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Dietary Decisions for Patients with Type 2 Diabetes

Dr. Anderson:
Welcome to Diabetes Discourse on ReachMD. I'm Dr. John Anderson, and today I'm sitting down with Dr. Kathleen Stanley to discuss dietary considerations for treating patients with Type 2 diabetes. Kathleen is a registered dietitian and a certified diabetes educator with the Baptist Health Center in Kentucky. Welcome, Kathleen.

Dr. Stanley:
Thank you for having me today, John.

Dr. Anderson:
Before we get started, tell us about your role with the Baptist Health System in Kentucky.

Dr. Stanley:
Absolutely. So I have been on staff here at Baptist Health Lexington in Lexington, Kentucky for over 20 years. I'm the Diabetes Education Coordinator. I'm also an active diabetes educator within our program, both inpatient and outpatient, and I also run the Outpatient Nutrition Services here in Lexington and Richmond.

Dr. Anderson:
So you have plenty to do.

Dr. Stanley:
Yes (laughter).

Dr. Anderson:
Let's talk a little bit about the role of the dietitian in patients with Type 2 diabetes, particularly at the time of diagnosis. How do you approach that new patient?

Dr. Stanley:
Dietitians absolutely are here to support the treatment protocols and plans of the providers, and we certainly want to be able to fill in those gaps, and nutrition education is one of those gaps we're happy to fulfill. A referral to a dietitian should be done definitely for the new diagnosis patients. Food, of course, plays the greatest role in blood sugar control, so you really want to, from the beginning, empower the patient from the start with knowledge and tools and resources for optimal success. And if you have that patient that says back to you, "Oh, I know what to do, I just don't do it. I don't need to see a dietitian," that's actually the best ideal person to refer to a dietitian, because we do counseling to patients, not just handing out a diet sheet and hoping for knowledge to stick. The dietitian's going to do a thorough assessment of the patient and also going to address the barriers of, "Well then, you know, what is standing between you and taking action on those healthier behaviors?" And also, we're able to look into things, such as food insecurity, which has been quite an issue this year with COVID, as well as addressing cultural preferences, lifestyle habits, emotional eating behaviors, and more. And without a comprehensive approach, the patient is less likely to succeed, which is going to mean more medication, more frustrations, and likely more complications, and not achieving the outcomes that you want.

Dr. Anderson:
So, tell us, Kathleen, what does the American Diabetes Association say, in terms of the standards of care for nutritional interventions in patients with Type 2 diabetes?

Dr. Stanley:

The American Diabetes Association's Standards of Care for Type 2 diabetes for nutrition are intended to provide a general treatment guideline because individualization is essential for appropriate clinical outcomes in patient satisfaction. So, you won't find anything specific in the guidelines, but the overall goals are to promote healthful eating patterns, emphasizing nutrition-dense foods in appropriate portions, as well as coaching our patients to achieve and maintain a healthy weight, achieve glucose, lipid and blood pressure goals, and to prevent acute and chronic complications. And while there's curiosity about what diet works best and what diet does the ADA endorse, there's not one diet approach to meet those goals. Rather, there are approaches such as carbohydrate counting using the My Plate method, a Mediterranean diet approach; those are just some examples, including also the plant-based diet, that have demonstrated clinical success in the literature. So there's not one perfect diet, but I think what a lot of people still question, John, is do we have an answer into what are the components of this meal approach? In other words, what's the distribution of the calories, proteins and fat that made these approaches successful? Am I right?

Dr. Anderson:
That's exactly right. Tell us a little bit about the plant-based diet, and what the science shows, both in terms of nutrition, weight reduction, treating insulin resistance. What do we know about this?

Dr. Stanley:
Yeah, so let's differentiate first on what a plant-based diet is. Some people confuse it with a vegan diet. A vegan diet is defined by having no animal products included in the eating behaviors. But a plant-based diet goes beyond that. It also tries to restrict processed foods. So, the way I kind of describe it to my patients is, let's say a granola bar was sitting on the table, and you have a vegan and a plant-based diet person at the table. Who's going to take the granola bar? And the answer is likely going to be the vegan patient, because it was processed. Even though it doesn't have any animal products in it, that's still okay for that choice, but a true plant-based diet is going to avoid processed foods. Now, if that was homemade granola bar, then they might be fighting over that granola bar.

Dr. Anderson:
Interesting, interesting. So, you're sitting down and individualizing the care for a patient. How do you deal with what I have found increasingly in my practice is, there's a substantial portion of our patients who do not cook at home. It's like the kitchen never gets used. Everything's a takeout, everything's a fast food. Those, I'm sure, are challenging. How do you try to make incremental change with patients like that?

Dr. Stanley:
A great question, yeah. A dietitian's role is not to turn everybody into a Top Chef. Rather, it's to help people figure out how their lifestyle can work with the guidelines. So in terms of trying to create change in your patients, first and foremost, be positive regardless of what change they're looking to make. Making a joke of the diet, saying well if it looks good, don't eat it, or you can't go out and eat again, those are very negative messages that's probably only going to shut your patient down into taking action to make healthy lifestyle changes with their food habits.

So it would be better if we can explain to the patient that seeing a dietitian is not a visit to the food police, nor asking them to cook 24-7-365 in the kitchen from scratch. Trying to work with them, just on short-term goals is a better approach. If you listen to your patients, they'll probably give you an idea for an opportunity for change. For example, if you're talking to a patient, and they admit they're drinking a lot of sodas, maybe one of their changes they could make is change from drinking three regular sodas a day to including one or two of them to be a diet soda instead. That can have a big impact. Or if they are going out to eat often, maybe they can choose a side salad instead of French fries at the workplace fast food stand. Or maybe just asking them to help identify where they want to start out with looking at a possible change in their eating habits, by having them do some food journaling, where they can identify where they might benefit from making changes.

And while these may seem like small recommendations, they are coming from the patient's perspective as an idea and area of needing adjustment, so you're likely going to have better success with that as a starting place, rather than just telling the patient what to do. Because once a small change gets made, this is an opening for the door for other changes to be considered as well. And follow-up also is important, John. If you're going to set a goal with a patient, follow up with it. Even if the patient is only 25 successful at that follow-up contact, you can congratulate them on that improvement. And then ask them, "This is great. You achieved 25% change in whatever they wanted to do, but what would it take you to make it 50% successful next time?" And then you can start working on looking at those barriers, rather than just making this an expectation of patients to figure it all out on their own. Education is truly a powerful tool, but it has to be combined with counseling.

Dr. Anderson:
Fascinating, Kathleen. The one last question I'm going to have for you is one of the other times that I really need a CDE and a dietitian is when it comes to – and it's less common now with GLP-1 receptor agonists – but when it comes to the initiation of prandial insulin. When

we start to talk about carbohydrate counting, what's the effect of walking after a meal? How much bolus insulin am I going to be able to give? For me, this is critical role for the CDE and the dietitian. And I know that you do a lot of that as well.

Dr. Stanley:
Absolutely. So, carbohydrate counting is a great approach for people to help manage those post-prandial blood sugar rises, so having the dietitian that can work with the patient to show them some different tools to make that easier, there's more technology available out there with apps and websites to determine carbohydrate content and help them with food journaling and record keeping to help them also understand how to read a food label, and understand that portioning; a dietitian can be very integral into making carbohydrate and insulin ratios work the way they're supposed to. Another interesting focus is we're now seeing that there are some people who are following a lower carbohydrate meal planning approach, and they're still struggling with post-prandial rises. The thought is, is it coming from the protein and the fat, or just the fat alone? I've actually been approached by a couple of clinicians to address that, as we know about 50% of the protein that we take in converts to glucose, too. So not only is carbohydrate counting something that we do daily, but I'm thinking in the future, we're probably going to start doing carbohydrate and protein counting. And actually, 30 years ago, that's how I taught nutrition to patients with diabetes taking mealtime insulin; we counted all the components for those on insulin, including carbohydrate, protein and fat, and there was a ratio for each one of those macronutrients. Talk about complicated! So, we've had to grow because the popularity of the higher protein diets, but I'm honest with my patients in saying that it can still affect their blood sugar, because many protein sources are still going to come with, again, the ability to raise the blood sugar after a meal. It's not neutral on the blood sugar.

Dr. Anderson:
Well, this has been tremendously informative for those of us in primary care and for our audience in general. And I want to thank Dr. Kathleen Stanley for joining me and providing insights on patients with Type 2 diabetes. Kathleen, thanks for taking the time to speak with us today.

Dr. Stanley:
Thank you, John.

Dr. Anderson:
I'm Dr. John Anderson. To access this episode and others in this series, visit reachmd.com/diabetesdiscourse, where you can Be Part of the Knowledge. Thanks for listening.