

# Certified Diabetes Educator Survey Results

-Idaho Diabetes Prevention and Control Program

Idaho Diabetes Educator Conference: June 21, 2013

# Survey Purpose

- Provide information to be used by the Idaho Gestational Diabetes Mellitus (GDM) Advisory Committee for program planning.
  - Identify future objectives for increasing awareness about GDM, testing, referral to DSME and follow-up care for high-risk women
- Understand how people are referred, have access to and participate in DSME.
- Results of the survey specifically assist the GDM Advisory Committee with ...
  - Identifying future objectives and activities around increasing awareness of GDM, testing and follow-up care for high risk women.
  - Gaining a better understanding of how referrals to lifestyle and behavior change resources occur in Idaho.

# Survey Methods

- The CDE Survey was developed by staff from the Bureau of Community and Environmental Health (BCEH) and the Idaho Diabetes Prevention and Control Program (DPCP) with input from the Idaho Gestational Diabetes Advisory Committee.
- The survey included just over 40 questions and addressed various diabetes education topics
- Surveys were administered in electronic and paper formats – 18 were completed on-line and 5 were completed on paper and sent to the DPCP.
- Response rate: Surveys (electronic and paper) were sent to 83 CDEs in Idaho. 23 completed surveys were returned for an overall response rate of 28%.

# Practice Settings

- All 23 survey respondents indicated they currently hold the Certified Diabetes Educator Credential
- The majority of CDEs practice under a Diabetes Self-Management Education Program (14) or hospital setting (7).

*Which of the following best describes your area of practice?  
(select all that apply) (n=23)*

	# of CDEs practicing
Diabetes Self-Management Education Program	14
Hospital	7
Community Clinic (FQHC)	1
Physician Practice	6
WIC	1
Public Health Department	1
Respondent's Private Practice	1
Outpatient Clinic	2

Note: Respondents could select more than one practice setting and therefore the number of settings was greater than the total number of survey respondents.

# Professional Credentials

- In addition to being CDEs, the majority of respondents were RDs (12) and RNs (11)

*Please select all credentials you currently hold:*

	# of CDEs holding each of the additional credentials
RN	11
NP	12
RD	1
Advanced Degree Nutrition	2
LD	2
IBCLC	1

- On average, CDEs responding to the survey have practiced for 13 years
  - Range: 3 to 25 years
- 8 of the 23 respondents indicated they were Diabetes Self-Management Education Program Directors.

# Professional Development

- Respondents were asked about their interest in receiving professional development (e.g., continuing education) on the following American Association of Diabetes Educators (AADE) competencies:

**Would you like to receive professional development on each of the following competencies identified by the AADE? (n=23)**

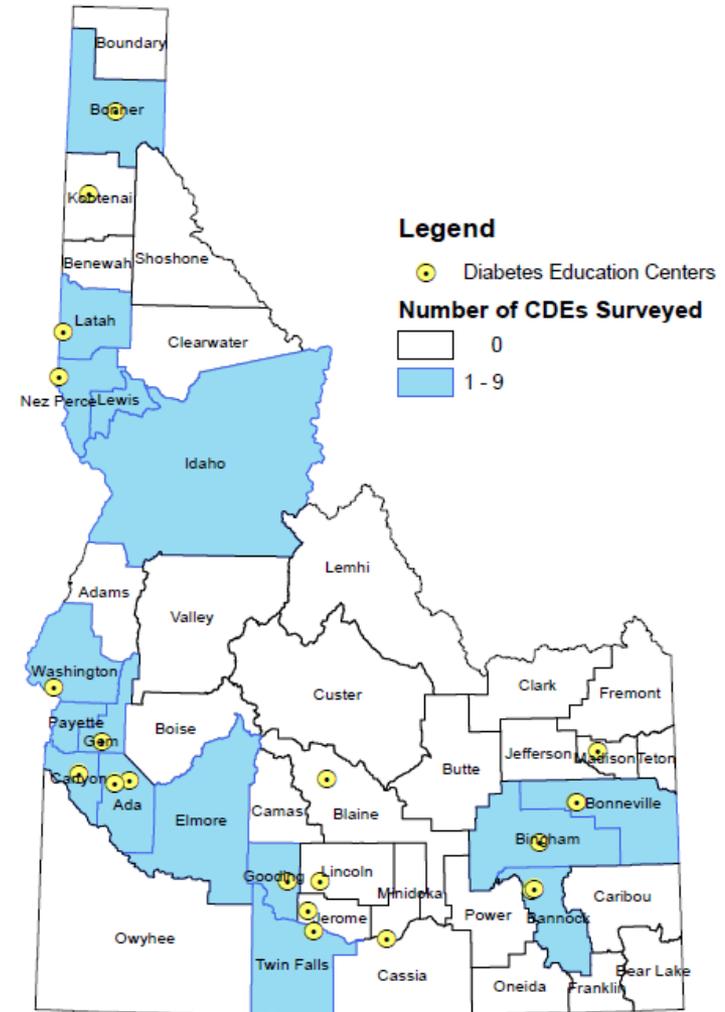
	# interested in Professional Development
Pathophysiology, Epidemiology, and Clinical Guidelines of Diabetes	21
Culturally Competent Supportive Care Across the Lifespan	20
Teaching and Learning Skills	22
Self-Management Education	21
Program and Business Management	19

# Diabetes Counseling

- Nearly all (22 of 23) CDEs indicated they had offered individual or group counseling for diabetes education within the previous two years.
- The 22 CDEs who had offered diabetes education counseling practiced in 16 of Idaho's 44 counties:
  - Ada, Bannock, Bingham, Bonner, Bonneville, Canyon, Elmore, Gem, Gooding, Idaho, Latah, Lewis, Nez Perce, Payette, Twin Falls, and Washington.

# Survey Response

The blue counties represent those counties which are served by the CDEs who responded to the survey.



# Populations Served

- CDEs were asked about the populations they typically served.

Approximately what portion of your clients could be described as: (n=21)	
	Most >60%
Low-income	5%
Uninsured	0%
Insured	52%
Medicaid	0%
Medicare	24%
White Non-Hispanic	67%
American Indian	0%
Refugee	0%

# Perceived Patient Barriers

- The survey asked CDEs their perception about potential barriers to accessing counseling or Diabetes Self-Management Education Programs.

**Percent of CDEs that “somewhat agree” or “strongly agree” with the following statements about patient barriers to accessing counseling or diabetes self-management education programs. (n=22)**

	Percent that somewhat agree or strongly agree
Patients with GDM find it hard to fit in appointments with CDEs, in addition to their prenatal care appointments.	36%
Patients cannot afford counseling with a CDE.	50%
Patients have difficulty accessing a CDE due to location of counseling services.	41%
Patients have difficulty accessing a CDE due to the appointment times offered.	36%
Patients do not understand the value or importance of counseling sessions with a CDE.	82%
Patients are not being referred to CDEs by their obstetrician or primary care provider.	55%

# Barriers to Communicating with the Referring Provider

- CDEs were asked about perceived barriers to sharing patient progress reports with the referring providers.

**As a CDE, what do you perceive as barriers to sharing information regarding your patients' progress reports with the referring provider? (select all that apply)**

	Percent
I always share progress reports with patients' referring providers	91%
I don't have a way to communicate with referring providers about patients' progress	0%
Lack of access to electronic medical records	5%
Lack of communication with referring provider	5%
Understaffed	0%
Patients are not aware of their condition	0%

# Patient Counseling/Education

- CDEs were asked several questions about the number of patients they counsel, the amount of time spent counseling, and the number of visits in a typical month.

**Approximately how many patients with GDM do you personally see in a typical month? (n=22)**

	Percent
None	14%
1-5 patients	77%
6-10 patients	9%
11-20 patients	0%
More than 20 patients	0%

# Patient Counseling/Education

## Hours spent counseling and number of counseling visits

	Average # of hours/ sessions	Median # of hours/ sessions	Range
Among your patients with GDM, approximately how many hours of counseling do your patients receive during their pregnancy?	2.9 hours	3 hours	.75 to 7 hours
Among your patients with GDM, approximately how many counseling visits do your patients receive during their pregnancy?	2.8 sessions	2 sessions	1 to 10 sessions

# Patient Counseling/Education

- CDEs were asked if they felt the amount of counseling time a patient with GDM receives during her pregnancy is adequate.
  - 8 said “Yes”
  - 3 said “No”
  - 8 said “It depends”
- The following statements were associated with the “It depends” response:
  1. ‘More scheduled if bGs [values] are off or insulin is started’
  2. ‘The time is adequate if we are also able to speak with the patient weekly by phone’
  3. ‘It depends on their current knowledge’
  4. ‘Visit number needed depends on when Dx, how well doing. Some need more visits but do not get’
  5. ‘Some need more but aren’t willing’
  6. ‘Follow-up is with primary provider sometimes’
  7. ‘GDM diagnosed in the first trimester, language, level of education, and cultural barriers may need more visits’
  8. ‘Depends on the patient. I feel that some need bimonthly appointments or at least monthly’

# Counseling Actions

- CDEs were asked about the frequency of specific actions when counseling women with GDM.

Percent of CDEs that report taking the following actions “most of the time” or “always” when counseling women with GDM. (n=19)	
	Percent who do each of the following “most of the time” or “always”
When I provide care to women with GDM, I typically refer them to a nutrition support group or other nutritional counseling.	37%
When I provide care to women with GDM, I provide them with nutritional counseling.	100%
When I provide care to women with GDM, I typically refer them to community resources to promote physical activity.	16%
If a woman has GDM, I discuss her long-term risk of developing type 2 diabetes.	100%
I encourage women with GDM to breastfeed.	74%

# Postpartum Glucose Testing

- CDEs were asked about different activities they may conduct to help encourage women diagnosed with GDM to obtain a postpartum glucose test.

Does your office practice or conduct any of the following activities to ensure women with GDM receive a postpartum glucose test? (select all that apply) (n=19)	
	Percent
Phone call to remind patient	21%
Text to remind patient	5%
Schedule a postpartum appointment before she delivers	11%
Provide educational materials that reinforces the need for a postpartum glucose test	58%
Have electronic alerts in the electronic medical record that inform the clinician of patient's need for a postpartum glucose test	0%
Discuss with the patient the need for a postpartum glucose test	79%
Schedule a postpartum appointment after patient delivers, but before she is discharged from the hospital	0%

# Postpartum Glucose Testing

- The CDE survey asked about tracking women with GDM to verify they received a postpartum glucose test. The majority of CDEs (16 of 19) indicated they do not track their GDM patients to verify they received a postpartum glucose test.
- CDEs were asked to describe how they track (if they do track) and why they did not track (if they do not track) patients with GDM to verify whether they received a postpartum glucose test.
- CDEs who do track their patients for postpartum glucose testing described the following methods for tracking:
  - “We send out a questionnaire or phone follow-up.”
  - “Scheduled for f/u with physician and diabetes educator. Test is done as part of physician visit.”
  - “Phone call survey quarterly. Low response rate.”

# Postpartum Glucose Testing

- CDEs who do not track their patients for postpartum glucose testing described the following reasons for not tracking:
  - “Time constraints/clerical support.”
  - “We refer them back to their OB physician for the test. We have discussed having them come back to our office for the test but have not implemented this yet.”
  - “I have never been instructed to do so.”
  - “No way of tracking.”
  - “We generally stress the importance of having a post partum glucose test. It’s left up to them to make the appointment if they notice high readings with their blood sugar.”
  - “We do a postpartum survey and we ask if they received a postpartum visit and BG test, however we do not have a process for reminding them to get the visit.”
  - “While we have EMR, because of my .4 FTE and working between 3 rural clinics, my follow-up isn’t what I’d like it to be.”
  - “Because they follow up with their physician after we instruct them on nutrition. If they are put on insulin, then we follow up for a longer period of time.”
  - “We are a stand-alone DSMT program and often lose contact with the patient after the 1<sup>st</sup> visit. They are not responding to our calls the way they would be to their health care provider.”
  - “Tracking and staff time constraints.”
  - “This is not my primary focus. The RDs do most of the care unless they need insulin so I do not have all the facts to answer these questions.”
  - “We do consults only and they return to the care of their primary provider.”
  - “This is done by the OB office.”
  - “No protocols/guidelines in place, however at my previous employment we did.”
  - “I am not sure if they receive this or not when they follow up with PCP after delivery.”

# Postpartum Care for Women With a History of GDM

- The CDE survey asked if there were any “insurance-related changes” which would better support women with a history of GDM.

**Which of the follow insurance-related changes would better support postpartum women with a history of GDM? (select all that apply) (n=19)**

	Percent
Including reimbursement for postpartum glucose test for women with GDM as part of standard prenatal/delivery package.	79%
Improving coverage and reimbursement for clinical specialties (e.g., endocrinologists).	32%
Improving coverage and reimbursement for lifestyle modification programs.	63%
Continued Medicaid coverage for women who currently lose Medicaid coverage 60 days after delivery.	58%

# Support for CDEs Addressing GDM

- The survey asked CDEs if there were training or tools which might better support their efforts in caring for women with GDM.

Which of the follow would better support you in your care for women with GDM? (select all that apply) (n=19)	
	Percent
Additional training in postpartum screening recommendations	26%
Additional training in risk factor identification/modification	11%
Listing of community-based programs targeting risk factor modification (nutrition, physical activity, etc.)	53%
Increased communication between obstetrician or prenatal care provider and myself	37%
Automatic reminder at postpartum visit of woman's GDM status in her chart or electronic medical record	52%
Improved patient education of her condition	26%
Increased patient responsibility for self-preventive care	84%

# CDE Resources

- CDEs were asked if they felt they had adequate patient education materials and community resources to increase physical activity and improve nutrition.

Percent of CDEs who “somewhat agree” or “strongly agree” with the following statements	
	Percent who “somewhat agree” or “strongly agree”
I have adequate patient education materials readily available for working with patients with GDM (n=22)	82%
I am aware of community resources to increase physical activity and improve nutrition (e.g., community gardens, recreational facilities) to refer women with GDM (n=11)	41%

# Living Well in Idaho Awareness and Referrals

- Several questions were asked to CDEs about their level of knowledge and/or history of referring patients to the Living Well in Idaho.

**Percent of CDEs that indicated they have knowledge of Living Well in Idaho, have referred patients, and will continue to refer patients to the Living Well in Idaho program.**

	Percent “Yes”
Before today did you have knowledge of Living Well in Idaho? (n=23)	43%
Have you referred any of your patients to Living Well in Idaho? (n=9)	67%
Will you continue to provide referrals to Living Well in Idaho in the future? (n=6)	100%

# National Diabetes Prevention Program

- CDEs were asked about their level of awareness of the National Diabetes Prevention Program (NDPP) and the Treasure Valley YMCA Diabetes Prevention Program (Y-DPP).

## Percent of CDEs that indicated they have knowledge of the NDPP or Y-DPP programs and had referred patients to the Y-DPP.

	Percent “Yes”
Before today did you have knowledge of the National Diabetes Prevention Program (NDPP)? (n=23)	96%
Were you aware that the Treasure Valley YMCA offers a Diabetes Prevention Program (Y-DPP)? (n=23)	35%
Were you aware pre-diabetes determined by clinical diagnosis of GDM during pregnancy qualifies a woman to participate in the Y-DPP? (n=8)	0%
Have you referred any of your patients to the Treasure Valley Y-DPP? (n=8)	25%
Will you continue to provide referrals to the Treasure Valley Y-DPP in the future? (n=2)	100%

# Tobacco Use Counseling

- CDEs were asked about tobacco use counseling, including referral to Idaho's tobacco cessation programs.

**Percent of CDEs that provide tobacco use counseling or refer patients who use tobacco to Idaho's free tobacco cessation programs (Idaho QuitNow and Quitnow.net/Idaho).**

	Percent "At every visit" or "Most of the time"
I assess and counsel all my patients about tobacco use. (n=23)	65%
	Percent "Always" or "Most of the time"
I refer all my patients who use tobacco to Idaho QuitNow (phone counseling) or Quitnow.net/Idaho (web-based counseling). (n=23)	26%

# Managing High Blood Pressure

- CDEs were asked if they discussed the importance of managing blood pressure with the patients they counsel.

**Percent of CDEs that discuss the importance of managing blood pressure with all of their patients. (n=22)**

	Percent “At every visit” or “Most of the time”
I discuss the importance of managing blood pressure with all my patients.	91%

Questions? Comments?