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The Role of the Certified Diabetes Educator: A Team Effort

Narrator:

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Dr. Russell:

As America moves into the new frontier of healthcare, team-based care is more and more important. Welcome to **Diabetes Discourse** on ReachMD. I am your host, Dr. John Russell. Today we are talking with Dr. Candis Morello on the *Role of the Certified Diabetic Educator: A Team Effort.* Candis, welcome to the show.

Dr. Morello:

Oh, thank you so much.

Dr. Russell:

I think one of the things that is not always clear to myself and probably to some of the listeners is, you know, how does one become a certified diabetic educator? What is the background of people? Is there one road that leads people to there? What training is involved to call yourself a CDE?

Dr. Morello:

Yes, that's a good question. I think there are a few guidelines in terms of you do need to have some sort of a health-science discipline. So either you are a pharmacist or a nurse or a dietician or a physician or, you know, some kind of…you've graduated from some kind of health-science program. In addition to that, you need to have a certain number of hours where you have trained patients in diabetes education before you sit for a national exam, a board-certified exam.

Dr. Russell:

So you've been doing this for 15, 20 years. How have you seen the role of the CDE change?

Dr. Morello:

Well, I think that when I first started I think maybe CDEs at the time were a little underutilized and the role of CDEs has expanded over the years. That's probably the biggest thing. So, when I first became a CDE – I am a pharmacist by training – and I trained patients on -- had a glucose meter training clinic and I trained them how to use their glucose monitors and then the other thing I primarily did was we had education programs, and so, I would talk as a multidisciplinary team to patients to educate them about the medications used to treat diabetes and, as you can imagine, there were a few number of medications available at the time.

Dr. Russell:

And not all the medicines were all that well tolerated either, right?

Dr. Morello:

That's right. We only had about four medication classes and, you know, now here we are 15 or 20 years later and we have so many different options and a lot of tools to help people with diabetes.

Dr. Russell:

So, when the new patient shows up to see you, has been referred in, how do you individualize the goals for that individual patient?

Dr. Morello:

That's very, very patient-specific, and so, the first bit of time, you know about 15 minutes of the visit, is really chatting with the patient and collecting a lot of information that has to be integrated to determine what their glycemic goals are, what's going to be best for them in terms of treating their diabetes, but also, like in my clinic, we treat hypertension, hyperlipidemia and neuropathy, and whatever other issues come around related to their diabetes as well. But in terms of goal setting and outcome measure achievement, you know, values, that is very, very patient-specific. And I am happy to go into that more like specifically with the A1c if you like.

Dr. Russell:

So, it is a misconception in my role as a primary care doctor that you want everyone's A1c to be 6, right?

Dr. Morello:

Yes. As it happens, the patients that I see tend to be a little older and most of them are male because I work at the VA, and I work primarily in type 2 diabetes. So, for my patients, I have had one patient in all the years I have worked in these clinics that has had a goal of less than 6. Many of them have goals of less than 7, but the majority of them because of their number of microvascular complications, their comorbid -- their other comorbid issues -- as well as their macrovascular complications. How the duration that they have had diabetes? I also use, if they live by themselves, so there is no one there to help them should they get hypoglycemia, I use their hypoglycemia risk and I also use what I call the fall

factor. Like how high is their risk for falling? So, if they have to get up at night to go to the bathroom, like what's the risk of them falling? So, I use all of that in determining what their A1c goals are.

Dr. Russell:

And we certainly learned over the last few years that hypoglycemia in senior citizens is not a trivial event, correct?

Dr. Morello:

Absolutely. I mean there are cardiovascular issues. There are psychological issues in a patient. All kinds of things associated with having hypoglycemia. So, really, all of our goals, no matter which area of the team we are on and helping our patients achieve goals, has to be glycemic control without hypoglycemia.

Dr. Russell:

So, also as having a pharmacy background, is the risk of hypoglycemia of any particular medicine, does that kind of lead you to maybe suggest this category versus that category?

Dr. Morello:

Absolutely, absolutely. And I will say some people might say, "Oh, insulin." Oh, then you just wouldn't use insulin. But with the newer formulations, such as glargine or detemir in terms of initiating patients on a basal insulin, you really don't have as high of a risk of hypoglycemia, and so, and not only that, we start low and we titrate them very consistently and regularly up over a period of a few weeks, so insulin is not off the board in selecting an agent.

Dr. Russell:

I think I read recently that the long-acting insulins have a lower hypoglycemia risk than the sulfonylureas. Does that sound true to you?

Dr. Morello:

That is absolutely true, and I will definitely even say that is true with older patients as well. The sulfonylureas are not as predictable as the insulin is, at least in what I have experienced.

Dr. Russell:

Your listening to ReachMD. This is **Diabetes Discourse** and this is Dr. John Russell and I am speaking with Dr. Candis Morella about the role of the Certified Diabetic Educator: A Team-Based Effort.

So are there studies that show better patient outcomes with regard to using, having a CDE as part of the diabetic care team?

Dr. Morello:

That's a really good question, and I really think that the answer to that lies in the way CDEs are used in the various hospitals, programs, outpatient programs. So, in our – I can speak for our program at the VA in San Diego – I happen to be a PharmD CDE. I work in the clinic, I see patients and I do a lot of the CDE insulin therapy, the … glucose training, pen, insulin pen initiation and teaching all of that. I try to do most of that myself, but we also have two other CDEs who are fabulous and they do a lot of different types of education in small groups, in one-on-one and I think that having a CDE, having them available within our clinic is very, very useful. The patients tend to like it because it is all done at one time in one clinic area. And they are not asked to go, be referred out to go see somebody else when they have already forgotten perhaps what you talked about that day. Do you know what I mean?

Dr. Russell:

Absolutely. So, you know, this team-based care which I think is so important, probably the most important thing is really that empowered patient, correct?

Dr. Morello:

Absolutely. And they don't come to you empowered. You know, they don't come to you like, "Oh right, I am ready to do it. That may control my diabetes." So, what I find is we talk a lot about the diabetes does not control them. We are going to give them tools so that they can take control over the diabetes. And that empowers them by giving them tools, giving them dietary tools, exercise guidelines, medications that are going to help them control their diabetes, teaching them how to interpret the glucose values that they get at home and knowing what to do with those numbers and they come back -- I see my patients about, you know, the first clinic visit 3 months and 6 months and usually by then they are tuned up and ready to go back to their primary care providers. But by that first followup visit at 3 months, they are like, "I feel better." They are sitting up straighter in their chair. They feel empowered and they feel really confident about their diabetes. And if there are a few areas that they are not, then we just help them figure that part out and then they go home and they are able to do that.

Dr. Russell:

What would be the role of a dietician in kind of this team-based care for a diabetic?

Dr. Morello:

Yes, I love… well, we all do, you know, diet education, but our dietician is fabulous. She is a dietician and a CDE as well. And she just gives them so much information on everyday living with diabetes, selecting food choices, what's healthier than another thing. If they are going to go out to eat, what are some great guidelines and tips that they can do. Food choices they can choose while eating out so they feel like they are getting a treat but they are not going overboard. I just think she is absolutely wonderful and it really helps the patients make better choices day to day and when they are with other people in a social environment where it might not be as easy to make the best choices. I think it is wonderful to be able to have a dietician as part of our group.

Dr. Russell:

Are there online resources that you find yourself using more often than others with your patients?

Dr. Morello:

Oh, that's a great question. Now as a pharmacist, I use more medication sorts of resources. You know like clinical pharmacotherapy databases and that sort of thing because I am always looking for drug interactions with the 25 other medications the patient might be on and that sort of thing. So, I use those sorts of references, but the ADA has some really great sites. The AADE also has some really good sites on education. Some of the drug companies also have very good educational materials that are not branded that I have found to be useful as well.

Dr. Russell:

And how important do you think an exercise program is for your recommendations for your diabetic patients?

Dr. Morello:

Oh, it is just essential. Just as diet and medications, that third prong is exercise, and you know, you just find what the patient likes to do. Like a lot of my patients love to dance and so that that's their program you know, and some patients have a trouble with walking or even in starting. So, we just say, "Okay, count houses. Go find a safe neighborhood to walk in. Count five houses and walk back." And then they do that and they add a house every day. So that is kind of how we do it. And they are so thrilled with themselves that they are feeling better and adding more than one house on different days. You know what I am saying?

Dr. Russell:

Absolutely.

Dr. Morello:

So, if you find a thing they like to do and you make it, you know, it's a fun thing for them to be able to do. They have a dog or they have grandchildren, or they have, you know, whatever it might be. I have patients who swim, bike, dance, walk, whatever. I mean, they do Pilates, some of them do yoga even.

Dr. Russell:

I would imagine that a fair number of your patients have some neuropathy. Does that kind of limit some of the choices that you are making for them, exercise wise?

Dr. Morello:

Absolutely. And sometimes we hold off on, you know, certainly if they have neuropathy that impairs their sensation. You know their shoes have to be the right type of shoes. A lot of times we can refer them to get the diabetic shoes, but usually if we can control their diabetes. By that… I see them again, they find 3 months and then at 6 months. So, at that third month visit usually their neuropathy is much improved and they are ready to do things. Otherwise, swimming is a really good option for people with neuropathy and biking isn't too bad. We use a recumbent, is what we recommend, but again, you just got to be very careful that patients are viewing their feet every day.

Dr. Russell:

So, how should I institute changing and self monitoring of blood glucose to that patient who suddenly starts dancing or walking? What should I recommend to them? Do you have them do it right after? Do you have them do it an hour after their activity? When do you incorporate that?

Dr. Morello:

One of my favorite things to do is say, "Okay, test your glucose before you go exercise and then …" You know, I really only start out with 5 or 10 minutes of exercise, and with this small, positive progression with their routine, because this is truly a lifestyle modification that they are embracing for their life. Do you know what I mean? It is not just a, you know, I think this week I am going to walk for 15 minutes. But we definitely do have them test before and then after the exercise to see if they can see any difference. But these are not type 1 patients who might go out and actually vigorously exercise. Most of them have type 2 diabetes and they are, you know, just getting them into a program is really good. And I am not a big proponent for 45 minutes of vigorous exercise in my patients because most of them are older and they can't tolerate that. But we definitely, if they can't exercise much at all, then we shoot for 15 minutes every day. Something 15 minutes every day.

Dr. Russell:

And if you had just some final things, what should be—as a referring clinician—what should be my expectation from excellence and best practices from a Certified Diabetic Educator?

Dr. Morello:

Well hopefully, they would be able to give your patient skills, lifetime skills, that they can use to control—help control—their diabetes. They should hopefully be able to empower patients and really educate them to improve their knowledge about their disease state, but also how to control that disease state.

Dr. Russell:

Candis, thank you so much for being on the show. The show is **Diabetes Discourse**. We have been speaking with Dr. Candis Morello on the role of the CDE, a team effort. Thanks so much.

Dr. Morello:

Thank you so much. It has been my pleasure.

Narrator:

You have been listening to **Diabetes Discourse** on ReachMD, brought to you by AstraZeneca, pushing the boundaries of science to create life changing medicines for people with diabetes.

With a portfolio of seven approved diabetes products and other compounds in development, AstraZeneca is ushering in a new era of innovative diabetes treatment options. AstraZeneca research aims to impact the burden of diabetes by researching the underlying mechanisms of the disease that could one day help lead to a cure.

In addition, AstraZeneca offers resources for patients dealing with diabetes including the recently launched Fit2Me diabetes diet and lifestyle support program and is committed to supporting patient access to its diabetes treatments through the AZ&Me patient assistance program. AstraZeneca is pushing the boundaries of science with the hopes of creating life changing medicines for people with diabetes.

To learn more about this diabetes diet and lifestyle support program from AstraZeneca, visit Fit2Me.com. That's fit2me.com.