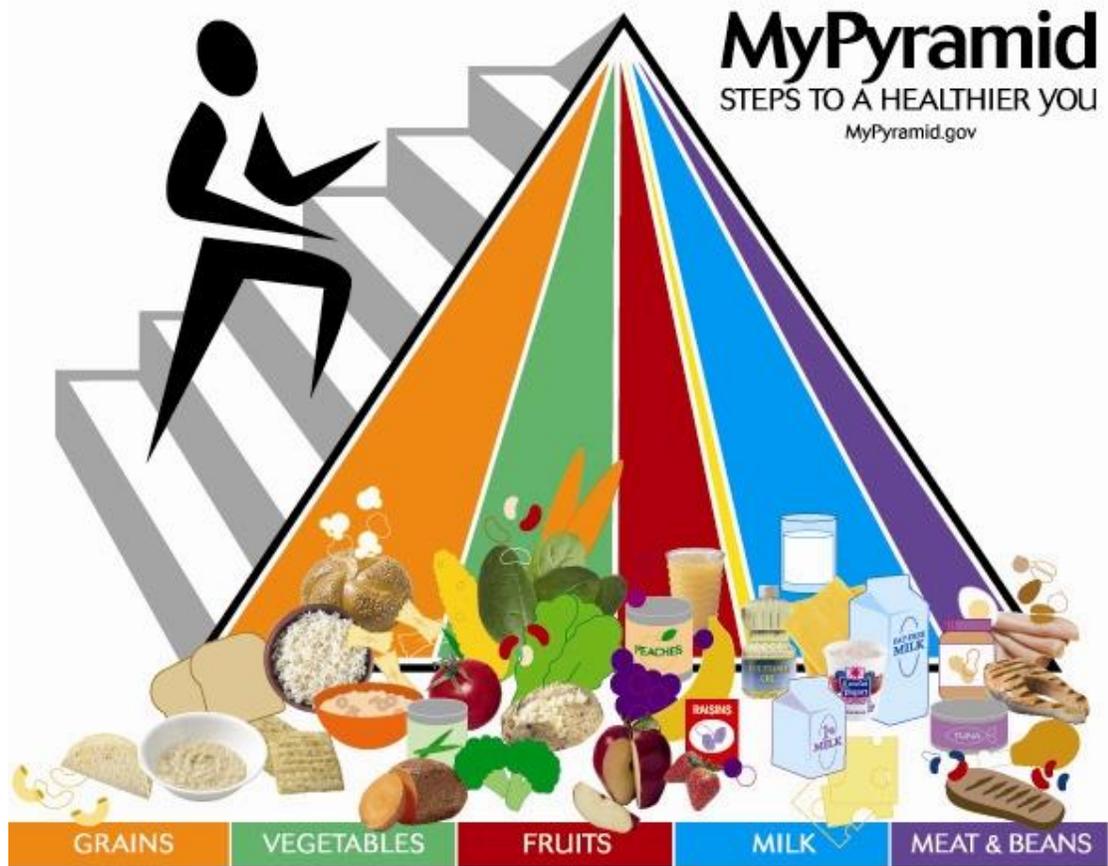
**Google moved
M&Ms to opaque
containers**

**3.1 million fewer
M&Ms eaten
by 2000 employees
over 7 weeks**

HOW TO TALK TO PATIENTS

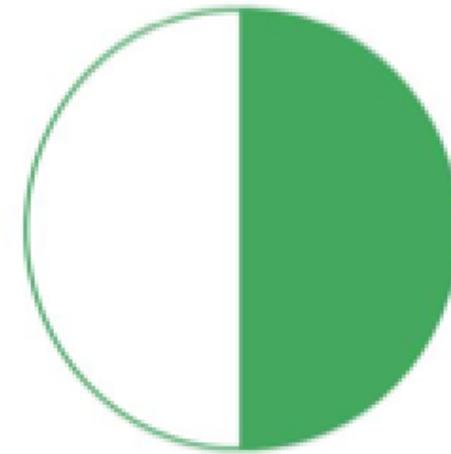
What are the chances
you will act on a
guideline you can't
remember?





HALF-A-PLATE

Be sure to fill half of your plate at every meal with fruits and vegetables!



What are some of the aspects that make the older Food Pyramid hard to understand?

From a communication perspective, how might the Half-a-Plate guideline be better?

MEMORABLE & ACTIONABLE GUIDELINES

**Simple &
specific**

**Actionable
behavior**

**Ease of
visualization**

**Embedding
triggers**



You need to
lose weight



What are some problems with that approach based on the memorable and actionable guidelines we just talked about?

You need to lose weight



Try not to buy sugary drinks when you're at the store



Try drinking only 1 sugary drink per week when you eat out

What made this approach better?



THANK YOU - PEACH LAB

Christina A. Roberto, PhD @RobertoCA
croberto@penmedicine.upenn.edu



ENHANCING COMMUNICATION WITH PEOPLE LIVING WITH DIABETES: STRATEGIES TO IMPROVE POSITIVE OUTCOMES

NICOLE BEREOLOS, PHD, MPH, CDE

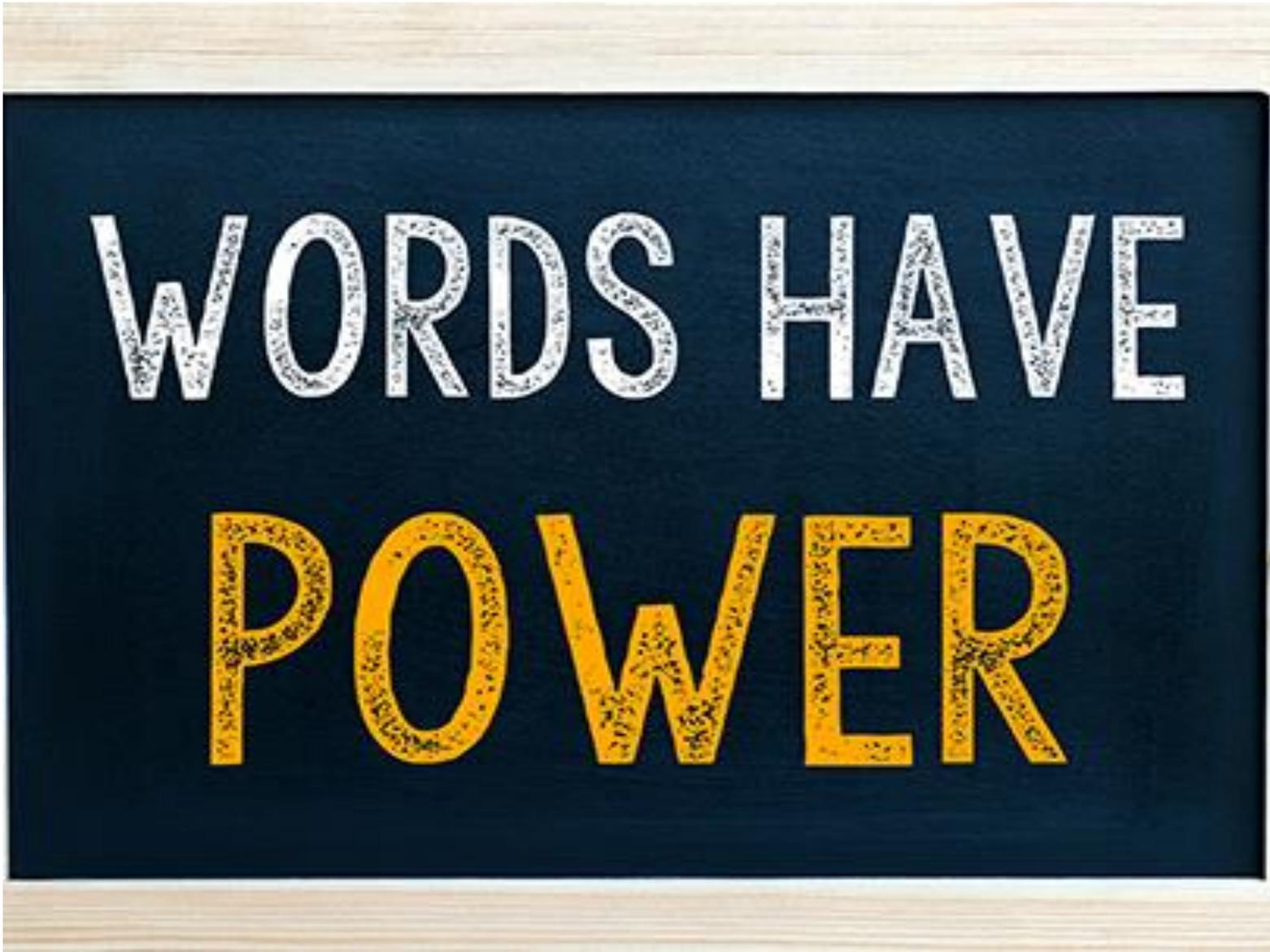
NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION





Nicole Bereolos, PhD, MPH, CDE **Clinical Psychologist/Certified Diabetes Educator**

- Member of the Board of Directors, American Association of Diabetes Educators (AADE)
- AADE national spokesperson on mental health and diabetes
- Helps individuals with behavioral weight management, smoking cessation, depression, anxiety, relationship problems, and stress management
- Received the AADE Rising Star Award in 2014



WORDS HAVE

POWER

PERSON-CENTERED CARE



- Explores the person's main reason for the visit, concerns, and need for information
- Seeks an integrated understanding of the person's world—emotional needs, etc.
- Finds common ground on what the problem is and mutually agrees on management
- Enhances prevention and health promotion
- Enhances the continuing relationship between the person and the doctor (health care team)

(Little et al, 2001)

SELF-EFFICACY

- Bandura's social cognitive theory
- "Individual's perception of own ability to perform a specific task in a given situation"
- Link between knowing what to do and doing it
- Determined by a history of doing the task, but can be achieved by seeing others' success and via verbal persuasion

(Bandura, 1997)

FACTORS IMPACTING LEVEL OF EMPOWERMENT

Intrinsic

- Attitudes/health beliefs
- Mental health
- Self-efficacy
- Level of diabetes knowledge & technical skill
- Ethnic perspectives
- Functional health literacy

Extrinsic

- Financial capabilities
- Family influences
- Workplace environment
- Community environment
- Clinical relationships
- Access to effective diabetes health care delivery

(Rodriguez, 2013)

STIGMA LIVING WITH DIABETES

- Stigma = exclusion, rejection, blame, fear, embarrassment
- With increased stigma
 - Less likely to self-disclose their diagnosis, use insulin pumps/continuous glucose devices, deviate from peers' eating habits
- Study of 12,000 online results indicated:
 - Stigma is greater for those with type 1 vs type 2 diabetes, especially parents of children with type 1 compared to people living with diabetes
 - For those with type 2, stigma increased as treatment complexity increased, especially those with higher glucose values and BMI

LANGUAGE MATTERS!

- Use language that is neutral, nonjudgmental, and based on facts, actions, and physiology
 - “Control” = disregards one’s efforts and elicits shame
- Use language that is free from stigma
 - “Uncontrolled, noncompliant, nonadherent” = lazy, unmotivated, not care, shame, embarrassment

What's the best word or phrase to use when discussing a problem with them?

- 1) Uncontrolled;
- 2) Non-compliant;
- 3) Non-adherent;
- 4) Running into some challenges.



What are some things you *could* say...
or some examples of positive language?

LANGUAGE MATTERS!

- Use language that is strengths based, respectful, inclusive, and imparts hope
 - Focuses on what is working therefore increasing empowerment
- Use language that fosters collaboration between people living with diabetes and providers
 - Good vs bad, should vs should not's = assumed, talked to like a child, less honesty, shame, etc.
- Use language that is person centered
 - Includes support, compassion, caring; not defining the individual by their condition

(Dickinson et al, 2017)

PEER SUPPORT

- Online and in-person
- Purpose: emotional support/practical advice for everyday problems (Fox, 2011); learn things health care professionals did not know (tech), help others, feel understood, make new friends, feel empowered (Litchman et al, 2018)
- Who is using it? (Litchman et al, 2018)
 - Mostly adults living with type 1 diabetes, high patient activators (very involved in their health care)
 - Tend to be younger and more comfortable with social media & blogging
- Benefits
 - More engagement correlated with more diabetes self-care
 - Higher health-related quality of life
 - Strong sense of community, even internationally (Australia, UK, Germany)

ROLE OF HEALTH CARE PROVIDERS (HCPS) IN PEER SUPPORT

- Peer support is complementary, not a replacement
- Health-related social media is driving person-centered care
- Puts individuals' preferences & values first
- HCPs can encourage how it is being used and support quality sources
- HCPs encouraged to participate in these dialogues
 - Learn real-world strategies being used
- AADE has a workgroup to further identify how peer support communities & diabetes educators can work together

METHOD TO INCREASING SELF-EFFICACY

Self-efficacy -

1. Primary judgment that a certain work or duty is possible.
2. The plan is divided into smaller and easier steps. This leads to success.
3. Repetition in action and behavior to be carried out.
4. To change behavior, reward, reinforcement, and recognition are essential

HELP TO INCREASE CONFIDENCE IN THESE AREAS

- Identify areas of satisfaction/dissatisfaction in living with diabetes
- Identify and achieve personal goals
- Problem solving own barriers
- Coping with emotional needs
- Managing stress
- Gaining social support
- Making cost/benefit decisions
- Staying motivated

(Anderson et al, 1995)

RECOMMENDATIONS FOR ENHANCING ENGAGEMENT

- E - Enter the world of the individual
- N - Need to determine the individual's daily challenges of living with diabetes
- G - Gather information on motivators for self-management (not fear!)
- A - Ascertain and address individual priorities for self-care
- G - Gather information about external risks (family, workplace and community)
- E - Educate to optimize positive self-management behaviors
- M - Minimize acute risk (hypoglycemia / diabetic ketoacidosis)
- E - Establish a clear plan for clinical care and self-management
- N - Need to identify and implement support strategies and appropriate follow-up
- T - Take steps to examine and improve your service's health care delivery system

(Rodriguez, 2013)

THE PRINCIPLE DRIVER OF PROVIDER SATISFACTION IS DELIVERING QUALITY PATIENT CARE

DR. MARIE BROWN



NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION





Marie Brown, MD

Internist & Associate Professor

Rush Medical College

- Practicing internist
- Associate professor of Internal Medicine, Rush Medical College
- Senior physician advisor, American Medical Association
- Former member, CDC/NIH National Diabetes Education Program (NDEP) Operations Committee
- Frequent guest lecturer on topics such as:
 - Practice transformation
 - Joy in medicine
 - Medication adherence and diabetes

The background of the slide is a detailed, artistic illustration of a mechanical watch movement. It features numerous golden gears of various sizes, some with intricate scrollwork patterns on their teeth. Several clock faces are visible, showing Roman numerals and black hands. The overall color palette is warm, dominated by gold, brown, and black tones, creating a sense of precision and craftsmanship.

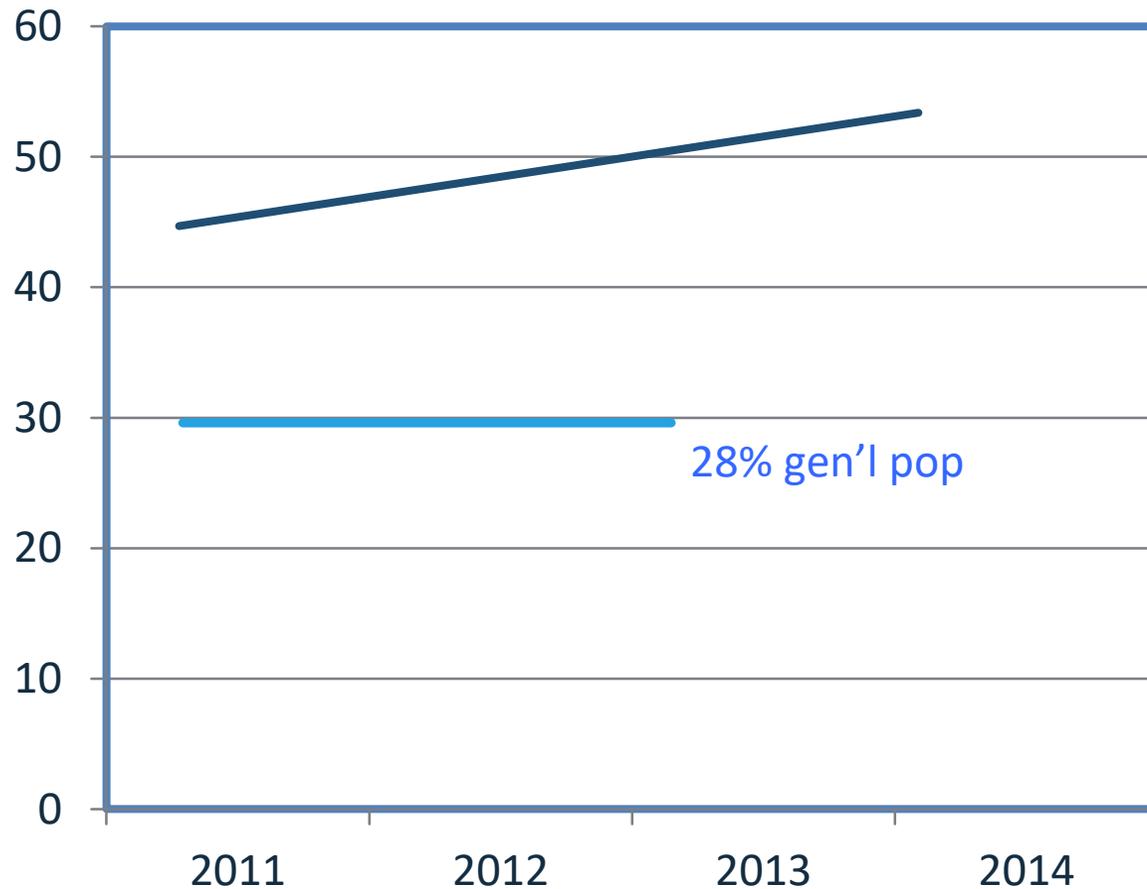
WHAT BRINGS JOY TO A PROVIDER?

PRIDE IN THEIR WORK

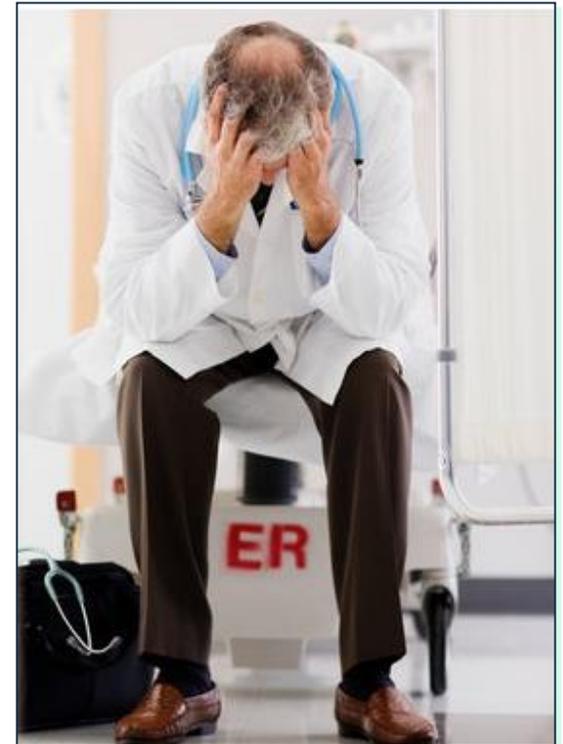
ALIGNED MISSION

CONTROL OVER THEIR DAY

PHYSICIAN BURNOUT RISING 45 → 54%



Also impacts NPs, PAs,
RNs, MAs



Shanafelt T, Sinsky C Mayo Clin Proc. 2015;90(12):1600-1613

CAUSES OF BURNOUT

- Time pressure
- Electronic health record (EHR) pressures
- Discordant values
- Work/life balance
- Lack of autonomy
- Insufficient resources
- Loss of control
- Meaningless work
- Lack of teamwork
- Poor peer support

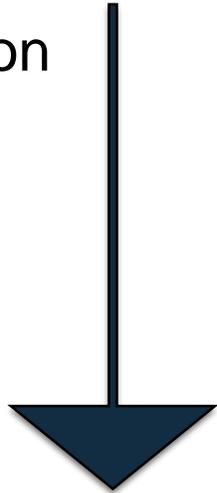
EFFECTS ON PROVIDER

- Cynicism
- Less enthusiasm
- Less pride in work
- Depersonalization
- Emotional exhaustion
- Exit practice
- Part-time work
- Divorce
- Suicide

BUT WHAT ARE THE EFFECTS ON PATIENTS, TEAMS AND ORGANIZATIONS?

Effects on patient/team

- Patient satisfaction
- Trusting relationships
- Med adherence
- Reimbursement
- Outcomes



Effects on organization

- Referrals
- Testing/labs
- Malpractice
- Readmissions
- Diagnostic errors
- Staff turnover



MRS. DAVIS 10:20-10:40

65-year-old retired teacher here for follow-up. She notes fatigue, insomnia, back and knee pain. Unsure if she needs refills.



Problem list:

- T2DM
- Depression
- Obesity
- Hypertension
- Hypothyroidism
- Osteoarthritis of both knees
- Low back pain
- Asthma
- Atrial fibrillation

1. You are 35 minutes behind schedule
2. Health maintenance goals and immunization rates poor
3. Her A1c was 8.0% 6 months ago, no record of TSH or BMP
4. BP today is 170/100 and gained 5 lbs since last visit 6 months ago
5. She thinks she needs refills
6. Ran out of hydrocodone
7. She is not sure which blood pressure medicines she is taking

Meds:

- Metformin
- Glyburide
- Sitagliptin
- Chlorthalidone
- Lisinopril
- Metoprolol
- Paroxetine
- lorazepam
- Estrogen
- Atorvastatin
- Levothyroxine
- Pantoprazole
- Vitamin D, E, A
- Albuterol
- Fluticasone
- Hydrocodone
- Warfarin

How would you approach this person's situation? What would you do first?

MRS. DAVIS 10:20-10:40

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Redesign your practice. Reignite your purpose.

AMA's Practice Improvement Strategies.

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Watch overview video >

Short 2-minute overview video of AMA's practice transformation series

“ You can see your ROI in a fairly short period of time. ”

“ I rediscovered the beauty of reconnecting with my patients! ”

“ Every day I was walking into a fire hose of stuff coming at me. ”



Module Categories

www.stepsforward.org

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 **Leading Change**

[7 Modules >](#)

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Preventing Physician Distress and Suicide

Recognize and respond to physician distress and suicidal behavior.



Physician Wellness: Preventing Resident and Fellow Burnout

Learn how to foster and implement a culture of wellness focused on the unique experiences of residents and fellows.



Improving Physician Resiliency

Foster self-care and protect against burnout.



Preventing Physician Burnout

Improve patient satisfaction, quality outcomes and provider recruitment and retention.

Help patients with type 2 diabetes achieve their glycemic goals.

Managing Type 2 Diabetes: A Team-Based Approach

Marie T. Brown, MD, FACP
Rush University, American
Medical Association

Katherine A. Kirley, MD,
MS American Medical
Association

Christine Sinsky, MD, FACP
American Medical
Association

★ CME CREDITS: 0.5



How will this module help me improve glycemic control and prevent complications in my patients with type 2 diabetes?

- 1 Outlines six steps for developing an efficient team-based approach to managing diabetes
- 2 Provides answers to common questions about diabetes management for patients with type 2 diabetes
- 3 Provides examples from other practices on how they are helping patients achieve their glycemic goals

Share     

 **Download module as PDF**

 **Download module PowerPoint**

Online module

STEPS in practice

Downloadable tools

Implementation support



Agenda and Medication Review process starts on the phone, days prior or in the waiting room

Ten steps to pre-visit planning

During the current visit

1. Re-appoint the patient at the conclusion of the visit
2. Use a visit planner checklist to arrange the next appointment(s)
3. Arrange for laboratory tests to be completed *before* the next visit

Before the next visit

4. Perform visit preparations
5. Use a visit prep checklist to identify gaps in care
6. Send patients appointment reminders
7. Consider a pre-visit phone call or email

During the next visit

8. Hold a pre-clinic care team huddle
9. Use a pre-appointment questionnaire
10. Hand off patients to the physician



MEDICATION MANAGEMENT

Physician time saved > 1 hour/day

Nursing time saved > 2 hours/day

40 million primary care visits each year

Weekend/night calls ↓

Medication errors ↓

Patient satisfaction ↑

Continue to see patients every 1-3 months

Save 2-3 hours each day
Improving medication adherence
annual prescriptions Rx 90 x 4



Time saved is needed to develop meaningful Relationship between patient and clinician



What are some things a provider can do
to build meaningful relationships
with a person they care for?

OBSTACLES

Unintentional

- Forgetting
- Shift work
- Cost
- Confusion
- Work restrictions
- Access/time

Vs.

Intentional

- Mistrust
- Fear of side effects
- Mental illness
- Lack of belief in benefit
- Fear of dependency
- Fear it is dangerous
- Lack of desire
- No apparent benefit
- Altruism

SOLUTIONS TO RETURNING JOY TO YOUR PRACTICE

- Previsit planning/labs
- Schedule efficiency
- Team-based care/workflow
- Staffing/team documentation
- Intervisit team-based care (panel management)

Time to Provide
Quality Care



MRS. DAVIS 4:20-4:40 – AFTER PRACTICE REDESIGN*

65-year-old retired teacher here for follow-up. She notes more energy and less pain. She brings in her meds and does not need refills. PHQ in waiting room = 4 (was 12)

Problem list:

- T2DM
- Depression
- Obesity
- Hypertension
- Hypothyroidism
- Osteoarthritis of both knees
- Low back pain

Meds:

- Metformin
- Bupropion
- Sitagliptin
- Atorvastatin
- Chlorthalidone
- Lisinopril
- Vitamin D, B12

1. Diabetes educator 2x since last visit and meds, diet and exercise were reviewed
2. Physical therapist 3x/week and has lost 3 lbs.
3. Your staff called her yesterday and set the agenda 5 min
4. Staff chart prep: health maintenance up to date, diabetes educator, vaccines 10 min
5. No refills needed

1. She had previsit labs and these are reviewed with her and med adjustments made
2. Her A1c was 7.0 2 days ago, annual TSH is normal, annual ACR up to date
3. BP today is 150/90
4. You received notice your health maintenance levels were at goal
5. You leave on time!

(No calls between this visit and next visit!)

MAKE THE BUSINESS CASE

Staff of 600 clinicians on average working .75 clinical time
is equal to 450 clinicians working full time

OR

Rehire your own staff
by providing the resources to
deliver quality care

Cost: 2-3x salary to replace a clinician
(recruitment, vacancy time, ramp up time, benefits)

REGULATORS/INSTITUTIONS/LEADERSHIP

Measure the wellness of your workforce

Align with team-based care
Avoid compliance creep
Rethink documentation
All working at the top of their license
Eliminate 1 billion clicks/day

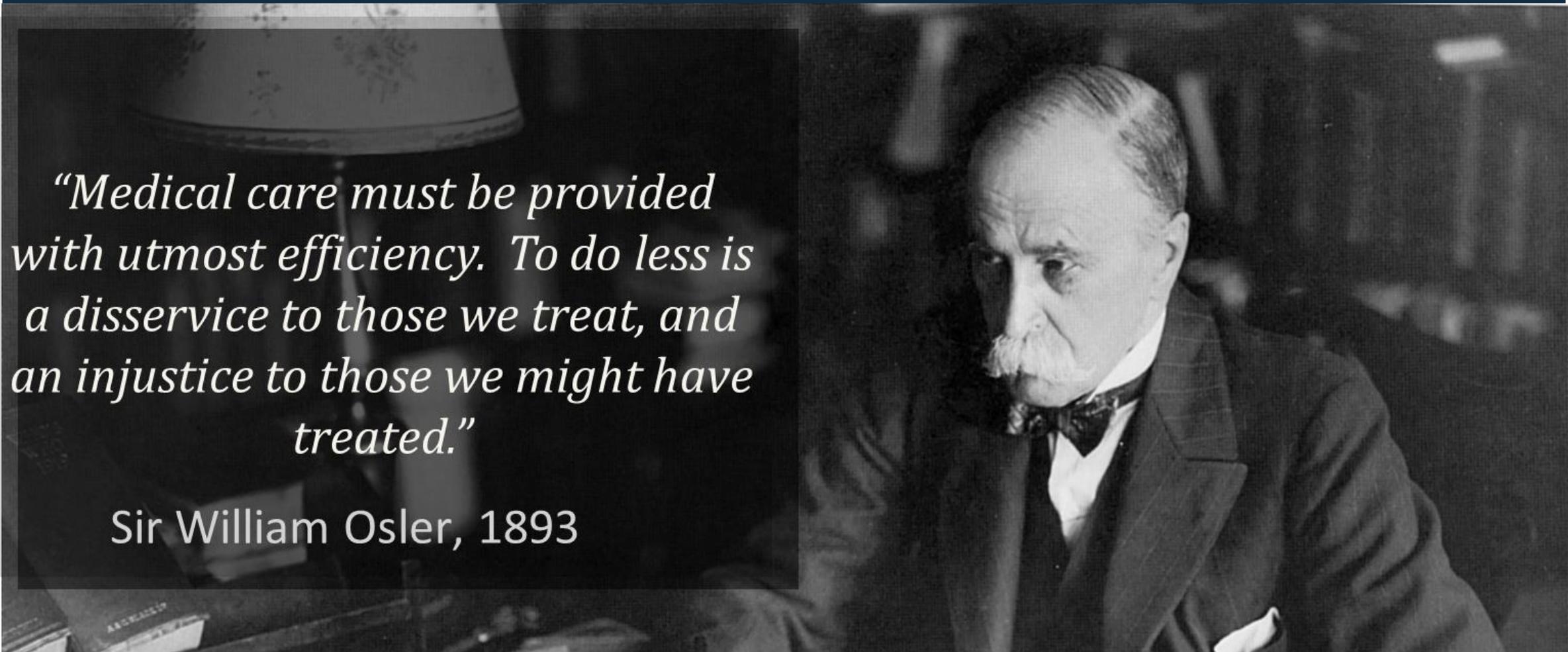




THE PRINCIPLE DRIVER OF
PROVIDER SATISFACTION IS
DELIVERING
QUALITY PATIENT CARE

TAKE HOME POINTS

- Providers care deeply about the quality of their work
- Engage your team
- Choose a project together
- Start small and celebrate success!
- The time saved allows you to do meaningful work!



“Medical care must be provided with utmost efficiency. To do less is a disservice to those we treat, and an injustice to those we might have treated.”

Sir William Osler, 1893

**PRACTICING WISELY...
SAVING 2 HOURS/DAY**

Marie Brown, MD

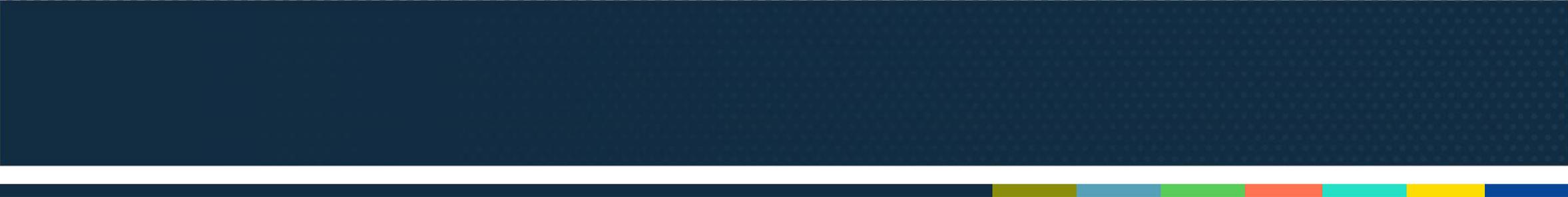
Senior Physician Advisor, AMA • Rush University

mbrown@mbrownmd.net · www.drmariebrown.com (videos)

QUESTIONS?

Comments?

Email: DDT_DiabetesWebinar@cdc.gov



Resources and Announcements





DOWNLOAD TODAY'S HANDOUTS

- Speaking the Language of Diabetes: New Language Guidance for Diabetes-related Research, Education, and Publications <https://www.diabeteseducator.org/practice/educator-tools/diabetes-language-paper>
- The Use of Language in Diabetes Care and Education
<http://care.diabetesjournals.org/content/40/12/1790>
- Learn, Connect, Engage: Peer Support Tip Sheet
- References
- Don't Blame Me webinar slides

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- In order to receive continuing education (CE) for SC2607-091918 - National Diabetes Education Program Webinar Series - Don't Blame Me: Helping Healthcare Providers and People with Diabetes Work Together to Overcome Challenges for Behavior Change - September 19, 2018 (Webcast), please visit TCEO (<https://www.cdc.gov/getCE>) and follow these 9 Simple Steps (<https://tceols.cdc.gov/Home/Steps>) before **October 22, 2018**.
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THANK YOU

For more information please contact the Centers for Disease Control and Prevention

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The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Division of Diabetes Translation

