

# The Sweet Spot of Patient Engagement: Creating Healthcare Partnerships that Actually Work

## Webinar Transcript

Mitzi Vince: Good afternoon and welcome to today's webinar, The Sweet Spot of Patient Engagement: Creating Healthcare Partnerships that Actually Work. My name is Mitzi Vince and I'm a communications specialist with Quality Insights. We'll get started with today's program in just a few minutes, but first a few housekeeping items.

Mitzi Vince: All attendees are currently muted, so if you have a question during the presentation today, we ask that you please type it into either the chat or the Q&A box to the right of your screen. When typing into the chat box, please be sure to type to all participants or all panelists and not just to the host. We'll answer all questions at the end of the presentation. Also, this program is being recorded. The recording and slides will be available soon on our website. Finally, we ask that you complete a short evaluation at the end of the program. Your responses will help tell us how we did and it'll help shape our future programming. We thank you for help with this.

Mitzi Vince: Right, now I'll go ahead and turn the program over to our moderator, Natalie Tappe. Natalie.

Natalie Tappe: Thank you, Mitzi, and welcome everyone. I'm glad you're joining us today on the webinar since it's World Diabetes Day. I'm Natalie Tappe, the network task lead for the Everyone with Diabetes Counts program for Quality Insights Quality Innovation Network. As Mitzi said, I will be your moderator for today.

Natalie Tappe: I would like to first introduce our panelists, which include Mrs Nancy Barnett, a Medicare beneficiary and DSME class graduate, Mr. Edwin Beckford, a Medicare beneficiary and a Diabetes Self-Management Education class graduate, Dr. Harry Paraison, executive director Perfil Latino TV Inc and DEEP Peer Educator, Miss Kelli Janowski, master's-prepared registered dietician, diabetes and heart disease prevention program trainer, and Educator III at the Division of Public Health Delaware Department of Health and Social Services Division of Public Health.

Natalie Tappe: And now, our guest speaker today is Christine Bechtel. She is the co-founder of X4 Health, a nationally known expert in patient and family engagement, and has been working for four years to help Quality Insights develop and deploy customized best in class patient and family engagement strategies across all settings and topics we work in. Welcome, Christine.

Christine B.: Hey, everybody. I'm glad to join you today. As Natalie said, I'm Christine Bechtel and I just started my video feed so that you guys can put a face with the voice. If

you are new to WebEx, on the upper right hand side of your screen in the black bar, there's a box that you can use to change the view that you have. In case my face is floating off in the ether, you can move that around up there. I'm gonna go ahead and dive right in. I know we've got a lot of ground to cover today. All right.

Christine B.: I'm gonna talk to you guys today about the sweet spot of patient and family engagement. As Natalie said, I'm a consumer advocate by background. I'm an expert in patient and family engagement and it's kind of the sweet spot for us as an organization. It's really our superpower, if you will. I'm excited to share with you today how we approach patient and family engagement. My sense is though, when I talk to people across the country, that people tend to define patient and family engagement in slightly different ways. It's almost like a Rorschach test. People see different things in different concepts of engagement.

Christine B.: I'm gonna start by really talking about what is best in class patient and family engagement? What do we know now in healthcare today that really works, and what do we mean by engagement? I'm gonna talk a little bit about the spectrum of engagement where partnership happens. I'm also gonna cover a little bit about what patient and family engagement is not, because sometimes that's a helpful way for people to really grasp the core concepts that we're talking about. I'm gonna start to tie that up with what I call our field of dreams operating principle. I'm gonna hopefully give you a compelling case for why you can approach patient and family engagement this way and get a lot more bang for your buck.

Christine B.: And then I'm gonna leave you with some operational guidance in three particular areas. First of all, what are the most popular options for partnering with patients, and when do you use them? These are the most common questions we get. Second of all, what kind of patients should we be partnering with? How do you find them? And I'm gonna give you an action plan kick-starter. The idea here is that you can walk away from this call today and have a very clear pathway to figuring out how you can deploy the concepts that I'm gonna describe to you right now in the work that you do every day.

Christine B.: I will say I'm gonna start with the concepts around patient and family engagement. What is it? How is it defined? How does it happen on a spectrum? I'm then gonna pause before I dive into that kind of operational tactical level information. I'm gonna pause there for questions. As you guys are listening, please, feel free to jump in on the chat, to chat in any questions or comments that you guys have, and then once I go through the operational stuff, we'll stop again before I hand it back to Natalie to go to the reactor panel. That's the game plan.

Christine B.: All right. When we're talking about best in class patient and family engagement, we had the privilege in 2013, about 5 years ago, to work with researchers from the American Institute of Research, and some of their colleagues, to look at what are best practices? What's really working the field today? Healthcare has

changed a lot in the last decade ... 15 years especially, right? What do we know now?

Christine B.: Essentially, what we built based on that research is the definition that you guys can see on your screen here. We published it in a Health Affairs article. But this dimension has two really essential elements to it. One is this idea of an active partnership. Active dynamic partnership between patients, families and those who represent them, and the health professionals and staff who are working across the system. Also, that partnership happens in both health and care. Those are two separate things, so I'm gonna show you a little bit about what I mean right now.

Christine B.: There's three levels, really, of patient and family engagement. One is direct care. This is how most people think about patient and family engagement. Although, what we found in terms of what's effective out there is focused on how to expand people's capacity to get and stay well. It's this notion of, what is called in professional parlance, self-efficacy. But really the underpinnings of the best engagement and care start with what matters to people. Do they believe they can change? What are their goals that matter to them? It's a much more in-depth and a two-way engagement that happens, as opposed to some things like ... patient education's more of a one-way. I'm gonna talk a little bit more about that in a moment.

Christine B.: The second level is system design and governance. This is where patients and families are really guiding the overall operations of a healthcare practice, a hospital, a system, an insurance organization. Lots of different options here for the type of group that they might work with. But you can think of this as patients and families as partners in transformation projects. Really being a part of a quality improvement team, or sitting on the board, or serving on a patient and family advisory council. Really, it's those initiatives where patient voices are part of co-creating the system itself. That might be co-creating, might be evaluating, et cetera.

Christine B.: The third level that we uncovered is engagement in policy-making. I won't talk too much about that today because I think most of you aren't in the policy-maker D.C. circles that we sometimes find ourselves in. But I will say engagement ... patients and partners in policy-making is really essential. I mean, you guys know, those of you who work in healthcare every day, what the federal government asks healthcare providers to do is ginormously influential. It follows that if healthcare is really a policy-driven marketplace, then patients and families should have powerful voices in those processes to reorient care around their needs as well.

Christine B.: Diving a little deeper into that first level, that engagement in direct care ... It is World Diabetes Day. Happy World Diabetes Day, everybody. When we think about direct care, it's really condition-specific often, for example. But probably the most powerful and effective examples are engaging patients in things like shared decision-making or collaborative care planning.

Christine B.: I mentioned patient activation. How do you really move someone up a readiness to change scale to a place where they're super activated and really engaged and on top of their care? Collaborative goal setting, very, very powerful. And also focusing on patient-reported outcomes. Now, you can see at the bottom of my screen, I talk about how these strategies share one thing in common. I call it their superpower. They are grounded in a genuine bi-directional partnership between clinicians and patients and/or family caregivers. That partnership notion is super essential. Anyway, let me keep going here. Let me go to the system design and governance.

Christine B.: This is our second level of patient and family engagement. These are the most common types that you guys see. They'll be familiar to you. Patient and family advisory councils. Pretty prolific today. But you can also survey patients, interview them, do focus groups, put them on quality improvement projects. I love case conferences and staff orientation and training today because ... especially case conferences. When clinicians have to talk about cases with patients in the room, then they start to have to speak with them and not just about them, and it's really a quick pathway to culture change. Involving patients and families in actually staff orientation and training for your new staff or CME, also another great way to elevate their voices.

Christine B.: I mentioned that patient and family engagement happens on a continuum. Within those categories ... particularly the last two that I just mentioned, direct care and system design and governance ... there's a continuum that really starts with consultation a little bit more one-way in terms of the direction, but really ends up that far right side as partnership and shared leadership. The farther right you go up the scale, the much more impact you can have on health outcomes. And, also, by the way, the more rewarding it becomes for staff and for health professionals if you do it well. The more we're really orienting treatment and care decisions around patient goals and preferences, obviously as well as evidence and clinical judgment, the better chance you're gonna have for patients to actually be inspired to create change in their life.

Christine B.: Same thing with really putting patients in leadership positions so they're co-leading quality and safety initiatives, sitting side-by-side with healthcare providers and experts on hospital ... let's say equality improvement committees or safety committees. Same thing with the physician practices and nursing homes, et cetera. But difference here is not necessarily off to the side as often patient advisory councils are, but really integrated elbow to elbow with clinicians and health professionals. There's lots of factors that influence that and we can talk about that in the Q&A as well.

Christine B.: I wanna mention though for you guys what best in class patient and family engagement isn't. You'll notice that today I have not used a single word like compliance or taking responsibility or having some skin in the game. The challenge is this. Patient and family true engagement real partnership, it doesn't feel like a forcing function, right? When we think about compliance, the first thing that comes to my mind, anyway, is sort of that legal concept, "I must

comply with the law." That doesn't feel good. The culture that surrounds vocabulary like that is not really empowering to patients. It's really disempowering.

Christine B.: It's definitely rethinking engagement. It's not just trying to get people to do what we think they should do, not compliance, taking responsibility, or foisting our most intractable problems onto consumers ... We see this happen actually in public policy a lot. But even in the healthcare system, a lot of you will be familiar with hand hygiene projects where they try to get patients in the policeman role to kind of ask healthcare providers or bust them if they haven't washed their hands lately. Patients, if you talk to them, they're like, "No, I'd like to focus on getting and staying well and not policing my healthcare provider partners," and it doesn't feel like a partnership, right? That theme of partnership is really, really critical.

Christine B.: I wanna say a special word about patient education here. Patient education is important and, also, it's never really been true in history that facts or figures change the way people behave, right? If it was true that simple education works, then everybody would be skinny and nobody would smoke, right? Everybody knows these things are bad, but they do them for different reasons, right? How do we think about patient and family engagement as an important part of the puzzle, but it is ... I'm sorry, patient education as an important part of puzzle, but it is not synonymous with patient and family engagement. True engagement. And I wanna dive in a little bit about why, and this helps you understand the mindset behind patient and family engagement.

Christine B.: Simon Sinek, if you haven't watched his TED Talk on the Golden Circle, I highly recommend it. It's like maybe 16 minutes long. Awesome talk. He talks about how great leaders and great organizations inspire action because they think and they act from the inside out. Meaning they start with why and they end with what. That's not how we operate in ... certainly in patient education in healthcare, but also just not as a society how we often do ... If you think about it, all of us know what we do for a living, right? A lot of us know how we do what we do, but not all of us necessarily get connected to the motivation, the purpose, and our belief system that really drives those actions.

Christine B.: If we are interested in truly inspiring action with patients ... which, again, doesn't that feel like a way better word than compliance? If we really wanna inspire action, then we've gotta start with what matters to people. What is their true motivation. What matters to them? What goals do they have, and then how do we wanna achieve that goal? And what do we need to be able to do that? That is a fundamentally differently engineered process than the way we often approach patient education today.

Christine B.: The reason this is important is because the part of the brain that controls human behavior, which is really what we're all about at the end of the day, right, it has no capacity for language. It actually is driven by belief and feeling and that gut instinct, and so your rational brain kicks into gear when you have a

sense of what you wanna do and you can rationalize it and you can explain it. But really, at the end of the day, no capacity for language at the part of the core of us that really makes decisions. How do we think about what are the belief systems that underpin and how do we then inspire action from there?

Christine B.: The sweet spot between these two levels that I've mentioned, which is direct care and that system design and governance, the sweet spot is really about that partnership. If you guys are struggling with how do I patient activation, or how do I do shared decision-making or collaborative care planning or shared medical appointments ... whatever your thing is, your priority and or your pain point, that's the point at which you can say, "Well, gee, how could I actually invite patients in to co-create that process with me?" And this is what I call the field of dreams operating principle and I'm just gonna give you the new innovative modern version of it.

Christine B.: You guys remember the movie Field of Dreams with Kevin Costner, right? If you build it, they will come. That has been the predominant mental paradigm of our healthcare system for like ever. We build it for them and we pray and hope that they come. Only, now the world has changed. Consumers have a lot more choice. They aren't necessarily coming to the things that we build, specifically in patient education, patient engagement, and patient activation. There is a reason it's called a dream, right? What I would suggest to you is that sweat spot of patient engagement is really thinking about if you build it with them, then they will already be there. That's the fundamental principle that we're really trying to drive towards here.

Christine B.: Let me pause there. There's some instructions here to chat in your questions. Before I jump in to how do we take all of this conceptual stuff and figure out how to operationalize it, let me go ahead and pause. Give you a chance to ask your questions and send them to all participants in the chat box and maybe Mitzi is gonna try to scroll through and if I'm missing a question, just let me know.

Mitzi Vince: I'm not showing any questions yet at this time.

Christine B.: Okay. Great. Awesome. Okay. It's because I must be super clear. I must be having a good day. Had enough coffee. All right. So, here's some-

Mitzi Vince: Wait. We do have one question that just came in.

Christine B.: Awesome.

Mitzi Vince: It says, "Is there another way of saying person-centered care?"

Christine B.: I'd love to know what time that question-

Mitzi Vince: Or is this another way ... sorry. It says-

Christine B.: The difference ...

Mitzi Vince: "Is this another way of saying person-centered care?"

Christine B.: Oh, got it. Okay. Got it. Got it. Perfect. That was a really important question. No. This patient and family engagement and person and family-centered care ... or patient and family-centered care are not synonymous. Patient and family-centered care is really ... There's a lot of literature on it, but it's really much more of a way of being as opposed to a way of doing. Patient engagement is more the way of doing. But the way of being patient and family-centered ... so, we think about some principles of what does it mean to be patient and family-centered? We share information with patients transparently. We excel at communication and coordination. Things like that. It's a little bit more of what I would describe as an attribute of care.

Christine B.: Whereas patient and family engagement is a verb, right? It's like this is a thing, an action you wanna take to partner with patients for their own health ... that's engagement in direct care ... or to partner with patients to create or co-create or imagine, reimagine, improve the system of care. These are really strategies. I think patient and family engagement ... or, I'm sorry, patient and family-centered care is more of an end goal. We would all like to be patient and family-centered where they're really at the center of their own healthcare. Great question.

Christine B.: Alrighty. I'm gonna go through some of these most popular options, and if you're gonna do the field of dreams, let's build it with them so we are sure that they're gonna come. What are some of the most popular ways you might build it with them, so to speak? And how do they differ from each other? Let me spend about five minutes doing that.

Christine B.: First of all, advisory councils. These are pretty rampant today. They are fixed entities. It's about usually 8 to 10 individuals. They advise the healthcare organization routinely on matters. It's a designed to be a fairly diverse group, meaning broadly representative of the major population types that your organization serves. They might meet once a month, they might meet once a quarter. They often meet in person. It does tend to limit the type of patients who can build, unless you're meeting at night and you can invite people who work for a living, but, nonetheless, these are a great option. My recommendation is that if you're thinking about a patient-family advisory council, you have 12 months of activity that you can imagine them partnering with you on, input that they can give you, things they can do, ways to engage in improvements within your institution.

Christine B.: If you don't have 12 months, think about some of these other options. First, focus groups. It might be 8 to 10, a limited duration. They come for two hours. They sit down with you. You might do a couple of different rounds of them, but they're used for specific topics or specific types of patients. If you wanna improve diabetes education, for example, the way you do that or some shared

decision-making. You might convene a focus group of people with diabetes, have a limited duration, ask them a set of questions, get their input, et cetera, et cetera. But that's different because it's not a standing body like an advisory council. Putting patients on your actual project initiative, like your quality improvement team or your safety team or creating a work group of your clinicians and staff. This is one of my favorite approaches and there's kind of two ways you can do it.

Christine B.: One is to embed them into the team itself. They are really alongside the staff and the clinicians who are working on this. That means they're part of influencing the discussion and the decision and like that's where the meat is. That's where the power. That's where the learning happens so they can really shape all aspects of the process or the project that you're working on. I love that. You can also do a hybrid. For some people ... so, for example, complex patients with end stage who are in a dialysis facility, they're not coming to your project meeting, right? They spend five hours in the chair three times a week as it is, but you could create a hybrid model where you have regular touchpoints with those patients and an ability for them to influence your work and your decisions by just creating a different sort of timing sequence and how you engage them.

Christine B.: Staff orientation and training, I actually talked about this earlier and case conferences. Again, talking with patients and not just about them really opens up different perspectives, helps people think outside the box, and then, lastly, I would say patient surveys. Most people go, "Oh, God. This is like a really complicated expensive thing." That's not what I mean here. I don't mean a giant statistically significant sample size mailed survey. I mean like grab a SurveyMonkey, do four questions on an iPad, and do it for two weeks in your waiting room or something like that. You can just get a broad cross-section of people, but do it easily. Make this easy for yourself.

Christine B.: If there's one message ... well, two messages that you should take away from today, one is this is really important that you guys engage with patients as partners in creating the approaches and the systems that you want to work for you, and then number two is make it easier because if it's not easy for you to do, you won't do it. But the more you are partnering them in the priorities that matter to you, the more powerful the impact is gonna be, and, also, P.S. it's super fun. It's such a rewarding process. The more you can that, actually, the more your staff satisfaction goes up for the people who have a direct contact with those individuals. You're about to hear from a reactor panel, and you'll see what I mean. They're absolutely lovely humans. You would be getting to work with people like them every day.

Christine B.: Who are you looking for when are you doing those types of options that I just described? One of the most important things is that they just have some experience with your particular institution. If you're trying to do a redesign of your shared medical appointments or something like that, then they've gotta have some experience with which to speak from, and they understand the

culture and the practice and the operations and how the clinicians work and all those things. You want them to be generally representative of the population that's most impacted by the changes being sought. Sometimes, that's a consumer advocate. Somebody like me where they might not be directly in your practice, but they can ... If really what you're looking for is information on a population, consumer advocate or community representatives who work with a large population of people with diabetes, for example, or people who've experienced Alzheimer's family caregiving, whatever the case may be, they can often give you a broad perspective.

Christine B.: They need to have a willingness and a capability to speak up to be part of a group discussion. Hopefully, a functional capacity for the duration of the project. Able and interested to devote the time and the effort to it, and ... and this is important, and it may sound dumb, but people overlook this a lot. They can work in the anticipated ways. Like if you were gonna do webinars and online stuff like we're doing today, you wanna make sure that you're partnering with people who are savvy enough or have a mechanism with which to engage in that particular medium.

Christine B.: And then we wanna welcome people with both positive and negative experiences. That's really, really important because the diversity of views that you invite creates a really rich discussion. Probably the number one question that we get is clinicians ... or how do I find these people? Clinicians and staff totally know who they are. It doesn't take them long to be like, "Oh, yeah. You know, actually who would be great is ..." That's probably the number one pipeline.

Christine B.: Okay. Here's your action plan kick-starter. The slides ... Mitzi's gonna tell us how to get them. They're, I think, on the Quality Insights website. But what I thought I'd do is just leave you with, "How do I just get started on this like tomorrow?" Step one, you can see it on the screen. What are the priority issues or challenges that you're really facing, and how do patients interact with those priorities or pain points? How are they really impacted by that?

Christine B.: Write out your answers and your findings in that middle column, and if it's the case that patients can influence the issue, then keep going. Step two, think about how do they interact with those pain points? What are the options given out for partnering with those patients? That's that slide that I gave you earlier with the check marks and six options that you might be able to use. Focus groups, surveys, whatever. And what are you gonna do? What patients are best suited to participate in whatever that mechanism is? Who's gonna lead this effort? Who's gonna organize it? You do need a have person who's gonna sort of keep eyes on it and keep it going and motivate the staff and inspire people.

Christine B.: Do you need any additional resources? Like, "Hey, this could take a little extra time out of my day?" Or, "You know what, I'd like to do a focus group, and I'm gonna need to create a moderator guide and also feed them food," things like that. Thinking through that. And then how are you gonna prepare both the

patients and the team to work together? You do need to think about, "Okay, well, this is the ..." It's like if you were going into a new advisory board position in your professional life. You would wanna know, "Well, who else is gonna be around the table? What's the goal we're trying to achieve? What's the background information on the issue that might be helpful for me to have in advance? And so will everybody else around the table."

Christine B.: If you think about how you might prepare your colleagues for something like this, it's the same thing. You can just apply that to patients and families. And then when are you gonna start? When will you finish? How are you gonna stay on track? Project planning 101. But hopefully this is a quick tool that just gets you some really easy actionable things that you can use to create practical strategies that will really work. And, again, it's that field of dreams things. Build it with them, and they will already be there. Let me stop there and ask Mitzi if there are any other questions that have been chatted in?

Mitzi Vince: Okay. We have a question. Let's see. It's, "Can you give an example of a quality improvement project that you have done?"

Christine B.: Sure. We've done a couple ... well, we've done a lot of them. We've done everything from redesigning the registration forms. It turned out that patients were showing up ... This is in a primary care practice. Patients were showing up late for ... well, they were arriving on time but they couldn't get in to the appointment until about 10 minutes late because there were 13 pages of registration forms. We helped the practice convene a group that, basically, identified two essential things. One is don't put new patients in the very beginning of the day because then if you're gonna ask them for that much information, it affects the rest of your schedule.

Christine B.: And then the patients went through the 13 pages and basically created a ton of efficiency that ended up really helping the staff as well. Minimized their data entry, really got them focused on the information that they truly needed, thought about the ways they could collect it. Not just when the person showed up but in advance. Things like that. And really pushed them for some much easier methods of getting the data that they needed. That was a fun one because it was, again, patients and staff side-by-side.

Christine B.: Quality Insights did an awesome project down in Louisiana on ... it was in a long-term acute care hospital. It was on hand hygiene. And so what we did ... and I used it as an example earlier. We went and interviewed the clinic director, went and interviewed patients about how did they experience the hand hygiene interventions that the hospital had already developed, and asked them ... basically, did a series of one-on-one interviews, about 10 of them, and then realized that they were educating patients about the importance of hand hygiene, washing, and cleaning their own hands and their visitors, but they were doing it at the wrong time. They were doing it right on admission. The patients weren't retaining any of the information.

Christine B.: And so they figured out a different point in time, a different workflow, and a different set of materials that they could use. They also realized that they had some physical layout issues, like they didn't have enough hand sanitizer in certain places that would've made a lot of sense to patients and visitors. It was great because, again, they opened the staff's eyes a way of experiencing their hospital that the staff don't experience it that way because they work there. That was another great one. But there's a ton of evidence on projects like that. Those are just two that have come to mind. Any other questions?

Mitzi Vince: This looks like it's more of a comment rather than a question. This is from Jeanette. She says, "I would also suggest letting the patient call in on a conference line to work with the team. They don't need to physically be at the meetings to participate."

Christine B.: Yeah, I agree. I think sometimes it can be hard, we all know that, when you're the only one on the phone. But the thing that I think is really kind of changing that practice right now is our video conference capabilities like Zoom. We use Zoom all the time. It's super cheap. Skype is another one. Even FaceTime. Once you can see people in the room and they can see your face ... It's why I'm using video today. You can see nonverbal cues. I know when Mitzi's got a question she flags me down. Whatever. I love that idea, and now, frankly, everybody's phone or iPad, and most people's laptop, have a camera and a mic on them. I definitely love technology-enabled meetings. That's great, Jeanette. Thanks. Any other questions, Mitzi?

Mitzi Vince: It looks like that's all we have right now.

Christine B.: Great. I'm gonna turn my video camera off. I'm gonna turn it over to Natalie, who's gonna explain not only the panelists who are gonna speak, but we have kind of a fun little exercise that we're gonna ask you guys to do to create a word cloud in real time. Let me first turn to Natalie and ask you to take over from here.

Natalie Tappe: Thank you, Christine. That was a very wonderful and informative presentation. As Christine said for our next segment, we're gonna be joined by our wonderful panelists and they are gonna be able to help us understand patient engagement a little bit better by sharing their experiences, excuse me, and putting a human story on the concepts that Christine just described.

Natalie Tappe: Like she said, while they're speaking, one of my colleagues will be creating a real time word cloud from what they're shared with us. At the end of the call, we'll be able to show you what we develop. This is how it works. We've asked everyone to lead in with a statement about the best kind of engagement, kind of like a ... or their engagement statement. I'm gonna start with Christine and I'm gonna ask her what's her statement? As a patient, when do you feel most engaged?

Christine B.: I feel most engaged when the clinician takes the time to really learn about me and learn about what matters to me, and then orients my care around my own goals for my life and my health.

Speaker 4: I'm confused about what we're supposed to be doing.

Natalie Tappe: That's an excellent ...

Natalie Tappe: Oops. I think we have some feedback. That's an excellent answer to the question. Thank you for that, and now I'm gonna ask Nancy Barnett, as a patient of the diabetes self-management classes, I want you to complete this sentence for me. I feel most engaged when ...

Nancy Barnett: I feel most [inaudible 00:35:32] ... how to take of yourself in these classes.

Natalie Tappe: Could you repeat what you said? Because I don't think everybody heard. I think we had a little glitch there. When do you feel most engaged?

Nancy Barnett: I feel most engaged when Susie would talk to us and then we could talk back to her and ask her questions and she could explain to us how to take care of our bodies and the way that we eat and everything to make our life better.

Natalie Tappe: Well, thank you for that, and that kind of goes in to our next question for you. What difference when you went to class and you graduated from the class, what difference did it make for you and how you now, since you have the knowledge, take care of your diabetes and yourself?

Nancy Barnett: Number one was I was a person that was in denial and I did not monitor my blood every day. I do that now every day and, also, my eating ... she showed us our portions on a little plate and how we could eat things that we thought we couldn't, but that was one thing that I have learnt and I've learnt to eat lots of vegetables and my protein. I really enjoyed the classes.

Natalie Tappe: Thank you for that. One thing I wanted to mention too was you have ... it's been a while since you actually graduated and we hear from you occasionally that you're actually keeping up with those practices that you learned in that class. Is that correct?

Nancy Barnett: Yes, ma'am. That is correct.

Natalie Tappe: Wonderful. Thank you so much for sharing your experiences with us. Now, I'm going to go to our-

Nancy Barnett: You're welcome.

Natalie Tappe: Thank you. Mr. Beckford, and I'm gonna ask him a question. As a patient of the diabetes self-management class, how did the class make a difference in your life?

Mitzi Vince: Natalie, I believe that he was having some connection issues, so I am not sure if he's available.

Natalie Tappe: Oh, okay. All right. Well, if they get back to us then we'll come back to him at the end. So-

Mitzi Vince: Can we try one more time? Mr. Beckford, are you on the line?

Natalie Tappe: Okay.

Mitzi Vince: Okay.

Natalie Tappe: Well, sorry about that. We'll go ahead and if they come back on the line, then we'll go ahead and ask him at the end. Now, I'd like to go to some of our educators. The first one that I'd like to talk to is Dr. Harry Paraison. He's an educator for the diabetes self-management classes and I'd like for him to complete this sentence for us. I think the best engagement is when ...

Harry Paraison: When I, as a facilitator, I'm able to relate with some of the participants in the diabetes empowerment education workshop and then we can discuss ways for them to improve their health.

Natalie Tappe: Excellent.

Harry Paraison: Thank you.

Natalie Tappe: Explain to us what are the opportunities you see for helping others learn about how to care for their diabetes.

Harry Paraison: When talking about the diabetes self-management classes or the diabetes empowerment education classes, I think it's really gives an opportunity for people to share their knowledge. Many of the participants, they have a pretty good knowledge, at least for the group that have been participating around this area of South Jersey. A lot of them have diabetes for a great number of years, 10, 15 years. They know what they need to do but, for some reason, they're not doing it. I find that the opportunity to be in the workshop, they can share their knowledge with some others.

Harry Paraison: It's also helped them to feel more in control because when they use the weekly action plan to report to us and also to report to their peers that motivates them to keep on what they plan in their action plan. That also empowers them to make change in their life that will help them to be healthier. For example, if they know that some companions in the class are going to be walking in the mall, for

example, they may join that person or they may start a small walking group in their neighborhood if they can. Also, it motivates them also to take better control of their blood sugar and motivate them to lose weight, motivate them to keep an eye on their A1C and then it motivates them ... They have more knowledge to talk to the doctor about what is their A1C. They can ask questions to their doctor.

Harry Paraison: A lot of them come back every week and then they're always have questions and then the group always have abilities to answer questions for them that led them to ... they feel good with the classes.

Natalie Tappe: Yes, definitely. I think it helps when you have people with the same ideas or the same even diseases, actually, to ... not compare notes, but to get together because a lot of them are going through the same thing, and we as the facilitators are able to, like yourself, encourage them to speak to others and be empowered to, like Christine says, be involved together with their physician. Not having the physician dictate to them their care, but working with them together to come up with a play of action for their diabetes. I see that as a real important part of what we do.

Harry Paraison: Yeah, and they can relate and they can have somebody, as we said before, with those same issues and then they can try to find solutions for that. Or what have you done to improve your A1C, for example, and then they can have different answers.

Natalie Tappe: Right. Definitely. Thank you, Dr. Paraison. I really appreciate that. That was a great explanation for us. And now for our last panel-

Mitzi Vince: Natalie?

Natalie Tappe: Yes?

Mitzi Vince: I think we have Edwin again if you wanna try him.

Natalie Tappe: Oh, sure. Sure. We're gonna go back, if you don't mind, to one of the beneficiaries, and the question I wanna ask, Mr. Beckford, is as a patient of the diabetes self-management classes, tell us how the class has made a difference in your life.

Edwin Beckford: Well, I've met a lot of people who have the same disease and we've established a group, a support group, and we're sharing information and it's really wonderful.

Natalie Tappe: That's excellent. You mean after you took the class, you formed a support group?

Edwin Beckford: Well, yes. And we decided to meet twice a month and it's working out great.

Natalie Tappe: That's wonderful-

Edwin Beckford: We're [crosstalk 00:44:14] to ... yeah, we're continuously thinking about new ways of making ... more than just talking, but taking things to the next step. I, during the week, thought about maybe we can get a scale and weigh in each time. More accountability and maybe since we weigh in, we might as well finish and compute the body mass index and that would give us a little goal, and not about making ... but it would be about making the goals doable.

Natalie Tappe: Yes, definitely. The action plans help us do that because they're definitely ... and that's a wonderful thing to be able to do is have a follow-up group. It's great that you're able to do that as far as having been graduated from the class and still keeping in contact and continuing to make those changes. Thank you so much, Mr. Beckford. That was a great explanation of how the classes made a difference in your life. I appreciate that.

Natalie Tappe: Now, lastly, we're gonna talk to our last panelist, Miss Kelli Janowski. Kelli, as an educator and a partner for the diabetes self-management education classes, tell us what are your best engagement strategies?

Kelli Janowski: My best engagement strategies are definitely the sharing that goes on in the diabetes self-management classes. When patients share their concerns with their educator and their peers, I think it gives them a lot of empowerment to move forward in better managing their diabetes. Also, they come with plenty of questions. That's always an engaging conversation to have with the group and the group activities that are involved with the diabetes self-management, and their involvement and knowing that they're involved in their own care plans and treatment plans and treatment options with their healthcare team is key to keeping that person with diabetes engaged.

Natalie Tappe: Yeah. Absolutely. Because they have to be ... like I always say, they have to be ... it's one of the things that I say. They have to be invested in their own healthcare to be able to form that partnership like Christine had said with their healthcare providers because many of them have multiple physicians so they have to be able to engaged to be able to do that with their multiple providers. Kelli, lastly, what is the reason ... tell us why you made the decision to teach diabetes self-management. What was your motivating factor?

Kelli Janowski: My motivating factor as a register dietitian is ... the main focus is the person and making sure that they have the tools or everything that they need to better manage their blood sugar levels, to better the manage diabetes and complications or comorbidity that many people with diabetes have. It's also about communicating and educating the person with diabetes about what they can do to live a healthy life. Teaching them to be more proactive in terms of preventing their blood sugar levels from elevating. We teach a lot about the self-care behaviors. So, teaching them about healthy eating, being active, taking their medications and the importance of monitoring.

Kelli Janowski: Within our diabetes self-management class, we talk about problem solving. We talk about how to cope. Diabetes distress and how to cope with those different emotions that one might have, and how to reduce the risks of not taking care, and if you don't take care of yourself, you're gonna be at a higher risk for having those comorbidities get worse. Also, as a dietitian, again, it's about empowering that patient to partner with their ... like you said, with their healthcare provider, which could be many. Could be their primary [inaudible 00:49:17], their endocrinologist, their podiatrist, the dentist, their kidney doctor, the nurse, the dietitian. It's a whole team approach. And making sure they know it's about lifestyle and behavior change and letting them know it's not easy, and I think as Dr. Harry alluded to ... managing their weight and being more active.

Kelli Janowski: All of these changes and this behavior change ... basically, I feel that it's important that we need to meet the patient where they are and help them get to where they wanna be as a healthy person, a whole person, and that's one of the reasons that I teach the diabetes self-management program is to empower people to make changes in their lives that are gonna benefit them in the long-run and definitely have a healthier outcome.

Natalie Tappe: That's awesome. Yeah, I agree with you too. We all like making a difference and, unfortunately, we all know what diabetes can do, especially if you're not a well-controlled diabetic. Coming to the classes, even though we try not to ... it's by their own free will. They come because I think they want to make that change, but it's hard to tell people that do have diabetes the importance of making those changes. That's one of the things I think also Christine alluded is it has to be important to them too to be able to make those changes. So, thank you so much, Kelli. I appreciate it.

Natalie Tappe: Thank you to everyone, to all the panelists. I'm now gonna turn to my colleague, Laurie, who will show us a word cloud of the best engagement themes that we came up with when the beneficiaries were talking. Christine, while Laurie gets that up and running ... Oh, there it is ... you wanna offer some closing remarks and share some ... That's great. I like our word cloud. And share some observations about it?

Christine B.: Sure. I thought that was great, you guys. I really enjoyed listening to each of you, and I think the word that I actually heard most often was 'empower'. I heard the word 'motivation' a lot. I heard 'sharing' and 'support'. I heard 'relating' and 'connecting'. I love those because those are really the attributes of best in class patient and family engagement in their own care, and I think to a degree they are ... many of them are the attributes of best in class patient and family partnerships for improving the way we deliver care itself. This idea of relating to each other and how do we work together to make life better for everybody, right? Not just patients and families, but also the staff and the health professionals who work in the system every single day and they feel its effects just as we do.

Christine B.: That motivation to work together, the knowledge that it takes to work together, how we support and connect to each other, those are really the spirits that I think underlie both engagement and care and engagement with patients as partners in improvement. I thought that was a terrific set of examples, particularly as they relate to engagement in care.

Natalie Tappe: Thank you, Christine.

Christine B.: Mitzi, are there any other questions before we wrap up? Or before Natalie takes it back?

Mitzi Vince: It does not look like we have any other questions ... oh, hold on. Just one second. It's not a question. But we do have someone that says that they love the word cloud and thank you to all the panelists for helping do a better job at engaging patients.

Natalie Tappe: Oh, well, thank you.

Christine B.: Awesome.

Natalie Tappe: Okay then. Well, I would like to take this opportunity to thank Christine Bechtel for helping us understand better patient and family engagement and also a thank you to Mrs. Barnett, Mr. Beckford, Dr. Paraison, and Miss Janowski. Thank you so much for helping us and being a part of our webinar today, and special thanks to Mitzi Vince for getting it up and running for us and Laurie Fink for helping with the word cloud.

Natalie Tappe: Again, you can reach us. The presentation will be available in a couple of days. Mitzi had posted the where to go to listen to the recording and if you need to get in touch with us on the screen now is our different Facebook, Twitter, Indeed, and YouTube. So, again, thank you so much and have a great day.

