

National Diabetes Education Program
Using Shared Decision-Making to Empower Underserved Populations with Diabetes
Webinar Transcript
March 12, 2015

Joanne Gallivan, M.S., RD—Director, National Diabetes Education Program, National Institutes of Health

Good afternoon, everyone, and welcome to the National Diabetes Education Program’s webinar, “Using Shared Decision-Making to Empower Underserved Populations with Diabetes.” I’m Joanne Gallivan, I’m director of the National Diabetes Education Program at the National Institutes of Health, and I will serve as moderator for today’s webinar.

As hopefully many of you know, the NDEP is a program of the National Institutes of Health and the Centers for Disease Control and Prevention along with more than 200 public and private partners. Our mission is to reduce the burden of diabetes in the United States by facilitating the adoption of proven approaches to prevent or delay the onset and progression of diabetes and its complications.

We offer topic-specific webinars to support partners working to improve diabetes management outcomes and to prevent or delay the onset of type 2 diabetes. We want to thank all of you today for joining us and hope this session provides you with information and resources that you can take back to your organization and to your community.

A couple of webinar logistics: You are all on mute, so you don’t need to mute your phone or computer; we really can’t hear you. There will be a Q&A session towards the end of the webinar. If you have a question, you can do two things: You can either type it into the “question” section on your webinar panel, or you can also click the “raise your hand” function, and then we will unmute your line so you can ask your question.

We are very, very pleased today to have two guest speakers for our webinar: Dr. Monica Peek and Dr. Linda Siminerio.

Dr. Peek is an assistant professor in the Division of General Internal Medicine at the University of Chicago, where she provides clinical care, teaches, and does health services research in the area of health disparities. Dr. Peek is also the associate director of the Chicago Center for Diabetes Translation Research, where she heads the Health Disparities and Community-Based Participatory Research Core.

She is an inaugural faculty fellow of the Bucksbaum Institute for Clinical Excellence, whose goal is to promote positive patient-provider relationships, and is a faculty member of the MacLean Center for Clinical Medical Ethics.

She has also authored more than 50 peer-reviewed research papers and publications and has served as the principal investigator for grants from NIH, NIDDK, the Robert Wood Johnson Foundation, and the Merck Foundation. And she was part of the NIDDK Strategic Planning Committee, whose 2010 report *Advances and Emerging Opportunities in Diabetes Research* sets forth the diabetes research agenda for the next 5 to 10 years.

She currently serves on the advisory boards of the Silver Lining Foundation, the Chicago Black Women’s Health Alliance, and the Greater Chicago Food Depository.

I'm sure many of you know Dr. Linda Siminerio. She is a nationally prominent advocate for diabetes care, education, and funding. As professor of medicine at the University of Pittsburgh's Division of Endocrinology and Metabolism, her academic focus centers around translational research in diabetes quality improvement, self-management, community interventions, and overcoming barriers to diabetes care in underserved populations. And we are very happy to say she is current chair of the National Diabetes Education Program.

Dr. Siminerio has authored numerous books and scientific publications and, in 2011, received the American Diabetes Association's prestigious Outstanding Educator in Diabetes Award, demonstrating significant contributions for the understanding of diabetes education.

I will now turn it over to Dr. Siminerio. Linda?

Linda M. Siminerio, RN, Ph.D., CDE—Division of Endocrinology and Metabolism, University of Pittsburgh

Thanks, Joanne. I'm so glad that the NDEP is offering this webinar. It's so important that we start to explore interventions like shared decision-making in an effort to empower our patients, particularly those in underserved populations.

I'll start by reviewing our learning objectives for today. The first one is to describe the importance of enhanced communications for patients with diabetes; to better understand the social and cultural barriers to shared decision-making, particularly for vulnerable patients with diabetes. We want our participants to be able to enhance their shared decision-making skills with vulnerable populations and learn the skills and identify resources to support successful patient-provider interactions.

I'm sure many of you have heard some of the comments on this slide, and I'm sure they're very familiar. One: "My patients are noncompliant." "Our patient population is different—a very unique group." "When you use these standardized approaches, it inhibits my critical thinking and limits my ability to individualize care." "I know what is best, and I know what is best for my patients based on my long experience." The traditional role of the experienced, more knowledgeable advisor.

Let's start with what we know about patient communication and think about diabetes. You know, we've experienced over the years that when we use the paternalistic, directive approach, it really isn't effective. And we know that just by improving someone's knowledge doesn't necessarily translate to improved behavior.

We recognize now that health literacy and health numeracy is a problem and that health care providers do not always communicate with each other. For years, we were trained to believe that what we said mattered, and when we spoke, patients understood and accepted our direction, and if people didn't do and accept it, they were classified—and many still are classified—as noncompliant. Does this sound familiar? And I think it's nicely represented in this cartoon. When we want your opinion, we'll give it to you.

Here is an example of a communication challenge that I heard recently. I was the diabetes educator partnering with one of our diabetes specialists on a telemedicine visit. The visits are done here remotely to provide access for our patients who live in rural communities.

When our rural patient was having problems with weight and following her meal plan—she snacks throughout the day—our very kind and well-meaning endocrinologist said, "We have lots of patients who have problems with grazing." Our confused and somewhat disgruntled patient whispered to me, "Does she think I eat or look

like a cow?” As someone who grew up and lives on a farm, that’s how she interpreted the word “grazing,” which many of us use when we refer to some nutrition challenges. Health literacy is a problem.

This cartoon depicts the long-accepted relationship of traditional health care decision-making. The provider can be any one of us—the physician, a nurse, an educator, a dietician, a pharmacist—represented in this large bold bubble, and the patient, illustrated below. Of course, this pathway leads to a provider-driven health care decision.

So, what about the evidence? What do studies tell us about patient-provider communication? We’ll look at some smattering of studies that looked specifically at provider-patient interactions, and one of the questions one of the investigators that was looking into this area asked is, “Are we empathetic?”

This was a study published by Gudzone. “Do physicians build less rapport with obese patients?” And this was published in 2013 in *Obesity*, and I think these lessons can apply to some of the patients that we see with diabetes or people at risk who do have weight challenges. And the study aimed to describe the relationship between patient’s BMI and physician’s communication behaviors. They audio-recorded encounters from 39 urban PCPs and 208 of their patients.

And what they found was that PCPs demonstrated less emotional rapport with overweight and obese patients than for their normal weight patients. And these findings, and findings like this, raise concern that low levels of emotional rapport can weaken a relationship, diminish adherence, and prohibit effectiveness of counseling.

Some other studies on empathy and diabetes, an important part of our relationship in communication with our patients. What they found in several of the study findings that are cited at the bottom of this slide is, patients of physicians with high empathy scores, as compared to those with low empathy scores, were more likely to have diabetes patients have good control of their A1c values—significant comparison in their findings. The proportion of patients had better LDL control, and this is also significant.

When there were physicians who had better empathy scores, there were lower rates of acute complications like hypoglycemia and DKA. And physician’s understanding of their patients’ beliefs were associated with better self-care among their patients. Their patients had better self-care behaviors with their nutrition plans and blood glucose monitoring.

What about patient satisfaction? Now many of us—and I’m sure you’re familiar with it in your own environment—we’re being graded, and I don’t think this is such a bad thing, on how satisfied our patients are. An important process measure.

So, here are some findings on some patient satisfaction studies. Fifty-two percent in ratings of care satisfaction was accounted for by the physicians’—not their clinical knowledge, but their levels of warmth and respect during their interaction with their patients.

Dieticians who had empathetic engagement was predictive of patient satisfaction and successful consultation. Empathy was rated as the most important quality for being considered a good physician. And patients who don’t have decision support more often blame their practitioner and not themselves for any bad outcomes.

The Institute of Medicine has become very interested in the area of communication, and they set forward to gather a team of experts who worked to develop strategies to guide evidence about communication among providers and patients, communication that holds the potential to yield hopefully better care, better health, and lower cost.



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

The work took place over several years in three distinct phases that included an environmental scan, individual interviews and focus groups in three United States cities, and a nationally representative poll of U.S. adults to quantify the prevalence of the attitudes, beliefs, and preferences. And what they found was there was a gap between what people want and what they get regarding engagement in their health care.

Eight in 10 people want their health provider to listen to them, but sadly, in these studies, only 6 of 10 say that it actually happens. Less than half of people say their provider asks about their goals and their concerns for their health—certainly important in diabetes management. And 9 in 10 people want their providers to work together as a team, but only 4 in 10 say it actually happens. And I would refer you to this document; it's full of very good information on studies of patient-provider interactions.

So, what can we do? Shared decision-making has been an intervention that has been proposed and now studied to help us to get a better understanding of how best to communicate with our patients. So, here is the definition of shared decision-making.

Shared decision-making is a collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available as well as the patient's values and preferences. Many of these things seem intuitive to many of us on this call today, but this is really a work in progress, because we need to make sure that this is a ubiquitous process that happens in all of our clinical and community environments.

So, what does the literature tell us specifically about shared decision-making and aids that are used to support it? In a Cochrane review of 86 clinical trials, they found that patient use of evidence-based decision aids led to improved knowledge of options, more accurate expectations of possible benefits and harms, greater participation in the decision-making process, higher satisfaction not only from patients but also from the providers themselves, and the choices resulted in a lower cost and better health outcomes for many disease states and surgical procedures, and specifically diabetes.

So, to learn more about how we facilitate shared decision-making, I'd like to turn this over to my friend and colleague, the real expert in shared decision-making, Dr. Monica Peek.

Monica Peek, M.D., M.P.H., FACP—Division of General Internal Medicine, University of Chicago

Good afternoon. I am really delighted to be here. Thank you so much for having me as part of this wonderful webinar, and I'm looking forward to the Q&A session at the end.

So, I'm just going to follow up on what Dr. Siminerio said with a lot of the excellent data and sort of rationale and reasoning for why shared decision-making is a good thing for our patients, and talk a little bit about the work that I do, which tends to focus on African-Americans, but that experience, I believe, is very generalizable to a lot of vulnerable populations who struggle with cultural discordance, with language or literacy issues, transitions or challenges with access to care, and issues around mistrust of health care systems. So, although I tend to focus my work on the working-class African-Americans with diabetes, I think that their experience has some broad implications for other populations.

And just as another similar disclosure, my work tends to focus on physicians, but I really think more broadly about physicians as a type of provider, and particularly with this kind of team-based care interventions that we are implementing, we are starting to train not just physicians but our certified diabetes educators, our nursing assistants, and the whole range of people who encounter patients within the clinical setting to really have a sense of organizational culture around supporting an empowered patient.



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

So, just to contextualize shared decision-making within the context of patient empowerment. So, patient empowerment has typically meant patients' ability to accurately or sort of comprehensively manage their disease at home, but increasingly, it has been expanded to incorporate shared decision-making with providers within the clinical setting.

And so, we already know that diabetes self-management interventions can be effective within minority populations, but there hasn't really been a lot of work that has combined both shared decision-making skills training with culturally tailored patient education for low-income minority groups, despite the sort of growing preponderance of evidence that shared decision-making can lead to significant improvement in health outcomes.

So, Dr. Siminerio sort of defined really nicely what shared decision-making is about, and I would just sort of add to that the incorporation of three core components of shared decision-making, and that would be the information sharing phase between physicians and providers about symptoms, and what is happening with the disease process, and really sort of what happens when you first get to the doctor's office or are encountering your health care provider.

And then the second is deliberation over the pros and cons of treatment regimens and whether or not we're going to try a medication option or really try and do some intensive lifestyle coaching—and really, this is a great opportunity for me, in clinic, to bring up the DPP and the evidence that shows that lifestyle changes can actually be more powerful than a pill.

And then the third phase would be the decision-making and not just sort of having a shared and common, and sort of verbally agreed upon decision about what's going to happen when the patient leaves the office or leaves the health care system, but that patients feel that they have the confidence to successfully implement that plan as well.

And so all of those are key to sort of understanding shared decision-making and how we think about its implementation within the clinical setting. And so, we do know for specifically shared decision-making in diabetes that it's central to how we are thinking about managing chronic diseases.

As Dr. Siminerio had mentioned, shared decision-making is correlated with a number of positive health communicators, including improvements in control of diabetes and hypertension, and are really right now—if we think about health policy—have strong implications for the patient-centered medical home, where we're really trying to center our care around patients. So really having an activated patient as the core is really crucial to how to begin thinking about reorganizing our health system and structuring our patient interviews and our interactions with patients in the clinical setting.

So, this is just a slide to remind me to mention that a number of organizations have signed onto the idea that shared decision-making is important. So, the American Medical Association, the American College of Physicians, the Association of American Medical Colleges, certainly the Institute of Medicine, and others have really taken a strong stance about the importance, particularly for areas that there's some divergence of clinical opinion or some ambivalence about the data, that this is particularly the time to engage patients in that decision process and not to exclude them just because all of the data isn't clearly pointing in one direction.

This is a slide that just—everything in here I've sort of already mentioned, with the exception of the last bullet, which shows that minorities experience less shared decision-making. So, we have a framework for understanding how effective it can be at improving health, particularly in the setting of diabetes, and that we already know that culturally tailored interventions for minorities can be effective around diabetes health management, but what we haven't quite done yet, again, is sort of combine the power and harness that power of

shared decision-making with patient education for patients who we already know experience less shared decision-making than others who are from different socioeconomic and different racial and ethnic backgrounds.

So, a part of that, and again this is sort of thinking about the African-American context, but a lot of the underlying tenets are similar or can translate to other populations, and it's really just understanding the sociopolitical context in which communities of people find themselves and how they operate as communities within this country or coming from other countries.

And so, I live here in Chicago, and so most of our African-Americans have come up from the South as part of the great migration, and so here in our country, obviously, we have the unfortunate but very strong legacy of not just slavery but a lot of segregation and Jim Crow structures, for which we have not only persistence—meaning lasting over generations—but also pervasive, meaning effecting numbers, a wide variety of our social structures, including our health care system, where we have structural inequities.

And so, within that context, we know that there is an interdependence between organizational inequity and interpersonal inequity, and those two feed off each other. And so in this broader context, many communities who find themselves to be politically marginalized or oppressed find strategies over time to help them personally survive and their community survive.

And so, one common thing is that people will use deference, or a sort of code switching; we can talk and act a certain way within our community that's a safe space, but then when we are outside of our community, then we'll talk and act in a different way—in a way that is helping to preserve either our function, our ability, or our survival, and so some of that within the African-American community has meant engaging with institutions of power like the police, our health care system, in ways that are not ones that optimally promote self-efficacy and an active engagement in the process.

And so, if we can understand that as sort of the social context in which people live and then understand that that translates and so people bring some of that baggage into the clinical encounter, then it really helps us as clinicians, sort of broadly defined, understand our patients and what their experience is when they come through the door.

So, this is a paper that we wrote that has a full citation on the left just about some of the barriers and facilitators to shared decision-making amongst this particular vulnerable population. And just to summarize, a lot of this sort of reflects what I was just talking about, so this inherent power imbalance that exists between physicians and patients, or any kind of provider and patients, is exacerbated by issues of race and class, and that issues around mistrust in health care providers and health institutions limited confidence or self-efficacy that you can actually have meaningful control over your own life with health care decisions. All of these things are sort of related to some of the sociopolitical context in which people live their everyday lives, and it particularly sort of interfaces with other known barriers to accessing health and optimizing your experience, like limited health literacy and other sort of cultural norms that people have around beliefs around health, denial as a coping strategy for sort of delaying disease control and prevention. And so, a lot of these things are ones that probably sound familiar to everyone who's on this webinar, but have direct application to the communication patterns and how we can touch base and sort of interact with patients in our health system.

Luckily, there are a lot of facilitators for shared decision-making, and so we know now that just inviting patients or engaging patients to be a part of this process, to really build a strong interpersonal relationship, validating people's concerns, and really feeling not just physically accessible but emotionally and sort of intellectually available and accessible for our patients really makes a difference and creates a safe space in which people are

able to open up and more actively engage in the shared decision-making process, despite some of the inherent barriers that they may have before walking in through the door.

And so, one of the things in a different avenue that we study is, we were thinking about these three central constructs for shared decision-making and how that sometimes gets interpreted for African-Americans. And so this next slide is very busy, but I'll just sort of highlight that for a lot of people, the idea that they will adhere or non-adhere to care really is a reflection not that they are not interested in managing their disease, but it's an expression of how they define sharing and the decision-making process.

So, people may behaviorally manifest their choice about a treatment without verbally expressing it to the clinician or health care provider. And so for some people, it's not that they aren't interested in getting better or don't want to do things that can help their health; it's that they may have not fully understood, or disagreed with, or not been able to fully implement the plan of care and did not really have the skills to express that to the provider and decided that they were just going to operationalize that by voting with their feet.

And so, this is part of a qualitative study that we did where—there are the quotes—one person said, “The doctor told me I need to go to the dermatologist. Now the lady up there at the checkout desk”—which is after she left the physician—“I told her that I didn't want to go. That if this skin thing, the skin growth, goes down, then I don't see a reason to operate. So, I'll have to think about that.” And then the interviewer says, “Well, did you tell your doctor?” She said, “No, no, I didn't tell my doctor about my preference for not messing with it, I just told her that I would go through with it.” To the lady at the checkout desk, she actually said, “You know what, don't make that appointment for the referral, I'll wait and see if I think it's going to get better, and then I'll decide whether or not I'm going to follow up with an appointment.”

A different patient said that some African-Americans still don't believe in everything the doctors say. “I have a neighbor, and she goes to the doctor, and when she gets the medication, she throws it in the garbage can.” So, a lot of sort of ambivalence around trust and mistrust. You trust enough to go, but maybe not to follow through with the plan. But not a great sense of always having the ownership and the ability and the skill set to verbalize these concerns in the clinical visit. And so, those are some of the things that we have been working on with some of the work that we do.

So, this is just for anyone who's in social media, this is how to find us and our project and our work. It's called Improving Diabetes Care and Outcomes on the South Side of Chicago. And what we're really trying to do is think about embracing the chronic care model with four key components, one of which is patient activation, and that's just what I'm going to talk a little bit about for the remaining few minutes that I have.

So, it's a program that's a 10-week program where we do a combination of culturally tailored diabetes education that was built off the evidence-based BASICS curriculum and added to it a shared decision-making component.

And so, again, we have the culturally tailored diabetes education that includes adult learning and health literacy issues, addressing those, as well as a shared decision-making component that really gives people the skills and tools and confidence, practicing with people in the class who either are physicians or are pretending to be physicians about that encounter so they feel more comfortable when they actually go and see their doctor and dealing with them.

And so what we tell patients, it's not about information sharing, deliberation, and decision-making, but we translate the shared decision-making domains into the three Ds: discuss, debate, and decide. Something that's easier for people to remember, that sort of sounds sort of catchy, and that they can sort of try and focus on when they're actually visiting with their physician.

And then the last thing to note is that after this 10-week program, we transition people into support groups, and after those groups, people sort of launch off and to do a range of different kind of activities, either mentoring other patients with diabetes who have not gone through the class, or working in community settings as lay health educators, and just doing a variety of things that reflect the amount of activation that they've experienced by going through this class.

Just to sort of also note that we do a lot of cultural tailoring in the Diabetes Empowerment Class, so we use a lot of the role of narrative and storytelling, testifying, setting goals as a group. We invite people to bring their family or other social members of their network who are important to them in helping to manage their diabetes. We don't tell people to stop what they're doing as far as food, but really, we talk about how to modify traditional diets that have a lot of cultural salience to people and to make them more healthy.

We have developed games and videos in ways to make it really fun and interactive, and I'm going to show a few minutes, there is about 2 minutes of a video clip that we use. We developed it for use in the class, but I found that we've been able to use it in other sort of non-class settings as well, and it really just is to try and get people to understand what sometimes feels like an abstract concept of shared decision-making, and just make it more real, and so we have sort of a good example and a bad example of shared decision-making, and then we sort of talk about it in the video. So, this is a visit from a not good, a shared decision-making encounter.

Video

Dr. Wood: Hello Mrs. Robinson, how are you doing today?

Mrs. Robinson: I'm fine, thank you. And you?

Dr. Wood: I'm well, thanks. How have you been?

Mrs. Robinson: Well, I've been pretty good.

Dr. Wood: Good, good. Have you noticed anything unusual or different about how you've been feeling?

Mrs. Robinson: No. Everything's about the same.

Dr. Wood: And have you been taking your medication and checking your diet?

Mrs. Robinson: Well, yes, I've been pretty good. I've been eating all my vegetables, because I know you said that was important, and I've been taking all of my medications every day.

Dr. Wood: Okay, that's great. It's really important, Mrs. Robinson. Now, are you experiencing any fatigue or other symptoms?

Mrs. Robinson: No, sir. I feel about the same.

Dr. Wood: Okay. If everything's the same, let's keep you on your current medication, and you can come back and see me in 3 weeks.

Mrs. Robinson: Okay.



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

Granddaughter: Grandma, did you tell him about the sore on your foot?

Mrs. Robinson: Just a little sore, and I don't think it's anything to worry about.

Granddaughter: She has a sore on her foot, Dr. Wood, she says it hurts, and she's tired all the time.

Dr. Wood: You have a sore on your foot?

Mrs. Robinson: Mhm.

Dr. Wood: Well, have you been wearing proper shoes and checking your feet every day?

Mrs. Robinson: Yes, I have.

Dr. Wood: Okay, then. Let's take a look.

Mrs. Robinson: Well, it's just a little sore. It doesn't even hurt that much. It's on my right foot.

Dr. Wood: Well, I do see some redness and some signs of infection. I believe that's a result of your diabetic condition. Now, the infection is still in its early stages, but it's important that we address this, because some serious problems could occur as a result.

Mrs. Robinson: Okay, doctor. I understand.

Dr. Wood: There are two ways to handle the problem with your foot. I can give you some antibiotics, which should clear up the problem, or we could have you see a foot specialist.

Mrs. Robinson: Really?

Dr. Wood: You know, I think I'm going to have you see the foot specialist.

Mrs. Robinson: Whatever you think is best, Dr. Wood.

Dr. Wood: I've a got a referral slip for you to see the foot specialist. Call his office, make an appointment, and they should take care of you.

Mrs. Robinson: Oh, I can't see the foot specialist today? I have to make an appointment?

Dr. Wood: Yes, I'm afraid so.

Mrs. Robinson: But I have to work all week, and I don't think I can take off another day for this.

Dr. Wood: Mrs. Robinson, I'm sorry for the inconvenience, but we don't have a podiatrist in this office, so you're going to have to make an appointment to go.

Mrs. Robinson: Okay. I will call as soon as I get home.

Dr. Wood: Great. Glad to hear that. You know, it's also time for your flu shot, so I'm going to send the nurse in, and she can take care of that for you.

Mrs. Robinson: Okay, doctor. Thank you. You have a nice day.

Dr. Wood: You're welcome.

Nurse: Mrs. Robinson?

Granddaughter: Grandma never made that appointment.

Monica Peek

So, that is just a clip that can show how patient-provider interactions can be positive and pleasant, you can like your doctor and respect them and want to do what they say, but you still may not be getting the full shared decision-making experience.

So, we really wanted to help underscore for people the difference between having a bad experience in general and just having one that does not sort of allow your voice to be optimally heard and so that you can sort of negotiate a treatment plan that you know you're actually going to be able to do.

And so we use that. There are a lot of sort of teachable moments within that video about both the physician's behavior and the patient's behavior and her support team, her back up team, her granddaughter that she brought with her, about how everyone can do a little bit better job of working together to have a more active role for patients and to end up with a plan of care that makes sense and that she ends up with, you know, her foot being treated and not potentially amputated.

So, if you want to know more just about the class and how we developed it, here's the citation here, and I would be happy to send anyone a copy of that. But it really just talks about how we try to tailor many aspects of diabetes education and shared decision-making to fit our patient population, and I think that a lot of the challenges that we had are ones that translate, again, to other communities.

One of the things that I'll underscore, particularly because I just showed that video clip, is the strong role of narratives that we use in the class, so not just with the use of video, but we use narratives throughout the class. And so we did a study sort of about the role of narratives, and here are two quotes that we have.

One person said, "It changed how I interacted with the doctor; by me seeing a video, I did at least have the presence of mind to at least ask, 'What is this medication for? How often should I take it?'"

And one person said about the role play that we did in class, "They kind of built me up. We'd be like we're at a doctor's session"—so we would practice like we were at the doctor—"and then she would say things that she knows is not right either, but then she wants to know if we're going to catch on to it and just let it go, or will we just speak up? And sometimes, you don't want to question your doctor. It's kind of hard, especially if you really like them and stuff, so she was just building us up so that you've got to be able to basically ask these questions whether you like the doctor or not." And so, again, having sort of real skills and having people practice in a comfortable, safe space for what they know they ultimately can do, and this addition was very helpful for our patients.

So, this is just a few summary slides about some of our outcomes for a number of patients that were in the study. Most of them were middle-aged women with a high school graduate degree, had diabetes for about 10 years, and had a number of comorbid conditions that go with diabetes, as we would normally anticipate.



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

When we looked at improvements for changes over time in self-management, you'll see that we saw improvements in overall confidence in managing diabetes, in dietary changes, exercise, managing our testing for blood sugars, and in self-foot care.

We also looked at measures of shared decision-making, and we saw that initially, everyone had improvements in their self-confidence as soon as the class was over, and then over time, as people actually were able to go in to see the physician at 3 months and at 6 months, we started to see improvements in measures of patient's ability to share in the decision-making process and, in turn, how they felt the physicians were responding to that and participating in the shared decision-making process.

And one of the things that we tell the patients a lot is that your physicians or your health care team will respond to your behavior, so you can prime them. So, if you ask questions this visit, when you go back next visit, they'll anticipate that and give you more information in advance, and so that's bearing out with some of the data that we saw in our survey responses.

And then last, we were specifically also looking at health outcomes. So, we saw some improvements in measures of diabetes control, improvements in HDL, improvements in self-reported health, and particularly in the mental health category, we did not see any changes in systolic blood pressure, unfortunately, but we're continuing to collect data on the [?] cohort, so we are hoping it will be [?] to see some changes in that as well.

So in conclusion to this part, I would say that combining both culturally tailored diabetes education with shared decision-making training can improve both self-management behaviors, shared decision-making behaviors, and diabetes-related health outcomes, and such strategies may serve to reduce some of the disparities that we see in diabetes outcomes in most African-Americans and other vulnerable populations that we have in our clinical practice.

And then this last little video clip is a little shorter. It just shows you how we had shown the video in a different community setting. So this was at a food pantry where we go every month and do health education, but it's not a diabetes class; the majority of the people who are coming don't have diabetes, but we just showed the video one time as one of the means of providing some health education around diabetes-related topics. And so we interviewed a few people afterwards just to see what they thought about the video. So that was, it's about one minute what the clip shows.

[Video not able to work]

Basically, the lady was like, "I'm really excited about seeing the video, and I think I'm going to make some changes in how I interact with my doctor at the next visit."

So, this is a slide that just talks about building a shared decision-making foundation organizationally. So, for us in a health care system, what can we do to try and support patients to feel more empowered?

And so the first thing I would say is specifically and explicitly make sure that we talk to patients about that. Let them know that we value their opinion and why. Tell them about the three Ds, and basically also try and increase their expectation, or their cultural norms, about what it means to be involved in care and that we see them as partners, that we value their opinion, and this is why it's important for me to have your impression about what should happen.

And then just realize that chronic diseases and shared decision-making in a chronic disease setting really is not about one major decision, but it's really multiple micro-decisions over time that we can revisit with our patients.



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

And so we can try the dietary changes and come back and see what barriers there were, and try a different angle, and so this all part of developing and maintaining good relationships with our patients.

I would also encourage people to address the elephant in the room, the really uncomfortable barriers that are really sometimes very problematic for patients, but without specifically saying—you know, I always give the same spiel to all of my patients. “This is a safe space. My job is to take the best care of you as possible.” And all of the things that we understand as clinicians but that patients may not be expecting from us. And so to really try and acknowledge that we may have differences in culture or language, but I’m really on your team; I’m your best advocate. That it’s really important that you trust me and then know that I’m going to do the best I can for you. And just explicitly saying that is an experience that a lot of patients actually don’t have, and they’ll feel surprised that we’re there not just to make money but to also really provide the care that we want to do.

And then last, I would say to make sure that as an organization that we involve all of the support staff in thinking about changing the culture. So not just for physicians when they are talking about treatment decisions, but shared decision-making is really something that should be in the water, in the air, of our clinics. And so something that we talk about at our staff meetings is that we have resources in the waiting room, like showing a video or having flyers and buttons and people wearing things; if they ask me questions, I’d love to talk.

Having some coaching. Studies have shown that pre-visit coaching by nursing support teams can really help patients remember and ask their physician questions. And really, for those of us that are lucky enough to have diabetes health educators and other kinds of specially trained staff on our clinical sites, to really use that as a way of reinforcing and incorporating messages and skills around shared decision-making.

So, this is all a team sport, and even though I’m a physician and mainly think about my peers, I think it’s also really important to think about everybody as we engage in this to try and increase the self-efficacy and skills of our patients.

So, I just wanted to acknowledge a lot of the team members who work very hard on all of our work especially my co-PA, Marshall Chin; acknowledge our funding sources, most of which has come from NIDDK; and then just again give you some of the cites for contacting us if you need any information. And I’ll just turn it back over to Joanne.

Joanne Gallivan

Thank you. Thank you, Dr. Peek, and thank you, Dr. Siminerio. That was a really terrific presentation. I just want to remind everybody on the call that the NDEP has a variety of resources that can be used in the patient care and education setting. We also have resources for you to help improve your patient’s diabetes care and patient interactions.

Two of our newest resources are shown here. First is *Guiding Principles for the Care of People with or at Risk for Diabetes*. We work with some very key partner organizations to develop the *Guiding Principles for the Care of People with or at Risk for Diabetes*, which is really a set of 10 guiding principles highlighting areas of agreement for diabetes care among the various organizations that can be used clinically in diabetes management education. It’s really aimed at assisting and identifying the management of the disease—of management support for patients, physical activity, blood glucose control, cardiovascular management, and other topics.

And then, if you go to principle 10, which is “Provide Patient-centered Diabetes Care,” it describes the elements of patient-centered care for diabetes prevention and management and highlights shared decision-making as a key component.



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

The second resource that you see is *Practice Transformation for Physicians and Health Care Teams*. This is a web resource that provides resources to help improve diabetes care within the context of the evolving health care delivery system by providing information and resources for health care professionals looking to explore new health care delivery models. What this resource really seeks to do is to help all of you understand the tasks involved. These tasks include challenges related to technology and team care as well as new ways of interacting with patients and communities.

And you'll find both of these resources on the NDEP website at www.yourdiabetesinfo.org.

I also want to remind you about our resource Diabetes HealthSense. It's another resource, which is related to shared decision-making and patient-provider communication. It is an online library that provides easy access to more than 160 resources from more than 80 organizations that support people with diabetes and people at risk.

Two resources that maybe particularly helpful to you in Diabetes HealthSense is the Health Care Professional Section—which includes research articles on behavior change and psychosocial issues including review articles, landmark studies, and meta-analyses—and then the section called “Make a Plan” that providers can use to help guide patients through the process of deciding on a behavior change goal and developing a plan to achieve that goal.

So now, a few notes before we move into the Q&A section of the call. Today's webinar, the slides and the recording, will be placed on the NDEP webinar page in the next 2 to 3 weeks. We will notify all of you when these materials are available, and you can visit this page to learn more about some future webinars that we're going to be having as well as download past recordings.

You will also receive an e-mail from us later this afternoon that asks you to evaluate this webinar. Please fill it out. We really appreciate your feedback, and we use it to plan future events. We will ask you if you have any topics that you would like NDEP to have future webinars, so please let us know if there's any topics that you hope NDEP can address in the future.

While we cannot give continuing education credits for this webinar, we can provide you with a certificate of completion that you may be able to use with your organization that says that you participated in this webinar, and if you need one, you can e-mail us at ndep@hagersharp.com.

So, now we will take your questions. Just as a reminder: All your lines are currently on mute, so please do not manually mute your phone or computer. If you have a question, you can type it into the questions panel or click on “raise the hand” icon on your webinar panel, and then we will unmute your line. So, Candice, I'll turn it over to you for questions.

Candice Hicks

We have one question. How do you balance shared decision-making with limited time for the patient visit?

Monica Peek

I'm sorry, can you repeat that?

Candice Hicks

Sure. How do you balance shared decision-making with limited time for the patient's visit?

Monica Peek

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

Yeah. That's a key question that comes up a lot, and a lot of people see this and think, "Oh my gosh, that's going to be 30 minutes' worth of time." One of the things I had mentioned in my slides—that was in my slide that I didn't actually call attention to—was just the fact that visits actually end up being shorter, because if you can learn more about your patients and they are trusting and open, then when you have a good solid working relationship, then it actually is faster, your communication over time.

And so I would say that it really is an investment on the front end. So, I spend most of my first visit just sort of getting to know people and then planning to come back and follow up and start some of the more medical aspects of care.

But what I have found is that—so, I would say two things. One, think about it as a front-end investment that certainly will have benefits not just as far as health outcomes but as far as your time efficiency in the clinic as well.

I would say, two, we always have to make decisions about things and that every decision is not ideal for shared decision-making. If it's a choice between a horrible decision and a really good decision, then really, there's nothing to talk about. But it's really more when there is some clinical equipoise, when there is some lack of consensus within the medical community where you want to sort of slow down and make sure that patients have a good understanding of all the pros and cons of the various options, because that's where patient preference and patient's ability to implement a plan really comes into play.

And so, I would say that every decision is not one that has to be stopped—you don't have to stop the train every 2 minutes for a shared decision, but that for key things, that you really should be able to, and that that process of sort of investing in the relationship on the front end means that you can get to the business of sharing in the decision much faster if you don't have to go through all of the sort of baggage.

And a lot of this experience is difficult patients, people who don't want to come to clinic, who clearly have a chip on their shoulder, don't listen to us, have all this verbal—I mean, non-verbal messaging that, "I really don't want to be here"; a lot of that can be addressed and unpacked, and if we take the time to do that on the front end, then everything else is faster and easier on the back end.

Candice Hicks

We have a few raised hands. We're going to give people dialing in by the phone an opportunity to ask their questions out loud if they are still on. Barbara Wahls, if you are still on, we'll unmute your line. Okay, we will move to Mary Oleszek; if you are still on, we'll unmute your line. Mary Oleszek?

Mary Oleszek

Yeah, I'm sorry, I had no question.

Candice Hicks

Okay, thank you. We have a question from Karen Davis. "How can a Medicaid plan help members with shared decision-making?"

Monica Peek

You know, that's a really, I think, great question. I'll take a first stab at it, and then I'm interested to see what other people have to say. I think that there is a lot of interest now with payers in sort of rolling their sleeves up, too, and thinking about innovative both community-based interventions and interventions that support this process. So, I know that CMMI has an innovation award to try and help practices in rollout to implement shared decision-making and to sort of have some sort of way of evaluating that. And so I know that there's certainly

interest in Medicaid and Medicare on trying to figure out how to incorporate this into the clinical day-to-day bread and butter of how we provide for medical care.

And I also know that Medicaid and Medicare are becoming more flexible with sort of the advent of global payment systems and some of the other health policy changes and thinking about how we are able to reimburse for care. And so, rather than trying to squeeze physicians as like this doer machine where we just sort of spit out a lot of things that we're doing, if we can reprioritize spending quality time with patients and sort of task-shifting other things to a broader network of team members including community health workers, then I think ultimately we can find a better, more efficient use for physician time that would allow us more of the space and breadth for establishing those relationships that support shared decision-making.

While on one hand, I know that it ultimately is more efficient, on the other hand, I think that we can make the argument to a lot of payers that investing, again, in prevention and patient relationships really does have financial benefits for them that they should be able to support as well.

Linda M. Siminerio Dr. Peek, this is Linda Siminerio, can you hear me?

Monica Peek

Uh huh.

Linda M. Siminerio

I had an interesting experience last week: One of our endocrinologists, in a very large meeting after a presentation, raised her hand, and I was quite taken by this, that she said the best visit she ever had with a patient was a patient she had been seeing for a couple of visits, and the one visit, all they did was just talk. They didn't even really approach all the management issues; she just got to better know that patient, and she said it was probably the most rewarding visit she's had with that patient, and she would suspect that the patient felt the same way.

So, do you propose those kinds of visits every once in a while to get to better just socially know your patient?

Monica Peek

Yeah, I mean, I would say invest that time at the very first visit, for a couple of reasons. One, we actually get more time to see patients the first time they come in. And two, it sets the contextual framework for patient's expectations, and it's better to get to know them at the first visit than in visit number 72, because if you don't know their home situation or their social habits or just kind of what their job is and their family support, that means that you're missing out on the ability to leverage a lot of their social network or to make decisions and recommendations with your patient that really have all the information.

So, you have more time on the front end, it sort of has more dividends as far as paying back, if you can do that on the front end. But also, you know, fold that into your regular practice. I take notes on all of the social things that my patients tell me, and so the first thing I will say when I see them again is, "How is your husband doing? I know that he was having some struggles and was in the hospital the last time I saw you."

My first question to them is about their social history so that they know that I am sort of seeing their whole person, their whole experience, and understand that their ability to adhere to medications or to feel down and depressed or to have some additional tests is really sort of affected by the context of their everyday life. And so I try and start that way in the beginning and then just sort of maintain that throughout our visit.

But, yeah, it's more fun for me and certainly is more fun for patients, and it helps people's health. So, it's sort of a win-win-win.

Linda M. Siminerio

Thank you.

Candice Hicks

We have a pretty similar question along the same lines from Stephanie Amelie. "Can you give some examples of providers showing empathy that patients have perceived as helpful and appreciated?"

Monica Peek

So, one of the things that we work with our medical students to do is to work on sort of social norms, or sort of normalizing potential experiences that people have where they may not want to tell you the truth about something that they've done. And so for chronic disease management, it's medication non-adherence or whatever.

So a lot of times we will say things like, "You know, a lot of people who have diabetes really have a hard time keeping up with all the things you're expected to do. Every day, you have to think about your medications and what you're going to eat, and if you're going to check your feet. It's like having a second job with all the doctor visits; we understand it can really be challenging. Can you tell me some of the challenges that you may have had, or how you've been doing as far as keeping up with your medications?"

So, just sort of contextualize, like, "This, we understand, is a bear, and that everybody has challenges, so let's just talk about the challenges that you do have as opposed to assuming that you haven't had any challenges, assuming that you are 100% adherent, and I don't want to hear anything else, because otherwise I'll be very upset that you're not following my professional opinion, and you must not think well of yourself or me."

And so, I think we really can work on reframing how we ask questions and contextualize it for patients in order to get more honest answers and to get ones that help people understand that we have sort of realistic expectations for them and can sympathize with their situation. And so that's one thing I say. We always try to set the questions up first.

But no matter what people say, if it's something that's horrible, I'll just say, "Wow, that sounds really horrible," or, "That sounds really hard, and I'm really sorry you had to go through that" or, "I can't imagine," or just use the same social skills that we use for our family and friends when we're not in a clinician role—just take that to the clinician encounter, because we're still people, and it's really just about relationships.

And when people have a sense that you care about them, then they're more able to listen to the advice you have to give them. And so we're in this sacred space of people telling us just their most secret things and most horrible things about abuse, and we sort of hear it all, and it really is contingent upon us to sort of honor that space and the vulnerability that patients have shown us with empathy and compassion, and to acknowledge that—not just to sort of think about how to roll that into a quick plan of care, but to acknowledge that gift that we've been given and give some of that back to patients, because it will continue sort of in a reciprocal manner.

Candice Hicks

We have a question from Janet Tennyson. "What's a good way to get providers using shared decision-making when they are medical-model oriented?"

Monica Peek

Yeah, so, it's a challenge. I think there are two things. There's one sort of camp of really trying to incorporate the use more of decision aids into routine clinical practice, and those can be extremely helpful particularly for some practices where, I would say, for more subspecialists, who are like, "I'm the knee guy; 90% of my stuff is a knee replacement," and so the decision phase can be very helpful in that sense, because it sort of gives the space for people to hear all the information and come a little bit more informed to when they actually are talking about it to the provider.

But what we also want physicians, and clinicians, and diabetes educators, and anyone who has a touch point with a patient to also sort of understand is that it's not just a discrete decision, like, "Just watch this video, and come back and tell me what you like," but it really is the process. And for people who are chronic disease providers like myself, diabetes doesn't go away; we just manage it better and better, hopefully.

And so we want to be able to build not only patient skills but physician skills. So, we actually do physician training for trainees as well as hardened crusty doctors who have been in practice for 50 years or whatever. We can all learn new tricks. We have CMEs that we have to do, and so we have created sort of a bundled packet of provider skills in a workshop that they can actually get CME credit for, and we bring food and sort of make it fun just like the classes are fun for patients. And so we try and couch it in ways that make providers more responsive, like tricks and tips for dealing with the difficult patient; well, everybody wants to know how to do that, and they can get credit for it, and they can get a great meal, and they can learn a real skill.

And so some of it is just sort of the framing and the pitch, but also understanding that it really is trying to think of about the ongoing process and not just that I had this quick video that I'll mail to somebody and then will sort of keep on with business as usual when they come in to see me.

Candice Hicks

One follow-up question to that. "So, is shared decision-making being taught in medical schools now?"

Monica Peek

I think there's a lot of variability, and I don't have a pulse on how many schools are doing it or to the degree that it's incorporated into the curriculum. I do sort of see some of the literature that have people writing about curricular advances in innovations and sort of a growing acknowledgement that this is important from our organizational institutions. So, then, practice curriculum follows what we consider to be important.

And so I think that there probably are a lot more changes than when I went to medical school 20 years ago. But I think we still have a long way to go, and there's a lot of room for growth and expansion for how we work with our trainees to understand how to share in that power and decision-making process.

Candice Hicks

Lynn Enny asked, "For pharmacists practicing in retail settings, how can pharmacists play a role in shared decision-making with patients?"

Monica Peek

Well, this is great. I think everybody's on the team, and so for pharmacists, it's a wonderful opportunity, and so, I tell my patients, "You should envision yourself to be like that man with the khaki pants on the cellphone commercial where there's like 1,000 people following him around, that is you and your support team. Everywhere you go, ask somebody a question, ask your pharmacist, because they, I am sure, get bored of just pouring pills into a bottle, and they would love to talk to people. They're people, they like talking, and so ask them questions, they have all of this information about side effects and interactions, and usually when they say, 'Do you have any questions?' you're like, 'No, thanks, no. I'm fine.' But they're there to answer your



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

questions.” And so certainly anybody, again, who has a touch point with a patient should help sort of reinforce the idea that—questions are the answer, the AHRQ says—and like, “I’m really excited that you have this,” and, “Let’s talk about this,” and, “Have you thought about this with your doctor,” or, “I can give you some advice about this.”

Everybody has a role to play, special expertise that they bring to the table, be it around nutrition or medications or anything, physical therapy. And so the more we can have patients come to expect that this is a team sport with individual patients and providers and that we actually like to play together, too, which we do not always do a very good job of communicating that to patients, sort of the idea of team-based care, then I think the better we’ll all be as far as having more activated patients, and certainly there’s an important role for pharmacists, because we interact with physicians all the time. We’ll get notices from the pharmacist saying, “So and so interacts,” and, “Do you really want this dose?” These are the kinds of questions that should also have patients involved in them.

Candice Hicks

Okay, well, we have more questions, but I know we are reaching the 3 o’clock hour, so Joanne, I will turn it back over to you.

Joanne Gallivan

Thank you. Yes. I know we have more questions. If you have more questions, you can send them to us at the same address when you send your evaluation forms in, and we will be happy to direct those questions to Dr. Peek and Dr. Siminerio, who have graciously offered to answer any additional questions after the call. So, again, we will place this webinar on the NDEP website. You’ll hear the recording, you’ll see the slides, and we will ask you to fill out the evaluation form.

And lastly, I just want to thank Dr. Siminerio and Dr. Peek for a wonderful presentation. Unfortunately, we cannot clone Dr. Peek and bring her around to all different parts of the country, but I think what she and Dr. Siminerio have shared with us today, certainly we can bring back to our organizations and our constituents. I think it would be very helpful. So, thank you, everybody, for listening today and participating in the webinar, and look for more NDEP webinars in the near future. Thank you.