Message from the Chair

Andrea V. Dunn, RD, LD, CDE
Cleveland, OH

Sounding like a line out of Dr. Seuss’ *There’s a Wocket in my Pocket*, my patient asked me curiously, “What’s in your pocket?” The check-in staff must have warned him that I’ve been known to carry around handy objects as part of my client education. Don’t we all keep something “up our sleeve” or in our mental “toolbox” for the patients or students who need that something extra?

Besides my pager, today’s lab coat pocket held a toy soldier (looking through a pair of binoculars), a similar-sized dinosaur, and a Sorcerer’s Apprentice Mickey Mouse figurine. I can use the soldier in a discussion about team work or how patients need to do reconnaissance work before eating (check blood sugar, count carbs, and take medications). I also have a soldier carrying a bazooka, and he might help patients blast away the large portions to help with weight loss. The dinosaur? That’s really in my pocket for me to remind me to stay progressive, keep learning, and try new things so that I don’t become fossil fuel. Have your patients ever asked you to perform magic: make the diabetes, the weight, the mother-in-law (seriously, someone once asked me this) go away? This is the reason I keep Mickey handy (you never know when you need some magic).

Sharing what works and what doesn’t makes for good networking. Over the past year as Chair of this great dietetic practice group, I’ve had the extreme pleasure of meeting so many of our members at conferences as well as through the Diabetes Care and Education (DCE) Facebook and the DCE Electronic Mailing List (EML). Thank you for your eagerness to help other members or ask the question that many of us were also pondering.

At our Spring Leadership Retreat in April in Cleveland, Ohio – where both the outgoing and incoming boards met – we had an opportunity to hear Mary Pat Raimondi, MS, RD, Vice President, Strategic Policy & Partnerships, The Academy of Nutrition and Dietetics speak about what’s happening in government and what we need to do NOW to secure the future of our profession. Mary Pat was joined by staff member Whitney Brown in asking us to send her case studies and stories of how our patient’s lives are disrupted by not being able to have Medical Nutrition Therapy delivered by a registered dietitian and Diabetes Self-Management Education classes on the same day if they have Medicare B as their primary coverage. These personal stories make a difference in

(continued on page 3)
TABLE OF CONTENTS

1 Message from the Chair
2 Message from the Print Communications Coordinator
3 Message from the NewsFLASH Editor
4 Aligning Medical Nutrition Therapy/Diabetes Self-management Training Programs With Today’s Health Care Models
5 Meet the Chef Marlisa Brown, MS, RD, CDN, CDE
6 Book Review: 1,000 DIABETES RECIPES
7 Diabetes Apps for High-tech Disease Management
8 Food Security and Diabetes
9 2013 Public Policy Workshop
10 2012-2013 DCE Officer Directory

The previous issue of NewsFlash, page 26 misspelled Canolainfo’s website incorrectly. The correct website address is www.canolainfo.org.

STRATEGIC PRIORITY AREAS

GOAL 1:
- Sustain and grow a high level of satisfaction and retention among members.
- Use electronic technology to engage new and existing members.
- Promote and support member professional development.
- Maintain a high value of membership.

GOAL 2:
- Advance DCE’s unique position as the authority in nutrition and diabetes prevention, education and management.
- Promote and maintain new DCE image.
- Develop domestic and global alliance and stakeholder relationships.
- Promote and support evidence-based practice and research.
Message from the Chair
(continued from page 1)

discussion with senators and staff. Please send your patient stories to Mary Pat at mraimondi@eatright.org.

Some local DCE members had a chance to join us at this Networking event dinner. It was great to meet you and hear the ways that DCE helps you in your practice. One member mentioned that she is the only Academy member in her department of registered dietitians. She felt that DCE was her life-line to nutrition and diabetes and looks forward to the e-updates, webinars and newsletters throughout the year.

DCE is here for all of us whose lives are touched by diabetes. DCE volunteers work hard to keep you updated and informed. Thank you to the DCE 2012-13 Executive Committee and working committees. I have never met a group of people as dedicated to promoting our profession. And to all DCE members, thank you for your calls, comments, member survey completion and attendance at in-person or online events. DCE is you!

Alison Steiber, PhD, RD/Chief Science Officer and Rosa Hand, MS, RDN, LD, Senior Manager, Dietetics Practice Based Research Network (DPBRN), Academy of Nutrition and Dietetics met with DCE members in Cleveland, Ohio during the Spring Leadership Retreat. They both stressed the need for research and outcome studies. Two great ways to be involved in research or look for information on how to get started with research is to join the DPBRN and to view the Research Tool kit. Both are free with Academy membership. Go to http://www.eatright.org/Members/content.aspx?id=7187 to join the DPBRN (or go to the Research section under the Members page). The tool kit can be “purchased” for free at https://www.eatright.org/shop/product.aspx?id=6442464902 or go to the “shop” section of www.eatright.org
Volunteering is at the heart of citizen action and central to serving communities. Fundamentally, volunteering is the free sharing of time, energy and skills. The generosity and dedication of volunteers is paramount to professional affiliations, civic programs, social organizations, and charities.

Diabetes Care and Education (DCE) has gained greater exposure to outside sources through the continuing efforts of our dedicated volunteers. Volunteers have increased partnerships and networking opportunities. In addition to assisting in the delivery, management, and enhancement of our dietetic practice, they bring fresh outlooks and new ideas. Can you imagine DCE without volunteers? While sharing their education, knowledge, and talent, volunteers gain a sense of pride, satisfaction, and accomplishment as well as professional and social connections.

Not all benefits of volunteers are tangible. Volunteering can add variety to everyday routine and create a balance in our lives. Discovering new interests through volunteering can be fun, relaxing, and energizing. Both the recipients of your volunteer efforts and your colleagues can be rich sources of inspiration and offer excellent opportunities to develop interpersonal skills. Volunteering also offers an incredible networking opportunity. Not only can volunteers develop lasting personal and professional relationships, but they can learn from a range of people from various backgrounds and walks of life.

You can never tell whom you will meet or what new information you will learn and what impact this could have on your life.

— World Volunteer Web (1)

DCE welcomes member participation. Volunteering allows members to network with colleagues and incorporate their skills and experiences to best meet the needs of our membership and organization. For information about volunteer opportunities with DCE, please visit http://www.dce.org/get-involved/volunteer-opportunities.

This is my last issue as Print Communications Coordinator. My appreciation goes to the amazing members of the Print Communications team, editors of both NewsFLASH and OTCE, and the Publications Chair for their service and dedication. Lorena Drago, MS, RD, CDN, CDE, will be taking on the Print Communications Coordinator position. Sue McLaughlin, MOL, RD, LMNT, CDE, will move from Associate Editor to Editor of OTCE. DCE welcomes Janis Roszler, MSFT, RD, LD, CDE, as new OTCE Associate Editor and Anna Henry, MPH, RD, LD, CDE, as new NewsFLASH Editor. It has been a pleasure working with so many talented DCE members committed to advancing our organization’s unique position as the authority in nutrition and diabetes prevention, education, and management.

REFERENCE
“They always say time changes things, but you actually have to change them yourself.”
– Andy Warhol (1928-1987), The Philosophy of Andy Warhol

Three years ago, Diabetes Care and Education (DCE) past-president Amy Hess-Fischl, MS, RD, LDN, BC-ADM, CDE, asked if I would like to transition from writing the “Crossroads in Culture and Nutrition” column to NewsFLASH editor. As a long time DCE volunteer, I had transitioned from an occasional newsletter contributor to DCE’s area coordinator, to a regular columnist and now NewsFLASH editor. I was hesitant at first, but I was certain that volunteering would lead to invaluable personal and professional gains. Here I am 3 years later, writing my last message as newsletter editor and passing the editorial baton to Anna Henry, MPH, RD, LD, CDE, from Finley, MN.

Change is constant, as reflected by many of the articles published in NewsFLASH. The “Meet the Chef” column resulted from an interest in providing patients with cooking tips and easy-to-prepare tasty and healthy recipes. Don’t miss my interview in this issue with Marlisa Brown, registered dietitian, chef, and author of Gluten-Free, Hassle Free. You definitely should sample some of Marlisa’s patient-approved “I can’t live without” gluten-free recipes. The advent and expansion of smart phones and tablets have served as a platform for applications (apps) that help patients and health care professionals alike. Every issue of NewsFLASH contains an article featuring applications that are considered indispensable for many diabetes educators and persons living with diabetes. Angela Major, RD, LD, a pediatric educator, blogger, and mother of two children with type 1 diabetes, compiled a list of her favorite apps that we feature in this issue.

Guest author Kerri Knippen, MPH, RD, LD, BC-ADM, writes about the patient-centered medical home. Although not a new term, this concept has gained popularity in the past several years since it was first developed for pediatric care. This model of care offers additional opportunities for dietetics professionals in diabetes management care. In 2011, MyPyramid transitioned to MyPlate. In “Have You Seen?” Jill Weisenberger, MS, RD, CDE, features new portion-control tools, many of which are inspired by the MyPlate method.

I challenge you to consider embarking on something new in 2013. Write an article, volunteer, transform your “I wish I could” moments into reality. The moment is now to transition into excellence. If you want to be a guest author, please email me at lorenamsrd@aol.com.

Thank you for your continued support of DCE. Please remember to renew your DCE membership with your Academy renewal. Tell your friends about the many benefits of DCE membership (free webinars, OTCE CEUs and great resources) and encourage them to join DCE – because diabetes effects everyone!
Health care is currently in the midst of a paradigm shift, moving away from procedure-based care and toward preventive care. The Patient Protection Affordable Care Act (PPACA) and other influencing factors have created a foundation for such changes. The dietetics workforce study reported a potential shortfall of more than 18,000 Commission on Dietetic Registration-credentialed professionals by 2020 (1). Although more than 50% of registered dietitians (RDs) currently work in clinical settings, the jobs that are likely to be created or needed in the next decade will be in nonclinical settings (1). Consequently, it is essential for health care providers, including RDs, to become aware of and involved in new models of health care delivery.

The patient-centered medical home (PCMH) is not a new concept, but it has gained popularity in the past several years. This model of care is characterized by a continuous relationship between a patient and a personal physician (2). The PCMH model encourages coordination of care for both wellness and illness. This approach aims to improve access to care, patient engagement, whole-person care, team-based care, care coordination, practice-based services, practice management, and health information technology (2). Practices can voluntarily become certified by the National Committee for Quality Assurance (NCQA) as patient-centered medical homes by meeting specific criteria and standards (3). Of note, a growing number of practices are engaging in PCMH without accreditation. Recognized PCMH NCQA providers and practices are listed on the NCQA website (3). Both RDs and diabetes educators should consider this resource to help determine available opportunities in their communities.

The accountable care organization (ACO) is essentially a large medical home model that engages both providers and institutions. The ACO brings together stakeholders (doctors, other clinicians, and hospitals) who are interested in reducing health care costs and improving outcomes through coordinated patient-centered care (4). At this time, an RD cannot form an ACO independently, but he or she can participate in ACOs with the appropriate ACO professionals (physician, nurse practitioner, physician assistant, and clinical nurse specialist). Qualified ACO professionals work with the patient to develop and coordinate the care plan. Developing a working relationship with these professionals can open doors for RDs to participate in ACOs.

Forming ACOs allows groups to voluntarily participate in the Medicare Shared Savings Program (SSP) from the Centers for Medicare & Medicaid Service (CMS). More than 100 new ACOs were announced as participants in the CMS-SSP in January 2013 (4). The SSP aims to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs (4). The PPACA enables CMS to incorporate Physician Quality Reporting System reporting requirements and incentive payments into the SSP (4). CMS measures quality of care using 33 nationally recognized quality measures in four key domains (4). One of the domains, “at risk population,” includes patients with diabetes, hypertension, ischemic vascular disease, heart failure, or coronary artery disease (4). Some of the quality measures for diabetes and coronary artery disease have an “all or nothing” requirement, meaning that no incentive will be received for performance unless all requirements are met (4). RDs can use these quality indicators when leveraging themselves into a practice. RDs should refer to the Academy of Nutrition and Dietetics Evidence Analysis Library to validate the benefits of medical nutrition therapy (MNT) for chronic disease management. Clinical and outpatient RDs can partner to promote coordination of follow-up and education, with the goal of reducing hospital readmissions.
Following are suggested strategies to align MNT or diabetes self-management and training (DSMT) programs to meet the goals of the PCMH model:

1. Open access: “Open scheduling time” enables patients to be seen the same day. Open access blocks should be considered early or late in the day as well as during the noon hour. Dietetics professionals can offer this type of service by including 30 to 60 minutes in the schedule to accommodate “add-on” patients. The patient and providers appreciate the flexibility and seamless transition of same-day access.

2. MNT/DSMT “drop-in” appointments: Once-weekly group training allows for flexible and rapid patient scheduling. Essentially this type of appointment is similar to “open access,” allowing providers to refer patients quickly to the MNT/DSMT program. Follow-up patients can also “drop in” to these appointments for additional education or training.

3. Shared medical appointments (“group medical visits”): These appointments should be scheduled during the work day and are a great option for providers to serve more patients while maintaining high quality and coordinated care. Shared appointments are one vehicle for including the RD in Medicare’s Annual Wellness Visit and Obesity Counseling Benefit. “Meeting the Need for Obesity Treatment: A Toolkit for the RD/PCP Partnership” from the Academy provides background information on Medicare’s Annual Wellness Visit and Obesity Counseling benefits (5).

4. Telenutrition: Although these services are not always reimbursed, telenutrition can allow RDs to connect with patients in their own environments. Using real-time online collaboration tools that are compliant with the Health Insurance Portability and Accountability Act of 1996, RDs and outpatient programs in rural areas could connect with patients requiring MNT/DSMT from multiple originating provider sites.

5. Peer models/training programs: RDs should move beyond traditional support groups and implement patient/peer education training and support. RDs should consider partnering with community groups, health and fitness facilities, and churches as sites for peer training programs. Inviting family and friends to medical visits can improve support and coordination for the patient in his or her own environment.

6. Health information technology: Dietetics professionals should become familiar with the technology available for their practices. RDs should use data registry systems for population management. Parameters can be established in the population management system to trigger RD referral, and RDs should work with providers to establish parameters. The quality indicators from CMS can serve as a beneficial guide in this process. RDs may also want to use patient portals for assessment forms, tutorials, and handouts. RDs should encourage use of the nutrition care process in the practice’s selection or development of the electronic medical record.

In looking to the future, RDs must recognize potential opportunities. Unfortunately, such opportunities are not guaranteed, and dietetics professionals need to advocate for the profession. As prevention receives increasing attention and reimbursement, other providers will offer competition. For this reason, dietetics professionals need to stay abreast of developments and learn the new language of health care. Dietetics professionals and diabetes educators may want to consider continuing education in health information technology, population management, health coaching, and case management. Specialty certifications may also offer additional credibility in these models of care.

REFERENCES


New Portion Control Tools

Jill Weisenberger, MS, RD, CDE
Yorktown, VA

Few aspects of diabetes management are harder for our patients than portion control. We pull out food models and give them handouts describing techniques to use their hands or household objects to estimate appropriate portions. We tell them to fill half their plate with non-starchy vegetables. Some of our patients even use food scales and measuring cups. Still, reining in portions remains hard, so the more tools patients have at hand, the better their chances at success. Here are several portion control tools that may be new to you.

Rethink Your Plate by Del Monte Foods
www.rethinkyourplate.com
Del Monte has made a 9-inch melamine plate with photographic images of foods in their appropriate portions. One-half of the plate is filled with green beans and carrots. The other half has a small serving each of spaghetti and chicken. The plate is designed as an educational tool, but it can be used as a guide for planning and serving dinner because the plate is dishwasher-safe. The plate sells for $7.95 and includes a layover booklet with six additional photographic plate images. Some of the images include fruit instead of two servings of non-starchy vegetables, which is consistent with MyPlate rather than the Plate Method of diabetic meal planning. You can download free, colorful handouts as well. The handout for diabetic meal planning lists examples and portion sizes of each food group. The second page identifies foods with carbohydrates and demonstrates how to read food labels for carbohydrates, fats, sodium, and serving size. An additional handout that is not specific to diabetes covers label reading tips and portion control. This handout is also available in Spanish.

Precise Portions
www.PrecisePortions.com
Precise portions offers a variety of dish sets. The Lifestyle Starter Set ($59.95) of attractive porcelain dishes includes a plate printed with portion guidelines, a plate that has a design outlining appropriate portions, a small plate for dessert, a glass with attractive 4-ounce and 8-ounce markings, and two bowls with appropriate markings. For those on the go or for patients who pack their lunches, Precise Portions offers the Go Healthy Travel Pack ($29.95), a set of four microwaveable sectioned dishes with covers. Finally, for those situations calling for disposable dishes, 100% compostable plates, bowls, and cups are available, each with portion markings. Each disposable unit is available in sets of 25. Prices range from $9.95 to $12.95.

Measure Up Bowls
www.slimware.com
This set of two white porcelain bowls is very plain. The 2-cup bowl has markings every ½-cup. The snack size bowl is marked at ¼, ½, and ¾ cups. The cost for the set is $29.99.

Wine-Trax
www.wine-trax.com
Wine-Trax offers clear glass dishes with attractive frosted lines to indicate portions. The plate (2 for $29.99) is divided into three sections resembling the Plate Method for diabetic meal planning. The stemmed glass (2 for $28.50) has markings at 4-, 6-, and 8-ounces. The bowl (2 for $27.99) comes with a lid and is marked at ½, ¾, and 1-cup measures. A three-piece set sells for $39.99.

Slimware
www.slimware.com
These eye-catching melamine or ceramic dinner plates stealthily guide portions. The proper portion is disguised within the design of each Slimware plate. Place veggies over the largest flower or geometric design. Meat fits on the smallest, and the medium design is just right for pasta, corn, and other starches. Depending on the patient, however, registered dietitians may want to recommend reversing the meat and starch portions. A set of four melamine plates costs $37.50. The ceramic plates are $59.00 for a set of four.

The many options and price points offer innovative solutions for everyone.
Marlisa Brown, MS, RD, CDN, CDE, is a registered dietitian, certified diabetes educator, chef, international speaker, private consultant for 19 years and president of Total Wellness, Inc, in Long Island, New York. Marlisa is the author of *Gluten-Free, Hassle-Free* and *Easy Gluten-Free*. Marlisa was also the DCE 2011 Diabetes Educator of the Year Award winner.

**Is there an association between diabetes and celiac disease?**
There is an association between type 1 diabetes and celiac disease. About 10% of those with type 1 diabetes have celiac disease. Type 1 diabetes and celiac disease share common alleles on chromosome 6. The standards of care recommend annual screening for celiac disease for persons with type 1 diabetes as well as their first-degree relatives.

**What is the difference between gluten sensitivity and celiac disease?**
Celiac disease is an autoimmune disorder that disrupts ingestion of the protein gluten. About 50% of people with celiac disease have gastrointestinal and nutritional malabsorption problems. The remainder may experience a wide range of problems, including migraines, canker sores, neuropathies, seizures, and an array of autoimmune disorders. Some patients are asymptomatic.

**How is celiac disease diagnosed?**
**What are the symptoms of each?**
Blood tests such as the immunoglobulin (Ig)A tissue transglutaminase and a dipropylene glycol (DPG) with a total IgA and genetic testing are used to screen for celiac disease. An intestinal biopsy is used to diagnose celiac disease. Using an endoscope, approximately 4 to 6 samples of tissue in the small intestine are tested to check for damage to the villi. Gluten sensitivity does not damage the villi and is a diagnosis of elimination after celiac and a wheat allergy are ruled out. If a person responds favorably to a gluten-free diet after all other disease states are ruled out, he or she is deemed to be gluten-sensitive. Because we are just learning about gluten sensitivity, additional research is needed.

**What inspired you to write the book *Gluten-Free, Hassle-Free* and to co-author *Easy Gluten-Free***?
I wrote *Gluten-Free, Hassle-Free* because following gluten-free diets can be very confusing. I wanted people to know what to eat from day one, have meal plans, and know how to dine out safely (so I created dining out cards in 14 languages). I wanted readers to have terrific easy recipes and safe food lists. Patients are overwhelmed with the disease, and this book is designed to make their lives easier. Tricia Thompson, MS, RD, wrote *Easy Gluten-Free* because so many gluten-free recipes feature starchy processed grains. This book describes the nutritional benefits of gluten-free whole grains, and most of the 100+ recipes are predominately made from gluten-free whole grains.

**You have developed many recipes for persons following a gluten-free diet. Which recipes are your patients’ favorites?**
It depends on the patients. Some are looking for sweets, so the Linzer tortes lava cakes, and cheese cakes are some of their favorites. Others are looking for pasta like my stuffed ravioli or homemade lasagna. Health-conscious consumers favor the peanut butter granola bars or the home-made veggie burger.

**What tips can make a big difference when registered dietitians counsel patients about gluten-free diets?**
Don’t be too rigid. The gluten-free diet requires a 100% life adherence and it is difficult to follow. If patients with celiac also have other health issues, give them some degree of flexibility in other areas. For example, I had a patient with type 2 diabetes and celiac disease who often ate regular cake and had no intention of giving it up. The compromise was to
MEET THE CHEF
(continued from page 9)

eat cake occasionally and substitute regular cake with gluten-free cake. I told her where to purchase the gluten-free ingredients and how to bake it.

What sections of your book are lauded by your patients as being the most helpful (lifesaving!!!)? Meal plans, recipes, dining out cards, and safe food lists.

What are some of your favorite “I can’t believe these are gluten-free foods” in the market? There are so many gluten-free foods today. Some are: Udi’s® GF cookies, Schar gluten-free bread sticks, thinkThin® divine chocolate coconut bars, and Everybody Eats gluten-free bread.

Other than your books, what are some of the “must go to resources” for persons with gluten sensitivity? We tell those with celiac disease and those with gluten sensitivity to eat gluten-free 100% of the time, so the books we recommend are the same for both. I like the various gluten-free grocery guides and Carol Fenster’s 1000 Gluten-free Recipes.

What is your final message to those who have gluten sensitivity and the professionals who work with them? People on gluten-free diets are entitled to have foods that look and taste good. When they go out to eat, they should be able to select bread, appetizers, entrees, and desserts just like everyone else.

These recipes are from my book Gluten-Free, Hassle-Free.

Stuffed Arepas
Serves 4
Delicious Hispanic flat breads, often served as a sandwich with eggs or cheese. It can be made from precooked corn or masa harina as below, really a great find
1 cup instant GF masa harina (precooked cornmeal)
1 ½ cups boiling water
½ tsp salt
GF cooking spray (or vegetable oil)
2 Tbsp parmesan cheese
2 oz hard provolone cheese
4 pieces of roasted red peppers
1. In a medium bowl mix together masa harina, boiling water and salt until well combined. Let it sit for about 5 minutes.
2. Preheat oven to 350 degrees.
3. Wet your hands with cold water and separate mixture into 4 balls, and flatten with your hands into patties.
4. Spray a large skillet with cooking spray (or coat with vegetable oil) and heat it over medium heat until hot.
5. Place each patty in the skillet and cook for 5-7 minutes on each side until it browns and it puffs up a little and center is mostly set. (middle will be a little soft like polenta).
6. Sprinkle top of each arepa with parmesan cheese
7. Slice each arepa open and fill with provolone and red pepper. Place on a baking sheet and bake in a 350 oven until the cheese melts.

Nutritional Information: 176 calories, 7.6 grams protein, 24.4 grams carbohydrate, 5.7 grams fat, 12 milligrams cholesterol, 456 milligrams sodium, 3.5 grams fiber, 178 milligrams calcium, 2.3 milligrams iron

Black Bean and Mango Salsa
Serves 12
This salsa gives a fresh, colorful, finished touch to any meal. A real crowd pleaser.
2-10 ½ oz cans black beans drained and rinsed
1 ear of corn, (kernels only, about 1 cup frozen if fresh unavailable)
1 chopped mango
Juice of 2 limes
1 chopped jalapeno pepper
1 chopped red pepper
1 chopped red onion
¼ cup chopped cilantro
1. Mix all ingredients together, and refrigerate until ready to use.
Nutritional Information: 63 calories, 3 grams protein, 13.2 grams carbohydrate, <1 grams fat, 0 milligrams cholesterol, 99 milligrams sodium, 2.9 grams fiber, <1 milligrams iron

Tips:
1. Great served over chicken or fish.
2. To remove the kernels from an ear of corn, remove husk from the corn, and run a knife down each side of the corn over a small bowl, removing and saving all kernels.
RENEW YOUR DCE MEMBERSHIP AND CONTINUE TO RECEIVE ALL DCE MEMBER BENEFITS

You are very important to us! If you haven’t already renewed your membership to the Diabetes Care and Education Practice Group (DCE) DPG #23, please do so today. You are a vital part of our network of nutrition professionals who specialize in diabetes care and education.

**Member Benefits:**
- Six peer-reviewed newsletters each year.
- Free continuing professional education credits.
- Continuing education events, webinars, networking and receptions.
- Access to your colleagues through the DCE Electronic Mailing List, web site (www.dce.org), Facebook (https://www.facebook.com/DCEdpg) and Pinterest (http://www.pinterest.com/dcedpg)
- Reproducible patient education handouts.
- Awards, grants, scholarships and stipends.
- And many more…check out Member Benefits at www.dce.org.

**Resources**
- An extensive list of diabetes professional resources can be found at www.dce.org.

**How to renew your membership:**
When you renew your membership to the Academy of Nutrition and Dietetics, select the DCE DPG #23. You can renew online at www.eatright.org or by calling 1-800-877-1600 x5000. DCE membership is $30; student membership is $15.

For more information you may contact DCE Membership Coordinator Carolyn Harrington, RD, LDN, CDE at Carolyn.harrington217@ymail.com
Dietitians are challenged by the vast number of clients with diabetes struggling to control their blood glucose. As an indication of the pace of this disease, 1.9 million new cases of diabetes were diagnosed in people age 20 years and older in 2010. Of those younger than 20 years of age, 215,000 or 0.26% of this age group have diabetes, which represents about 1 in every 400 children and adolescents. Diabetes is present in 25.6 million or 11.3% of those 20 years and older and 10.8 million or 26.9% of that 65 year and older.

Most dietitians find that clients are overwhelmed as they struggle to make changes to control their blood glucose while still trying to enjoy eating. The most common questions I receive from my clients are: What can I eat? Can you give me a meal plan? Can you give me recipes?

Jackie Mills, MS, RD, is a registered dietitian and food writer who has written for Cooking Light®, Family Circle®, and the American Medical Association and was formerly editor of Redbook®. This book of 1,000 recipes is a wonderful reference for patients with diabetes.

Jackie states that her desire in writing this book was to help others recognize the positive impact that a healthful diet has in preventing type 2 diabetes and delaying complications for those who have diabetes. She believes that preparing flavorful and nourishing meals is excellent advice for everyone because it can prevent not just diabetes, but heart disease, high blood pressure, and some forms of cancer. Jackie’s introduction states, “This book is an essential guide to eating healthfully, whether you have diabetes yourself, prepare meals for someone who does, or just want to cook delicious meals for your family.”

The introduction reviews in very simple terms types of diabetes, what causes diabetes, definitions of prediabetes and gestational diabetes, diabetes complications, and care. Also included is a section entitled “How To Eat Smart When You have Diabetes” that covers the role of carbohydrates, explaining that carbohydrates are essential to any eating plan, some carbohydrates are better than others, and that fiber has benefits. Also included is a discussion of the glycemic index. In the section on “Other Nutritional Considerations,” Jackie concisely reviews calories, fat, types of fat, how to choose healthy fats, cholesterol, protein, and meal planning. The “Eating Well for Life” section offers a refreshing look at the many helpful behavior changes that dietitians use in counseling their patients. This discussion covers setting small goals, training the taste buds, eating foods rather than products, doubling vegetable intake, planning ahead, shaking the salt habit, concentrating on moderation, measuring and weighing, being restaurant savvy, and most importantly, not forgetting the importance of daily exercise. There are 7-day sample meal plans for 1,500 and 1,800 calorie levels. I have recommended this book to my clients not just for the wide variety of recipes, but to reemphasize the basics of diabetes. Clients do better when they have written information to which they can refer, and I encourage clients to reread these early sections when looking up recipes.

The recipes include breakfasts and brunches, starters and snacks, pizza and sandwiches, salads, soups, poultry, beef, pork, lamb, fish,
Today, more than any other time in the history of diabetes diagnosis and management, technology is influencing and contributing to patient care and self-management. There are literally hundreds of free or low-cost software programs and apps available for home computers, smart phones, and other devices that make recording, managing, and tracking diabetes data easy and convenient. Here are just a few of my favorites:

**CalorieKing**
http://www.calorieking.com
This fantastic database of foods has an easy-to-use search tool to find calorie, fat, and carbohydrate counts. Search by name, brand, or restaurant. Available for mobile phones or as an iPhone app.

**Log Frog**
http://www.logfrogapp.com
This iPhone app easily tracks blood glucose, medication dosages and administration, and carbohydrate intake while patients are on the go, subsequently generating and emailing reports directly from the phone.

**OnTrack**
http://bit.ly/12qShy4
A similar tracking app for Android, OnTrack keeps records of blood glucose, medication, and food and generates e-mail reports.

**GoMeals**
http://www.gomeals.com
This gorgeous application, developed by diabetes drug company Sanofi, is a comprehensive online management program with blood glucose tracking, exercise logs, food records, reports, social media sharing, and the ability to sync between mobile devices as well as backing up data to the Cloud. GoMeals is compatible with both Apple and Android.

**dlife:** http://www.dlife.com
A fully interactive multimedia online platform, dLife produces educational videos and supports an online community as well as offering a podcast library, extensive disease and nutrition educational information, and Q&A access to diabetes educators. A coordinating mobile app for iPhone offers a full complement of tracking tools. I love their tagline: “It’s YOUR Diabetes Life!”

Whether you are looking for an easy and user-friendly mobile tracking tool or you desire a more comprehensive all-in-one diabetes hub (or a little of both!), numerous high-quality and extremely valuable technology tools are available for patients with diabetes and their caregivers. These apps offer one more path to optimal diabetes control!
Patients who had type 1 diabetes and participated in both resistance and aerobic exercise experienced less initial decline in blood glucose during resistance activity but more prolonged reductions in post-exercise glycemia relative to aerobic exercise.


This 3-month double-blind, placebo-controlled, multicenter clinical trial evaluated the effects of exenatide on body mass index (BMI) and cardiometabolic risk factors in 22 adolescents with severe obesity (BMI ≥1.2 times the 95th percentile or BMI ≥35). All patients received lifestyle modification counseling and were randomized to exenatide or placebo injection twice per day. The primary endpoint was the mean percent change in BMI measured at baseline and 3 months. Secondary endpoints included absolute change in BMI, body weight, body fat, blood pressure, glycolated hemoglobin, fasting glucose, fasting insulin, and lipids at 3 months. Exenatide elicited a greater reduction in percent change in BMI compared with placebo. Similar findings were observed for absolute change in BMI and body weight. Although not reaching the level of statistical significance, reductions in systolic blood pressure were observed with exenatide. These results provide preliminary evidence supporting the feasibility, safety, and efficacy of glucagon-like peptide-1 receptor agonist therapy for the treatment of severe obesity in adolescents.


Easily implemented insulin regimens are needed to facilitate hospital glycemic control in general medical and surgical patients with type 2 diabetes. This multicenter trial randomized 375 patients with type 2 diabetes treated with diet, oral antidiabetic agents, or low-dose insulin (≤0.4 units/kg/day) to receive a basal bolus regimen with glargine once daily and glulisine before meals, a basal plus regimen with glargine once daily and supplemental doses of glulisine, or sliding scale regular insulin (SSI). Improvement in mean daily blood glucose (BG) after the first day of therapy was similar between the basal bolus and basal plus groups (*P* =0.16), and both regimens resulted in a lower mean daily BG than did SSI (*P* =0.04). In addition, treatment with basal bolus and basal plus regimens resulted in less treatment failure (defined as >2 consecutive BG measurements >240 mg/dL or a mean daily BG measurement >240 mg/dL) than did treatment with SSI (0% vs. 2% vs. 19%, respectively; *P* <0.001). BG values <70 mg/dL occurred in 16% of patients in the basal bolus group, 13% in the basal plus group.
group, and 3% in the SSI group (P=0.02). There was no difference among the groups in the frequency of severe hypoglycemia (<40 mg/dL; P=0.76). The use of a basal plus regimen with glargine once daily plus corrective doses with glulisine insulin before meals resulted in glycemic control similar to a standard basal bolus regimen. The basal plus approach is an effective alternative to the use of a basal bolus regimen in general medical and surgical patients with type 2 diabetes.


The American Diabetes Association updated their estimate of the total economic cost of diabetes (in 2012) to $245 billion, a 41% increase from their previous estimate of $174 billion (in 2007 dollars). These figures highlight the substantial burden that diabetes imposes on society and do not include such intangibles of cost from pain and suffering, care provided by nonpaid caregivers, and the burden associated with undiagnosed diabetes.

Key points in the findings are:
- Total estimated costs of diagnosed diabetes have increased 41% to $245 billion in 2012 from $174 billion in 2007.
- Direct medical costs are $176 billion, including costs for hospital and emergency care, office visits, and medications.
- Indirect medical costs total $69 billion, including costs for absenteeism, reduced productivity, unemployment caused by diabetes-related disability, and lost productivity due to early mortality.
- Medical expenditures for people with diabetes are 2.3 times higher than for those without diabetes.
- More than 1 in 10 health care dollars in the United States are spent directly on diabetes and its complications, and more than 1 in 5 health care dollars in the United States goes to the care of people with diagnosed diabetes.
- The absolute cost of hospital inpatient care for people with diabetes has risen from $58 billion in 2007 to $76 billion in 2012 (43% of total direct medical costs; down from 50%).
- Overall pharmacy costs for antidiabetic agents and diabetes supplies remain unchanged at only 12% of medical expenditures.


In countries where the rate of diabetes increased, the availability of sugar had also increased. Each extra year of living where sugary foods were widely available was linked with an increase in diabetes prevalence of 0.053% (P<0.05). When sugar availability was scarce, diabetes decreased by 0.074% (P<0.05). The study also found that every 150-calorie increase in sugar availability was associated with increased diabetes prevalence of 1.1% after testing for potential selection biases and controlling for other food types, total calories, overweight and obesity, aging, and income.


Eight articles with 17 reports (nine for coronary heart disease, eight for stroke) were eligible for inclusion in this meta-analysis of 3,081,269 person-years and 5,847 incident cases for coronary heart disease and 4,148,095 person-years and 7,579 incident cases for stroke. No evidence of a curvilinear association was seen between egg consumption and risk of coronary heart disease or stroke (P=0.67 and P=0.27 for non-linearity, respectively). The summary relative risk of coronary heart disease for an increase of one egg consumed per day was 0.99 (95% confidence interval [CI] 0.85 to 1.15; P=0.88 for linear trend) without heterogeneity among studies (P=0.97, I(2)=0%). For stroke, the combined relative risk for an increase of one egg consumed per day was 0.91 (95% CI 0.81 to 1.02; P=0.10 for linear trend) without heterogeneity among studies (P=0.46, I(2)=0%). In a subgroup analysis of diabetic populations, the relative risk of coronary heart disease comparing the highest with the lowest egg consumption was 1.54 (95% CI 1.14 to 2.09; P=0.01). In addition, people with higher egg consumption had a 25% (95% CI 0.57 to 0.99; P=0.04) lower risk of developing hemorrhagic stroke. Higher consumption of eggs (up to one egg per day) is not associated with increased risk of coronary heart disease or stroke. The increased risk of coronary heart disease among diabetic patients and reduced risk of hemorrhagic stroke associated with higher egg consumption in subgroup analyses warrant further studies.
Food security is often a major concern for low-income people who have diabetes. Food insecurity is defined as not having enough resources available to fully meet everyday food needs. It occurs when “the availability of nutritionally adequate and safe foods or the ability to acquire acceptable foods in socially acceptable ways is limited or uncertain.” (1). According to the United States Department of Agriculture, almost 15% of all households in the United States experienced food insecurity in 2011 (2). Those living in food-insecure households are more likely to be unemployed, have low education levels, be obese, and lack physical activity (3). They may also be more likely to skip meals when resources are limited and binge eat or overeat when food is available. Some clients must make difficult decisions about whether to buy the healthy nutritious foods recommended to manage their diabetes (whole grains, fruits, vegetables, lean protein, and low-fat dairy) or the cheaper, energy-dense food options that contain added fats, sugars, and sodium. In addition to being cheaper, many clients prefer these poor-quality foods because they taste good. If housing is limited or transitional, the clients may also lack access to facilities to cook or store fresh ingredients for meals (4).

Clients with diabetes also often have many medical needs that strain their monthly budget. Much of their disposable income is spent on prescriptions, testing supplies, multiple doctor visit co-pays, and transportation services to medical appointments. Studies have shown that people diagnosed with diabetes have an additional $13,700 in medical expenditures per year, more than double the costs of those without diabetes (5). Food insecurity can seriously compromise diabetes self-management. Research has shown that those with food insecurity have higher glycosylated hemoglobin values, lower diabetes self-efficacy, and lower fruit and vegetable intake than those who are food secure (6). Food-insecure clients with diabetes are also more likely to report difficulty affording a diabetic diet and experiencing greater emotional distress related to diabetes (7).

Clients with food insecurity often need help accessing safety net programs such as Women, Infants and Children or food stamps that can increase household resources and purchasing power. Referrals to local food pantries and congregate meal programs are useful for those in transitional housing. Clients can be counseled to plan for the boom/bust nature of their monthly finances by purchasing items in bulk, on sale, and when they have more money (the beginning of the month) so that these resources last the entire month. Clients should be directed toward long-lasting nonperishable foods in their meal plans, such as whole grain cereals, pastas and rice, dried beans and seeds, nuts, canned vegetables, and canned fish (tuna, salmon, or sardines) to help stretch their food dollars.

Several resources are available for educators to help clients:

REFERENCES
The President of the Academy of Nutrition and Dietetics, Ethan Bergman, PhD, RD, CD, FADA, kicked off the Academy’s 2013 Public Policy Workshop (PPW) with a powerful challenge: “If dietetics is your profession, then policy should be your passion!” Dr. Bergman reminded attendees that advocacy starts with every member. He inspired the audience by saying that if we “work locally to improve the health of our community...it becomes a national movement.”

Diabetes Care and Education (DCE) members have a special opportunity to do just that when Congresswoman Diana DeGette (D-CO) reintroduces the Preventing Diabetes in Medicare Act in the United States Congress. Dr. Bergman, along with Susan Yake, RD, CD, CDE, CLC, DCE Public Policy Liaison, and Marissa Claiborne, RD, CD, Washington State Academy of Nutrition and Dietetics Public Policy Coordinator, requested that Senator Patty Murray (D-WA) introduce the bill in the United States Senate. On March 13, 2013, National Dietitian Day, Dr. Bergman and Marissa attended a morning coffee with each of the Washington state senators to meet them personally and promote the dietetics profession.

Successful passage of the Preventing Diabetes in Medicare Act requires every member of DCE to be passionate about advocating to their lawmakers about how dietetics professionals are key to saving health care dollars through disease prevention. This bill provides for coverage of medical nutrition therapy for diabetes prevention. To guide your discussions with lawmakers, the Academy has developed talking points that you can find on the DCE website at: http://www.dce.org/resources/public-policy/how-to-talk-with-lawmakers/. These talking points should not be copied and given to the lawmakers; rather they are designed to provide you with the background knowledge to speak personally to your U. S. Representative or Senator. Your lawmakers are in Washington, DC, for 3 weeks most months, followed by 1 week when they should be home and available to their constituents. The congressional recess in August should allow lawmakers to be home for the entire month and available for appointments. On the same page of the website as the talking points are leave-behind point papers that are designed for you to give to your lawmaker.

To be most effective, the Academy recommends that you contact your lawmakers monthly with a phone call, email, or letter. These contacts are tallied and used to determine the priorities of the legislators’ constituents. Right now the budget is the priority. Let Washington know that there are more than 74,000 dietetics professionals ready to save money in the Medicare budget with diabetes prevention measures using medical nutrition therapy. They need to know that 58% of the general public and up to 71% of Medicare-eligible patients can prevent diabetes through diet and exercise.

Besides the Preventing Diabetes in Medicare Act, the Academy has several other priority issues this year. These priorities for the 113th Congress are:

- The FARM bill that contains Title IV, which authorizes community nutrition programs such as Supplemental Nutrition Assistance Program (SNAP), SNAP-Ed, and the Fresh Fruit and Vegetable Program so school children eat more fruits and vegetables to reduce chronic disease
- Agriculture Research for evidence-based research to drive decisions
- The Emergency Food Assistance Program (TEFAP) that provides nutritious foods for food banks and helps families stretch food dollars
- Seniors Farmers Market to help older adults obtain fresh produce and help local farmers
- The Commodity Supplemental Food Programs (CSFP), a nutrition program that benefits families using United States Department of Agriculture commodity foods

The Academy is also encouraging Congress to introduce bills (continued on page 18)
reauthorizing the Older Americans Act and the Ryan White HIV/AIDS Program.

The final issue is of special importance to dietetic students: the Access to Frontline Health Care Act introduced by Congressman Bruce Braley (D-IA), whose daughter is a registered dietitian. This act will help address the health care workforce shortage by placing health care personnel (including registered dietitians) in underserved areas via a new Frontline Providers Loan Repayment Program. The legislation will provide student loan repayment in exchange for a commitment to practice in a region with a scarcity of “frontline” health services.

To learn more about activities during PPW, go to the DCE website http://www.dce.org/resources/public-policy/, where you can access the three PPW Today publications, A Daily Update for Public Policy Workshop 2013.

Julie Drzewiecki, MS, RD, LD, CDE, was presented with the 2013 DCE Legislative Activity Award for her 16 years of volunteer work in public policy for the Academy. President Ethan Bergman and Susan Yake, who hold direct ties to Julie, presented the award to her during the PPW in Washington, DC. Julie first served as a Legislative Network Coordinator for the Washington State Dietetic Association after Dr. Bergman held the position, and Julie trained Susan before moving to Alabama when Julie married her rocket scientist husband Adam, who works for the National Aeronautical and Space Administration (NASA). She continued to serve as Legislative Network Coordinator and a State Public Policy Representative in Alabama. Her enthusiasm for politics is contagious as she makes public policy so much fun. One of the highlights of her experiences was watching the Space Shuttle make its last flight over the Mall in Washington, DC, during the hill visits at PPW last year. To learn more about Julie’s accomplishments, go to the DCE website at http://www.dce.org/resources/public-policy/.

---

Save the Date

DCE is celebrating our 35th Anniversary at FNCE October 19th -22nd

Watch your email and dce.org for details and to RSVP

Texas fun facts:

State Motto: Friendship  State Symbol: Lone Star
What better place to come connect with old friends, meet new friends and celebrate 35 years with DCE. You will not be a lone star at the DCE events, but among the many stars of DCE. Hope to see you at FNCE in Houston.
EXECUTIVE COMMITTEE

Chair
Andrea Dunn, RD, LD, CDE
440-871-1421
dm2rdcde@gmail.com

Chair-Elect
Lisa Brown, RD, LD, CDE
612-889-5633
brown1457@gmail.com

Past Chair/Industry Relations Chair
Amy Hess Fischl, MS, RD, LD, BC-ADM, CDE
847-528-2804
AmyFish12@aol.com

Secretary
Ann Constance, MA, RD, CDE
906-361-9754
Ann.constance@yahoo.com

Treasurer
Amber Wamhoff, MA, RD, LD, CDE
314-583-4525
wamber470@yahoo.com

Membership Coordinator
Carolyn Harrington, RD, LDN, CDE
941-882-3071
carolyn.harrington217@gmail.com

Print Communications Coordinator
Liz Quintana, EdD, RD, CDE
304-293-7246
equintana@hsc.wvu.edu

Electronic Communications Coordinator
Betty Krauss, RD, CDE
616-242-0494
betty.krauss@maryfreebed.com

Professional Development Coordinator
Susan Rizzo, RD, LDN, CDE
847-352-2035
Nutrizz6RD@comcast.net

Public Policy
Susan Yake, RD, CD, CDE, CLC
360-475-4681
yakes36@bigplanet.com
susan.yake@med.navy.mil

Research Coordinator
Maria Chondronikola, MS, RD
646-244-2920
Chondronikola@gmail.com

Dietetic Practice Group Delegate
Maryann Meade, MS, RD, CD, CDE
203-265-9756
mameade@sbcglobal.net

Nominating Committee Chair
Carol Hamersky, MBA, CDE, RD
609-216-3112
cmhamersky@comcast.net

NEWSLETTER COMMITTEE

NewsFLASH Editor
Lorena Drago, MS, RD, CDN, CDE
718-263-3926
lorenamsrd@aol.com

OTCE Editor
Diane Reader, RD, CDE
952-993-3840
Diane.Reader@ParkNicollet.com

OTCE Associate Editor
Sue McLaughlin, MOL, RD, LMNT, CDE
402-397-3280
Smclaughlin8303@aol.com

ELECTRONICS COMMITTEE

e-Update Editor
Deborah Ting, RD
206-518-3556
robotschmobot@hotmail.com

Website Editor
Laura Russell, MA, RD, CDE
701-390-9541
lcruzz58@gmail.com

Web Site Monitor
Sherri T. Isaac, MS, RD, BC-ADM, CDE
isaakrd@yahoo.com

Listserv Moderator
Marylou Anderson, MS, RD, CDE
253-572-9175
fourcats2001@msn.com

COMMITTEE CHAIRS

Alliance/International
Amy Hess Fischl, MS, RD, LD, BC-ADM, CDE
Lisa Brown, RD, LD, CDE
Andrea Dunn, RD, LD, CDE

Awards Committee Chair
Neil Stuart, MS, RD, LD, CDE
304-276-3785
neilslvstuart@gmail.com

Awards Committee Assistant Chair
Johanna Burani, MS, RD, CDE
973-538-1101
jburani@gmail.com

Publications Committee Chair
Naomi Wedel, MS, RD, CD, BC-ADM, CDE
608-630-0983
naomi.wedel@gmail.com

Mentor Program Chair
Pat Severson-Wager, MS, RD, CD, CDE
518-674-8213
Preaw1234@aol.com

Reimbursement Committee Chair
Marla Solomon, RD, LD/N, CDE
773-753-1313
marla@marlasolomon.com

SPECIAL PROJECT HEADS

National Diabetes Education Program/ NDEP Liaison
Ann Constance, MA, RD, CDE
906-361-9754
ann@diabetesmichigan.org

MEMBERSHIP COMMITTEE

Membership Representatives
Janice Friswold, RD, LD, CDE
216-844-1058
janicefriswold@uhhospitals.org

Joann K. Rinker, MS, RD, LDN, CDE
704-985-0624
Joanne.Rinker@dhh.snc.gov

Carolyn Tampe, MS, RD, LDN, CDE
ctampe@gmail.com

Social Media Chair
Jennifer Hyman, MS, RD, CDN, CDE
516-570-0758
jenhyman@gmail.com

Social Media Committee
Constance Brown-Riggs, MSEd, RD, CDN, CDE
516-795-4288
constance@eatingsoulfully.com

ACADEMY/DCE STAFF

Administrative Manager
Linda Flanagan Vahl
312-899-4725
800-877-1600 ext 4725
Fax: 312-899-5354
lflanagan@eatright.org

DCE SUPPORT SERVICES

DCE Webmaster
Aurimas Adomavicius
aurimas@devbridge.com

DCE Web Address
www.dce.org

DCE Copy Editor
Deb Kuhlman
dk edits@speakasy.net
Get Involved in DCE — We Want You!
Diabetes Care and Education (DCE) is always looking for members interested in becoming involved in DCE activities. Dozens of members volunteer in many ways to promote the activities and goals of DCE. If you would like to get more involved in DCE, let us know. E-mail the appropriate contact listed below.

☐ **Committee Involvement**
   May include activities such as judging award nominations.

**If you are interested in the above opportunity, contact:**
   Carolyn Harrington, RD, LDN, CDE
   E-mail: carolyn.harrington217@ymail.com

☐ **Writing Opportunities**
   May include writing an article for a newsletter, reviewing publications, or developing an educational tool. Please list your areas of expertise and/or experience in special aspects of diabetes care.

**If you are interested in a writing opportunity, contact:**
   Lorena Drago, MS, RD, CDN, CDE
   E-mail: lorenamsrd@aol.com