

Table 2. Pre- and Postintervention Measures

Concept	Instrument
Mindfulness	Five Facet Mindfulness Questionnaire (FFMQ)
Perceived stress	Perceived Stress Scale (PSS-10)
Diabetes-related distress	Problem Areas in Diabetes Survey (PAID)
Diabetes coping	Diabetes Empowerment Scale—Short Form (DES-SF)
Satisfaction	Satisfaction questionnaires, diaries, and field notes
Diabetes self-management	Diabetes management behaviors
Self-care goals	American Association of Diabetes Educators 7 Self-Care Behaviors Assessment
Engagement	Home practice diaries
Metabolic control	HbA <sub>1c</sub> determination

Diabetes-related distress decreased by about 19% at 1 month ( $p < .01$ ) and 41% at 3 months ( $p < .01$ ). Awareness, coping, self-management, and self-care scores increased throughout the 3-month study, with the latter 2 scores being significantly greater at 3 months than prior to the first intervention ( $p < .01$  for both). Baseline and 3-month HbA<sub>1c</sub> data were 8.4% and 7.3%, respectively, which was a significant decrease ( $p < .01$ ).

Study limitations include the small number of subjects and an uncontrolled design. Although the results cannot be generalized, the study establishes the feasibility of mindfulness meditation in easing diabetes-related distress. Larger controlled studies using real-time recording of daily meditation sessions are needed.

## Partnership Between Diabetes Educators and Insurers Can Improve Patient Outcomes

Written by Lynne Lederman

The increasing number of patients with diabetes and the pressure to make health care more accountable have contributed to the need for more patient-oriented approaches to effectively manage diabetes. Because of this need, health care providers not only pay for health care costs but also directly manage the health plans of their members. Patricia Johnson, RN, University of Pittsburgh

Diabetes Institute and University of Pittsburgh Medical Center (UPMC) Health Plan, Pittsburgh, Pennsylvania, USA, and colleagues presented the Leveraging Education and Diabetes Support (LEADS) program, an approach to using certified diabetes educators (CDEs) as a clinical and community resource for health plans.

The LEADS program was intended to develop a chronic disease management model using CDEs as the “hub” resource of a network of insurer-driven diabetes care management services. The program was initiated 2 years ago and funded by the UPMC Health Plan. Two CDEs established best practices for consistent communication, competency development, and support and collaboration with caregivers and patient members.

In supporting the practice-based care managers, the CDEs coordinated, anticipated, and assisted in the care management and support of UPMC Health Plan members in primary care practices. Support included helping physicians address patient knowledge gaps concerning condition, education, and lifestyle management. CDEs coordinated the development of care plans between clinical support staff and primary care physicians. CDEs contacted patients directly and indirectly using both traditional and novel means (eg, in person, e-mail, calls, electronic medical record, telemedicine) to provide education and support.

Supporting the role of the health management lifestyle coaches, CDEs provided diabetes educational resources, assisted in developing care plans for high-risk patients, and coordinated resources among the insurer,



the community, and the health system. Supporting the role of the senior care community coordinators, the CDEs provided training and support, such as collaborating with a certified registered nurse practitioner to train senior care community staff in the use of insulin pens.

Direct member support was provided by the CDEs through participation in events at mobile units and mall kiosks, during member retention events, and by helping members connect with health system resources. In the role of supporting the transition coordinators, the CDEs provided ongoing diabetes education and helped connect transition coordinators to community diabetes resources.

The LEADS program helped to establish standardized diabetes management education and training. This program created core competencies in diabetes care and assisted health care providers in recognizing a current evidence-based standard of care for their patients with diabetes. It also increased the confidence of staff in their ability to help these patients, and it improved the communication among staff in different insurer departments, allowing care to be coordinated among staff, the patients, and their health care providers. For high-risk patients who had been identified in the patient-centered medical home, guidance concerning their diabetes treatment and referral for high-risk management resulted in improved blood glucose control.

Facilitating the management of diabetes using CDEs as a central resource should be evaluated for its effect on outcomes, costs, and use of health care resources.

## Collaborative Approach Improves Diabetes Education for Oncology Patients at Discharge

Written by Lynne Lederman

Oncology patients treated with corticosteroids are at an increased risk for hyperglycemia; however, they may not be aware of this risk. Lisa Gurman, RN, MScCH, and Bo Fusek, RN, MEd, both of Hamilton Health Sciences, Hamilton, Ontario, Canada, described a patient-centered study within their tertiary care hospital to improve the discharge process by enhancing staff autonomy and knowledge in diabetes discharge planning.

Challenges in improving diabetes education in an oncology unit included knowledge gaps of health care professionals, some of whom did not realize the importance of testing blood glucose in patients without a history of diabetes, as well as feelings of being overwhelmed among the staff with last-minute duties at discharge time. In addition, only 1 diabetes clinical nurse specialist (CNS) worked in the hospital.

To address these challenges, a collaborative approach was encouraged. Open-dialogue education sessions allowed the staff to first identify the challenges to teaching home glucose monitoring to patients at discharge. The staff then discussed the implications of learning the new skill and practiced teaching it.

The study investigators helped to develop a nursing process flowchart where the diabetes CNS provided staff education, the inpatient oncology staff identified patients and educated them, and the outpatient pharmacist taught the patient how to use the home glucose monitor. Training on the home glucose monitor began within 24 hours of discharge to avoid the pressures at discharge time. Nurses obtained the glucose monitor prescription, sent it to the pharmacy, and arranged for the patient's education time.

Patients' education sessions included family members and occurred in a quiet room (established during the program) to avoid the distractions of multipatient hospital rooms. The pharmacy provided all medications at discharge and offered to transfer all prescriptions to the patient's home pharmacy, if desired.

Data collected during the study included pre- and postvoluntary responses to 6 knowledge measures on a 5-point Likert scale: the rationale for training, the 4 steps of home glucose monitoring, what to advise the patient (eg, where to get meters and supplies), glucose goal ranges, when to test, and a weekend contingency plan (eg, where to find glucometers on the unit) when the outpatient pharmacist was not available. The data also measured pre- and postlevels of confidence and conviction.

Postknowledge scores increased for all 6 measures. The greatest impact was related to goal ranges. Knowledge increased among 92% of respondents, and 90% found the hands-on portion of training helpful. Conviction levels increased by 26%, and confidence levels around discharge teaching increased 40%.

These results show that in this hospital setting, open-dialogue education sessions and a hands-on collaborative approach can be effective in enhancing nursing staff knowledge, increasing conviction that home glucose monitoring is important, and improving staff confidence levels.

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