GATEWAY COMMUNITY HEALTH CENTER, INC.

Certified Diabetes Educator Guidelines

This product was developed by the diabetes self management project at Gateway Community Health Center, Inc. in Laredo, TX with support from the Robert Wood Johnson Foundation® in Princeton, NJ.

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Table of Contents

NEWLY DIAGNOSED "DIABETIC" CLIENT

- Review clients chart, lab values, medication, vital signs
- Develop a comprehensive individualized plan of care, taking into consideration any other chronic disease the client may have.
- Take a holistic approach; this gives one an idea of how client is going to respond. If a problem exist, refer as needed
- Assess clients knowledge
- Give client a brief review of what happens in diabetes (I usually draw a simple diagram as I talk, its simple and effective.
    - eating
    - blood glucose levels
    - insulin, etc…
- Give normal range for blood glucose, compared to their lab values. This gives them an idea of where they stand. I stress that if they follow their treatment plan, they should be seeing a change

Survival Skills

Signs and symptoms of hyperglycemia and hypoglycemia (especially important if they are started on medication).

Diabetic Diet:

- type of diet everyone should follow
- recommended for whole family
- able to have traditional Mexican dishes
- determine usual food pattern (helps to focus on changes or setting goals)

Teach:

- foods that contain carbohydrate (use food models of three groups)
    - starch, fruit and milk have approximately the same amount of carbohydrate
    - will have the same effect on the blood glucose level (works with them until they understand this concept)

Soluble Fiber:

- delays absorption of glucose into the blood
    - cactus (nopal) is high in soluble fiber (draw diagram of how it works)
    - give examples of foods that contain soluble fiber
        - can help control glucose and weight
        - incorporating fiber into their meals
    - consider:
        - monounsaturated fats
        - buying low fat items

        - leaner cuts of meats
        - using less salt at the table
        - increasing water intake and non-caloric drinks
    - talk about:
        - portion size
        - eating three meals a day
        - high fiber, low fat snacks
        - not eating too late in p.m. (unless medication warrants a snack or having episodes of hypoglycemia)
        - eating out
        - making better choices, sample menus, etc…
    - Note: If a client has hypertension, more specific information on a low sodium diet is given
        - clients are given a specific caloric diet, based on their age, activity level, weight, height, etc.
        - some clients might need a more stringent adherence to certain components in their diet
        - diets are individualized, based on specific clients needs

Exercise covered briefly on this visit. Give literature on diabetes, nutrition, exercise, meal planning (which show list of different food groups and what constitutes a portion size) Give written specific diet plan

Medications:

- review action, possible side effects
- review onset, peaks, duration
- stress importance of taking medications as indicated (ac/pc)
- relate eating and exercise to medication peak time
- teach signs & symptoms of hypoglycemia, action to take (Give illustrated forms)
- give forms to send off for emergency I.D. necklace or bracelet
- have client do self blood glucose monitoring and log
- set goals to be reviewed on next visit
- advise client to call or come in if he has any questions or problems
- schedule for appointment in 2 weeks

2nd Visit

- review clients self blood sugar monitor log
- take clients weight, glucose level???
- ask if client has any questions, correct any misconceptions.
- ask client to tell you how he has been following diet plan, revise as needed
- if glucose level still very high, reduce carbohydrates:
    - no more then 45 grams of carbohydrate per meal or less
- have the client do self blood sugar monitor and report results
- if glucose level still very high, confer with primary physician

Topics:

- reading labels
- exercise, adjusting food and medications (advice on medication peak times
- see section on exercise

Sick day rules:

- continue to take insulin or diabetes medication
- testing blood sugar more often
- testing for ketones (explain what they are)
- getting plenty of rest
- drinking plenty of fluids, keep hydrated, tell them what to do if stomach can't take it
- follow normal meal plan if able to tolerate
- example of foods to take if can't keep food down, when, what, and how often
- when to call primary care physician
- what to report

Cover complication that client might be experiencing in more detail (all possible complication covered in SM class)

- give general health tips:
    - wearing covered shoes
    - avoiding being out in heat
    - keeping hydrated if working outside
    - adjusting meals and medications when working night shift, etc.
    - focus on clients needs
    - set goals for next visit, set ups appointments as needed

3rd Visit

- review clients self blood glucose monitor log
- look for patterns, explain to client what meaning this might have
- review goals, modify as needed
- review material covered on previous visit
- correct any misconceptions
- reteach as necessary

Topics:

- monitoring
    - normal values
    - clients values
    - clients goals
        - fasting
        - after eating
        - p.m.
- stress importance of self blood glucose monitoring and keeping records, bring to visits, mutually set up blood testing schedule
- ask client if he has any topic he would like to discuss
- does client need further clarification on anything

Other topics of concern:

- celebrations
- holidays
- eating out
- traveling
- family problems, increased stress

Ask open ended questions, get patient to voice concerns, follow up, and refer as necessary.

Set goals

- follow up in three months or sooner if clients glucose reading or weight is not improving
- follow up with primary physician as needed
- refer to self management classes

DIABETIC CLIENT WITH NEPHROPATHY

- Review clients chart, lab values, medication, vital signs
- Assess clients knowledge
- Explain that protein restriction as an adjunct to blood glucose and blood pressure control can slow the progression of renal disease and help preserve renal function
- Onset of overt or end stage renal disease (See memo)

Survival Skills

Teach them to monitor their weight, edema, B/P, urine output

- Decrease protein:
  - Foods that contain protein-amount of protein in different foods
    - Specify amount of protein if ordered; based on their preference, let them choose distribution

- Decreasing sodium in diet (Briefly give reason)
  - Discuss foods high in sodium:
    - milk products
    - canned goods
    - foods with concentrated tomato, etc…

  - Have products available, give examples:
    - regular V8 vs. low sodium V8
    - melba toast, low sodium crackers vs. regular bread, etc.

  - What to use instead:
    - lime juice and cilantro to replace salt in fixing Mexican chicken soup.
    - use grapefruit and Mrs. Dash (no salt) product in carne asada instead of meat tenderizer.
    - No salt shaker at table
    - Don't over salt foods when cooking
    - Have family members add salt after food cooked, if desired

  - Have appropriate literature available on low sodium, low fat, and low cholesterol. Discuss and give as indicated by clients needs and understanding.

  - Briefly teach on how to read labels (fats and sodium) if time permits. This would be done for clients who have the comprehension and desire to learn.

- Control of glucose:
  - Diet
  - Exercise
  - Medications
  - Monitoring signs and symptoms of high and low glucose levels
  - Action-snacking – foods to carry

- Early assessment and prompt treatment of urinary tract infection, teach signs and symptoms of urinary tract infection.
- X rays – caution contrast dye??
- Set goals for next visit

2nd Visit

- Introductory information on kidney disease
  - function
  - preventive measures

- Also cover preventive measures for
  - eye care
  - foot care

- Allow client to voice fears and concerns-determine if client has any misconceptions
- Evaluate goals-modify if necessary
- Review previous material-correct any misconceptions
- Have client do a "Diet History/Recall"
- Set goals for next visit

3rd Visit

- Review goals-review previous material
- Have client do a "Diet History/Recall"
- Determine if client following diet plan – re teach if necessary
- Go over normal range for B/P, Review clients' B/P measurements – set goals
- Refer to self management classes or support group
- Confer with MD if needed
- Next visit in 3 months for follow up or PRN

DIABETIC CLIENT WITH MACRO VASCULAR COMPLICATIONS

- Review clients chart, lab values, medication, vital signs
- Assess clients knowledge
- Brief explanation of CAD and PVD
- Make client aware of significance of macro vascular disease for diabetic client if needed
    - Heart attack more prevalent in DM client
    - Occurs at younger age
    - More often fatal
    - Men and women equally affected, etc.

1st Visit

- **Survival Skills:**
    - Signs and symptoms of CAD and PVD
        - Teach them to monitor for chest pain, congested cough, SOB, dizziness, headaches, feeling light headed, cold feet, pain with walking, etc.
        - Teach them to take pulse and B/P when appropriate for particular client

- **Diet:**
    - Low cholesterol, low fat
        - Foods high in fat and cholesterol

    - Increasing fiber, how it relates to lipids
        - soluble fiber – foods found in
        - incorporating into their diet

    - Making better choices
        - cooking oils
        - cuts of meat
        - broil, bake, etc.

    - Go over sample menus, let them make suggestions
        - Assure them they will be able to eat traditional Mexican dishes, but now using monounsaturated oils, leaner cuts of meat, adding more fiber, etc.

    - Decreasing sodium in diet (Briefly give reason)
        - Discuss foods high in sodium:
            - milk products
            - canned goods
            - foods with concentrated tomato, etc…

        - Have products available, give examples:
            - regular V8 vs. low sodium V8

- melba toast, low sodium crackers vs. regular bread, etc.

- What to use instead:
  - lime juice and cilantro to replace salt in fixing Mexican chicken soup.
  - use grapefruit and Mrs. Dash (no salt) product in carne asada instead of meat tenderizer.
  - No salt shaker at table
  - Don't over salt foods when cooking
  - Have family members add salt after food cooked, if desired

- Have appropriate literature available on low sodium, low fat, and low cholesterol. Discuss and give as indicated by clients needs and understanding.
- Briefly teach on how to read labels (fats and sodium) if time permits. This would be done for clients who have the comprehension and desire to learn.
- set clients goals for next visit
- set up appointment in two weeks

2nd Visit

- Ask if client has any questions. Correct any misconception. Brief mention of topics covered on last session, often triggers questions from client. Evaluate goals, modify if needed.

- Obesity:

  - Explain how it relates to heart disease
  - following diet prescribed
  - high fiber – effect on weight loss
  - monitoring portion size
  - review what constitutes a serving
    - ½ cup rice
    - small fruit, etc.

  - not eating too late in p.m. (Do not forget clients on multiple insulin injections, might need a p.m. snack)
  - healthy snacks (if needed) high fiber, low fat
  - mutual goal setting, appropriate for client

- Exercise:

  - Briefly explain how it affects B/P, weight loss, glycemic control, triglycerides and benefit to circulation
  - See section on exercise

- Medication:

  - Does client know what medication he is taking, what they are for?
  - Review action, possible side effects

- Stress importance of taking medication as indicated (ac, pc)
- Stress importance of not stopping without doctors order
- Teach client or clients' family to take clients' pulse or B/P if medications warrant it.
- Set goals for next visit

3rd Visit

- Evaluate goals. Reassess if not met, modify as needed. Ask if client has any questions, correct misconceptions. Brief review of previous material as needed. Assess clients understanding of material covered on previous visits, re-teach as needed.

  - Monitoring

    - Lipids
      - Normal ranges
      - clients values
      - clients goal

    - HTN
      - Teach how to take own B/P if they have equipment
      - Stress importance of frequent monitoring, record readings
      - Discuss normal range, clients values, clients goal

    - Blood Glucose Level
      - Teach how to use glucose meter
      - Discuss normal range, clients values and goals
      - Review action to take if glucose high or low
      - Keep record (review pattern), mutually determine, when, how often SBSM will be done.
      - Bring record on visits (primary physician, CDE).

    - Set Goals
      - Follow up in three months or PRN if problems occur
      - Refer to SM classes or support group
      - Confer with primary physician if needed, send client for triage, as needed.

DIABETIC CLIENT WITH HYPERTENSION

- Review clients chart, lab values, medication, vital signs
- Assess clients knowledge
- Brief explanation of hypertension
- Make client aware of significance of hypertension for diabetic client
    - More prone to develop cardiovascular disease
    - More prone to develop renal disease
    - More prone to have CVA
    - Risk factors for development of diabetic retinopathy

- Make client aware that controlling their blood pressure can decrease the risk of diabetic complication:
    - Cardiovascular complications
    - Nephropathy
    - Retinopathy

Survival Skills

- Signs and symptoms of hypertension
    - Headache
    - Dizziness
    - Shortness of breath
    - Fluid retention, etc…

- Teach them to monitor B/P, strive for B/P reading of less then 130/80 when possible

- Decreasing sodium in diet (Briefly give reason)
    - Discuss foods high in sodium:
        - milk products
        - canned goods
        - foods with concentrated tomato, etc…

    - Have products available, give examples:
        - regular V8 vs. low sodium V8
        - melba toast, low sodium crackers vs. regular bread, etc.

    - What to use instead:
        - lime juice and cilantro to replace salt in fixing Mexican chicken soup.
        - use grapefruit and Mrs. Dash (no salt) product in carne asada instead of meat tenderizer.
        - No salt shaker at table
        - Don't over salt foods when cooking
        - Have family members add salt after food cooked, if desired

- Have appropriate literature available on low sodium, low fat, and low cholesterol. Discuss and give as indicated by clients needs and understanding.

- Briefly teach on how to read labels (fats and sodium) if time permits. This would be done for clients who have the comprehension and desire to learn.

- Exercise:
  - See section on exercise
    - No stressful activity if having overt symptoms of hypertension, follow up with primary physician as needed

- Smoking cessation a must
  - Refer to primary physician for medications
  - Refer to smoking cessation class if available
  - Set goal - remain non-judgmental

- Recap, make sure that client has good understanding

- Set goals for next visit

2nd Visit

- Evaluate goal - reassess, modify if needed

- Briefly review material covered on last visit, correct misconceptions

- Obesity:
  - Explain how it relates to heart disease
  - following diet prescribed
  - high fiber – effect on weight loss
  - monitoring portion size
  - review what constitutes a serving
    - ½ cup rice
    - small fruit, etc.

  - not eating too late in p.m. (Do not forget clients on multiple insulin injections, might need a p.m. snack)
  - healthy snacks (if needed) high fiber, low fat
  - mutual goal setting, appropriate for client

- Losing weight:
  - Give specific caloric diet
    - based on clients age
    - activity level
    - BMI, etc.

- Adhere to calories prescribed
- Distribute calories and carbohydrate throughout day
- Eat three balanced meals plus healthy snacks if needed (low fat, high fiber)
- Eat meals at scheduled times
- Adjust food intake with high level of exercise (if on medication for glucose control or insulin injections)
- Discuss better choices when eating out - give examples
- Effect of weight loss on hypertension
- When weighing:
  - same scale
  - same time
  - same amount of clothing

- Medications:

  - Does client know what medication he is taking, what they are for:
  - Review action, possible side effects
  - Stress importance of taking medication as indicated (ac, pc)
  - Stress importance of not stopping without doctors order
  - Teach client or clients' family to take clients' pulse or B/P if medications warrant it.
  - Monitor B/P and pulse
  - Set goals for next visit

3rd Visit

- Evaluate goals, reassess if not met, modify if needed. Assess clients' knowledge of material previously covered, correct misconceptions. Re teach as needed

  - Hypertension:

    - Teach client how to take B/P, record readings
    - Discuss normal range, clients value, clients goal range
    - Review action to take if glucose high or low
    - Keep record (review pattern)
    - Mutually determine when, how often SBSM will be done, unless specified by primary physician
    - Bring record on visit (primary physician, CDE)

  - Set goals
  - Follow up in three months or PRN if problem occur
  - Refer to SM classes or support group, confer with primary physician if needed, send for triage as needed.

EXERCISE
Incorporating physical activity into lifestyle

- Doctors clearance
- Assess physical status
- Assess level of activity
- Assess physical mobility
- Assess clients physical environment
    - Where will they walk
    - Who will walk with them
    - Consider safety, ex. High traffic, dogs, crime, etc.

- Appropriate attire for physical activity
    - Comfortable clothing
    - Well fitting supportive shoes
    - Extra insoles
    - Orthotics if needed or prescribed
    - Cotton socks, etc.

- Walk early in a.m. or p.m., avoid heat
- Keep hydrated
- Avoid exercising at medication peak time
- Carry fast source of sugar
- Advise to SMBS before and after exercise
- Wear medical alert ID
- Mutually decide on appropriate activity for client
    - Mild, moderate or high
    - Type

- Set specific self management goals with client
- Evaluate goal or next visit
    - Determine if goal met, not met or partially met

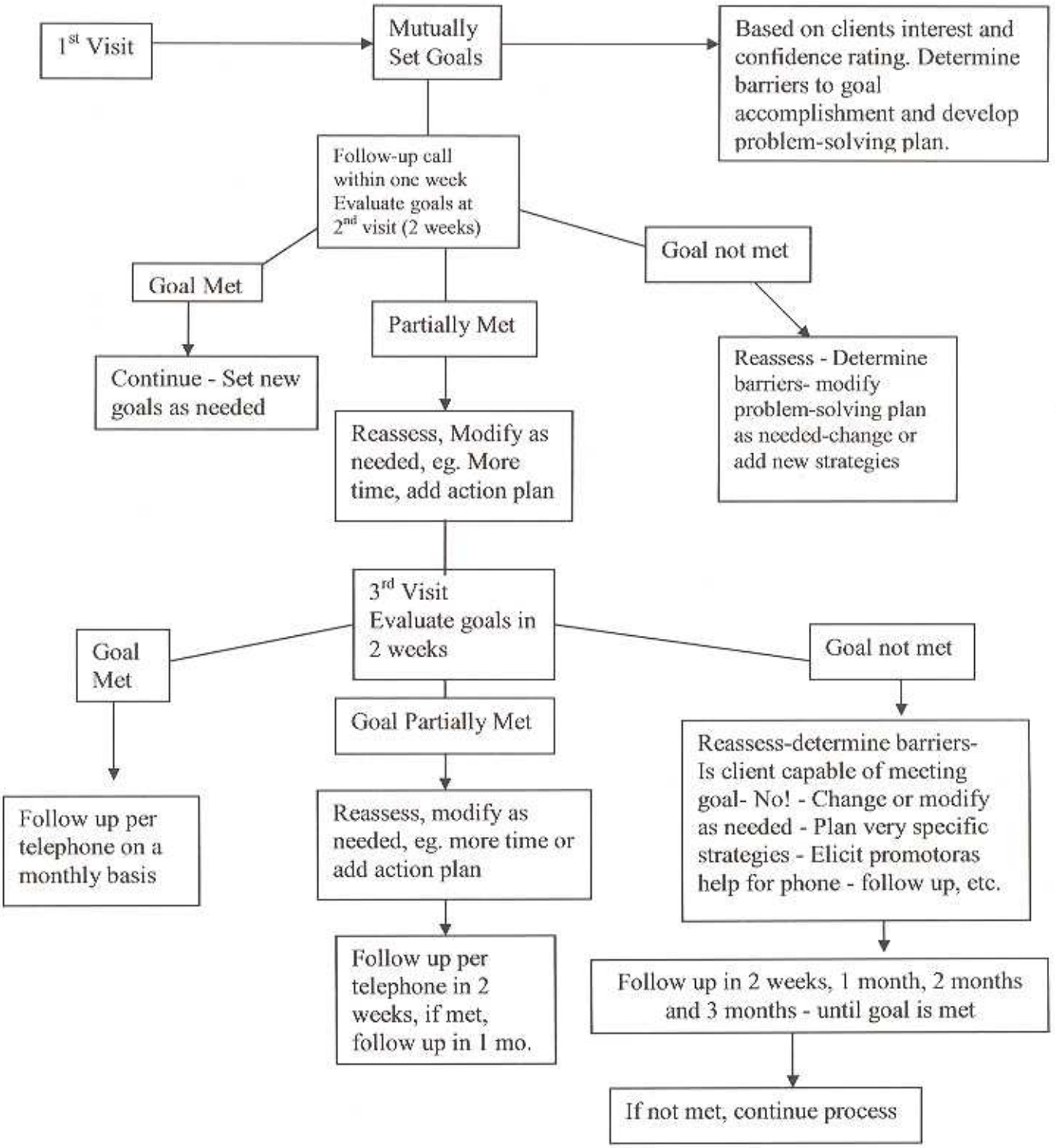
- If goal met, continue with activity, if not met or partially met, reassess.
    - Determine barriers, problems solve with client, modify goals as needed.

- Document specific goal setting and evaluation of goal appropriately
- Review signs and symptoms of CAD, PVD, HTN or high or low glucose if needed. Advise to stop and call primary care physician if symptoms occur
- Refer to self management classes or support group classes if not attending

<u>Caution: Do not exercise if:</u>

- Blood sugar level is over 240 mg/dl
- Overt signs of:
    - Neuropathy
    - Retinopathy

Algorithm for Goal Setting and Follow Up
Diabetes Self Management Clients



Gateway Community Health Center, Inc.

Certified Diabetes Educator Patient Dietary Assessment Tool

Name: _____ D.O.B.: _____ M.F. # _____

Present health status: _____

Current exercise level: ☐ Sedentary ☐ Moderate ☐ Active

Diet Pattern:

☐ High in starch

☐ High in sweets

Fiber:

☐ Adequate

☐ Low

☐ High

Meats:

☐ More white

☐ More red

☐ Equal amounts of red & white meats

Eggs:

☐ > 3 per week

☐ < 3 per week

Liquids:

☐ Water ☐ Other

☐ Regular sodas

☐ Diet sodas

☐ Juices

☐ Milk

Gateway Community Health Center, Inc.
Certified Diabetes Educator Patient Dietary Assessment Tool

Factors That Influence Food Intake:

	Yes	No
1. Has good appetite	☐	☐
2. Resides alone	☐	☐
3. Prepares own food	☐	☐
4. Follows 3-meal pattern daily	☐	☐
5. Has elimination problems	☐	☐
6. Has food allergies	☐	☐

7. Type of food preparation	☐	conventional cooking
	☐	fast foods
	☐	snack foods
8. Location of meals	☐	home
	☐	restaurant
	☐	other
9. Food cravings	☐	sweets
	☐	fried
	☐	salty
10. Food preferences	☐	ethnic
	☐	regional
	☐	other

GATEWAY COMMUNITY HEALTH CENTER, INC.

Certified Diabetes Educator Patient Self-management Plan

Patient Name: _____ **Date:** _____

Most Recent Data: FBS _____ **SBGM (yes or no)** _____ **BS Range** ___ **to** _____

HbA1c _____ **Other Labs** _____

Patient Long-term Goals: Wt.____ **BMI** ____ **B/P** __/___ **HbA1c**_____
Other _____

Behavioral Goal/s _____

_____

Importance of Goal to Patient: _____ **(scale of 1 - 10 with 10 being most important)**

Patient's confidence in Meeting the Goal: _____ **(scale 1-10 with 10 highest confidence)**

Patient's Barriers to Meeting the Goal: _____

Plan for managing the barrier: _____

_____

Follow-up Date/s: _____

Goals: ☐ **Met (Accomplishment):** _____

☐ **Not met (Problems):** _____

☐ **Partially met** **(Progress, problems):** _____

Revised Goals:

_____

_____