



**Diabetes Fundamentals– Class 6**  
 Hypo, Sick Days, Foot Care and Spiritual Aspects  
 Beverly Dyck Thomassian, RN, MPH, BC-ADM, CDE  
 President, Diabetes Education Services

[www.DiabetesEd.net](http://www.DiabetesEd.net)




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**Objectives – Hypo, Monitoring, Sick Days, Lower Extremities, Coaching**

- ▶ Discuss risk and prevention of hypoglycemia
- ▶ Strategies to get the most out of blood glucose monitoring
- ▶ Review sick day management, from hospital to home
- ▶ Lower extremity assessment
- ▶ Spiritual aspects of diabetes care
- ▶ Graduation





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**Hypoglycemia - The limiting factor**





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## Hypoglycemia – “Limiting Factor”

- ▶ Glucose of 70mg/dl or below
- ▶ 50% of episodes occur during night
- ▶ Mortality with severe hypoglycemia secondary to sulfonylureas
  - ▶ Especially (glyburide) Micronase<sup>®</sup>, Diabeta<sup>®</sup>
- ▶ Blood glucose levels don't describe severity, response is individual



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## Hypoglycemia: Clinical Risk Factors



- ▶ Diabetes medications
- ▶ Intensive insulin therapies
- ▶ Impaired kidney or liver function
- ▶ Advanced age, poor nutrition
- ▶ Near normal A1c
- ▶ History of frequent hypoglycemic episodes
- ▶ Neuropathy

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## Glycemic Threshold Values

John White, PharmD, Diabetes Spectrum, 2007

Classification	BG	Physical Response
Lower euglycemia	80-90's	Endogenous insulin
Hypoglycemia	70's	Glucagon, adrenaline
Symptoms	60's	Growth hormone, cortisol
	50's	Cognitive deterioration
Neuroglycopenia	40's	
	30's	
Severe neuroglycopenia	20's	Coma, seizures
	10	

(shortage of glucose in the brain affects function of the neurons)



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## Hypoglycemia Symptoms



- ▶ Autonomic
  - ▶ Anxiety
  - ▶ Palpitations
  - ▶ Sweating
  - ▶ Tingling
  - ▶ Trembling
  - ▶ Hypoglycemic Unawareness
- \* Neuroglycopenia
  - Irritability
  - Drowsiness
  - Dizziness
  - Blurred Vision
  - Difficulty with speech
  - Confusion
  - Feeling faint



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## Nocturnal Hypoglycemia

- ▶ Signs include:
  - ▶ Vivid dreams
  - ▶ Waking up with headache
  - ▶ Night sweats
  - ▶ Waking up hungry
  - ▶ Elevated (rebound) or low morning blood glucose



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## Hypoglycemia Awareness

- ▶ Autonomic symptoms adrenergically based (stress hormones)
- ▶ After 2-5 yrs of type 1 dm,
  - ▶ glucagon secretion impaired
  - ▶ epinephrine secretion becomes primary mechanism to restore BG levels
- ▶ Over time, epinephrine response diminished or delayed
- ▶ decreases awareness of hypo symptoms = danger



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## Learn Their Own, Most Reliable Symptoms - BGAT



- ▶ Symptom diary to identify their unique response
- ▶ Alcohol can increase risk
- ▶ Beta blockers may mask early signs (Perspiration not masked)
- ▶ BGAT - blood glucose awareness training
- ▶ Log each hypo event and try to identify symptoms and pre-event associated behavior



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## Treatment of Hypoglycemia

- ▶ If blood glucose **70mg/dl** or below:
  - 10-15 gms of carb to raise BG 30 - 45mg/dl
  - Retest in 15 minutes, if still low, treat again, even without symptoms
  - Follow with usual meal or snack
  - If BG less than 40, allow recovery time



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## Tx of Severe Hypoglycemia

- ▶ If can swallow w/out risk of aspiration, try gel, honey, etc. inside cheek
- ▶ If unable to swallow, D50 IV or Glucagon
- ▶ Glucagon injection – teach support person
  - ▶ Dosing:
    - ▶ Adults 1mg
    - ▶ Children <20kg 0.5mg
  - ▶ Glycemic effect 20 - 30mg, short lived
  - ▶ Must intake carb as soon as able
  - ▶ Need prescription, check exp. date



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## Glucagon Emergency Kit



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## ADA Guidelines

- ▶ Ask those at risk for hypo, about frequency and symptoms at each visit
- ▶ Glucagon prescription for those at risk of hypo.
  - ▶ Instruct family and caregivers on safe use
- ▶ Hypoglycemia unawareness or 1 event of severe hypo indicates regimen adjustment needed.
  - ▶ Raise glycemic targets for several weeks
- ▶ SMBG or CGM are essential tools



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## Preventing Hypoglycemia

### Nocturnal Lows

- ▶ If bedtime glucose <110, eat snack
- ▶ If increased daytime activity, may need extra hs snack
- ▶ Eval pre-dinner insulin/meds

### Other

- ▶ Monitor kidney function / wt loss
- ▶ Monitor BG trends
- ▶ Too much meds?
- ▶ Skipped /delayed meals?
- ▶ Plan ahead
- ▶ Alcohol precautions



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## If on insulin or sulfonylurea – special precautions required

- ▶ Carb source on person, car, by bed at all times
- ▶ Identification
  - ▶ Phone (ICE)
  - ▶ Wallet Card
  - ▶ Bracelet
- ▶ If pattern of lows, med adjustment required
- ▶ Pre-meal target
  - ▶ 80-130
- ▶ Post meal
  - ▶ Less than 180
- ▶ Bedtime
  - ▶ 110 - 180



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## Life Studies

- ▶ Patient on glyburide tells you, "I feel funny when my blood sugars go down to 140"
- ▶ Pt on insulin tells you, "I only feel hypoglycemic when my blood sugar goes below 50"



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## Monitoring, sick day management and Hospital goals

Objectives:

1. Identify barriers to monitoring and strategies to overcome them.
2. Discuss sick day management
3. State glucose goals during hospitalization.



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## Pt with new diagnosed diabetes

- ▶ 62 year old
- ▶ Came in for treatment for her Urinary Tract Infection
- ▶ Now finds out she has diabetes
- ▶ Her A1c is 6.7% - How often does she need to check?
- ▶ Her A1c is 10.4% - How often does she need to check



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## Self-Monitoring Why Should I do it?

- ▶ Feel better everyday – sense of control
- ▶ Avoid hospital admissions
- ▶ Fewer missed work /school days
- ▶ Avoid hypoglycemia situations - safety
- ▶ Avoid unwanted weight gain
- ▶ Enhanced athletic performance



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## How will it help me?

- ▶ See if your treatment plan is working
- ▶ Make decisions regarding food and/or med adjustment when exercising
- ▶ Find out how that pizza affected your BG
- ▶ Find patterns
- ▶ Manage illness



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## How Often Should I Check?

- ▶ Be realistic!!
- ▶ Type 2 on orals – Medicare covers 100 strips for 3 months
- ▶ Based on individual - Consider:
  - ▶ Types and timing of meds
  - ▶ Goals
  - ▶ Ability (physical and emotional)
  - ▶ Finances / Insurance



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## ADA Guidelines

- ▶ Self monitoring before: meals, snacks, bedtime
- ▶ Occasional postprandial and before exercise
- ▶ When patient suspects hypo and keep checking until BG in safe zone.
- ▶ Before critical tasks such as driving
- ▶ Some patients need to test more depending on activity level, frequency of eating, med regimen.
- ▶ Be practical, no two patients or two days are alike



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## Running into Roadblocks?

### ▶ HUG Patients

- ▶ Help with
- ▶ Unconditional
- ▶ Guidance and Support

Anne Peters, MD, CDE  
ADA Post Grad

### ▶ Unconditional Positive Regard –

*involves showing complete support and acceptance of a person no matter what that person says or does.*

Carl Rogers



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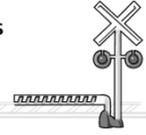
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## No one is Unmotivated

.... to lead and long and healthy life

### ▶ These are the 3 usual Critical Barriers

- ▶ Perceived worthlessness
- ▶ Too many personal obstacles
- ▶ Absence of support and resources



Bill Polonsky, PhD, CDE



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## Overcoming barriers

- ▶ Confront the key misbelief. Ask the question, does DM cause complications?
- ▶ Offer pts evidence-based hope message
- ▶ Frequent contact
- ▶ Paired glucose testing (Match BG to activity foods)



- ▶ Ask pt, "Tell me 1 thing that is driving you crazy about your diabetes"
- ▶ Discuss medication beliefs

Bill Polonsky, PhD, CDE



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## Alternate Site Testing?

- |                                 |  |
|---------------------------------|--|
| ▶ Yes                           | ▶ No   |
| ▶ Finger fatigue                | ▶ Pregnant   |
| ▶ No risk of hypo               | ▶ On intensive insulin therapy                       |
| ▶ Stable BG Levels              | ▶ During hypoglycemia                                |
| ▶ If BG < 90, recheck on finger | ▶ During illness                                     |
|                                 | ▶ <i>Not as accurate during glucose fluctuations</i> |



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## Glucose Monitoring Baseline Learning

- ▶ Care for meter and test strips
- ▶ Perform quality control
- ▶ Proper disposal of lancets
- ▶ Identify BG target and when to test
- ▶ Recording and interpreting data
- ▶ 800 number
- ▶ Adequate sample
- ▶ **User Error most common reason for inaccurate results**



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## Monitoring Issues

- ▶ “Monitor Talk”
  - ▶ avoid judging glucose levels as good and bad
- ▶ Say stuff like..
  - ▶ I am impressed that you are checking your blood sugar at least once a day and writing it down.
  - ▶ I am curious to learn what is helping you succeed with blood sugar testing.
  - ▶ I am interested to see that you are skipping some days, can you share more about that?



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## JR gets the flu

- ▶ Suddenly, his BG levels are in the 200s
- ▶ He is not hungry
- ▶ Nausea and diarrhea, some fever
- ▶ On Metformin
  - ▶ How often should he check his BG?
  - ▶ When should he call the doctor
  - ▶ Should he keep taking his metformin?



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## Sick Day Patient Guidelines

- ▶ Continue to take diabetes medication, may need adjust dose down or **up\***
  - ▶ Test glucose at least every 4 hrs
  - ▶ Drink plenty of liquids
  - ▶ Rest
  - ▶ Contact physician
  - ▶ Plan ahead
  - ▶ Check urine ketones, if BG >240 & ill
- \*If at risk of dehydration, hold metformin



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## Sick Day Guidelines Reasons to Call MD

- ▶ Vomiting more than once
- ▶ Diarrhea > than 5x's or for > 24 hrs
- ▶ Difficulty breathing
- ▶ Blood glucose > than 300mg/dl on 2 consecutive readings
- ▶ Temperature > 101 F.
- ▶ Positive ketones in urine.



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## Hospitals and Hyperglycemia- What's the Big Deal?

- ▶ Hyperglycemia is associated with increased morbidity and mortality in hospital settings.
- ▶ Acute Myocardial Infarction
- ▶ Stroke
- ▶ Cardiac Surgery
- ▶ Infection
- ▶ Longer lengths of stay



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## BG Above Normal = Trouble

### ▶ Pre Diabetes

- ▶ Fasting Glucose = 100-125mg/dl
- ▶ A1c 5.7 – 6.4%

### ▶ Diabetes

- ▶ Fasting Glucose = 126 mg/dl +
- ▶ Random Glucose = 200 mg/dl +
- ▶ A1c 6.5% +
- ▶ **Any blood glucose above 140 requires treatment**



Umpierrez et al



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## WHAT SHOULD WE AIM FOR?

### Critically Ill pts

- BG > 180- Start insulin
- BG goal 140-180



### Non Critically Ill patients BG Goals

- Premeal <140
- Post meal <180
- Insulin therapy preferred treatment
- Have hypoglycemia management protocol

•Consensus: Inpt Hyperglycemia, Endocr Pract. 2009;15 (No.4)



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## Management of Hyperglycemia and Diabetes

Stop oral agents (ie) metformin & sulfonylurea on admission

“The sole use of Sliding Scale insulin is discouraged” For discharge, oral meds can be resumed

### Start Basal/bolus therapy

- ▶ NPH and Regular insulin
- ▶ Long-acting and rapid-acting insulin
- ▶ Premixed insulin



▶ – ADA 2014



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## PZ is having gallbladder surgery

- ▶ On Metformin 500 mg BID
- ▶ 20 units of Lantus at HS
  - ▶ A1c 6.9%
  - ▶ A1c 10.3%
- ▶ NPO after midnight
  - ▶ What adjustments in insulin?
  - ▶ What adjustments in metformin?



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## Preparation for Surgery

- ▶ Try to schedule surgery in am, resume meds/insulin when eating and stable.
- ▶ Oral medications: Hold morning dose. If on sulfonylurea, may need to hold night before
- ▶ Basal Insulin:
  - ▶ for type 2s, give 50%-100% of usual am/pm basal dose
  - ▶ for type 1s give 100% of basal dose (individualize)
- ▶ Bolus insulin: Use mild insulin bolus coverage for type 1 and type 2's



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## PZ is having gallbladder surgery

- ▶ On Metformin 500 mg BID
  - ▶ Hold am metformin
- ▶ 20 units of Lantus at HS
  - ▶ A1c 6.9% - Only give 10 units
  - ▶ A1c 10.3% - Full dose probably okay



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## Hospitalization, DKA and HHS

- ▶ Visit our Level 2 Online Series for detailed coverage of these topics!



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## Lower Extremities

- ▶ Lift the Sheets and Look at the Feet



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## Vascular Risk Factors



- ▶ Nonmodifiable
  - ▶ Duration of diabetes – longer = more risk
  - ▶ Age – older increased risk
  - ▶ Gender – women have more CV protection pre-menopause
  - ▶ Race – risk varies
  - ▶ Genetics – family history

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## Vascular Risk Factors

### ▶ Modifiable

- ▶ Blood Pressure
- ▶ Lipids
- ▶ Smoking
- ▶ Obesity
- ▶ Other factors – lack of exercise, Type A personality, dietary habits



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## Peripheral Vascular Disease – Venous Disease

- ▶ On exam
  - ▶ Skin brownish, reddish, mottled
  - ▶ Skin warm to touch, may be edematous
  - ▶ May have stasis ulcers on lower leg
  - ▶ Pulses difficult to locate due to edema
- ▶ Treatment
  - ▶ Support hose
  - ▶ Elevate feet
  - ▶ Avoid constriction
  - ▶ Shoes that can accommodate feet



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## Peripheral Arterial Disease (PAD)



- ▶ Affects 30% of people w/ dm over age 50
- ▶ Inadequate blood & oxygen to lower extremities
- ▶ Signifies ↑ risk of stroke, HTN, sudden death
- ▶ Pain w/ walking, relieved by rest “intermittent claudication”
- ▶ Pt c/o pain, cramping in calves, thighs, buttocks
- ▶ PAD + Neuropathy = increased amputation risk

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## Peripheral Arterial Disease Intermittent Claudication

- ▶ Physical Exam – Skin
  - ▶ Pale or blue, purple
  - ▶ Dependent rubor, blanching when elevated
  - ▶ Cool to touch, loss of hair, nonhealing wounds, gangrenous
  - ▶ Diminished pulses
- ▶ Treatment = Protect feet
  - ▶ Avoid constriction, increase walking, stop smoking, medications and/or surgery



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## Foot Care Standards ADA

- ▶ Provide foot care education to pts w/ diabetes
- ▶ High risk pts – use multidisciplinary approach
  - ▶ Wound specialist, Vascular specialist, Podiatrist etc.
- ▶ Refer to foot care specialists for lifelong surveillance if:
  - ▶ smoke, loss of protective sensation, structural abnormalities, hx of lower extremity complications
- ▶ Initial screen for PAD includes:
  - ▶ Assess for intermittent claudication and pedal pulses.
  - ▶ Refer high risk pts for further vascular assess and consider exercise, meds, surgical options.



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## Profile of a High Risk Foot ADA

- ▶ Previous amputation
- ▶ Previous foot ulcer history
- ▶ Peripheral neuropathy
- ▶ Foot deformity
- ▶ Peripheral vascular disease
- ▶ Vision impairment
- ▶ Diabetic neuropathy (esp if on dialysis)
- ▶ Poor glycemic control
- ▶ Cigarette smoking



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## Diabetes and Amputations

- ▶ Diabetes = 8 fold risk of amputations
- ▶ Highest rate in those over 75
- ▶ 50% of amputations can be avoided through self-care skill education and early intervention
- ▶ Rate declined by 65% from 1996-2008
  - ▶ From 11.2 per 1000 to 3.9 per 1000

Stats from CDC 2012



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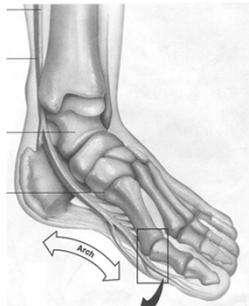
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## Healthy Foot

- ▶ Nerves
- ▶ Blood vessels
- ▶ Bones
- ▶ Joints



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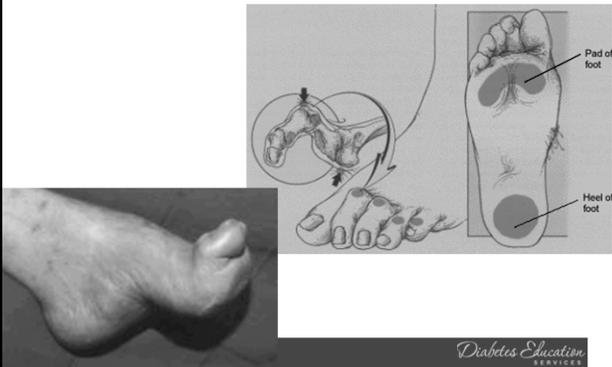
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## Foot Deformities



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## LR Life Study

- ▶ Diabetes Type 2 for 8 years
- ▶ On glyburide for 8 years
- ▶ A1c 8.7%
- ▶ Doesn't know how to check blood glucose
- ▶ Smokes pack per day
- ▶ Has calluses on his feet that he trims with a razor



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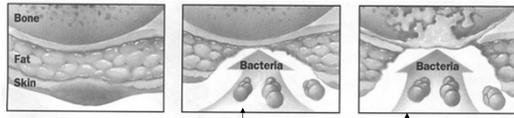
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## Foot Wounds



Blisters  
Infection  
Calluses

Ulcers

Bone

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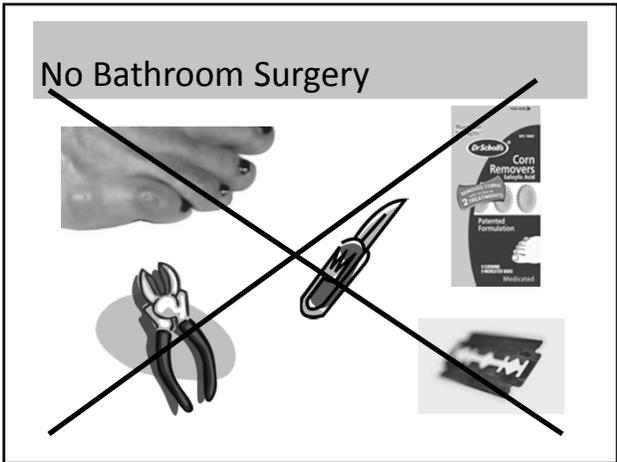
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### You Can Make A Difference

- ▶ Assess
  - ▶ Nail condition, nail care, in between the toes
  - ▶ Who trims your nails
  - ▶ Have you ever cut your self?
  - ▶ Shoes – type and how often
  - ▶ Socks
  - ▶ Skin/skin care and vascular health
  - ▶ Ability to inspect
  - ▶ Loss of protective sensation



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## Lower Extremities

- ▶ "Every time you see your doctor, take off your shoes and socks and show your feet!"
- ▶ For those at high risk for foot complications
- ▶ All patients with loss of protective sensation, foot deformities, or a history of foot ulcers



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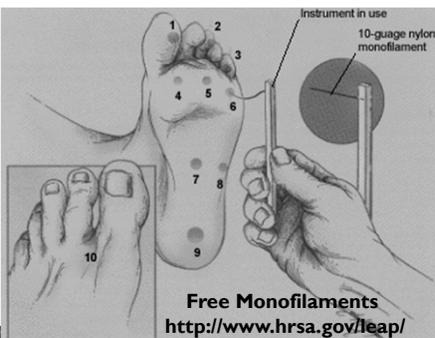
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## 5.07 monofilament delivers 10gms linear pressure



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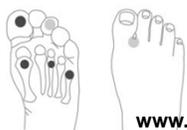
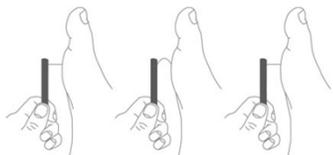
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## 5.07 monofilament delivers 10gms linear pressure



10 Free Monofilaments  
[www.hrsa.gov/hansensdisease/leap/](http://www.hrsa.gov/hansensdisease/leap/)



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## Three Most Important Foot Care Tips



- ▶ Inspect and apply lotion to your feet every night before you go to bed.
- ▶ Do NOT go barefoot, even in your house. Always wear shoes!
- ▶ Every time you see your doctor, take off your shoes and show your feet. Report any foot problems right away!



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### Medicare Pays for Therapeutic Shoes

Under the Therapeutic Shoe Bill, Medicare patients with diabetes are entitled to one pair of shoes and three pairs of orthotic inserts. You are entitled to this benefit every calendar year. We call your doctor and take care of the paperwork too. Our Certified Pedorthists come to your home to ensure a proper fit. All sizes available and many selections to choose from. Call today to get your shoes. Deductible or co-payments may apply. Sorry, no HMO's.

Ohio, Pennsylvania, Western New York, Florida and More.



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## Lower Extremity Assessment

- ▶ Complete and
- ▶ detailed course in Level 2



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## Spiritual Care



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### ***"The highest form of wisdom is kindness."*** **The Talmud**

How many times has a person arrived in my office disheartened and beating themselves up for their weight, their blood sugars, what they eat and what they don't eat?



This moment of discouragement and despair provides us the opportunity to help them recognize how hard they are being on themselves.

We can remind them that having diabetes is not their fault and no one can do it perfectly. By modeling kindness and understanding, we can encourage them to be a kinder self-coach from this day forward.



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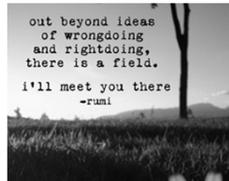
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### ***Give the gift of Non-Judgment***

- ▶ People with diabetes often feel judged by others, including providers, family, friends and even sometimes by diabetes educators.

When we provide the gift of "non-judgment" we can help open unexpected doors of insight and understanding.

- ▶ Meeting them in the field of understanding and compassion can provide them with the courage and belief that they can start rewriting their journey.



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## Diabetes - a Self-Managed Condition



- ▶ What is *their* motivating spark? Is it to make healthier life choices so they can be actively involved with their grandchildren, wanting to maintain independence, or making it to their nieces' wedding?
- ▶ "Our job is to help discover the spark that motivates people to move **toward** health through our sincere curiosity and thoughtful questions
- ▶ **Once the spark is discovered, only one person can ignite it. We stand close-by holding the match.**

▶ ***No one saves us but our self. No one can and no one may. We ourselves must walk the path"***  
 – Buddha



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## "Getting diabetes saved my life."

~ Sherri Sheperd



No one wants diabetes. Diabetes is not fair in who it affects. Once a person has diabetes, it does not go away. The question then becomes, how is this person going to incorporate diabetes into their life? Are they going to battle it? Deny it? Accept it? Like many of the courageous people I work with, **Sherri Shepard decided to embrace diabetes and use it as a motivator to improve her health.**



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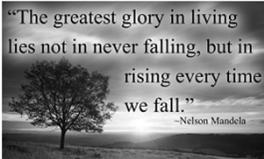
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## Diabetes Vacations



When they arrive back at our office or call us up after one of these "falls", they are trusting that we will help them back up with a kind and gentle hand. Embark on a process of discovery. Look for barriers to self care and try and find work-arounds. Give space for the Emotions swirling around their diabetes. Make one small goal that signifies their commitment to try and get back on track. This goal has to be absolutely achievable. It's purpose is to remind them that they can succeed.



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## Setting Goals

- ▶ Specific
  - ▶ Measurable
  - ▶ Attainable
  - ▶ Realistic
  - ▶ Timely
- ▶ Learning Objective– Describe portion size for 3 favorite types of carbohydrate.
  - ▶ Behavioral Goal – Count and document carb intake at each meal for 2 weeks.



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▶ Words of wisdom from my diabetes educator:  
*"You don't have to be perfect, Mom!"*

Certified diabetes educator (and daughter):  
 Beverly Thompson, PhD, MPH, CDE, BC-ADM, president of Diabetes Education Services, Chino, CA



Patient:  
 Last name: Betty Opek, 73  
 Resident: Chino, CA

**HOW IT HELPS ME:**  
 "I've had diabetes for two years now, and I used to get very panicky whenever my blood sugars were out of range—especially when they were low. Then Beverly, who happens to be my daughter, explained to me that it's common for blood sugar to fluctuate, and rather than panic, it's a good idea to try to understand why. She pointed out that doing extra homework or exercise can lower blood sugar for 24 hours. So now, when I get a low reading, I ask myself questions like, *What did I eat or not eat? Did I exercise more than usual? Fasting like that instead of panicking helps me figure out what happened and what I can do about it next time.* The strategy has helped me cope with my diabetes and realize that some days may just be different, and it's okay!"

**WHY IT WORKS:**  
 "Diabetes requires a lot of work. We ask people to eat healthfully, take medications, keep active and try to keep their A1C and blood sugars within specific targets. But sometimes, in spite of the Herculean effort, their blood sugars spike or go too low and patients feel like they have failed. I remind them, it is not you that is failing; it is your pancreas. And, I suggest the 80/20 rule. Let's just work toward getting to target 80% of the time. The other 20% is the 'wiggle room' that allows for blood sugar fluctuations, a treat or an exercise vacation day. It's impossible to do it right all the time, and diabetes isn't a lifetime. So we have to focus on keeping it real and celebrating daily successes, no matter how small." ☺

**80 /20 Rule – Perfect Not Required**



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## Thank You – What's next?



- ▶ Sign-up for Level 2 Series Bundle
- ▶ Attend Diabetes Educator Course in Carmel or San Diego
- ▶ Join



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