**Don’t Blame Me Webinar**

**September 19, 2018**

**Slide 1: Welcome**

Operator: It is now my pleasure to turn the conference over to Dr. Michelle Owens-Gary. Ma'am, please begin.

**Slide 2: Adobe Connect Chat Box**

Michelle Owens-Gary: Good afternoon and good morning to viewers on the West Coast and in Hawaii. My name is Michelle Owens-Gary and I'm with the Division of Diabetes Translation. Welcome to our webinar, Don't Blame Me: Helping Health Care Providers and People with Diabetes Work Together to Overcome Challenges for Behavior Change. You may already be familiar with the chat feature for webinars like this one. You should see the open chat box on the right side of your screen. You're encouraged to ask questions at any time.

**Slide 3: Edit My Info**

If you haven't included your affiliation after your name, please do so by selecting Edit My Info from the top-right corner of the attendees’ box. You will then see a popup allowing you to edit your information. Making this change will help connect participants and let us know where you're joining from today.

**Slide 4: Raise Your Hand**

At several points in the presentation, we may ask for a show of hands to answer a question. If you'd like to participate, you can click the button at the top of your screen that looks like a person with their hand raised. Presenters may also ask you to type answers in the chat box. You will see it at the upper right part of your screen.

**Slide 5: Download Handouts**

The handouts section on the right side of your screen allows you to download any of the webinar materials throughout the event. Simply click on the link to save a copy to your computer. We're also recording a portion of this webinar. The files and the recording will be made available on CDC's training and technical assistance webpage in the very near future.

**Slide 6: Download Today’s Handouts**

Today's handouts include the presentation slides and several articles and tip sheets for better patient/provider communication. If you're joining us today on a mobile device, you will not be able to download the handouts. If you drop us a note at ddt\_diabeteswebinar@cdc.gov, we will be happy to email the files to you.

**Slide 7: Don’t Blame Me**

And now let's get started with today's webinar, Don't Blame Me: Helping Health Care Providers and People with Diabetes Work Together to Overcome Challenges for Behavior Change. We have three fantastic guests today: Dr. Christina Roberto, Dr. Nicole Bereolos, and Dr. Marie Brown.

**Slide 8: Michelle Owens-Gary Bio**

As I mentioned, I'm Michelle Owens-Gary. I'm one of your moderators for today. I'm a licensed clinical psychologist, and I’ve served as a behavioral scientist at CDC's Division of Diabetes Translation for the past 17 years. I lead the diabetes and mental health efforts of our division, focusing on increasing knowledge about the association between diabetes and mental health issues. I also help to develop health education tools about diabetes and depression, lifestyle change programs, and women's health issues.

**Slide 9: Nancy Silver Bio**

Nancy Silver: Thank you, Michelle. Hi, I'm Nancy Silver and I'm a health communication specialist, and I've been with CDC Division of Diabetes Translation since 2003. I work on multiple projects such as diabetes retention tools, webinars, product research, and preparing plain-language documents and web content. I also serve as the liaison for graphics and translation materials for DDT. Michelle and I will be your moderators for today's webinar.

**Slide 10: Continuing Education Disclosure**

Michelle Owens-Gary: Thank you, Nancy. For those of you who are receiving continuing education credit, CDC and our planners, our presenters and their spouses/partners, would like to disclose that they have no financial interest or other relationship with the manufacturers of commercial products, suppliers of commercial services or commercial supporters, with the exception of Dr. Bereolos who wishes to disclose a relationship as faculty for the Johnson & Johnson Diabetes Institute. And Dr. Marie Brown who wishes to disclose a relationship as a lecturer for GlaxoSmithKline. Planners have reviewed content to ensure there is no bias. Presentations will not include any discussion of the unlabeled use of a product or a product under investigational use. CDC did not accept commercial support for this continuing education activity. We have no financial disclosures to make. Information about how to claim credit for today's webinar will be provided at the end.

**Slide 11: Managing Diabetes Can Be Challenging**

We're here today to talk about a common problem for both providers and people with diabetes: blame. Managing diabetes is a challenge. There are setbacks. And often providers and people with diabetes blame themselves. Those negative feelings can make it even tougher to manage the condition. And often the underlying reason for challenges in diabetes care comes from the environment, not the individual. And the way to solve the problem is by collaborating to overcome those environmental barriers. In today's webinar, we're going to acknowledge the blame and look for ways to overcome it, including using behavior change theory to help people with diabetes address barriers to lifestyle change [and] using patient-centered techniques to reduce the blame and stigma people with diabetes may feel. And also self-care for us as providers.

**Slide 12: Dr. Christina Roberto Bio**

Our first guest today is Dr. Christina Roberto. Dr. Roberto is an assistant professor of medical ethics and health policy at the Perelman School of Medicine at the University of Pennsylvania. She is a psychologist and epidemiologist whose research aims to identify and understand factors that promote unhealthy eating behaviors and design interventions to improve eating habits. Christina is director of the Psychology of Eating and Consumer Health Lab, or PEACH Lab. In her work, she draws upon the fields of psychology, behavioral economics, epidemiology, and public health to answer research questions that can provide policymakers and institutions with science-based guidance. Let me now turn it over to you, Christina.

**Slide 13: Helping Patients with Diabetes Make Healthy Choices**

Christina Roberto: Terrific. Well, thanks so much. I'm really delighted to be here and to talk to this group. So, I'm going to be talking about helping patients with diabetes make healthy choices. And there's really two goals for the talk today. I want to discuss several ways the food environment interacts with different vulnerabilities we have—so biological, social, and economic vulnerabilities and psychological vulnerabilities. And how they interact together to promote unhealthy eating habits that contribute to diabetes. Then in the second half of the talk I'm going to discuss ways in which health care providers can talk to their patients to support healthy behavior change.

**Slide 14: 2013-2020 Global Action Plan, Noncommunicable Disease Target**

The first slide that I have up here shows a piece from the World Health Organization's report. They basically put together these global action plans for noncommunicable disease targets. And if they project out to 2020, and you look at what their target is—actually, that 2015 number isn't right, but they have this projection out to 2020. They say the goal is no increase in obesity prevalence. And I highlight that because I think it's kind of shocking and pretty sobering that it's not even like, let's reduce obesity prevalence, but we're really just trying to stop this. And even that is going to be enormously difficult to achieve. And so, I bring that up just so we're all on the same page with this reminder of just how challenging it is to try to move the needle on things like weight loss and health habits that go along with it.

**Slide 15: Who or What Is Responsible for Weight Gain & Diabetes**

People tend to either blame themselves or individuals or the environment for excess weight gain and related problems like diabetes. But I really think it's a false dichotomy. And if you look at your screen, I'm showing you this kind of classic visual illusion called the duck rabbit. Some of you might be seeing a duck; some of you might be seeing a rabbit. By now you should be able to kind of toggle back and forth and see both. But I'm using that just to remind us that, you know what, I don't think it's either one or the other. And I think it's useful to acknowledge that, of course, it's true that people bear some personal responsibility for their food choices, and of course, it's true that the environment promotes unhealthy food choices. Now a lot of the research that I've done really focuses on these environmental drivers. And I don't want to underestimate their influence. It's really, really enormous. And so, when I talk to patients—I used to do behavioral weight loss treatments with patients—you know, I do try to have conversations around how the environment influences them and the kind of effect it has and why it can undermine personal responsibility. But I've also learned through that experience that to not acknowledge that someone does have some agency and does have some role in this can actually be difficult for the patient. I think it is good to recognize both pieces.

**Slide 16: Biological Vulnerabilities**

What I'm going to do in the next few slides is provide a very quick overview of some different vulnerabilities—really we all have in our current food environment. And when I say our current food environment, I'm talking about just the access, the sort of constant promotion and marketing of food, you know, healthier foods at times being more expensive, and just the way it’s structured where we're constantly bombarded with unhealthy food choices. The first vulnerability is biological. And I'm just going to give a few examples of this, but first for example, you know, we're hardwired to like salt, sugar, and fat. And with an environment where it's so abundant, it's just very, very enticing, and it's kind of in our biology to crave it. We've got some emerging research on the potential addictive quality of many foods packed with salt, sugar, and fat. And that is something that you'll find definitely resonates at least with a subset of patients who feel like they can relate to that language and have had that experience. And then there are even examples like our biological preferences for sweet foods where children, in particular, have an even stronger preference for sweet foods. And that can really pave the way for unhealthy habits at a very young age. Those are just some biological vulnerabilities.

**Slide 17: Social & Economic Vulnerabilities**

Now let's think about social and economic vulnerabilities. There's some mixed data on whether healthier foods actually cost significantly more. At a minimum, there's certainly a perception that they do. And you know, that's often thought of as a barrier to helping people make healthy choices. There's also other examples like targeted marketing, and there are some groups in particular, like blacks and Hispanics, where food companies acknowledge that there are segments that they're increasingly targeting with marketing of unhealthy foods. We've even done some research, for example, to show that the marketing of sugary drinks in stores—in corner stores, for example—there's actually more of it that happens at the beginning of the month. And the reason that that's significant is the beginning of the month is when SNAP benefits are distributed. And what we've seen in our own research is that marketing is actually happening more frequently in lower-income areas at the beginning of the month where there are higher percentages of SNAP participants. So that's just one example of the kind of targeted marketing that I'm talking about. And of course, there are broader social determinants like job loss, which can increase stress and promote less healthy dietary choices.

**Slide 18: Psychological Vulnerabilities**

Now let's think a little bit about the psychological vulnerability. I'm going to start with just some foundational insights from psychologists. Psychologists have long observed that people use heuristics. And when I say that, I mean rules of thumb to make decisions quickly. And these kinds of heuristics normally serve us very well, right? We have to make lots of decisions during the day. It's useful that we can do that in a relatively quick way. But occasionally they lead us astray, and they lead to these systematic biases or decision errors that can really go against our own self-interest. And so from psychology, these kinds of insights have impacted a lot of different fields. And there's many, many biases that I can talk about. I'm just going to highlight a few here to help us think about how they can trip people up in terms of eating choices. The first bias that psychologists have talked about is something called present bias preferences. What that really means is that we often struggle with two competing selves. To make this concrete, there's the version of you in the present that has a brownie in front of you, and you want to eat it now, versus the future self that wants to lose weight over the next month and eat a little bit healthier. We tend to be really highly susceptible to that present self as opposed to that future self.

And then this gets exacerbated by different kinds of biases we have. I'm sure everyone can relate to something called the planning fallacy or optimism bias, where you just are overconfident or overoptimistic about how much you can get done, right? The translation here in terms of food choices, an example of this would be, "Sure, I can eat this brownie now because I'll exercise later." But then when later rolls around, it's hard. You know, you're busy, you're stressed, there's a lot of other things going on. You're sort of optimistic about it early, but then when the time comes, it's hard to follow through. So that's a short bit about present bias preferences.

Let me talk about another bias that's very powerful called the status quo bias. And this is a simple idea that's basically the idea that humans tend to stick with default options or the status quo. A concrete example of that, what that translates into, is that when a meal is served in a restaurant for example, the default tends to be French fries. And you'd have to ask or make some sort of effort to switch that up for salad. We just have this innate sort of human tendency to not do that. We just go with whatever the default is. And there's a whole bunch of reasons that that might be. I won't get into all of them. But what it means is that in the current environment we live in, most of our defaults are unhealthy, and so people—because of the status quo bias—tend to just stick with that for inertia and other reasons.

And then finally there are a host of other biases that interact with environmental factors that lead us to engage in mindless eating. Some examples would be susceptibility to eat more when we're served larger portions, right? Most of us just kind of go through the world; when we're making eating decisions, we're not thinking terribly hard about them. And so just by virtue of being served more food, you're likely to consume more of it, regardless of how hungry you are. Okay, so that was a bit of a whirlwind tour of these different vulnerabilities, and I want to put them together into models to think about. What is your patient experiencing?

**Slide 19: Vicious Cycle**

At the very top of this slide you're seeing environmental drivers. And those are things like, you know, marketing, lots of access to all these unhealthy foods. And then we talked about the way those environmental drivers interact with different vulnerabilities—the biological ones, psychological ones, and social and economic ones. And then what happens is that tends to lead to overconsumption of food. And what that also does over time is it creates preferences and demands for these foods and then you can see how this sort of vicious cycle continues.

**Slide 20: Context Matters**

To tackle this cycle, I think we're really going to need a lot of effort at different levels, and I think that's going to include broad policies to change the environment. I'm using another visual illusion here to illustrate the point that the choice context or the environment that we live in matters. If you look at your screen, those two dots should look like different sizes to you, but they're actually the same size. They look different because of what they're surrounded by, and so this is just kind of hitting home, this insight that the way things are presented, the way our environment structure really shapes our perception. And right now, we do live in this environment that is deeply, deeply tilted toward promoting unhealthy food. Part of the goal, part of the reason I say we need policies, part of the goal of both institutional-level policies and government-level policies, is really to try to shift that balance towards healthier choices. I'm going to give one example of an institutional-level policy that really tries to integrate different behavioral insights.

**Slide 21: Google Example**

Everyone’s heard of Google. Now to be fair, Google is a very unique place. They offer free food, an abundance of free food, to their employees and they're trying to retain really good talent, so this is considered a perk. But interestingly, over time they really got worried about the health of their employees. And they worked with a behavioral science team to think about sort of small micro-changes or nudges they could make. And this is just one example where they had these M&M's in these clear containers that were available to employees. And what they did was they actually moved the M&M's to opaque containers. Now without presenting a lot of data on a rigorous study, I can just tell you what they reported, but there's other data to support this kind of thing. They said 3.1 million fewer M&M's were eaten by 2,000 employees over 7 weeks. And this is a subtle change to try to nudge people to a healthier choice.

**Slide 22: How to Talk to Patients**

We've talked a bit about these different vulnerabilities, a bit about the environment that our patients are living in, and I do think it can be worth it to bring up and sort of acknowledge how that can undermine personal responsibility. But let's talk a little bit more concretely about talking to patients when it comes to managing diabetes and weight loss. I have this rhetorical question up here. It says, “What are the chances you will act on a guideline you can't remember?” And the answer to that is zero. Let's talk about this.

**Slide 23: Food Pyramid vs. My Plate**

A classic example of the difficult-to-follow guideline is the old food guide pyramid. And I've got it up on the screen here. And I want us to take a look together, and I'm going to open it up to the group. I want everyone to sort of think about when you look at this, what are some of the pitfalls of this communication strategy? What is confusing about it? What do you think would be hard if you were trying to communicate to patients? And I would love folks to enter into the chat some thoughts about this. So please go ahead. What do we think about this? All right, so we have folks typing in here. Yes. Yep, so each category of food seems to be weighted equally. That's a good point. All the food melts together. I totally agree with that. It looks like you can eat a buffet. Yep, okay. Yeah, it's hard to tell the amount. A lot of people are saying it's missing portion sizes. Exactly, exactly. These are great thoughts. Right. Yeah, so great. And then the question, too much information. I totally agree with that. Right. So, you guys are hitting on all these great points, where you look at this, and it's really unclear. The foods are mushing together. What are the portion sizes, the categories? You know, it seems very hard. And if you were to communicate with the patient, it's hard to imagine that they would have an easier time walking away with some concrete things they can do. I'm going to contrast that with something like this. I've got this little symbol here. It says half a plate and it says be sure to fill half of your plate at every meal with fruits and vegetables.

**Slide 24: Half-a-Plate**

Let's just think a little bit about that. From a communication perspective, how might the half a plate guideline be better? Let's hear your thoughts about contrasting that. Yep? Someone's chimed in already. It's easy, it's simple, it's clear. Yep, love that. Simple, simple, yes. Simple to remember, perfect. Yeah, exactly, I mean it's just very intuitive, and you see it right away. The other thing I want to point out about the half plate is it has something called an embedded trigger and that's actually the plate. And so, part of what's built into that guideline is that when you're going to eat, you're often grabbing a plate, so that's an embedded trigger that might help remind you of that half-plate guideline.

**Slide 25 Memorable & Actionable Guidelines**

What I want to do now is share with you a framework that hopefully you can use and think about when you're talking to patients. And it's called the memorable and actionable guidelines. And this was actually developed by Rebecca Ratner and Jason Reese. They have a really nice paper on this. And then I've added some additions to expand it. But there are recommendations to keep in mind, and I think that's true even when you're having conversations with patients. First of all, simplicity is key. Like we just said, contrast the half plate with the food guide pyramid. There's one simple message with half plate: fill half your plate with fruits and vegetables. Second, you want to make sure you're recommending an actionable behavior. Losing weight is not a very actionable behavior. Filling half your plate with fruits and vegetables is. And third and fourth, when possible, you want to provide something that's easy to visualize, like a half plate, [and] use the embedded trigger approach that I was talking about. So again, we talked about the plate serving as that embedded trigger that can help remind you.

**Slide 26: “You Need to Lose Weight”**

We're going to wrap up with one more example and interactive component, not a specific, concrete or actionable behavior. And so, one thing I want you to think about is what could be some other alternatives? I'll give one in a moment, but what are some ideas you have? What are other behaviors applying the memorable and actionable guidelines that you could recommend? Think on that. Okay, so track your food intake, some folks are saying. Exercise, okay. And we'll talk a bit about these. Move every day. There you go. Something concrete and actionable, yep. Eat half veggies at each meal, yes, very concrete and actionable one. Yep. Yep, great. These are great. Drink more water, yep. That's a good one. This is very specific behavior.

Okay, so let's talk. I'm going to also offer up one that I think is particularly useful. We just talked about this. Okay. One that I'm going to offer, and I want to hear your thoughts on it, is about drinking sugary drinks. Here's a specific one that I'm suggesting. So “try not to buy sugary drinks when you're at the store.” Or “try drinking only one sugary drink per week when you eat out.” Can people tell me, what is useful about this approach? What do you think is helpful about these messages? Okay, so we have folks typing in. Specific, yep. Very simple. You can imagine the scenario, exactly. Exactly. Yep, they're attainable. That's a good point. We didn't talk about that, but that's right. People are saying yeah, it's more attainable. It's got the embedded trigger, yep. Yep. Great. Some of these—there's a lot coming in, so I'm trying to keep up. Yeah, it gives the option to choose. Yep. Great. You guys are hitting on all these terrific points. Right, we know, for example, sugary drinks—there's a lot of research to support that it's going to be a key behavior change that people can do to improve their health. And what all of you are saying is this kind of message—as opposed to "you need to lose weight"—is very concrete. It's something very specific they can focus on. It's one thing. Losing weight is sort of very amorphous. This is a clear behavior change. And I'm trying to embed these in there, like "When you're at the store," so you can visualize that. And this would be quite dependent, but if you know someone eats out a lot, try to set a goal with them around eating out specifically so that when they're at the restaurant, there's a trigger there, a reminder to not do it as often. Terrific. Okay, and we just talked about that.

**Slide 27: Thank you – PEACH Lab**

All right, so I'm going to wrap up there and hopefully this was helpful. And I think there will be some questions at the end. But thanks so much. I appreciate all your participation and I'll turn it back over to Michelle.

Michelle Owens-Gary: Great. Thanks, Christina. Now that we've had some tips for ways to use behavioral science to help people with diabetes overcome barriers in their environment, let's talk about better patient care and patient-centered communications.

**Slide 28: Enhancing Communication with People Living with Diabetes: Strategies to Improve Positive Outcomes**

To discuss that today, we have Dr. Nicole Bereolos. Dr. Nicole Bereolos is a clinical psychologist and certified diabetes educator working in private practice in North Texas.

**Slide 29: Nicole Bereolos Bio**

Currently, she is serving a 3-year term for the board of directors for the American Association of Diabetes Educators (AADE), and she is the national spokesperson on mental health and diabetes. Her clinical practice focuses on helping people better cope with living with a chronic medical condition, especially diabetes. She also helps others with behavioral weight management, smoking cessation, depression, anxiety, relationship problems, [and] stress management, and she conducts pre-surgical evaluations. Dr. Bereolos also speaks to patient-centered and professional groups, discussing communicating with health care providers, peer support, working with those with serious mental illness, and coping with living with a chronic condition. She received the Rising Star Award from AADE in 2014. She, too, has been living with type 1 diabetes since 1992. Now I'd like to turn it over to Nicole.

Nicole Bereolos: Thank you so much. Good evening, good afternoon everyone. I'm here in Dallas like she said. And I straddle both sides of diabetes, both living with diabetes and working professionally.

**Slide 30: Words Have Power**

I have immersed myself in diabetes and I have so much passion in talking about the subject. Many of you clinicians notice a gradual shift in the involvement of people, kind of in their health care and learning about their condition, learning about the treatment options available, technologies, CGMs [continuous glucose monitors], talks available, off-label uses of medication. They're becoming very proactive in the treatment of their condition, which is why this is such an important topic. We as health care providers have to be very mindful of the words that we choose in our encounters with these individuals. So that's why it has become kind of a hot topic, and hopefully you've seen that across your professional organization. I'm sure many of you have heard person-centered care, or maybe you refer to it as patient-centered care.

**Slide 31: Person-Centered Care**

That term has been around for about 20 years. We all want to put our patients first, to prioritize them, make their treatment as individualized as possible. But first it starts with a foundation of letting them talk. You know, closing our computers, putting our notes down, hearing their story. You may have heard of the term hearing their narrative. Letting them talk about what their struggles are, what their life stresses are, what their demands are, their emotional needs, financial situation. Things that are very much outside of maybe the diabetes world. Because it's not always about diabetes, is it? Things outside of diabetes can very much play into that person's ability to effectively manage their diabetes or any other chronic medical condition.

And when trying to develop a treatment plan—whether that be medication or looking at one way of eating or insulin or testing glucose values, weight, whatever—you've got to be on the same page. Because your goal with them may not be their goal. So, it's very important to have that conversation, to find something that's mutually agreed upon. Because if that individual can be on board with the goal, the likelihood of being successful goes up tremendously. You've got to make sure that you're each aligned with that treatment goal. You know, if you're in primary care, I think you're in a very wonderful place to promote prevention, health promotion, looking at smoking cessation, working with those with prediabetes, looking at cholesterol, stroke prevention, heart health, just kind of effective well-being. Right, because all of these conditions, we know, interplay with diabetes management; [they’re] all connected. And then once you establish this type of connection with the individual you're working with—the patient—when you have that foundation early on within that first or second visit, that really helps build that foundation for effective care of that patient, potentially lifelong. Your outcomes will improve if you can have that foundation early on, and that rapport, is really what I'm getting at.

**Slide 32: Self-Efficacy**

Self-Efficacy. Again, social cognitive theory, you probably learned about it even in high school, maybe even middle school. Again, it's been around since the '70's roughly. It's very well-studied across multiple chronic conditions. But this basic premise is that one's perception of their ability to do something is so critical. It's truly a link between knowing what to do and actually doing the task. You can also work backwards and identify past successes. That could be extremely powerful. You can also offer stories of individuals who have had similar successes so that you can also hope to increase that self-efficacy through that verbal persuasion through basically somebody else's narrative. For example, in fact, just this week, I had an adult living with type 2 [diabetes] for I think about 20 years or so. He was drinking a case of beer a night, but he was able to quit successfully on his own. And he was actually in to see me for weight loss. I think he wanted to lose 75-100 pounds, something like that. So not something that's very easy. But he was having difficulty. But my goal was I wanted him to see that if he can do something as difficult as quitting drinking a case of beer a night on his own without any type of AA [Alcoholics Anonymous] or inpatient rehab substance abuse program—if he can do that on his own, he has the strength, the pull to be able to effectively lose weight, right? To show him that he has the power to do that, that's self-efficacy, having the ability to do it. You need to show these people that you're working with that they have the ability to effectively manage their diabetes. You want to get their strength up. You want to help increase their hope. There's a kind of a saying that I say a lot: Set them up for success. You as the clinician want them to be well, right? Holistically, you want them to be well. So, no matter how minor, you want them to have a small success and then build on that.

**Slide 33: Factors Impacting Level of Empowerment**

There are many, many, many factors—intrinsic or internal, [and] extrinsic, which are external factors that can affect someone's level of empowerment. And empowerment is similar to self-efficacy. It's my ability, how I feel about my ability to be something. Think about what's embedded in the word empowerment: power, right? My ability to do something. So, I'm sort of seeing people who think they can change everything, right? As a psychologist, I see this all the time. "Oh, if my spouse would only do this. If my kids would only do this, life would be so much better,” right? Well, that's not likely, right? You can only change, more or less, you, right? You can change your attitude. You can change your thoughts about yourself. You can change your knowledge. You can change your health literacy through education, right? You can't change your ethnicity. You can't change your family. You probably really can't change your workplace. Yeah, you can change jobs, but all jobs have workplace drama, right? It's just apples to oranges, right? There's drama with apples; there's going to be drama with oranges. Thinking about community… You know, some of us are more fortunate where we can change communities, but there's always going to be some drama, some stressor involved with the community in which we live. Clinical relationships… You know, we all talk about firing our physician, firing our provider, right? Or our relationships with our health care professionals, that's a relationship. We are all people. No relationship is ever going to be ideal or perfect, right? I'm thinking of people who live rurally. They don't have a lot of options for health care professionals, especially if you need a specialist. If you're needing that pediatric endocrinologist, you may need to go 3 hours. You know, this is a big issue here in Texas. What do you do? You can't change everything. So, what you need to look at as a health care professional is helping these an individuals talk about in your encounter things that you can change. Okay? Because people get worried. They get just tied up in anxiety about things they cannot change. But we need to help them to separate what they can change. Again, have them find success in those things that they can change to help decrease some of that anxiety.

**Slide 34: Stigma**

Stigma, oh boy. You know, stigma, living with diabetes, it's rampant in so many different situations, right? Stigma is associated with exclusion, rejection, blame, fear, embarrassment, so many words. If you asked 100 people, you'd probably come up with 75 different words, right? We know that those who believe they are stigmatized because of their diabetes are less likely to tell family about their diabetes. And sometimes they might not even tell other health care professionals about their diabetes. I'll never forget when I was working in the Fort Worth area, when I was doing some research. One of the questions on the questionnaire was, "Do you have diabetes? Yes or no." Remember, these were all people with known type 2 diabetes. I think it was over half of those individuals marked no. That was an eye-opener to me. And this was about 2002, 2003. I couldn't believe that it was that high. I mean, these individuals are less likely to test glucose values, they're less likely to take their medication in public. But really less likely to take it at all because they're constantly hiding their diagnosis. When dining out, they're likely to eat what other individuals are eating. They're less likely to be mindful of their carbohydrates that they eat, or high-sugar foods. And that is particularly important for those that are on oral medications only, because if they're eating high-carbohydrate foods, they're going to have a harder time lowering their glucose values if they're not on insulin, right? Because they don't have that agent that effectively lowers their glucose values like insulin does. You know, there was this study of over 12,000 people, and it was online so of course there's issues there. But parents of children with type 1 reported more stigma than those living with type 1, which I thought was kind of interesting. And then for those with type 2, stigma was more common in those that had a more complex treatment regime and then those who had higher A1C's and higher BMI.

**Slide 35: Language Matters**

So, language. Language matters, right? Control… We all have used the word control, right? But what does that word say to us? Control. Can we effectively control diabetes? I don't think we can. I wouldn't say I can control my diabetes, regardless of what my A1C is, right? I mean, you can have an A1C of a 6, but that could mean my blood sugars range from 40 to 300, and I could still get an A1C of 6. That doesn't mean my diabetes isn’t controlled. I mean, that word control is just very robotic when I hear that word. It doesn't take into account the effort I put in or the day-to-day stress it provides. I mean, it just seems very black and white. You have control, or you don't have control, right? A lot of shame it can bring for somebody. It's like a checkbox—yay or nay? Well that's not very individualized. That's not putting the person first, is it? Because we want to use language that is neutral, non-judgmental, and based solely on facts, action, and physiology. And it was actually back about 5 years ago that the Obesity Society coined—there were ones who said, we need to use the term persons with obesity as opposed to obese, right? So, if you read charts, it will say 45-year-old, obese, blah, blah, blah. Well, they were the ones who said, "No, we need to change this." I mean, you all remember it, especially for those who worked in hospitals. Good, old Accucheck, right? It's all, you would get a postprandial Accucheck. Well, I mean, dozens of meters have come out that are not the brand Accucheck, right? But you'll still hear good, old die-hard nurses, they get that Accucheck, right? But again, it takes that community to get away from that terminology. So, as we are now talking about this language with diabetes, this has just come up about a year ago. In the paper in one of your handouts here, that was just published last year. We're going to have a long way to come until this becomes part of one's vernacular. I mean, we don't want the people we work with to feel lazy, to feel unmotivated. We don't want them to feel like when they come into the office, that they're going to get shamed, and they're going to get punished when they come into the office. That's not something we want to do at all.

**Slide 36: Poll**

So, you should see a poll box come up here. It's 1–4. When you're talking about an individual who's challenging, maybe having some difficulties working with diabetes and managing their diabetes, maybe you're doing some documentation after the visit about how your visit went. What's the best term, would you use here? I think I partly kind of gave away the answer. But that's okay. A hundred percent, 104 of you said right. Because could you imagine if that individual got ahold of their medical record and saw that they've now been labeled noncompliant, nonadherent, uncontrolled? Could you imagine how that makes them feel? I'll give you a little hint, tell you a little secret I've done. I've actually, now I get a copy of my history and physical if I see a new provider, and I check it for accuracy. Because when I say I had KA [ketoacidosis] when I was 16, blah, blah, blah, you know, type 1 when I was 12, blah, blah, blah, I'm checking for accuracy. Because these are major issues. If there are major errors in that initial visit, I don't return, right? Because that means they weren't truly listening to me. I mean, if they got my age wrong or if they said I was single and I'm married, to me that's minor. But if there are major issues, errors in my medical history, I don't return. I find a new provider. You understand what I'm getting at?

**Slide 37: What Are Things You Could Say?**

So, next I'd like to hear from you. In the chat box, like Dr. Roberto did, I'd like you to put in what are some examples of some positive language that you can think of when you're working with people with diabetes? So, obviously compliance, adherence, in control—very common terms we've been using for decades. But what are some other words that you think you might like to hear? Management challenges, opportunities for improvement, I like that. Let's see, room to help improve your diabetes care from Miss Robin. What else? Manage. Patient is working on, very matter-of-fact. Good, overcome. Yeah. Some of your struggles from Pat. Yep. We can turn this around. That's very motivating from Miss Paula. Let's see here, obstacles to the patient achieving. Yes. Take a look what's going on, positive change. What are your goals? I like that from Kara. Concerns, yep. Are you happy about your journey? From Erica. Yes, the fact that you're here—I like that. The fact that you're here in this office shows that you are concerned about your well-being, about your diabetes. That is great. That's empowering them—that regardless of what these laboratory values say, that you are taking this as important. That's awesome. Nice stuff. Management, right. When you get those lab values, that's just a picture in time, right? We like to take a lot of value in that one picture in time, don't we? But you don't know what went on that one month, two months prior to that picture in time. Right? How you've been able to take care of yourself. What would you like to do? Let's see, wonderful. I love it. I appreciate it. Another thing, you can even just stick to the facts, right? "I see that you're checking your blood sugar three times a week, five times a week. You brought in your food diary and I noticed that you are trying new vegetables, that you are trying to dine out less." You know, all these are awesome. But could you see how by doing this, you're blaming less the patient. They're not seeing it as a chore to talk to you. They get uplifted by talking to your health care providers in this manner, right? They're more apt to come back. They want to show you the good work they've done. Awesome. So, strength-based, perspective, inclusive, hope, I've mentioned before. It's not good versus bad. You know, I'm not a child. What's good diabetes? What's bad diabetes?

**Slide 38: Language Matters!**

There's a thing that says, what's the one thing people with diabetes can't eat? You know, somebody said, "Well, poison." Well, of course. People with diabetes can eat pretty much anything, right? But it's about following your treatment regime. It's about taking insulin properly, you know, trying to do a pre-meal bullet, all of these things that we already know. Support, compassion, not identifying the individual by their condition, right? Not the diabetic, not the bulimic, not the schizophrenic. These are people first. You don't want people to have this identity of their condition, right? None of you would want that.

**Slide 39: Peer Support**

And I want to touch base a little with you about peer support because it's so important. It's another big thing right now. We have peer support not only online but in person, right? From the support groups that some of you are having, maybe at your hospitals, at churches, at grocery stores, whatnot. But these are happening 24/7, right? This is everyday struggles, right? We're only meeting with our patients for a sliver of time. People are living with these conditions day in and day out. But it helps them feel more understood. It's validating their feelings. "Oh my gosh, I've been 300 all day, and this darn sugar won't go down. I don't know what to do. I don't know what to do." They reach out, and somebody else says, "Oh my gosh, I've struggled too. But you know what, I've been drinking my water, I don't have any ketones. It will be okay." People get so much value even internationally. They find a strong sense of community by reaching out, finding peer support. And health care providers, there's a role for health care providers in peer support.

**Slide 40: Role of Health Care Providers (HCPs) in Peer Support**

It's very important that you realize it's not a replacement for what you do as health care professionals. It's complementary. You as health care providers can work especially through Twitter chat. You can see all these strategies and all these tricks for how to get CGM [continuous glucose monitoring] tape to stick. And you know, things that are just happening in the community that maybe aren't discussed. Maybe they're not FDA-approved, but you know what, they're happening. AADE has a workgroup that's composed of both individuals living with diabetes and diabetes educators to find ways that we can work together to make this even more powerful.

**Slide 41: Recommendations for Enhancing Engagement**

I want to end with this. Engagement. This is just something that's deep in the back of your mind. You want to enter the world of the individual, talk, determine where they're at. You know, be at their level, gather information. Don't interject fear. Interject hope. Address their priorities, right? Talk about things that they necessarily can't change. That's where some of the angst and anxiety can come. Educate where it's appropriate. Minimize acute risks, right? If they're in a severe low or a severe high, of course that's going to be a priority, always, always. But establish a clear plan. Establish support strategies where you need to. Help them find peer support in the community or online. And there are some tip sheets here in the handout. If you need to, you know, look at the population health if you're a large health care delivery system. See what can happen at that level if you're able to. So, I'm going to pass it back on to CDC, and thank you for your time.

Michelle Owens-Gary: Thanks, Nicole.

**Slide 42: The Principle Driver of Provider Satisfaction is Delivering Quality Patient Care**

Caring for people with a chronic disease like diabetes can sometimes take a toll on health care providers. It's easy to feel responsible when patients don't make progress or to become frustrated when there are setbacks. Here to talk about how we can care for ourselves as providers is Dr. Marie Brown.

Marie Brown: Thank you very much, Michelle. I am speaking with all of you, and thank you for taking the time to spend with us an hour and a half, and hopefully you're sitting down, maybe having lunch, taking a little bit of a break.

**Slide 43: Recommendations for Enhancing Engagement**

I'm a practicing internist here in Chicago. I started my career at a federally qualified health center and then was in private practice in a small practice for 20 years, and now at Rush University. So, I've seen and cared for patients with diabetes and chronic illness in multiple settings, and hopefully during the Q and A maybe we could talk about some of those challenges that we have in different settings. As Michelle said, the title of this webinar is Don't Blame Me. We often focus on the patient, but more and more we really need to focus on you on the call: the providers.

**Slide 44: What Brings Joy to a Provider**

And never more so than in health care today. We all know that with the health care reform coming in January 2019, which has nothing to do with the ACA [Affordable Care Act], we are going to—and our organizations are going to—sink or swim, dependent on outcomes. And A1C is often one of those outcomes that we are being judged by with MIPS [Merit-Based Incentives Pay System] and MACRA [Medicare Access and CHIP Reauthorization Act of 2015]. So, it is a game-changer. It really is the biggest transformation that I will experience in the past 25 years. And for the first time, I feel that our missions are aligned. We're trying to keep people out of the hospital, not putting heads in beds. But that brings its own concerns. And more pressure on you and me on the call. And what we have found with research is that three things really rise to the top when we ask what brings joy to a physician, a nurse practitioner, a diabetes educator, a medical assistant? Pride in their work. We are all very comfortable working really hard, but at the end of the day we want to feel like we did the best job we could do, and we didn't spend our time doing needless, unnecessary tasks that someone else with less education might be able to accomplish, and free us up to do what we were trained to do. So, pride in our work is key to preventing burnout and improving the joy in the workplace. The second, an aligned mission; it’s something that all of us struggle with, and what will hopefully diminish come January 2019 if it isn't already happening in your organization. Sometimes I feel like I've got one foot in each canoe. Am I trying to put people into the hospital and put heads in beds? Or am I trying to keep people out of the hospital? And once those missions become more aligned, burnout will decrease. And the third that rises to the top is having some autonomy and control over our day. And those three things bring joy, and the lack of them can cause burnout.

**Slide 45: Physician Burnout Rising**

And burnout today is the huge problem. This is a study looking from 2011 to 2014, published in Mayo. And there the blue line, the general population also experiences burnout. That's not insignificant, more than one out of four. Our firefighters, our teachers, people in other professions. But what we're seeing is a huge rise above 50 percent in physicians, which also of course other health care providers, nurse practitioners, PAs, and MAs. So, this is an enormous issue. And what are the causes? Let's just briefly look at some of the causes. And we always want to blame the EHR [electronic health record], but the EHR is often the face of a lot of regulation, a lot of compliance, a lot of things that our local IT departments may do that doesn't have to do with actually the vendor.

**Slide 46: Causes of Burnout and Effects on Provider**

I highlight in the left column the lack of autonomy and control, doing meaningless work, and insufficient resources. Many of us out in primary care have very few support staff or have a team that looks like a skeleton compared to some of the other more well-resourced specialties. I think that this is a time to change that. If you don't have a diabetes educator easily available, now that MIPS and MACRA are upon us, and usually the insurers follow, and value-based care is coming or already is at your institution, now may be the time when your organization will begin to listen and give you those resources that we need to care for our patients with chronic illness and diabetes. On the right are the effects on the provider. We become less enthusiastic. We can feel emotionally exhausted. Signs of that are referring to a patient with depersonalization. The diabetic ulcer patient in room two, as you heard Nicole talking about. We don't ever want to use that term—the diabetic person. It's the person with diabetes. And what is happening is that many of us, in order to avoid personal issues—divorce, suicide, turning to alcohol to deal with these stresses—we're exiting practice. Which is an effective way to decrease burnout but does not serve our population very well. If you lose providers, they go from 100 percent FTE to 80 percent FTE, that stresses the people who remain, because they have 20 percent more work. So that is not a solution for the organization. It may be a very effective solution for the person who's doing it, but it is not going to serve our patients well. But what are the effects on the patients, the teams, and the organizations?

**Slide 47: But What Are the Effects on Patients, Teams, and Organizations?**

The effects on the patient and the team is that patient satisfaction will go down if the provider's burned out or experiencing symptoms of burnout. Trusting relationships go down, medication adherence goes down, reimbursement goes down. And outcomes are lower in patients who are treated by providers who are experiencing symptoms of burnout. On the organizational side, a burned-out physician is emotionally exhausted, and it's easier to end a visit and socially acceptable to refer the person to someone else. And that does not serve our patients well either. Someone experiencing burnout is more likely to order more tests, more labs. Their diagnostic error rate is higher, and staff turnover, as we talked about, goes up. So, let's look at a typical patient.

**Slide 48: Mrs. Davis 10:20-10:40**

I'm in my clinic today. I've seen patients with diabetes this morning. I'll see patients with diabetes this afternoon. Now the point of this is really not to look at each of the problems or all of the medication, but this might be a pretty typical patient some of you see. I don't have very many patients—I can probably count on one hand—who only have type 2 diabetes. Almost all have a myriad of other problems. The average visit in the United States is 20 minutes. For family practice and internal medicine, there are 1,600 guidelines that we are supposed to follow, and it is challenging. You're already 35 minutes behind schedule. When you opened up your EHR, you were blasted with how you're doing on all sorts of metrics. Maybe you saw a lot of red, maybe a lot of orange. And as soon as something turns green, they take it off your screen. So, this patient has a lot of problems, and there's a lot of things that need to be done here.

**Slide 49: How Would You Approach this Person’s Situation?**

And I'm going to ask you—and there's no right answer, but I'll share what I would do. How would you approach this person's situation? What would you do first? You have a 20-minute visit, and there's the patient again. And if you want to put in the chat box what any of you might choose to do, I will try to read them.

**Slide 50: Mrs. Davis 10:20-10:40 (con’t)**

I can see that in the med list, we can see that sulfonylureas is one that we don't use too often anymore. I see some of you saying order new labs. Right, because we don't want to make a change in medicine based on an A1C from 6 months ago. Somebody else [is] saying address the blood pressure, adjust the weight gain, apologize for being late. I think that's great. But for many people, that is the norm. And that makes everybody feel, especially our patients, but it makes the team feel bad that we're not delivering good care. Ask the patient what's the most important problem you have that you would like to talk to today? Of course, and I think we learned that from Nicole and Christina as well. What would she like to work on? And what is your goal for today's visit? I begin the conversation when the patient registers at the front desk. In my office they receive a piece of paper and they can write down their priorities for the day. The second page is a list, a very simple list of their medications, and we begin medication reconciliation in the waiting room. Because for her, this could take an hour, right?

So, there are many, many things. And the only mistake you could make here is trying to do too much in one visit. What I would highlight here is to look at that medication list, because that is polypharmacy and that is almost impossible for anybody, for this patient, to take. So, I would ask her what her concerns were, and we'd also take a look at and address that. And then also take a look at the medicines. And often what I do is make sure that we aren't adding to her problems. And I can see right away that she is on a weight-gaining drug. She's on an antidepressant that is associated with weight gain, and she may not even know that. So, I might ask her if we would like to switch that. We also know that trying to achieve increased adherence, motivating somebody to start exercising, all these other things that we need to do—behavioral change—is probably going to be better accomplished if the patient's depression is under control. But she has to decide whether that's where she wants to start. I'm also looking that she's on hydrocodone down at the bottom there. And there's some medicines that we may be able to stop that are no longer recommended. Perhaps the estrogen. I wonder if she's ever been to a diabetes educator. So, there are many things that need to be done.

The important thing is to not overwhelm the patient, and I would start with probably getting her depression under control. In my office, again to save time, anybody who's on an SSRI [selective serotonin reuptake inhibitor] is handed a PHQ, a patient health questionnaire, and a GAD [generalized Anxiety Disorder] which are very simple and easy. You can just find them on the Internet. They fill those out in the office, so I would see it when I come into the office. And I call it a blood pressure of the brain. So, her depression is not under control. That's where I would start. I would be quick to get that blood pressure under control, but I would be quicker to try to get that depression under control as well. But how do we do that? How do we do that and stay on time? I'd want to taper the lorazepam as well because that may be adding to her depression. I'd want to make sure her TSH [thyroid-stimulating hormone] is under control and her thyroid medicine is adequate. And I would tell the patient, this may take six visits to address all these issues. But agree on what we're going to start with and then make sure the patient wants to go on that part of the journey down that road with you. And celebrate when you see her again that she and you accomplished whatever it is that you wanted to do. But it can't be done alone. And there are some tools that I'm going to share with you, and many organizations have them.

**Slide 51: Free and Open Access**

This is from the AMA [American Medical Association]. This is open access. You do not need to be an AMA member. You do not need to be a physician. You don't even have to give your email. In green there is the website. And I would encourage you to look at that on your phone or on your computer. And I will highlight the 50 modules. There are six on professional well-being and that addresses burnout. These are some of them. The sixth one is being developed now.

**Slide 52: AMA Professional Well-Being**

The top one is talking with leadership about addressing joy amongst our providers and at different levels in your career. And you'll find tools to do that. But experts think that the causes of burnout is really not so much the personal resilience that you on the phone and I have. We think it's about 80 percent due to the chaotic environment and under-resourced environment in which we work, and maybe only 20 percent our own personal resilience.

**Slide 53: AMA Managing Type 2 Diabetes**

So, the rest of the next 6 or 7 minutes I'm going to share some tools that you can find also on this website—again, free and open access. That green box should be ORG; the G didn't fall into the box. One of them is Managing Type 2 Diabetes. And there are downloadable tools.

**Slide 54: Waiting Room**

The paper that I told you that I hand out in the office… the receptionist hands it out. And the beginning of the visit starts in the reception room and continues. But then I extend my 17 minutes pretty good. So, this might be what your waiting room might look like. We can certainly begin to take advantage of that time there.

**Slide 55: AMA Ten Steps to Pre-Visit Planning**

This is an example of another way to improve and decrease the chaos in our offices. This is pre-visit planning. I didn't think my patients would like this, but I began to arrange for laboratory tests to be completed before the next visit. Actually, 95 percent of my patients loved it. They didn't want to play the phone tag after their visit, and they didn't mind coming in a little earlier so that I had what I needed, and the patient and I could speak face to face about what needed to be done, and any adjustments that needed to be made.

**Slide 56: Medication Management**

Another module, we'll talk about medication management. Now 6 or 7 years ago with chronic medications, I started refilling it for a whole year rather than 6 months. I stopped holding patients hostage for fear they wouldn't come in. I don't do this for everyone, but I do it for probably 90 percent of my patients. I continue to see the patient as often as the patient and I agree to, but if you started doing this today, in 6 months—you'd have to wait 6 months if this is the only change you make—in 6 months, you'll probably get an hour back in your day and save probably half the number of messages in your inbox. So, this is a real time-saver, which allows us to develop that relationship with patients.

**Slide 57: Video**

Also, there's a module on medication I did a video on immunization as well with support from the CDC, thank you. And this interviews real patients who had diabetes and hypertension and were nonadherent. And they share their stories, and the most surprising thing is that the patients were hiding their nonadherence from me.

**Slide 58: What Are Some Things a Provider Can Do to Build Meaningful Relationships with a Person They Care For?**

So, what are some things that you can do to build a meaningful relationship with the person that you care for? Any thoughts? Well, as you're typing in, I found that making sure that I had time to really look that person in the eye and, I think as Nicole or Christina said, we're facing the computer and we're not sharing that time, that connection with the patient. And unless we do that, we're not going to uncover the nonadherence, and then we certainly can't address the nonadherence, because we don't even know. And what happens if you don't know that they're not taking their medicine and they say they are? Then you're going to reach for the second- or third-line drug when they weren't even taking their first drug. And you'll hear those stories on the video. So, there's some great ideas. Build a rapport, be nonjudgmental, and laugh. Smile. Sometimes we forget that we really have to smile and be careful that we make sure our patients feel good after they've come. Because nobody wants to be a patient.

**Slide 59: Obstacles**

Some of the reasons very briefly that somebody would be not taking their medicine are actually forgetting, the cost, access. But actually, most patients don't take their medicine because they intentionally choose not to take their medicine. And if you want to learn more about medication adherence, we go into this much more in-depth, and there's a really fun video with real patients telling their stories that could be used as a lunch and learn. Other solutions can include schedule efficiency, learning how to do team-based care, and panel management.

**Slide 60: Solutions to Returning Joy to Your Practice**

And so, this website has numerous tools to help you be more efficient, so you have more time to develop that very important trusting relationship so that you can motivate the patient as well as uncover nonadherence. The last few slides, I'll just revisit Mrs. Davis. And perhaps over the next 6–12 months you would have tried some of these designs and implemented some changes.

**Slide 61: Mrs. Davis 10:20-10:40 – After Practice Redesign**

Again, you want to do one small change amongst your team at a time. And if you do, this might be your experience. You are now seeing the patient on time. Her problem list is shorter. Her medication list is probably only a third. She had her pre-visit labs, her A1C is coming down. Her blood pressure's not at goal, but it's getting there. And she sees the diabetes educator regularly. Many of us don't realize that you can see a diabetes educator; Medicare pays for it every year, not just the year that they are initially diagnosed. And we don't take advantage of that.

**Slide 62: Make the Business Case**

How do you sell this? How do you make sure you have the resources to do team-based care? Maybe get more medical assistance or support? Remember, to make the business case up in the C suite, if you have a staff of 600 clinicians and they've decreased their time so that they can accomplish quality work, you've lost 150 physicians. So, you could rehire your own staff by just increasing the support they have. Because most providers want to work full-time. They're just taking 80 percent so they can accomplish what they need to in the time that they have. We know that for every 1 hour of face-to-face time, it's 2 hours of documentation time. And that cannot be done if you're seeing full-time clinical care.

**Slide 63: Regulators/Institutions/Leadership**

So, to wrap up, measure the wellness of your workforce. There are many tools out there. Those are on site: the Mini Z (10 item Zero Burnout Program survey), the Maslach (Burnout Inventory). Align with team-based care. Make sure the compliance office is not putting more clicks in for some reason. Take the promise, "I'll never say it's only three more clicks." Rethink the documentation. Get your IT people on board, and make sure that everybody's working at the top of their license. Tying compensation and review for the leadership to the wellness of the workforce is really going to change the culture.

**Slide 64: The Principal Driver of Satisfaction of Provider Satisfaction is Delivering Quality Patient Care**

And I will have one or two more slides here because remember, the principal driver of satisfaction for you on the call is being able to deliver quality patient care.

**Slide 65: Take Home Points**

So, these are the take-home points. We care deeply. We need to engage as a team. Choose a project together. Start small. Make sure you can celebrate the success in just a few weeks. And this time saved will allow you to do meaningful work and get home and have the evening with your family and your friends so that you're reinvigorated to take care of our patients the next day.

**Slide 66: Closing Slide**

I'll end with Osler’s saying that “medical care must be provided with efficiency. To do less of a disservice to those we treat and injustice to those we might have treated.” And with that, I'll send it back to you, Michelle.

**Slide 67: Questions?**

Michelle Owens-Gary: We will now hear from Nancy Silver for questions.

Nancy Silver: Thank you, Michelle. We've heard some great information here today. Christina, Nicole, and Marie, thank you. I'd like to bring my co-moderator Michelle back in now and we'd also like to invite all of our presenters back now to ask if there's anything to add and to answer your questions. Our operator is standing by if you'd like to ask a question on the line. Or you can ask your questions using the chat box on the right side of your screen.

Operator: All right, as a reminder, before I open up all lines, if you have any background noise on your line, please remember to mute your line. If you do not have a mute function on your phone, you may press \*6 to mute and unmute your line. All lines are now open.

[ Inaudible ]

Marie Brown: Do you want me to take one of these questions, Michelle?

Michelle Owens-Gary: Yes, why don't we do that?

Marie Brown: Okay, a couple people asked where we can find the videos we referenced. The diabetes one on medication and adherence is on the National Diabetes Education [Program] site as well. And that is sponsored by the CDC and the NIH. It's also on the American College of Physicians website along with the AMA. And that's at www.stepsforward.org. And the CDC one on immunizations is there as well. Somebody said [inaudible].

Somebody asked something about sugary drinks. I have a soda bottle in each of my exam rooms and I've emptied it, dried it out and filled it with the amount of sugar that is contained in that size bottle. And it's amazing how many people—you don't have to say anything. They just start playing around with it while they're sitting there, and they're amazed at how much sugar is in there. And that simple intervention has changed some people's understanding at least and motivated them to stop drinking sugary drinks. Back to you, Michelle.

Michelle Owens-Gary: Okay, Nancy, can you read some of the questions in the chat box?

Nancy Silver: Sure. It sounds like we're having a little bit of audio problems. So, this one looks like it's for you, Marie. It says Talbert and Dean argue that moral injury is a better descriptor of physicians experiencing burnout because burnout resonates poorly with physician's experience because burnout suggests the failure of resourcefulness and resilience. In their view, moral injury more accurately captures what physicians are experiencing these days.

Marie Brown: I think you could change that, you could call it moral injury. I did mention that we do think it is very important to stress that this is not a failure of one person. So, we think it's 80-20. It's 80 percent due to the environment. We're hearing somebody speaking.

Operator: Please be reminded that all lines are open, and if you have any background noise or wish to not participate in the discussion, please mute your phone. You can mute your phone by using your own mute button or pressing \*6. Thank you.

Marie Brown: So, it's definitely about 20 percent personal resilience. We don't want to blame the victim. But 80 percent is an under-resourced, overly complicated, burdensome amount of work that couldn't possibly be done with the tools that we have and meet all the needs of the patient with so many comorbidities. So, I would agree with you that it is not about the failure, and we certainly don't want to blame the victim. Back to you, Michelle.

Nancy Silver: Thank you, Marie. Okay, we have a question about how can we get doctors to make referrals to the diabetes and chronic disease self-management workshops? And I think any one of our panelists could answer this question. Hello?

Marie Brown: I'm here, but Nicole, is she able to answer that as a diabetes educator?

Nancy Silver: Nicole, are you there?

Nicole Bereolos: I am. I am here. Usually, if you get the diabetes educator involved actually in making that referral, that's where you get the greatest involvement as opposed to relying on the physician to do it. So, if you have an interplay, either a check-in or check-out, the communication at that point is where that referral needs to be made, if that makes sense.

Marie Brown: Yeah, and I would add that the way to really change things is just make a standing order so that every single patient that comes in—don't wait for somebody to write the order. It can be a standing order that every single patient with diabetes is referred to the diabetes educator. It would be almost impossible to care for a patient in those 17 minutes and try to do diet and lifestyle changes. So, make it a standing order if you really want to change things.

Nicole Bereolos: And that can be particularly useful for your new diagnoses. I know if they've had longstanding issues with reimbursement, but definitely if it's a new diagnosis, that would be much easier.

Nancy Silver: Okay. Well, thank you, Nicole and Marie. We have another question. What is the role of the primary care clinic in denouncing the effect of predatory advertisement of unhealthy products? Christina, could you address that question?

Christina Roberto: Sure. Yeah, you know, I think there's sort of two ways to think about this. I think physicians focus a lot on their relationship with their patient, understandably, but I also think physicians are a really important potential advocacy group. And so, they are getting involved in organizations through AMA or other related ones. I think policy changes is one avenue to try to do that. You know, restricting marketing to schools for kids. But the other level to think about it is the individual one. And so, you know, to the extent that you're having a conversation with your patients about it, I think it's nice for them to hear this acknowledgement of what's happening in the environment. Oftentimes, you know, it will resonate. They'll say they notice it too. I think it does help to take some of the blame off them by giving them a sense of, look, there are these predatory marketing practices. This isn't all your responsibility to bear. So, I think those conversations are useful, but I would think of yourself as—if there are issues about that, there are ways to act as an advocate for them.

Nancy Silver: Okay, thank you, Christina. Stacy wants to know, when you tell a patient to limit sugary drinks, what is your response when they say they will switch to diet drinks instead?

Christina Roberto: This is Christina again. I'm happy to chime in on this. You know, this is a tough one. So, I always try to push and recommend obviously for options like water, but I do appreciate that it can be hard to do a kind of cold turkey stop. And so, given the available evidence right now, I would say there's no solid evidence to suggest that diet drinks are very problematic. And so, I would be okay with it, but I would check with that individual patient over time and see if it's working for them. I will say there is some emerging data that's raising some [inaudible] around diet drinks, but we just don't have enough evidence right now to say they shouldn't. I think it's a reasonable first step.

Marie Brown: Yeah, I agree. This is Marie. I would say that what I've told patients is that if they're drinking one 20-ounce sugary drink a day and they do nothing else but just cut that out, they will lose about 20 pounds in a year. And they are amazed at that.

Nancy Silver: Thank you. We have another question about drinks. It says, what soda bottle did you use? Christina or Marie, would you like to respond to that?

Marie Brown: Oh, I just took a clear soda bottle and calculated how many teaspoons was in about—I think it's a 20-ounce—and I think it's about 12 teaspoons. You can find it if you just Google it online. It's kind of a fun thing to do as a team, is everybody bring in their favorite drink and then bring a five-pound bag of sugar and pour it in. Because for most of us, many members of our team are struggling with obesity or diabetes as well. And the other thing that is very surprising is that patients think that juices are all healthy. And that is another source of liquid calories that our bodies don't know how to handle.

Christina Roberto: Yeah, I would really underscore that. I also think that's a very simple message to get the word out on, because that's consistently demonstrated that people think juices are healthy. And so that's an easy thing to just talk to patients about really quickly.

Nancy Silver: Okay, thank you, Nicole and Marie. We have a question on how to target patient burnout. Some just don't care anymore. Marie, could you answer that for us?

Marie Brown: Patient burnout? I think that would be—Christina can chime in here. I think what we need to do is not overwhelm the patient with all that's wrong. I don't know how many times this morning I was talking about immunizations and this and that and lipids and blood pressure, but I said—I always finish saying, "You are very, very healthy. Everything we're talking about here is to keep you that way." I don't want you walking out of here feeling like you have an illness. And sometimes we have to remember, especially with this huge pressure on all of us to get the blood pressures under control, because with these metrics and MIPS and MACRA coming in January, organizations—there's a big financial impact if you don't meet those goals. And that can add to burnout if we don't have the resources to get there. And you can even make a patient and a physician feel like they're almost in an adversarial role because that patient's A1C of 12 may have a financial impact on the provider. And that is not an aligned mission. And that really speaks to professionalism and also some other problems. But finding something that the patient did well. And I'll end with the *Annals of Internal Medicine* did a very nice review on obesity, and the first thing to do is treat depression and not address the obesity. And make sure they're not depressed. And second, try not to gain for 6 months. And if they don't gain for 6 months, I pat them on the back and say, "You did a great job. You stopped gaining weight." Because until you stop gaining weight, you can't begin to lose. And I think Nicole would have other very positive things to share with a patient to motivate them.

Nancy Silver: Okay, well, Marie, thank you very much. And thank you for all the good questions and answers. Thank you to everyone in the audience for some great questions today. If you have additional questions, please send them to the Division of Diabetes Translation mailbox, noted here on your screen. We will follow up with you after our webinar. Thank you again for joining us. Your feedback on today's event is important, and you'll have an opportunity to share that when you complete the process for continuing education credit. Before that, we have a few resources and announcements to share.

**Slide 68: Resources and Announcements**

Today's handouts include the presentation slides and several articles and tip sheets for better patient/provider communication.

**Slide 69: Download Today’s Handouts**

If you're joining us today on a mobile device, you will be unable to download the handouts. If you drop us a note on DDT\_diabeteswebinar@cdc.gov, we will be happy to email the files to you.

**Slide 70: Claim Your Continuing Education Credit Today**

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Operator: Thank you, ladies and gentlemen, this concludes today's teleconference, and you may now disconnect.