

**CDC/National Diabetes Education Program
Discovering the Full Super-Powers of DSMES
July 3, 2018**

TRANSCRIPT

Slide 1: Welcome!

Announcer: It is now my pleasure to turn to the conference over to Pam Allweiss. Ma'am, you may begin.

Pam Allweiss: Thank you very much. I am Pam Allweiss. I'm with the CDC Division of Diabetes Translation and I will serve as your moderator for the webinar today. I want to wish everyone a good afternoon and a good morning to our folks on the West Coast. We welcome you to our Webinar, "Discovering the Full Super-Powers of DSMES," or Diabetes Self-Management Education and Support. First, I'd like to go over some logistics.

Slide 2: Chat box

You may already be familiar with the chat feature for webinars like this one. You should see an open chat box on the right side of your screen. You are encouraged to ask questions at any time.

Slide 3: Affiliation

On another note, 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 pop-up 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.

Slide 5: Download Handouts

The handout section on the right side of your screen allows you to download any of the webinar's materials throughout the event. Simply click on the link to save a copy to your computer. Another note, we are recording a portion of this webinar. All of the files and the recording will eventually be available on the CDC Diabetes website. When all the slides and the recording are loaded to the CDC website, we will be sending out an email to all of our attendees with the link, so that all of the slides and the recording will be available to you as soon as it is uploaded to the CDC website.

Slide 6: Handouts

Today's handouts, the presentation slides, the DSMES joint position statement that we will go over later, and the Toolkit will all be available as downloads. If you're joining us today on a mobile device, you will not be able to download the handouts, but if you drop us a note at bjr6@cdc.gov, we will be happy to email the files to you, and eventually they also will be available on the CDC website. Also, after we share the handouts and go over a few additional resources, we would like to get your feedback on this webinar. A few questions will appear on your screen at the end of the webinar. It will only take a moment to complete and definitely your comments will help us shape our future events.

Slide 7: Continuing Education Disclosure

For those of you receiving continuing education, we have no finance disclosures to make. We have not received commercial support, nor have we charged any fees for today's activities. Information about how to claim credit for today's webinar will be provided at the end.

Slide 8: Discovering the Full Super-Powers of DSMES

So now, let's get started with today's webinar, "Discovering the full super-powers of DSMES." Today's hosts for the webinar will be Betsy Rodriguez and me, and we are from the Centers for Disease Control and Prevention, the Division of Diabetes Translation. To talk about those super powers, we are also joined today by other "wonder women" in the world of DSMES and diabetes education: Marjorie Cypress and Linda Siminerio. So now I'm going to give you my other identity.

Slide 9: Pam Allweiss

I'm Dr. Pam Allweiss, and I'm an endocrinologist, working with CDC for about 18 years. I definitely consider myself a DSMES referral champion. When I was in practice, they were my best friends. They did wonders for my patients. We have worked in various collaborative studies, so I'm so glad we are here to look at how we can increase physician referrals.

Slide 10: Betsy Rodriguez

I'd like to introduce my colleague and co-moderator today, Betsy Rodriguez. Betsy is a senior public health advisor with the CDC Division of Diabetes Translation. She is a bicultural specialist in health communication strategies and the development of diabetes educational resources for the Hispanic/Latino population and other ethnic minorities. She is chair of the American Diabetes Association National Health Disparities Committee, and the Chair of the Community Health Workers Working Group at CDC, and a national and international trainer for

organizations such as the American Association of Diabetes Educators, the International Diabetes Federation, and the Community Health Workers and Promotores associations and networks. She has a Master of Nursing with primary role as a clinician and secondary role as educator. Betsy, take it away.

Slide 11: CDC support

Betsy Rodriguez: Thank you, Pam! And thank you for the support of the Centers for Disease Control and Prevention and Health and Human Services in making this webinar happen!

Slide 12: Learning Objectives

Today's learning objectives are:

- Identify the four critical and most powerful times to “assess, provide, and adjust” Diabetes Self-Management Education and Support.
- We're going to use the Joint Position Statement to increase referrals to DSMES services.
- Apply the five guiding principles of initial and ongoing DSMES.
- Employ “special powers” that will change the lives of people with diabetes by connecting them with DSMES.
- And locate resources that support the implementation of the joint statement on DSMES.

There will be an opportunity to ask questions, and we will conclude by sharing resources and announcements.

Slide 13: The current state of DSMES Enrollment

Pam Allweiss: Thank you, Betsy. Let's start first with a current snapshot of DSMES, and how many people are getting to experience its super powers. Here to talk more about this is the first of our diabetes education wonder women, Marjorie Cypress. Dr. Cypress is an adult nurse practitioner,

specializing in diabetes care in Albuquerque, New Mexico. She has worked in diabetes management and education of patients and health care professionals for over 30 years and has been a certified diabetes educator since 1986.

SLIDE 14: Marjorie Cypress

She has authored numerous articles and professional and lay journals, book chapters, and is an associate editor for the American Diabetes Association's Complete Nursing Guide to Diabetes Care. She has received numerous awards and has held many leadership positions for the American Diabetes Association and the American Association of Diabetes Educators. Although retired from clinical care, she continues to do consulting and volunteer work for the ADA and diabetes community through speaking, writing, and advocacy activities. Let me turn it over now to Marjorie.

Marjorie Cypress: Thank you so much, Pam. And hello to everybody.

SLIDE 15: Some Useful Definitions

So, some useful definitions before we get started I think are helpful. I think you all know that there's certain work that diabetes educators do, and it's usually called DSME and so you may be wondering where the "S" comes from. So, DSMES stands for diabetes self-management education and support. And over time, diabetes education has been evolving from DSME to DSMES. The "S" for support is a really important distinction. So, the difference is that DSME refers to the ongoing process of facilitating the knowledge, skill and ability necessary for diabetes self-care. But when you add support into that, we're talking about activities that assist people with diabetes in implementing -- and more importantly, sustaining the behaviors that they need to manage their condition on an ongoing basis. And that's things like support groups, or classes, peer support, maybe even joining a gym. And there's one additional definition that

you should just be aware of, which is DSMT. And this comes from the centers for Medicare and Medicaid, or CMS, and they use the term training instead of education when they define the reimbursable benefits. So, the term DSMT is used really specifically just for billing purposes.

SLIDE 16: Recognizing the Many Benefits of DSMES

Now here you see a really interesting chart and in a 2016 paper in Diabetes Care, Dr. Maggie Powers raised the question, if DSME was a pill, would you prescribe it? Now she thought about how we rate diabetes medications and we usually rate them on efficacy, the risk of hypoglycemia, their weight effect, side effects, costs, and psychosocial benefits. And so, Dr. Powers applied this rating system to DSMES to provide an objective comparison to metformin, and they chose metformin because it's commonly used as a first-line medication and it's a very low-cost therapy. So, when you look at these comparisons, you'll see that some of this information, by the way, comes from research, so it's not something we just made up. So, as you can see, DSMES and metformin had very similar ratings for efficacy, the risk of hypoglycemia. You can see in terms of weight that metformin can possibly cause weight loss, but it's also weight neutral, so is DSMES. Side effects, couldn't think of any for DSMES, but we know that with metformin, you can have GI effects. Cost-wise, very low. And the psychosocial issues are really a difference here because it really shines. You can see that DSMES increases or improved quality of life, self-efficacy, empowerment, healthy coping, knowledge, self-care behaviors, adherence to a food plan, healthier food choices, increased physical activity, and use of glucose monitoring. But, of course, I'm sure you all know this, right? It also reduces blood pressure and lipids, and it also decreases the incidence of acute complications and the risk of long-term complications. So, in summary, the rating scorecard for DSMES is impressive and it confirms the benefits and value of DSMES. And the scorecard really challenges providers to sort of think

about what they can do besides medication in their treatment plans and all providers should be referring all patients with diabetes to DSMES, including MNT.

SLIDE 17: What Is the Purpose of DSMES:

So, what's the purpose of the DSMES? Well, it's to prepare people to make informed decisions. And they need to make these decisions in order to cope with the demands of living daily with a very complex and very difficult chronic disease. And they make changes in their behaviors that support their self-management efforts and improve outcomes. Basically, the outcome of DSMES is behavior change, right? That leads to improved clinical outcomes.

SLIDE 18: What Is Not the Purpose of DSMES:

Now what's not the purpose is lecturing people. And, you know, unfortunately, many of us have been taught and socialized that teaching patients involves standing in front of a room and lecturing. And the information that we give them is probably very important, but it may not be important to them. And so, you're speaking at people instead of with them. Diabetes education is a process and a conversation. We've also, as educators, been essentially pushed to have a checklist of diabetes education topics, and we've had to do that when we apply for credentialing and recognition. And in the past, we would check off that we taught or covered a topic and thought we were doing the right thing. And so, really, we should be asking ourselves, instead of, oh, I checked off that, I taught this. It's, did I teach the right content? And the other thing we know about with knowledge, we used to measure pre- and post-knowledge, but research has shown us that that doesn't change behavior at all. So, the old way of doing things was more focused on the educator than the patient and it kind of left the patient out. I mean it may be very nice to know where the pancreas is but sometimes, people just want to know what they're supposed to eat, right?

SLIDE 19: What Percentage of Newly Diagnosed People with Diabetes (PWDS) Are Getting DSMES:

So, now that we know all the benefits of DSMES, this is going to be a little poll and we're going to ask you to check, what do you -- what do you guess the rate of utilization is? And so, just check off on your screen there.

[pause]

Okay. Well, it looks to me like most of you are aware that less than 10% of people with diabetes -- oops I think I -- I'm speaking too soon. But yes, if you look at the next slide --

SLIDE 20: Sorry State of DSMES Utilization:

As I said, most of you are aware then that DSMES is not routinely utilized. And in Medicare, only 5% of people newly diagnosed with diabetes used that benefit. Only 1.7% of those with diabetes had a claim in 2012. And even those people with private insurance, only 6.8% of those who were newly diagnosed received DSMES within 12 months of diagnosis. And so, as you know, diabetes is a complex and burdensome disease that requires the person with diabetes to make numerous decisions regarding food, physical activity, medications, and really everything. And DSMES facilitates the adoption of these skills by providing knowledge and skill training, as well as helping that individual identify barriers, facilitate problem-solving, and develop coping skills. While there's a lot of data demonstrating the effectiveness of DSMES, the vast majority of people with Medicare and private insurance, as you see, don't receive DSMES in the year that they're diagnosed, a very important time. And Medicare does provide coverage for 10 hours of DSMES in the first year of using that benefit. And it provides coverage for three hours of medical nutrition therapy in the first year and two or more hours in subsequent years. So, unfortunately, those people who even participate in the year that they're diagnosed engage in only one and a half hours, 30% participated for only a half an hour, that's just incredible.

SLIDE 21: Every Person with Diabetes Needs DSMES:

So, before I start speaking about this, we know every person with diabetes needs DMS -- DSMES, I wanted to see by a show of hands, how many of you, before this webinar, were familiar with the joint position statement? And if you could just click on your little hands there, just so I can get an idea.

[pause]

I'm impressed. Okay. Many of you. I have a lot of hands here. But I also have people who haven't heard and that -- that's great. So, as a response, it was decided something needed to be done. And this was led by Dr. Maggie Powers who had this concept that she wanted to have a DSME algorithm for the treatment of diabetes, just like there's pharmacological algorithms for the treatment of diabetes.

SLIDE 22: What is the "Joint Position Statement?":

So, she came up with this concept and three major national organizations, the American Diabetes Association, the American Association of Diabetes Educators, the Academy of Nutrition and Dietetics, they all published this joint position statement, having the benefits of DSMES and providing guidance on how to increase referrals to DSMES. There's also a toolkit, there's slides, there's things that can help you, as an educator, introduce this to your colleagues, your clinics, whatever. So, using the guiding principles and recommendations of the joint position statement is really the topic of today's webinar. And the guidance that is listed can be used, not only by you, as educators, but can also be used by providers. It's really a very helpful document, and I hope you see that as we go along.

SLIDE 23: Guiding Principles and Key Elements of Initial and Ongoing DSMES:

So, I'm going to start with what we call the Guiding Principles and Key Elements of Initial and Ongoing DSMES. And as you can see, there are five here, engagement, and you're all probably very aware of the importance to reflect the person's life, their preferences, cultural, experience, capacity. But I think much more important is making engagement a conversation, a dialogue. A lot of us have been taught that we need to fix things. And so, an important part of engagement is remaining solution neutral, so holding back on your temptation to fix everything. Instead, you want to provide support. In terms of information sharing, determine what people need to know to make decisions about daily management. So, what does the patient need to know to make those? There's always that need to know versus nice to know. And people need to know things like treatment changes over time, and make sure that you're using teachable moments. And you're sharing, you're not talking at. Next, we're looking at psychosocial and behavioral support. And that's really validating feelings, supporting a person's self-efficacy, and addressing them as a whole person, not a diabetic. And one thing to remember is that it takes two to eight months to change a behavior. So, being patient and giving support to patients is very, very important.

Integration with other therapies. Well, you're engaging integration with and referrals for other therapies, things like medical nutrition therapy, and other referrals, as needed, maybe mental health or behavioral health. Maybe you're referring them for medication changes because you can see that whatever is being done isn't working, or physical therapy, social services, whatever a person really needs. And lastly, coordination of care, cross-specialty care, facility-based care and community organizations. This is very, very important. We need, as educators, to know and understand what the primary care provider is thinking and what their treatment plan is. So, it's important that we all communicate with each other on the team and that we do make sure that the care that's being given is culturally appropriate.

SLIDE 24: Sample Questions:

Next, in the joint position statement, you'll notice a group of sample questions, and it's sometimes difficult to know how to start a session with a patient. And, you know, the old, what can I do for you, doesn't really help. And this is something that primary care needs to learn as well because the tendency, when somebody comes in and sits down in the office, primary care is used to saying, how can I help you. But these sample questions are patient-centered and they're empowering. And so, it's really given to the patient to think about on how to focus on how diabetes is affecting them. So, they're how questions, right? How is diabetes affecting you? What questions do you have now? What's the hardest part that's causing you the most concern? What's the one thing that you're doing you can do better to manage your diabetes? And then how important is a behavior? How important is blood glucose monitoring? And do you think that you can do it? How important is physical activity? So, I just want to give you an example and point out for one thing, these are not yes and no questions. They require thought and explanation. So, this helps us, as educators, zero in on what the person is thinking at that moment. Now I want to just do a little, quick example of importance and confidence. When we ask somebody to do something, they're not going to do it, unless they think it's important. So, we may often say, on a scale of 1 to 10, with 1 physical activity is not at all important to me or physical activity is very important to me, how would you rate how important it is? And most people will actually put a very high number on that because they'll say, yeah, I know it's important. So, maybe they'll say an 8 or 9. And you may say to them, wow, that's really high. I wonder why you didn't pick a 6. And they will tell you how important it is to them. Next, how much confidence do you have that you can change that, that you can do this physical activity on a scale of 1 to 10, with 1 no confidence, and 10 very confident? Most people are going to say, I'm not so confident, maybe I'm a 5. Well, that's an opportunity to say, wow, so 5. So, I wonder why you didn't pick 3 or 2. They're going to start telling you why they do have some confidence.

And that can be followed by, how can I help you then for you to rate your confidence as a 9? So, this really gets a combination of empowerment, thinking about what the best strategies are to use.

SLIDE 25: Using the Guiding Principles in Practice:

So, using all those guiding principles is really saying, be curious. Ask a lot of questions. Use open-ended questions, as we showed you in the samples. And one of the things that I like to do when I first meet someone is say, take me through a typical day. What time do you get up in the morning? And then, what's the next thing that you do? And that helps you get an idea of what this person's life is like. You want to reflect and restate things like, so what you're saying is, this is very difficult for you. Validate their feelings. Yes, it must be very hard. I can imagine all the things that you do in your life, taking care of your grandchildren, that's really hard to take care of them and take care of yourself at the same time. And empathy, which is just the ability to understand and share their feelings. So, lots of times, this works really well because you're saying to someone, I hear you, and I understand that you have these feelings. And it creates trust and a very good rapport. It's a great way for us to get started with people.

SLIDE 26: Using the Guiding Principles in Practice 2:

So, again, using these guiding principles, this really makes us have to look at ourselves and what we're currently doing. Because apparently, whatever we think we're doing, we may not be doing it as well as we think. We're not getting the referrals. And so, we also don't see people often coming back. So, let's start looking at ourselves. Are we giving lectures or are we trying to support empowerment? Am I truly helping to help people develop a personalized plan, as opposed to just a general topic? Are some people going to do better one on one than in group classes? And do you have outcomes to show your own effectiveness? It's hard to ask people to

refer to you if you can't show them how effective your work is. And do you have good relationships with other providers? Are you using evidence in what you're doing? And then what about advocating for your patients and using research to help guide people to make decisions?

[pause]

SLIDE 27: Using the Guiding Principles in Practice – Collaboration:

My last thing about using guiding principles that I want to mention is about collaboration because I think we all think we know how to collaborate, but most of us have been educated in silos and we're really not taught how to collaborate. There's a difference between a multidisciplinary team and an interdisciplinary team. And so, each of us, no matter what our discipline, brings specialized care. And unfortunately, as I said, we haven't been educated in that way. Interdisciplinary teams integrate their knowledge and expertise. And they have very open boundaries. They don't get involved in turf issues of no, this is what I do, and it's very flexible. So, the importance is engaging in that kind of teamwork. And I -- we pay a lot of lip service to it, but I'm not sure that we all do it. And part of this is to sit down with the team, communicate, discuss, maybe set up some algorithms for treatment that everyone agrees on, maybe set up a practice agreement with the providers that you work with. So, I think we need to look at making a change in education and a change in culture.

SLIDE 28: Case: "Patient A":

Okay. Now I'm going to start with a patient that I saw, Patient A. This is a 75-year-old man with type 2 diabetes for 12 years. And he was referred to me by his PCP because his diabetes was out of control with an A1C of 9.5%. He came very agitated, I don't know why my doctor referred me here. I'm fine, I feel fine. Don't bother talking to me about diet and exercise because I've worked hard my whole life and I feel like now is the time I can sit back and relax and not do anything I

don't want to do. Oh, and by the way, I am not going to check my blood sugars. It's a waste of time, and I am not going to take insulin. No way. Now I wonder if any of you have ever seen this patient.

Pamela Allweiss: So, Marjorie? This is Pam. So, how did you respond to this patient? But before you respond, I'd love to ask our webinar audience.

SLIDE 29:

How would you respond to this patient? So, we'd love for you to add some of your comments to the chat box you see on the right side of your screen.

[pause]

So, audience, just add some of your answers.

[pause]

Well, we have some excellent responses.

Marjorie Cypress: Yes, we do.

Pamela Allweiss: You know, some people will say, hey, to the -- to the person with diabetes, you sound frustrated, definitely validate his feelings, kind of echo, reflect what he said. Yes, you definitely have some strong feelings about diabetes. But definitely to validate what he was saying. Definitely, people are saying we have to be respectful of the person, etcetera. So, these are wonderful responses. I'm going to turn it over to you, Marjorie. How would you respond?

Marjorie Cypress: Okay. Well, I'll tell you how I respond, and some of you, I think, did -- have commented on things that I absolutely did, which was, it sounds like you're really upset about this. And I can understand that with your feelings of doing fine and healthy, you see no reason

to check your blood sugars or change any behaviors. And then I asked him if it would be okay if I asked him a few questions. And what I tried to do is ask questions that were not threatening, things like, how's your energy? Are you sleeping okay? I -- do have any symptoms of hypoglycemia? Do you have any symptoms of [inaudible], things like that? And then he told about taking glipizide, 5 milligrams a day. And I asked him about how he was eating. So, things that I hoped he could speak to me, answering those questions, but not feeling attacked. And at that point, he started to ask me what his A1C should be. And so, we discussed what we thought was a good goal for that and he knew he was on a relatively low dose of medication. But I expressed to him that I was concerned about increasing it because of the high risk of hypoglycemia. And I said, it's okay if you don't want to check your blood sugars, but that does make my job a little bit higher -- harder. He proceeded to ask me more questions about things that might make his glucose go up or down, things like that. So, I told him some general things and -- but when he wanted to be more specific, I said, you know it's really hard for me to tell you how things are going to change your blood glucose without you checking it. I'm kind of guessing. So, we discussed some very general dietary guidelines. And I said, you know, sometimes some people find that walking can help bring their glucose down but, you know, you really need to check your glucose to know. So, I told him if he wanted come back, he was certainly welcome to. And interestingly enough, he did come back a few weeks later. And I was quite amazed, and he was not angry anymore. He was not defensive. He was smiling. He asked me to look at his blood glucose log, so he started checking his glucose. And we talked about the factors that may have caused his high readings, his lower readings, whatever. And I realized, this guy is really in -- engaged. And so, at that point, we switched him to a DPP4 inhibitor, just to decrease his risk of hypoglycemia and he was very willing to make those changes. And a few months later, his A1C did come down to about 8%. So, that was a very exciting -- I thought it was an exciting thing,

seeing that this guy who I thought was going to chop my head off actually turned out to be someone who was willing to work on this. And I think I used the principles of -- the guiding principles for the joint position statement, just that engagement, information sharing, the support, integrating other therapies, and obviously, I sent this information to his primary.

SLIDE 30: Critical & Powerful Times to Assess, Provide, and Adjust DSMES:

So, according to the Joint Position Statement, the secret to making successful DSMES referrals, even with challenging patients, is listening and watching for the most critical times when patients will be most receptive.

SLIDE 31: Diabetes Self-Management Education and Support:

So, what you hear -- see here is the beginning of the algorithm. And in addition to education, nutrition, and emotional needs of each individual, we know that this is the most important thing. And you'll see it at the top of the algorithm right here. And we know that the ADA standards of care also recommend that all patients be assessed and referred for these three things. So, the position statement defines when DSMES should be provided for type 2 diabetes, what's included at each of the timeframes for quality care, and how best to provide DSMES in a patient-centered manner.

SLIDE 32: Critical Times to Assess, Provide, and Adjust DSMES:

So, the very critical times, as you can see, are at diagnosis, annual assessment, or new complicating factors, influence of management, and when transitions occur. So, looking at these, you can see a diagnosis; we know that's a very emotional time. You want to focus on teaching just survival skills, finding out what kind of baggage people come with, just the skills that people need at the time. And obviously, you're going to be doing a full assessment, as you

normally would do. Annually, absolutely, review problem-solving skills, identify strengths and challenges. Review reinforcing treatment goals. Support efforts to sustain the initial behavior change. Now at a year, people sometimes fall off and need some more support. And then when new complications occur, or other factors that might influence their self-management, it could be pregnancy, you want to identify some of those things and set goals. And they may need referral at that point for other things, like behavioral therapy. And also, helping patients to develop their own personal strategies. And last, when transitions occur, you want to make sure that everyone on the health care team is on the same page, establish follow-up. And these things could be things like a person going off to college, planning pregnancy, or being pregnant, or postpartum, going into a nursing home, loss of significant other, or loss of health, some of those things. And that we know that people should be referred at other times as well, but this is a starting point. And this is really important if they're changing medications, or if they just have uncontrolled diabetes. So, this helps you and it also helps providers.

SLIDE 33: Using the Position Statement to Increase DSMES Referrals

Pamela Allweiss: Excellent. Thank you, Marjorie.

Slide 34: Linda Siminerio Bio:

So, now we will go to our next topic. We're going to focus on the how the joint position statement can increase referrals. So, our next DMSES Wonder Woman is Linda Siminerio. She is a professor of Medicine, Nursing, Health and Community Systems at the University of Pittsburgh. A nationally recognized expert on self-management education and health care delivery models in both pediatric and adult populations, she serves as the principal investigator on numerous studies related to diabetes prevention and treatment. She served as the president of Healthcare and Education, the American Diabetes Association, and senior vice president of

the International Diabetes Federation. In these positions, she has organized and led national and international efforts on the development of program, standards, and care models directed toward health professionals, patients, and the community. Let me turn it over to Linda.

SLIDE 35: Access to Self-Management Education:

Linda Siminerio: Thank you, Pam. Thank you, guests, for joining this webinar today and, Marjorie, for giving some really good strategies on how to work with individual patients. And I'm going to switch gears a little and talk about how we can help with systems changes in order to address the challenges that we have in providing DSME(S). So, I'm going to start by talking about access, something that's close to my heart. And I'll first focus on some studies that have been done in regards to referrals in our system. And just as a gentle reminder, you know, for many of our systems to receive reimbursement for DSME(S) services, we do need a provider referral, so referral is important.

SLIDE 36: NDEP National Diabetes Survey (NNDS)

So, I'd like to start by sharing with you some data from a national survey that was done. It was actually done about 10 years ago, and we revisit it. Naturally, much of the same is still happening. And so, we wanted to explore in this national survey why so few people in the United States receive DSMES. So, we looked at referral practices and what we found in that survey is the providers did say that they want their patients to receive education, but they also said that they weren't sure when to refer.

Back to SLIDE 35: Access to Self-Management Education:

There goes the position statement with the algorithm, so that was created based on some of these reported findings back in the earlier 2000s. And providers in that survey said that they

feared that there may be a conflict if they referred to a diabetes educator at a DSME(S) program because the management goals and philosophy that they have for their patients may be in conflict or a bit different with a diabetes educator. And some of them feared that once a patient has received DSMES that they would lose their patients to a diabetes specialist. So, to get some information on systems, in addition, this particular survey looked at programs. And programs were reported to reside in a fragmented system. DSMES is historically delivered in a hospital-based program that may not always be convenient for people to attend, parking, traffic, the program or hours may be in conflict with their schedules. Plus, there is a disconnection often with communication. We traditionally would send hard copies of letters and then all with electronic medical records and databases, hospital-based educators may not be on the same electronic medical record system as the referring doctor in a primary care office where 90% of patients with diabetes receive their care. So, connecting those two would be potentially a solution to some of our problems.

Back to SLIDE 36: NDEP National Diabetes Survey (NNDS):

In another national survey done by the National Diabetes Education Program, the NDEP. The NDEP periodically does a probability-based population survey as U.S. adults that provides information on diabetes-related knowledge, attitudes, and behaviors.

SLIDE 37: Diabetes Education (PWD):

And what they found in their survey is disappointing, indeed. Of people with diabetes, referred to as PWD, who reported having a usual health care provider, sadly, only 7% in this survey reported regularly seeing a diabetes educator, in addition to their usual provider.

SLIDE 38: Diabetes-related Education or Counseling (PWD):

When people with diabetes, in that same survey, were asked who provided their advice or counseling about how to prevent other health problems caused by diabetes, the doctor is mentioned above all others. And I don't know about many of you in this audience today, but what I know is given that doctors have very limited time in a visit, I find it quite amazing that all of the things that need to be assessed and covered during a diabetes visit, like labs, medications, healthy eating, eye exams, monitoring, etcetera, etcetera, can really be done effectively by the physician.

SLIDE 39: Diabetes Educators: Advice Types (PWD):

In that survey, people with diabetes who had received comprehensive advice or counseling from a diabetes educator, it's not surprising, that topics related to weight control are reported to be the highest. However, in addition, important other topics for diabetes management were noted, like paying attention to activity, taking your medicine, and follow-up visits were discussed.

SLIDE 40: Room for Improvement (PWD):

Same survey, when people with diabetes were asked, in general, would you say your way of managing your diabetes has usually been effective, sometimes been effective, or not. 67% say their way was usually effective, not sure what that usually means. Because from my point of view, people with diabetes, as Marjorie has mentioned, should be empowered with their self-management, their knowledge, and skills, to feel that they are doing their best and are effective, of course not all of the times but most of the time. And there's certainly room for improvement, as the other third of the respondents admitted that they really aren't quite effective. With the chronic disease of serious diabetes, this is important information. In my own experience, many times, people don't realize what they're supposed to know and are quite surprised, in some

cases frustrated, that no one, other than an educator, told them what they needed to do to be an effective diabetes self-manager.

SLIDE 41: Pittsburgh Regional Initiative for Diabetes Education (PRIDE):

Now I'll shift gears a bit and present some of the work that my team has done in examining and addressing the challenges of diabetes self-management education and support. We call our program, the Pittsburgh Regional Initiative for Diabetes Education, we refer to it as PRIDE. And this education is not only for people with diabetes, but we include providers, that means doctors, nurses, dieticians, endocrinologists, community workers, and the community affected and at risk for diabetes. We designed our PRIDE initiative to answer some questions about DSMES and to test some potential solutions. We realized that we needed to take a good look at ourselves and examine access, so important for DSME(S) services. We asked ourselves, were we really reaching people with our PRIDE recognized programs? We had built a diabetes education system in our western Pennsylvania region from three programs in 2000 to 55 ADA recognized programs in 2018.

SLIDE 42: Diabetes Education Services in University of Pittsburgh Medical Center (UPMC) Database:

And is this enough? Are we doing the job? We began, first, by reviewing our University of Pittsburgh Medical Center, UPMC, diabetes database. UPMC provides diabetes care for almost 200,000 people in the region in our 20 hospitals and practices. My colleagues and I carefully examined a cohort of 12,745 patients. We used G, and MNT codes charged during a specific timeframe and found that of that 12,745 patient study, only 1,512, 12%, had received DSME. None had just received medical nutrition therapy, MNT. 672, 5%, received both, DSME and MNT, while a disappointing 83% received neither service. All these opportunities and still, numbers low.

SLIDE 43: Examining Risk Factors, Co-morbid Conditions, Participation, and Physician Referrals to a Rural

DSME(S) Program:

We then wanted to specifically examine services in one of our outlying rural communities, where we have a recognized program that is familiar to all of these UPs in the community. We reviewed 265 of the practices' type 2 diabetes patient records, where we found that 65% -- now this is after the diabetes educator has made herself known and marketed to all of the practices in that community and the hospital program is at the center of that community -- but 65% had never received DSME(S) services, despite the educator efforts, and what we consider PCP where awareness of the local services. 76% of the 170 -- 162 patients never received a referral. Interestingly, however, 83% of the patients who had received a PCP referral attended the DSMES program.

SLIDE 44: Number of Co-Morbid Conditions & Education:

So, a referral could really be a culprit. So, then we wanted to know, were these same patients -- when were they referred to education? And I'm sure this feels familiar to many of you -- many of you on the call today. It looks like, according to this bar graph, when all else failed, refer to the DSME(S) program. As you can see, depicted on this bar graph indicated in orange, the more comorbidities for one to four, the more likely the patient would have received a referral for education. So, the sicker the patient was, then they were referred for education services.

SLIDE 45: Broken? Consider Participation Rates:

More recently, there has been reports that Marjorie has already referred to about the proportion of persons with newly diagnosed who participate in DSME(S) services and shown in this CDC publication, looking at commercial claims from 2009 to 2012, as Marjorie's already shared with you. Those patients privately insured with newly diagnosed diabetes, sadly, only

6.8% had seen an educator within their first year of diagnosis. And an estimated percentage -- 4% of Medicare recipients with diabetes had enrolled into a diabetes education program. These data suggest that there is a large gap between the recommended guidelines and current practice and there's an opportunity and a need to enhance rates. And we need to do that because many of you know that our services are often looked at as a reimbursable service. So, many of our institutions are interested in how many patients we can see. Lastly, on this slide, 31% of PCPs, 65% of specialists reported having a diabetes educator available to them in their practice setting. So, what we took home as a message to us is maybe there are some opportunities to look at how referral and participation rates could be escalated.

SLIDE 46: Diabetes Education Recommend By:

Because what we do know, and so should everyone, is that DSMES is a recommended service. And who says so? The Institute of Medicine -- next slide please -- the National Committee on Quality Insurance, the American Diabetes Association, the Endocrine Society. And when you poll providers, physicians nationwide, they do report, overall, one thing, DSME(S).

SLIDE 47: Why the Need for a Position Statement:

So, why a position statement? Well, we know -- based on what Marjorie and I both shared -- participation and referrals are abysmal, despite everybody knowing the benefit. Barriers are confusion among providers regarding referral criteria and limited patient access, what Marjorie referred to in the creation of the position statement with the algorithm. And so, in 2015, the referral algorithm was published calling for innovative approaches to improve referrals, and of course, ultimately, improve participation. Presented is the evidence-based algorithm that Marjorie shared with you.

SLIDE 48: DSME/S Algorithm of Care:

And we used this algorithm in a study that I'm going to share some preliminary findings with you, and it's how providers in the practices that we worked with responded to the algorithm.

SLIDE 49: Pittsburgh Regional Initiative for Diabetes Education (PRIDE):

Next slide, please. And next slide.

SLIDE 50: Improving Glycemia in Primary Care: A Model Integrating Diabetes Education into Practice:

Okay, so for our PRIDE Program, we found that we needed to reach more people. But asked ourselves, how should we promote access? Remember, I talked about that fragmented system? So, we tested various models for delivery and I'm going to share our Glucose to Goal model. We've also looked at things like using technology that – I – limited time with the webinar -- more to learn and more to examine, in regards to using technology to support our services. So, we submitted a proposal to the National Institute of Diabetes, Digestive and Kidney Disease at the NIH and were rewarded -- awarded a research study with aims to look at referral rates and participation from primary care practices.

SLIDE 51: Patient Centered Medical Home:

We knew that a number of healthcare providers, systems, and big-time decision-makers were paying attention to how we are providing quality patient-centered care, moving away from quantity to quality. This patient-centered medical home is a nice framework for fitting in diabetes self-management education services and that's what we did because we wanted to improve access and quality. It dawned on us that education could be nicely nested into the patient-centered medical home, since the home is built to assure overall quality and safety, the roof, DSME(S), exactly what we're aiming to do, quality and safety. The foundation that supports that roof includes care management, population management. What does population

management mean? Not just looking at the patient in front of you but looking at your program, looking at your community, using a population management approach to identify those patients in your community that are most in need. Coordinated team-based care that Marjorie referred to, diabetes education has a place in all of these boxes in the medical home but door, access, is the key.

SLIDE 52: Glucose to Goal:

This slide outlines our program called Glucose to Goal, fully recognizing that diabetes education is more than just improving glycemia. But we use the word Glucose to Goal because it was a term that resonated with our community, our providers, and people with diabetes. In our Glucose to Goal model, we built it in keeping the patient-centered medical home in mind and this Glucose to Goal model was the model that we use in our NIDDK supported research study. What is Glucose to Goal? And again, this system now is being used by our whole entire health system and our educators within the system. A diabetes educator is made a formal member of the primary care practice team. The educator is available from their hospital-based program to work in the practices, to communicate with the practices, etcetera, so that they become familiarized and trusted by the primary care providers serving 90% of our patients. We use electronic medical record system to the utmost. We share communication with the providers. We use our database to identify patients at high risk, patients who may have had recent hospitalizations, patients who have hemoglobins that have been in distress for quite some time. And we proactively identify those patients and collaboratively work with the primary care providers to say, this is a patient who looks like they're having difficulty achieving their goals. And then we coordinated that care, and much of it coordinated through the electronic medical records. So, from our Glucose to Goal NIDDK study, we used three certified diabetes educators. They were introduced to practices in their respective urban, suburban, and rural communities.

And through the primary electronic medical record systems, they identified patients, reviewed the list with the primary care providers or the practice managers for education, automatically got the referral, and invited the patient to come on behalf of their provider.

SLIDE 53: HBA1C Outcomes by Category:

We knew that this system had worked for Glucose to Goal because we had tracked A1Cs in several of our Glucose to Goal sites prior to this study. And we -- when we looked at Glucose to Goal data, knowing that diabetes education lowers values for A1C significantly, our Glucose to Goal findings held true. Let's look at this graph and certainly, you can go back to it and carefully study it. But just to give you a briefing on it, we start with the gray line, which is at the top on the graph. And starting at the left-hand side is when we look back at the patient's history this is a mean A1C of this patient population of 9.8%, so a group that was not in good diabetes glycemic control. And this group, over time, didn't improve, so when we looked at their past A1Cs, this was a group that got worse, not better. And that is when, when you see the peak of that curve, they were referred to diabetes education. And then take a look what happened to this group, the dramatic decrease, decline, in A1C values. The other groups were -- who were at the start between 7 and 9% or less than 7 didn't have a need to have that dramatic of a drop, but you can see that they also improved after education. We looked at them historically and then at their education peak. And if you follow the lines in the graph, you can see that if education isn't ongoing, as Marjorie referred to in the "S," for DSMES, support, it eventually will start to creep up again. And that is why the algorithm says, ongoing assessments.

SLIDE 54: Can Practice Redesign Improve DSME(S) Referrals:

Next slide. So, the question in our study, can a practice redesign improve our referrals? We knew the primary care providers report challenges that include inadequate time for education and a shortage of resources.

SLIDE 55: Objective:

And a proposed solution to overcome these barriers, we thought, was to integrate educators into the practice. Our objective was to deploy a model that relied on the elements of the medical home with direct delivery of education in primary care. And we wanted to see if we gave them an educator, and certainly not every day. The educators work with the practice to say, in your practice, what's a good day for me to come in and be available to your practice to be able to support diabetes education? And some practices that were large, they may appoint in several days a week. In some practices that were remote and very teeny practices, they may have gone in twice a month. But the providers knew, and so did the practice know, when the educator was going to be available. So, the patient was starting on insulin or monitoring, then the physician, or the nurse practitioner, or the provider could say to the patient, please go out to the desk, our educator is here on Tuesdays and I need you to make an appointment.

SLIDE 56: Chart:

And what we wanted to do is if we gave the educator to the practice, would that help to improve referrals? So, this next slide just depicts a -- somewhat of a cartoon to show what our research question was. In the top of the Box in A is the traditional model, lots of people with diabetes, the number is growing, lower referral rates for hospital-based programs, we know that and low DSME(S) participation. In Box B, this is what we hypothesized. Again, large population. We wanted to improve DSME(S) with greater participation. We wanted to see if we gave an

educator and we taught those practices about the algorithm, would have improved referral and participation.

SLIDE 57: Does the DSMES Position Statement Algorithm Improve Referrals?

Next slide. We address the barriers by training the primary care practices on a position statement and the referral algorithm. We led focus groups with them, and had huddles with them, and showed them the algorithm, and how they could refer. And then we integrated the educators into their practice, introduced them, etcetera, and then we examined the referral and participation.

SLIDE 58: Methodologies:

I'm going to share referral rates because we're still continuing to analyze our participation rates. And this was a mixed method study, where we did the qualitative focus groups with the practice managers, with diabetes educators, with providers, asking them lots of questions about DSMES.

SLIDE 59: Study Design:

And then the intervention was Glucose to Goal with the educator. And then just for your reference, the next slide is the study design. We had five UPMC communities and what we did was we had three intervention communities, where we had three educators who had two large primary care practices in their community that they work with. And we compared them with two educator's practices that did the traditional method of DSME(S) and their hospital-based programs.

SLIDE 60: Practice Focus Group Results:

So, with the practice focus group results, PCPs reported in this group -- remember, we only studied this group of PCPs -- that the algorithm is appropriate but too complicated for them for practical application. The providers agreed that high A1C and a new diagnosis warrant referral.

SLIDE 61: DSME(S) Referral Rates

The providers didn't agree on additional referral criteria, not a criticism of the algorithm, as much as, what do we need to learn to improve their understanding and use of tools like the algorithm. Well, what happened with our referral rates, midway through this study -- so this is an interim analysis. And these are the groups in the blue, you'll see the intervention group, Glucose to Goal -- intervention group is Glucose to Goal, educator in the practices. Yellow is the control group, the traditional method. The intervention group, as you can see, compared to the control group, 12.6 versus 7.9 with referral rates, still not perfect, however, better than the 5 and 6.8% that we saw before.

SLIDE 62: Results/Conclusions:

So, you can see that those practices who've got the education about the algorithm and had an educator with access and pre-identifying patients were 1.9 times more likely to refer their patients to DSME(S). So, for us, this was enlightening and we'll be anxious to see what our final results are because we revisited the algorithm again midway through this study. So, other factors found to predict referrals in this group were females were more -- were referred more often, people who were overweight, [had obesity], and those with higher A1Cs. And what we found in other focus groups with our educators is oftentimes, providers get confused and think that educators are only there to do nutrition education.

SLIDE 63: What Gets in Our Way??

So, our findings suggest that the intervention positively influenced DSME(S) referrals, however, we have some more work to do. So, what gets in our way? Or you can see on the next slide, this is sometimes the frustration that I have. Next slide, please. That's me pulling my hair out after 45 years of looking at access and knowing how important self-management is. We still have some challenges and any of you who know me tend to know that I get quite upset about this. One of the challenges -- and we have this -- within our own study, are reimbursement and deductibles. You know, many of our providers said, hey, you know, this is great. We want to refer our patients, but they can't afford the copay or the deductible. Accessibility, transportation, parking, so we're going to closely look at other mechanisms to support that. And I can tell you, one of our -- a couple of our programs are doing telemedicine and it is really enhancing our ability to get more patients to DSME(S). Poor referrals, we're going to continue to look at it. Continue to inform our patients and providers because as Marjorie suggested, it could be a cultural issue that patients and providers aren't aware of what educators can do for their patients. And then look beyond our box, and move outside the box, and look for ways to better reach our patients, be it through technology or new models of care, similar to what we had done. We still keep our traditional programs; however, our educators are also actively working to engage with their local primary care providers.

SLIDE 64: What can a Diabetes Educator and DSMES Do for You?

And as Marjorie said, we need to start looking at opportunities to engage our patients and it can be in a group setting rather than giving them the old traditional lectures. So, what are our educators telling us about what educators can do to help increase things like referrals? One of the things I can tell you that's worked in our system, and I know nationally they're looking at these kinds of opportunities, many of our practices are in shared savings programs, and programs, the providers, practices are getting incentivized for quality improvements. And I can

honestly say that I have gotten letters from primary care providers saying, Linda, could you please get me an educator because their A1Cs, their lipids, getting people to go on insulin, taking their medications has improved, patients they've been struggling with to help over many, many years. Educators can also ask how did they increase practice efficiency? And our educators have also taken on a role, in many cases, you know, we're limited in how often we can have detailing from industry, etcetera, or training practice staff, and our educators have assumed those roles when they're trusted in the practice. When you're in the practice, you need -- the educator can monitor patient care and progress and provide status reports. Remember that population health, how great it would be to show the practice how well or where they needed to look at some other interventions to improve outcomes. And remember, it's not all about glycemia. Educators help with metabolic control, looking at lipids and blood pressure. And remember, many of our insurers are looking at these things, star ratings, Medicare reports, etcetera, etcetera, look at elements. Like how many patients are on statins? How many patients had their eye exam? Important quality metrics that an educator can help address. And also, just as I showed you with that line graph, help those very patients who are at highest risk because as you can see, we had a dramatic effect. It wasn't anything other than magical than listening to the patient.

SLIDE 65: Case Study:

So, I will also provide a little bit of a story from a patient that was referred to me and our practices. This was a 60-year-old with newly diagnosed type 2. I'm going to refer to him as GD. His A1C was 10.2. He had no education at diagnosis and he was started on meds. He was frustrated with his A1C level that remained at 8.9 six months later. And he said to his PCP. The PCP mentioned the diabetes class at the local hospital and this gentleman had said the times and dates simply weren't convenient for me. At nine months visit, the local educator serving the

practice now got a referral. The patient came in and I can -- I was assured that the patient's A1C had dropped to 6.9%. The patient started walking. He had set behavioral goals. He did simple things, like just eliminating sugary beverages that -- he didn't realize that juice has a lot of calories -- and changed his snacks. He walks daily and his closing statement to us was, why didn't I meet with you a year ago?

SLIDE 66:

So, I'll turn it over to you, Pam, for some polling.

Pamela Allweiss: Okay. Thank you. So, we'd like some of your input. What do you think changed this patient's situation? We'd love to see some of your answers in the chat box that you see on the right of your screen. And once we see some of that, we'd like to ask some of our panelists on their thoughts. So, I'd like to know how many of you have had similar experiences? How many of you are aware of patients like the one just discussed, etcetera? So, we're seeing some easier access to the educator, definitely patient centered, and support, and time, definitely. Support system from the diabetes educator. So, anyway, I'm going to turn it over to some of our panelists, Betsy, Marjorie, Linda. How typical is this situation? And what are some of the challenges? Name some of the reasons. And I'm sure many of you know patients like this one but have not gotten a referral. So, I know that we're short on time, so let's hear about two or three answers from our panelists on your thoughts for this particular case.

Linda Siminerio: I'll just refer to the response we had from providers, given that they were still -- even after we educated them -- thought that only patients with high A1Cs, those who were overweight and, in our group, females, were the ones that needed a referral. We need to do a lot more education that diabetes is a lifelong disease. It has many points for educational opportunities.

Pamela Allweiss: I think that's really important.

Marjorie Cypress: This is Marjorie. I just wanted to comment that what I see is that PCPs wait until the A1C gets up, until the patient gets sicker, before they send them for diabetes education. It's like they feel like, well, we -- I can do it, you know, if their A1C is only like 7. But they wait and then when they wait, it makes it much harder.

Pamela Allweiss: Exactly and speaking as a provider, you know, some -- many people don't know -- many providers don't even know what the rules are. So, I'm going to turn it back to you, Linda, to tell us about some of the regulations so that we all know the rules because I think it's very important. So, often the provider will say, well, but I don't the rules and can -- you know, it's a referral, so I'm going to turn it back to you, Linda, to continue and educating us about some of the regulations.

SLIDE 67: Regulations...:

Linda Siminerio: Okay. The good news is -- I have good news today -- is our national organizations like AADE, and as I understand, ADA, are looking at the challenges that we have. For example, must have a provider referral. And I had already mentioned this, but this can be a challenge. And also, the referrals, in many cases, have to be very specific. It has to be your PCP. So, if you're a hospitalist, in some cases, and you're discharging a patient with a lot of challenges and transitioning, the hospitalist may not be the one who's able to provide the referral. Medicare covers 10 hours of initial education and reimburses for two hours annually. Diabetes changes as you get older with the many -- and all the transitions that we have, and that's the algorithm, because it needs to be ongoing. So, our reimbursement structure that was created years ago doesn't match the evidence and the science that we know about diabetes self-management today. DSME(S) and MNT cannot be billed on the same day, so you're coming three hours away

to a site to get -- to see both the nurse educator and a dietician, and oh, gee, I can't see both, but this is inconvenient if I don't. And also, there are telemedicine restrictions in that nurses cannot do a telehealth diabetes self-management visit and bill for the services. Again, all of these regulations are being reviewed. And I can tell you that organizations, like the AADE, are -- have created toolboxes to help folks in being able to market their surveys.

SLIDE 68: Acknowledgements:

So, I would like to close by thanking all of you for your attention to my part of the lecture today and to acknowledge the members of my team on in doing the work that we've done on DSME(S). Thank you.

SLIDE 69: Applying the Five Guiding Principles of DSMES:

Betsy Rodriguez: Thank you, Linda. We have talked today about the five guiding principles for diabetes management education and support. But in addition to these principles [inaudible] in the process is the person with diabetes, themselves.

SLIDE 70: Treat PWDS as the Experts on their Lives:

The diagnosis of diabetes can often be overwhelming. It can feel like a lot -- a loss -- a loss of control. Allow the patient and their needs to be your guide. Give them that sense of control. Build self-efficacy and behavior control by treating the person as the expert of their own life as part of the health care team to come from all the adoption or maintenance of new diabetes management behaviors but sustaining them is often difficult. Your visit should strive to build self-efficacy and help sustain it. Since the patient has no experience living -- since the patient now has experience living with diabetes, it is important to begin each maintenance visit by asking the patient about successes he or she has, and any concerns and struggles and questions

they might have. The focus of each section should be on patient decisions and issues. What choices have they made? Why has the patient made those choices? And if those choices -- and if those decisions are helping them. Patients should understand that treatment will change over time as type 2 diabetes progresses, so set up that expectation now so that the changes in the therapy do not make it seem that the patient has failed. Change will happen because DSMES asked us to constantly assess, provide, and adjust DSMES.

SLIDE 71: Employing Special Powers that Can Change People's Lives:

So, now let's talk about the impact of DSMES. It's really a superpower that can change people's lives and it provides benefits for every stakeholder.

SLIDE 72: DSMES Is a Win-Win:

For example, the superpower of DSMES are win-win for every stakeholder. For the person with diabetes, why clearly DSMES can be life-changing. [Inaudible] related to medications, diets, and physical activity can address multiple medical conditions, maximizing outcomes and increasing quality of life. For the caregiver, it can reduce stress and uncertainty, especially in cases where the patient is having difficulties meeting basic life needs, such as food security, adequate housing, and safe environments, and access to medication and healthcare. And the lifestyle changes in a household can reap health benefits from family members who might themselves be at risk for diabetes. For the physician, as an option in glucose level can help meet objectives or metrics created by insurance company or health care organizations. Many physicians also find their practice benefits when they establish an office-based DSMES program. And, of course, all of us win when we reduce complications from diabetes in America and human costs associated with them. Nothing works like DSMES. It is truly a superpower. Getting more people referred and enrolled is the key to reduce both the human and financial costs associated with

complications from diabetes and we are the people with that superpower at our disposal. If you're looking for ways to help you use the guiding principles and help you identify the four most powerful times to assess, to provide, and to adjust DSMES.

SLIDE 73: Resources to Implement the Joint Position Statement:

The great news is that there are tools to help you. There is our entire toolkit available to support the joint position statement, so check out this link.

SLIDE 74-76: Resources to Support Implementation of the Joint Position Statement:

There, you will find high quality downloadable PDFs you can print for yourself and your diabetes education health workers. Slide show -- the slide shows all the materials you can use to locate providers and other people who can make referrals, as well as flyers, educational videos, and other material for you to use in your work with people with diabetes. Any questions?

Pamela Allweiss: Okay, Thank you, Betsy.

[end of presentation, beginning of Questions, end of recording]

Slide 77: Questions?

Slide 78: Resources and Announcements

Slide 79: Downloads Today's Handouts

Slide 80: Claim Your Continuing Education Credit Today

Slide 81: Thank you