Core Competencies in Diabetes Care: Educating Health Professional Students

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Regardless of their chosen fields or places of employment, all health care professionals (HCPs) need to be competent in the care of people with diabetes. There is no question that there is a worldwide diabetes pandemic.[1] We rely on diabetes educators within all of the professions (nurses, dietitians, pharmacists, nurse practitioners, physician's assistants, and behaviorists) as well as endocrinologists and other physicians who specialize in diabetes to lead the charge against this menace. But in reality, it is not only such diabetes specialists, but also HCPs of all sorts who will come into contact with patients with diabetes or be in a position to affect the incidence of diabetes by encouraging lifestyle changes to reduce the risk of developing diabetes.

Evidence-based standards for diabetes care and its associated risk factors have been establish and disseminated, yet limited progress has been made in reducing the risk factors associated with the complications of diabetes.[2] Diabetes is a complex disease, and there are multiple reasons why the established patient targets for blood pressure, lipid, and glucose levels have not been met. These include but are not limited to medication costs, the burden of living with a chronic disease, systems issues related to the delivery of care, lack of patient education, limited provider time, and failure of providers to maximize medication adjustments.[3]

Another factor is the question of whether HCPs have adequate knowledge, skills, attitudes, and value training to provide optimal diabetes care. Are today's graduates from our HCP schools adequately prepared to provide patient-centered, culturally appropriate, evidence-based diabetes care? Do these students recognize the importance of the interdisciplinary team necessary to provide the long-term support needed by individuals with diabetes and their families? Are they prepared to help patients adopt lifestyle changes that will result in the prevention of many of our most common diseases including diabetes? Are students learning in an environment that emphasizes an acute-care or a chronic-care model? Where do residents and nurses spend the majority of their training time, in hospitals or clinics? Are the students who are graduating from our HCP training programs competent in diabetes prevention and care?

The American College of Medical Schools published a report in July 2004 that outlines a "vision for medical education in the United States."[4] The report called for fundamental changes in medical education for doctors and other HCPs and recommended that HCPs must be educated "to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics."[4] This report further addressed the problem of residency training programs that are not adequately training physicians for their future responsibilities. It suggested that our residents are spending too much time in hospital settings. The same criticism could be made of our nurse and dietitian training programs.

Does the American Diabetes Association (ADA) have a role to play in changing the way HCP students are trained? ADA cannot be all things to all people. It is a vast organization with an audacious mission: to prevent and cure diabetes and improve the lives of all people affected by diabetes. But I believe it is time for ADA to rejoin the ongoing debate regarding how and what our HCP students are learning. Ideally, HCPs across the nation would achieve a set of core competencies related to diabetes prevention and care before graduation from their training programs.

There is a precedent for what I am suggesting. In 1993, as the result of the work of the ADA Council on Education's Task Force on Nursing Curriculum, a document titled "Competencies in Diabetes Care for Schools of Nursing" was developed, published,[5] and made available to schools of nursing throughout the United States. This document, also called the "core competencies," identifies the diabetes education competencies critical to the education and clinical functioning of the graduating generalist nurse that should be included as a curriculum component in all professional schools of nursing. It provides recommended educational materials and resources for both student and faculty use.

There have been recent requests for a revision and update of this document, although none is yet in development. From personal communication, I know that a number of diabetes educators are working individually with nursing programs around the country to improve the quality of education for generalist nurses. These educators are helping to develop "core competencies" for these programs, and there are similar individual efforts happening at a few medical schools across the country.

In 1993, Robert Ratner, MD, provided a commentary in conjunction

with the publication of the core competencies for nursing in this journal.[6] He challenged all health care facilities and administrators to look carefully at the competencies for inclusion in their educational programs. At that time, the findings of the Diabetes Control and Complications Trial were new and provided much-needed evidence of the importance of diabetes educators in helping people with diabetes adapt to their management regimens. Ratner also noted that the typical medical school then included only 8 hours of didactic lecture on diabetes during the 4-year course of study.

As providers in 1993, we were excited about the prospect of reducing the complications for diabetes with intensive diabetes management. We believed then that only those with a specialty or particular interest in diabetes would need to be experts. Today, with more than 36 million people in the United States having diabetes or prediabetes, we know that all HCPs must be competent in both the prevention and care of diabetes.

As the leading authority on diabetes care, ADA should make this goal a priority and take the lead in identifying and disseminating core competencies in diabetes care for all HCPs. The association's various councils are a logical resource for this effort. The original core competencies for nurses document was developed by a task force of the Council on Education. We have available ADA councils on nutritional sciences and metabolism, clinical endocrinology, health care delivery, and public health. The ADA Professional Practice Committee is instrumental in establishing the association's standards of care recommendations. It would also be essential to collaborate on such efforts with our partner diabetes organizations, including the American Dietetic Association's Diabetes Care and Education Practice Group, the American Association of Diabetes Educators, and the American Association of Clinical Endocrinologists.

Imagine a future of diabetes care and prevention in which all HCP students receive core competency–based education in diabetes care and prevention. This would go a long way toward fulfilling the ADA mission on both fronts: preventing and curing diabetes, as well as improving the lives of all people affected by diabetes.

References

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