

(REVIEWED)

Case ID # |\_\_|\_\_|\_\_|

UIC/IRB # \_\_\_\_\_



## **Provider Diabetes Training Needs Survey**

**Chicago Southeast Diabetes Community Action Coalition  
Quality of Care Committee**

**Midwest Latino Health Research, Training, and Policy Center  
University of Illinois at Chicago  
1640 W. Roosevelt Rd. #636  
Chicago, IL 60623**

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National Center for Chronic Disease Prevention and Health Promotion  
Centers for Disease Control and Prevention**

This survey does not ask your name or for any other identifying information. You will see it is marked with a number (upper right corner). This number matches to your name on a list. This mailing list will only be used to track those who have not responded. We expect to follow-up with those who have not returned the survey by (date). After we have completed the follow-up, we will destroy the list. This will not link you to the names of persons who have completed the survey.

## DIABETES PROVIDER SURVEY

Thank you for taking time to complete this survey. **Do not write your name on this survey.** Your information will be kept confidential. The return of the survey will be interpreted as consent to be part of this study. Further, it would be helpful to have complete answers but you are free to not respond to any part of the survey.

1. Your Work Location by Zip code: |\_\_|\_\_|\_\_|\_\_|\_\_|      **Date:** \_\_\_\_\_

2. What is your profession or medical practice?  
 ? 1. Physician → 2a. What is your medical specialty? \_\_\_\_\_  
 ? 2. Nurse  
 ? 3. Nurse Practitioner  
 ? 4. Dietitian\Nutritionist  
 ? 5. Health educator  
 ? 6. Other allied health, specify: \_\_\_\_\_

3. If you are a physician, what year did you graduate medical school? \_\_\_\_\_

4. If you are a physician, are you board certified?    ? Yes      ? No

5. If you are a physician, are you board eligible?    ? Yes      ? No

6. Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male				
7. Ethnicity/Race: <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic\Latino <input type="checkbox"/> Asian <input type="checkbox"/> Non-Hispanic White <input type="checkbox"/> Other _____				
8. Age Group:    ? 20 – 29 yrs    ? 30 – 39 yrs    ? 40 – 49 yrs    ? 50 – 59 yrs ? 60 – 69 yrs    ? 70 – 79 yrs    ? 80 – 89 yrs    ? 90 + yrs				
9. Formal Training/Degrees:				
10. Language Skills:	Speak fluently	Read	Write	Clinical Terminology
a. English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Spanish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. What is your primary language?				

12. What hospitals or clinics are you affiliated with:     No hospital affiliation

<input type="checkbox"/> Advocate Trinity	<input type="checkbox"/> Jackson Park	<input type="checkbox"/> South Shore
<input type="checkbox"/> Christ	<input type="checkbox"/> La Rabida	<input type="checkbox"/> University of Chicago
<input type="checkbox"/> Chicago Family Health Centers	<input type="checkbox"/> Roseland	<input type="checkbox"/> Other _____
<input type="checkbox"/> Chicago Dept. of Public Health	<input type="checkbox"/> St. Margaret	_____

13. How long have you worked in southeast Chicago (60617-28-33-49)? |\_\_\_\_\_|\_\_\_\_\_| years

**PRACTICE SETTING**

14. Is your primary practice location a  Hospital  Clinic  Private Office  Other \_\_\_\_\_

15. Are these services or specialties provided at your office, facility, or referral? (check all that apply)

Primary Health Medical Care	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source
Specialty Health Medical Care			
Endocrinologist	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source
Ophthalmologist/Optomestrist	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source
Nephrologist	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source
Neurologist	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source
Podiatrist	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source
Psychiatrist	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source
Other:	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source
Nutritionist/Dietician	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source
Certified Diabetes Educator on staff	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source
Pharmacy / medical supplies	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source
Patient Education	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source
Hospital Inpatient	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source
Long-term care/Nursing home	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source
Mental health/Substance abuse	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source
Home health related services	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source
Social Work/ Case Management	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source
Other Health services Please Indicate	<input type="checkbox"/> Private Office	<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Referral Source

16. Does your organization offer diabetes education? ? Yes ? No  
 16A) Who provides it? \_\_\_\_\_ ? Dietitian Consult  
 16B) What kind? \_\_\_Inpatient \_\_\_Outpatient  
 16C) How often offered? ? As needed by patient  
 ? As allowed by insurance plan / patient means  
 ? Other: \_\_\_\_\_  
 16D) Do you offer any free diabetes education classes? ? Yes ? No

**CLIENTELE**

17. How many of your clients or patients represent:  
 17a. Race/Ethnicity: a) Black or African-Americans \_\_\_\_\_ %  
 b) Hispanics or Latinos \_\_\_\_\_ %  
 c) Non-Hispanic Whites \_\_\_\_\_ %  
 d) Other ethnic/race groups \_\_\_\_\_ %

17b. Limited English speakers: \_\_\_\_\_%

17c. Gender: a) Females \_\_\_\_\_%  
b) Males \_\_\_\_\_%

17d. What is the primary language of your patients? \_\_\_\_\_

18. Do you see persons with diabetes? ? No ? Yes

19. What percent of your patient caseload are persons with diabetes? \_\_\_\_\_%

20. Of your patients with diabetes, which of these are barriers?

- ? a. lack of time in the patient visit
- ? b. language barriers
- ? c. cultural differences
- ? d. patient unfamiliar with medical system
- ? e. the patient's educational level
- ? f. patients understanding of clinical terms
- ? g. patients non-compliance
- ? h. OTHER: \_\_\_\_\_

**PRACTICE GUIDELINES AND PROTOCOLS**

21. Do you follow the American Diabetes Association guidelines for managing your patients with diabetes? ? Yes ? No

22. If no, what guidelines do you follow? \_\_\_\_\_ or ? None

23. How often is it recommended that a diabetic patient should have the following tests or exams:

Foot exam by provider	? Each Visit	? Every 3 mos	? Every 6 mos	? Annually	? As needed
Nutritional counseling	? Each Visit	? Every 3 mos	? Every 6 mos	? Annually	? As needed
Skin exam by provider	? Each Visit	? Every 3 mos	? Every 6 mos	? Annually	? As needed
Hb A1C	? Each Visit	? Every 3 mos	? Every 6 mos	? Annually	? As needed
Fasting Blood Glucose	? Each Visit	? Every 3 mos	? Every 6 mos	? Annually	? As needed
Diabetes Education	? Each Visit	? Every 3 mos	? Every 6 mos	? Annually	? As needed
Dilated Eye Exams	? Each Visit	? Every 3 mos	? Every 6 mos	? Annually	? As needed
Electrocardiogram	? Each Visit	? Every 3 mos	? Every 6 mos	? Annually	? As needed
Influenza vaccine	? Each Visit	? Every 3 mos	? Every 6 mos	? Annually	? As needed
Pneumococcal vaccine	? Each Visit	? Every 3 mos	? Every 6 mos	? Annually	? As needed
Dental Screen	? Each Visit	? Every 3 mos	? Every 6 mos	? Annually	? As needed

When should a person receive extensive (1hr or more) diabetes education

**(Check all that apply):**

- ? a. within 45-60 days of diagnosis
- ? b. within a year of diagnosis
- ? c. when medications are changed
- ? d. if they have been identified as having risk factors for diabetes (obesity, family risk)
- ? e. when they begin to develop complications
- ? f. when their glycosylated hemoglobin (HgbA1c) is greater than 9%
- ? g. other \_\_\_\_\_

**DIABETES INFORMATION AND TRAINING**

25. How long has it been since you attended a lecture, workshop, or conference on diabetes?  
? In the past 6 months ? 6 months to a year ? 1-2 years ? 2-3 years ? Over 3 years
26. About how many hours of CMEs/CEUs did you get related to diabetes in the past 3 years?  
Diabetes CME/CEU |\_\_\_\_|\_\_\_\_| hours
27. Have you ever considered becoming a Certified Diabetes Educator (CDE)?  
? Yes  
? No  
? Never heard of it
28. Do you have access to the Internet or e-mail?  
? NO  
? At work or office  
? At home  
? Both
29. Do you collect Diabetes patient data? ? Yes: computerized  
? Yes: manual  
? No
30. What software do you use to collect computerized diabetes patient data?  
\_\_\_\_\_
31. Do you report Diabetes patient data? ? Yes → to whom reported \_\_\_\_\_  
? No
32. To facilitate the management of your patient caseload with diabetes, would you be interested in learning about diabetes software? ? Yes ? No

**These are all the questions we have. Thank you for your cooperation.**