Message from the Chair

Liz Quintana, EdD, RD, LD, CDE
Albuquerque, NM

It’s amazing how quickly time flies. Already half way through my term as chair, I reflect on DCE’s recent accomplishments. At the Academy’s Food & Nutrition Conference & Expo™ (FNCE®), the DCE Leadership discussed our many accomplished and currently in-progress projects. DCE volunteers have been exceptionally generous in sharing their time and expertise in their contribution to our various initiatives. Many thanks to the Academy and our valued sponsors for their support.

The recent membership survey reveals that our newsletters and continuing education materials continue to be both outstanding and valued benefits of DCE membership. DCE is blessed with consistently wonderful Print and Electronic Communications Teams.

Diabetes is a public health concern and must be prevented and treated appropriately. RDNs are poised to lead in the prevention and treatment of diabetes. To practice competently and provide quality nutrition care for persons with diabetes, RDNs must:

• be aware of available educational resources and tools
• effectively assess their own level of current competence, diabetes knowledge and care skills
• advance their practice through continuous professional development

At FNCE®, Chimene Castor, EdD, MD, RD, LDN and Kimberly Bisanz, MFCS, RDN, LDN, CDE presented “Diabetes and the RDN: A Continuous Road to Skills and Practice Advancement.” Discussion of key findings of the DCE survey was highlighted by gaps in diabetes knowledge for generalist RDNs. They described how the recently updated Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitians (Generalist, Specialty and Advanced) in Diabetes Care can be used as a self-assessment tool. The SOP/SOPP will be published in the *Journal of the Academy of Nutrition and Dietetics* this spring. Included are competencies for cultural sensitivity as the Academy membership continues to grow in diversity and expands worldwide. The SOP/SOPP and the DCE survey process will be

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STRATEGIC PRIORITY AREAS

Goal 1: The public trusts and recognizes DCE members as food, nutrition and diabetes experts.
• Work collaboratively with industry, media, medical and other health care disciplines and their organizations.
• Use evidence-based science on issues related to nutrition, food and diabetes.
• Advocate for leadership positions within the Academy.
• Engage with policy makers and decision makers.

Goal 2: DCE members optimize the health of individuals and populations impacted by diabetes.
• Engage DCE members to impact food and nutrition policies through participation in the legislative and regulatory processes at local, state and federal levels.
• Prepare and support DCE members to lead, contribute, conduct, interpret and use research in practice.
• Review and update the Diabetes Scope of Practice for the continuum of care for diabetes as needed based on research, practice guidelines, etc.
• Utilize and expand reimbursement for MNT throughout the continuum of diabetes care.

Goal 3: DCE members and prospective members view DCE as vital to their professional success.
• Reach out to Registered Dietitian/Nutritionists, Nutritionist/Dietetic Technician Registered, students and former DCE members.
• Provide relevant and valued resources and services for a diverse audience through the enhancement of social media presence.
• Create state-of-the-art professional development opportunities.

MISSION
Empowering DCE Members to be leaders in food, nutrition, and diabetes care and prevention.

VISION
Optimizing the health of people impacted by diabetes using food, nutrition, and self-management education.
used to develop an online certificate training program in diabetes targeting the generalist RDN.

DCE partnered with the Chinese Americans in Dietetics and Nutrition (CADN) Member Interest Group to translate the popular DCE handout “Ready, Set, Start Counting! Carbohydrate Counting — a Tool to Help Manage Your Blood Glucose” into Chinese. The English and Chinese versions are now available both from the DCE and CADN websites.

DCE Chair Elect, Alyce Thomas, RDN, is currently looking for volunteers for appointed positions. Please complete the form online and you can become a valued DCE leader.

liz.quintana.rdcde@gmail.com
Hello DCE members! So many exciting things have happened since the last issue. Many of us attended AADE17 in Indianapolis in August where we heard cutting-edge information and had rich discussions amongst our professional cohort. Much of this year’s focus was on the psychosocial aspects of diabetes including mental and emotional health. Speakers provided the attendees with useful tools and tips to help people with diabetes start and maintain behavior change. We also learned more about the “egregious 11” which is an expansion of our famous “ominous octet” and is comprised of interesting aspects of the pathophysiology of diabetes including the role of gut microbiota on insulin resistance and the “hungry brain,” where hormones that control appetite can lead to overeating. Last but not least, we also learned about cardiovascular outcome trials in diabetes and what medications have shown to reduce cardiovascular mortality.

Insulin pumps, CGM technology, and new ultra-long acting insulins and how their profile is revolutionizing diabetes care was also a large focus during the meeting.

Also, we attended the Food & Nutrition Conference & Expo™ (FNCE®) in Chicago where we celebrated 100 years! During FNCE®, we heard from our President Donna Martin about the new strategic plan to expand the profession while coordinating efforts of all DPG groups. Our keynote speaker was Sanjay Gupta, MD. Dr. Gupta shared that only 5% of people contribute to 50% of U.S. healthcare costs and we know diabetes is a big player. He also highlighted the power of technology and the media and how our role is to help our clients navigate this immense platform of information in order to transform what is read online into knowledge that will benefit their lives. Lastly, Dr. Gupta spoke about navigating away from the “dark” side of counseling and re-focusing our conversations to include current and positive language such as, “healthy food will make you feel stronger, have better relationships and be more productive.” Although many of us have already implemented this strategy, it reminded me that it is essential to find what is important to our patient in that exact moment of interaction, whether it is being a better employee, spouse, parent or friend.

As a follow up to my last note in newsFLASH about “recreating a new model for RDs/ CDEs,” we heard from Stacy Hanke, author, expert and influencer. Stacy provided leadership tools designed to make an impact from “Monday to Monday” and provided accountability challenges to support our commitment to continual growth and self-improvement. Many of the challenges addressed were interesting, but these concepts stood out to me most: 1) recording ourselves during a phone conversation to count the number of filler words we use (umm, aah, so); 2) having a silent observer on a conference call to provide feedback; 3) not underestimating the power of brevity and focusing on pausing while we present to an audience; and 4) implementing the “only speak to someone using eye contact” (for example: instead of speaking to the menu when ordering food). At the end of the day, leaders are self-aware every day of the week, and within the evolving healthcare landscape, as Donna Martin alluded to, the RD/CDE role will most likely change. We as professionals want to be seen as innovators and leaders in our field and that may mean deviating from primarily clinical roles. Finally, at FNCE®, we learned more about the Medicare and Chip Reauthorization Act (MACRA). Although RDNs are not yet considered eligible clinicians under the Medicare Incentive Payment System (MIPS) track, RDNs can add value by helping providers and practices achieve quality reporting and benchmarks to maximize Medicare payments. Furthermore, RDNs are considered eligible clinicians right now in Medicare Advanced Payment Models (APMs). This includes the Oncology Care Model, the Comprehensive Primary Care Plus Model (CPC+), and some Accountable Health Organizations (ACOs).
Congratulations to all our DCE awardees who were honored at FNCE® 2017 in Chicago, IL!

Sharon K. Hull, MD, MPH, “Proof in Numbers: Making the Business Case for Registered Dietitian Nutritionist Services in Diabetes Care.” Also, these links provide valuable information:

- https://www.eatrightpro.org/resource/payment/medicare/qpp-track-two/apm-resources
- http://www.eatrightpro.org/resource/payment/medicare/qpp-track-two/apm-resources
- This newsFLASH issue features:
  - Cardiovascular Risk Reduction
  - Review and Summary of Select Diabetes Medications and Trials
  - Overview of Updates for the 2017 DSMES Standards

Liz Quintana, DCE Chair (center) with the 50 year members from left to right: Gail Bruno; Suzanne Powell, MS, RDN, LD, CDE; Nirmala Auerbach, MS, RDN; and Catherine Shumard, RDN

From left to right: Liz Quintana, DCE Chair; Legislative Activity Award Recipient Charlotte Hayes, MMSc, MS, RDN, CDE, ASCM-CEP; and Donna Plyer, DCE’s Policy and Advocacy Leader

Liz Quintana, DCE Chair (center) with Student Stipend winners from left to right: Kasey Hageman; Jessica TeaYu-Hsin Wang; Meghan Deering; and Abigail Crum

Liz Quintana, DCE Chair with AND Medallion Award Winner, Rita Batheja, MS, RDN, CDN, FAND

Liz Quintana, DCE Chair with DCE Publications Award Winner Maureen Chomko, RDN, CDE

From left to right: Lenna Frances Cooper Memorial Award and Diabetes Educator of the Year winner Ann Albright, PhD, RDN; Liz Quintana, DCE Chair; and Medallion Award winner Sandra Parker, RDN, CDE

From left to right: Susan Yake, DCE Past Chair and Industry Relations Chair; Liz Quintana, DCE Chair; DCE Champion Award Recipient, Matt Stella, National Policy & Advocacy Director, Cardiovascular and Diabetes, Johnson and Johnson Healthcare Systems, Inc.

From left to right: DCE Distinguished Service Award winner Naomi Wedel, MS, RD, CD, LDN, CDE, BC-ADM; Liz Quintana, DCE Chair; and sponsor of the award, Matt Stella, Johnson & Johnson Healthcare Systems, Inc.

From left to right: Legislative Activity Award Recipient Charlotte Hayes, MMSc, MS, RDN, CDE, ASCM-CEP; and Donna Plyer, DCE’s Policy and Advocacy Leader

Sharon K. Hull, MD, MPH, “Proof in Numbers: Making the Business Case for Registered Dietitian Nutritionist Services in Diabetes Care.” Also, these links provide valuable information: https://www.eatrightpro.org/resource/payment/medicare/qpp-track-two/apm-resources

- Myths & Facts about Nutrition Therapy for Diabetes
- Families with Diabetes under Poverty Threshold
- “Have you Read?”
- Member Spotlight
Introduction
The incidence of diabetes continues to grow; however, the armamentarium of medications used to treat diabetes has also grown considerably over the past several years. These expanding options allow us to individualize patient therapy. The Centers for Disease Control (CDC) reports that the national trend in the number of people diagnosed with diabetes from 1980 to 2012 has quadrupled (1). There is an estimated 33.9% of the population, or 84.1 million, with prediabetes, and 9.4% of the population, or 30.3 million people, with diabetes. An estimated 23.1 million people are diagnosed and 7.2 million are undiagnosed. A joint study with the National Center for Chronic Disease Prevention and Health Promotion, the Division of Diabetes Translation, and the CDC was conducted to project the burden of diabetes by the year 2050 (3). The study used forecasting models and included US Census data on prediabetes and diabetes. The study concluded if there is a low incidence but high mortality rate, the total prevalence for diagnosed and undiagnosed cases would be 21% by 2050, which is an estimated 76 million people. If the incidence remained the same but mortality decreased, the prevalence would be 33%. With moderate growth in incidence and a moderate mortality rate, the incidence would be 29%. This study has identified significant implications for long-term health and comorbidities as well as the health care costs associated with diabetes.

Cardiovascular Significance
Research has demonstrated initiating occurrences of insulin resistance, impaired insulin secretion, impaired fasting glucose and impaired postprandial glucose begins with the onset of prediabetes (4-5). Studies have also shown that the macro and microvascular complications begin in the prediabetes phase, as well with many individuals who experience overt complications upon actual diagnosis. Additionally, with large epidemiologic studies like the Framingham, it is well-known that diabetes is a major risk factor for cardiovascular (CV) disease and is labeled as ‘risk equivalent’ to coronary heart disease (CHD). Many risk factors that occur during the prediabetes phase increase an individual’s risk of CV complications (6-8). Environmental risk factors such as unhealthy nutrition habits, obesity, and physical inactivity all impact metabolic syndrome as well as CV outcomes. Chronic hyperglycemia can contribute to: decreased levels of high-density lipoprotein; increased triglycerides; increased platelet aggregation atherosclerosis; hypertension; the activation of oxidative stress, advanced glycation end products and other inflammatory markers (IL6 and CRP); and increases in plasminogen activator inhibitor 1 levels, further promoting thrombosis and contributing to vascular damage. As the hyperglycemia continues and progresses, these complications worsen. A study conducted from 1994 to 2000 of 9.4 million patients with and without diabetes in Ontario, Canada demonstrated that for both men and women, the incidence of CHD and CVD increases up to four-fold compared to those without diabetes; this risk was higher in women (9). Conclusions from a meta-analysis that included 26 studies found that for every 1% increase in A1c there is: (1) a 15% increase in all-cause mortality; (2) 25% increase in CVD mortality; (3) 17% increase in CVD; (4) 15% increase in CHD; (5) 17% increase in fatal CHD; (6) 11% increase in heart failure; (7) 11% increase in stroke; and (8) 29% increase in peripheral artery disease (10).

There are many studies supporting that glycemic control reduces microvascular complications, but the effect on macrovascular complications has been questionable. For many years we have been left with the inconclusive results of the well-known ACCORD, ADVANCE and VADT trials which demonstrated with intensive glucose control and no statistical benefit, a nonsignificant trend towards reduced CV risk (11-12). The ACCORD specifically found an unexpected 22% increase in relative...
risk of death with aggressive glucose lowering and the trial was stopped. However, the mean age of participants in this trial was 64 and overall, these trials prompted questions as to whether a benefit would have been explicitly seen had the therapy started earlier in participant diagnosis, and further, if the follow-up had occurred longer than five years. A long-term ten-year post-trial follow up to the UKPDS and DCCT/EDIC trials demonstrated that earlier glycemic control is important for reducing long-term macrovascular complications with a 15% risk reduction for myocardial infarction (MI) and a 13% risk reduction in all-cause mortality raising the theory of a legacy effect. Additionally, the existing drug classes sulfonylurea (SU) and thiazolidinedione (TZD) have come under scrutiny for their negative CV impact (11-15). In the 1970s, the UGDP trial concluded that the first-generation SU tolbutamide may impair ischemic preconditioning. In 1998, however, the UKPDS 33 refuted these findings concluding there was no difference in rates of MI or CV death with SU or insulin. In 2011, the TZD rosiglitazone had strict restrictions placed on prescribing. This decision was partly due to a 2007 meta-analysis that found that rosiglitazone increased the risk of MI by 43% and CV death by 64% (13). The exact mechanism could not be explained; however, the trials included in the meta-analysis were not originally intended to assess CV outcomes. The RECORD trial was published shortly after and concluded that rosiglitazone was no different than the combination of metformin and SU, or each of these agents individually with rosiglitazone on CV death, MI, or stroke (14). The RECORD trial, however, did conclude that there is an increased risk of hospitalization due to heart failure.

FDA Guidance on Cardiovascular Outcomes Trials (CVOT)

With the significant impact of CV complications on patients with diabetes and the history of the CV risks associated with the various medication classes, the FDA issued new guidelines in 2008 for approval requirements for any new diabetes drug (16). All new drugs must demonstrate that the drug will not cause an unacceptable increase in major adverse CV events or MACE. The CV events or endpoints must include CV mortality, MI, and stroke. Trials have the option to include hospitalization for acute coronary syndrome and urgent revascularization procedures. The trials must also include patient populations that are high risk, including advanced disease, the elderly and those possessing some degree of renal impairment. The trials must demonstrate with an upper bound two-sided 95% confidence interval (CI) for the estimated CV risk ratio of drug vs. control of <1.3. If the risk ratio is >1.8, the approval will be denied and additional single, large safety trials will need to be conducted so that in isolation, or when added to other trials, the risk ratio will satisfy that upper bound. If the ratio is between 1.3 and 1.8 the overall risk-benefit supports approval, but a single, postmarketing trial that is adequately powered alone, or by combining results of several premarketing trials with a similarly designed postmarketing safety trial, will be needed to definitively show the risk ratio is <1.3.

Review of Select Classes of Diabetes Drugs

Since 2013 the successful completion of several trials has prompted the introduction of new diabetes management drugs. The majority of these trials are placebo controlled noninferiority study designs, which demonstrates safety but has little focus on efficacy. The three drug classes that will be reviewed include dipeptidyl peptidase-4 inhibitors (DPP4s), glucagon-like peptide-1 agonists (GLP1s), and sodium-glucose cotransporter-2 inhibitors (SGLT-2s).

Dipeptidyl peptidase 4 is the enzyme that breaks down the incretin hormone glucagon-like peptide-1, or GLP1, which has many well-documented positive effects including decreased inflammation, oxidative stress, blood pressure, lipids, and improved antplatelet effects (17). The DPP4s inhibit the incretin hormone breakdown which prolongs the aforementioned positive effects. There are four drugs in this class: saxagliptin (Onglyza) alogliptin (Nesina) sitagliptin (Januvia) linagliptin (Tradjenta). Three CVOT with DPP4s trials have been published: SAVOR TIMI53, EXAMINE and TECOS (18-20). Table 1 provides a summary of these key trials. The primary endpoint for all trials were based on the 2008 U.S. Food and Drug Administration guidance and included the composite time to first occurrence of CV death, nonfatal MI, nonfatal stroke, and hospitalization for unstable angina. The population of the three trials was very similar. The mean age was in the 60s, mean duration of diabetes ranging from seven to ten years, mean baseline A1c 7-8% and there existed a similar CV risk profile. All three trials demonstrated noninferiority (meaning no increase in CV profile when compared to placebo). EXAMINE showed that the primary endpoint occurred in 11.3% of individuals with alogliptin and 11.8% with placebo (20).

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SAVOR showed that the primary endpoint occurred in 7.3% of individuals with saxagliptin and 7.4% with placebo (18). In TECOS, the primary endpoint occurred in 11.4% of individuals in the sitagliptin group vs. 11.6% in the placebo group (19). The results for the hospitalization for heart failure were noteworthy. In SAVOR-TIMI 53, 3.5% of individuals on saxagliptin were hospitalized for heart failure vs. 2.8% of individuals on placebo (p=0.009). In EXAMINE, 3.9% of individuals on alogliptin were hospitalized vs. 3.3% in the placebo group. The EXAMINE trials furthermore showed that increase in hospitalization for heart failure was not statistically significant (p=0.238), but in a post-hoc analysis, there was a trend for increased hospitalization for heart failure vs. placebo (p=0.001). This was a 26% reduction and found to be significant for the primary endpoint occurring in 13.2% of individuals in the placebo group and 7% in the liraglutide group (p=0.50).

The baseline characteristics for LEADER were again similar to other trials and specifically between placebo and liraglutide groups (22). The mean age was 64, mean duration of diabetes was a longer at almost 13 years, about 80% had CVD and about 18% had CV risk factors. LEADER showed that liraglutide met the primary endpoint of noninferiority with the primary endpoint occurring in 14.9% of the individuals in the placebo group and the significantly lower 13% in the liraglutide group (p<0.001). This was the first study to demonstrate superiority (p=0.01) with a number needed to treat (NNT) of 66. When CV death was analyzed separately, fewer individuals died from CV causes in the liraglutide group at 4.7% vs 6% in the placebo group showing a significant 22% reduction (p=0.007). The outcomes for nonfatal MI and nonfatal stroke when analyzed separately were lower, but did not show statistical differences.

The baseline characteristics for individuals enrolled in SUSTAIN 6 were similar across the study groups (23). The mean age was 64, the mean duration of diabetes was longer than all other trials at 14 years, and the CV profile was similar across the groups. In SUSTAIN 6, 8.9% of individuals in the placebo group experienced the primary endpoint and statistically significantly lower 6.6% in the semaglutide group. This was a 26% reduction and found to be significant for both noninferiority (p<0.001) and superiority with a NNT of 45 (p=0.02). When looking at the endpoint nonfatal stroke independently, it occurred in 2.7% of individuals in the placebo group and 1.6% of the semaglutide group and was

Glucagon-like Peptide-1 (GLP-1) is secreted in response to food and has several different mechanisms of action, including: increasing glucose dependent insulin secretion, decreasing glucagon secretion, increasing beta cell growth, slowing gastric emptying and decreasing food intake. There also exist many positive CV effects, including improved weight, blood pressure, lipids, endothelial function, increased vasorelaxation, increased peripheral and coronary flow, increased ventricular function, and decreased microvascular permeability (21-22). There are five FDA approved drugs in this class:
- Liraglutide (Victoza)
- Exenatide ER (Bydureon)
- Dulaglutide (Trulicity)
- Lixisenatide (Adlyxin)
- Semaglutide (Ozempic)

These are analogues of the endogenous GLP1 and resistant to DPP4 breakdown. The key trials are ELIXA (lixisenatide), LEADER (liraglutide), and SUSTAIN (semaglutide) (see Table 1). These trials were also a noninferiority study design with the primary endpoint guided by the FDA. The baseline characteristics of individuals in ELIXA were similar with the mean age at about 60, mean duration of diabetes nine years, mean A1c 7.6% and a similar CV background. In ELIXA, the primary endpoint occurred in 13.2% of the individuals in the placebo group and 13.4% in the liraglutide group (21). It was statistically significant for demonstrating noninferiority (p<0.001) but not significant for superiority (p=0.81). Other findings that were evaluated and found to be nonsignificant for a including hospitalization for heart failure and death from any cause. Hospitalization for heart failure occurred in 4.2% of individuals in the placebo group and 4% of the liraglutide group (p=0.75), and death from any cause occurred in 7.4% of individuals in the placebo group and 7% in the liraglutide group (p=0.50).
There are four drugs in this class:
- empagliflozin (Jardiance)
- canagliflozin (Invokana)
- dapagliflozin (Forxiga)
- ertugliflozin (Steglatro)

The key trials are EMPA REG OUTCOME and CANVAS (see Table 1) (25–26). EMPA REG OUTCOME was specifically designed to assess for noninferiority and superiority (25). The baseline characteristics were similar to the previously discussed trials. The mean age was 63, almost 60% had diabetes for greater than ten years, mean A1c was 8%, almost half had a history of MI, and the mean BMI was 30. The CV background was similar between the drug and placebo groups. The pooled primary endpoint occurred in 10.5% of the individuals in the empagliflozin group and 12.1% of placebo and was found to be non-inferior (p<0.001) and superior (p=0.04) with a 14% relative risk reduction. Hospitalization for unstable angina occurred in 12.8% of the empagliflozin group and 14.3% of the placebo group. This was found to be non-inferior (p<0.001) but not superior (p<0.08). There was a significantly lower rate of all cause death occurring in 5.7% of the empagliflozin group and 8.3% of placebo with a number needed to treat of 38.5 and a 32% relative risk reduction (p<0.001). Additionally, there was a significantly lower rate of death from CV cause occurring in 3.7% of the empagliflozin group and 5.9% of placebo with a number needed to treat of 45.5 and a 38% relative risk reduction (p<0.001).

When looking at the 10mg and 25mg doses individually, the outcomes were still statistically significant. There was also a statistically significant 35% pooled demonstrating relative risk reduction in heart failure (p=0.0017). The nonsignificant findings were for nonfatal MI and nonfatal stroke.

The baseline characteristics of individuals in CANVAS and CANVAS-R were similar to the other trials and were similar between the study groups. The mean age was 63, mean duration of diabetes almost 14 years, mean A1c was 8.2%, the majority had CVD, mean GFR about 76 and about 22% had microalbuminuria (26). The composite primary outcome occurred significantly less in patients treated with canagliflozin and found to be significant for noninferiority (p<0.001) and superiority (p=0.02). The secondary outcomes occurred less in the canagliflozin group (death from... (continued on page 10)

Table 1: Summary of Key Trials

<table>
<thead>
<tr>
<th>Trail/Drug</th>
<th>SAVOR-TIMI 53/ saxagliptin</th>
<th>EXAMINE/ alogliptin</th>
<th>TECOS/ sitagliptin</th>
<th>ELIXA/ lixisenatide</th>
<th>LEADER/ liрагluтид</th>
<th>SUSTAIN6/ semaglutide</th>
<th>EMPA REG OUTCOME/ empagliflozin</th>
<th>CANVAS/ canagliflozin</th>
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<tr>
<td>Design</td>
<td>• 16,492 patients</td>
<td>• 5,380 patients</td>
<td>• 14,671 patients</td>
<td>• 6,068 patients</td>
<td>• 9,340 patients</td>
<td>• 3,297 patients</td>
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<td></td>
<td>• 532 sites</td>
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<td>Duration</td>
<td>• 2.9 years</td>
<td>• 3.3 years</td>
<td>• 3 years</td>
<td>• 2.9 years</td>
<td>• 3.8 years</td>
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<td>• 3.1 years</td>
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<td>Population</td>
<td>• T2DM</td>
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<tr>
<td></td>
<td>• Age ≥40 with previous CVD or M≥55, W&gt;50 with at least 1 risk factor</td>
<td>• Age ≥18</td>
<td>• Age ≥50</td>
<td>• Age ≥30</td>
<td>• Age ≥50 with CVD or ≥60 with CVD risk factors</td>
<td>• Age ≥50 with CVD or ≥60 with CVD risk factors</td>
<td>• Age ≥50 with CVD or ≥50 kg/m²</td>
<td>• Age ≥30 with symptomatic ASCVD or age ≥50 with at least 2 CV risk factors</td>
</tr>
<tr>
<td></td>
<td>• A1c 6.5-12%</td>
<td>• A1c 6.5-8%</td>
<td>• A1c 6.5-8%</td>
<td>• A1c 6-10%</td>
<td>• A1c ≥7%</td>
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<td>• 2017</td>
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T2DM: type 2 diabetes mellitus; M: men; W: women; ACS: acute coronary syndrome; ASCVD: atherosclerotic cardiovascular disease
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(continued from page 9)
any cause, death from CV cause, hospitalization for heart failure and progression of albuminuria) but were not found to be significant.

Conclusion
SAVOR TIMI53, EXAMINE, TECOS, and ELIXA have all demonstrated neutral effects of no harm and no benefit. LEADER, SUSTAIN 6, EMP REG OUTCOME and CANVAS have all demonstrated beneficial results on CV outcomes. The drugs that demonstrated superiority, however, may not be translatable to lower CV risk patients, and because of the trials’ short duration, at about three years or less, the long-term effects are still not known. While there are many theories that currently exist, the definitive underlying mechanism that caused the positive CV effects in these trials remains unknown. Although there are still unanswered questions, there are several upcoming longer-duration trials that will help further clarify if these positive effects are a class effect or isolated to specific drugs, elucidate the underlying mechanism for CV benefits and identify whether there is an affect to slow the atherosclerotic process. Upon the reveal of these upcoming results, we may very well have a clinical paradigm shift in how we approach diabetes treatment and our initial choices in drug therapy.

References:
As an active member of the American Association of Diabetes Educators (AADE) and as a thought leader in diabetes digital health, I was asked in 2016 to serve on the AADE and American Diabetes Association (ADA) work group to develop the 2017 National Standards for Diabetes Self-management Education and Support (1, 2). A group of 20 thought leaders from a variety of disciplines and areas of expertise convened to review and revise these standards which are used by Medicare (CMS) to accredit and recognize DSMES program that they reimburse for delivery of this service. A map of available DSMES service providers is available at https://www.diabeteseducator.org/patient-resources/find-a-diabetes-educator.

Believing that words matter, I highlight here some of the important updates with an emphasis on some of the terminology changes.

At the outset, a change from using the term Program to Service
- Why this is significant: Diabetes education is not finite but ongoing; it occurs in many settings and is delivered in different ways by diverse health care team members; it is not about checking off a box that something was done or delivered, but it is about meeting the needs of the individual at that time and in a way that helps them improve their diabetes management. This will be fluid and dynamic, recognizing the ebb and flow of living with and managing the complexity of a chronic condition.

Standard 2 was changed from External input to Stakeholder Input
- Why this is significant: Diabetes care and education is moving and changing and so are our stakeholders. Diabetes educators need to establish themselves as the indispensable leaders in the rapidly evolving payment and care models by engaging with and seeking input from new stakeholders such as those representing Accountable Care Organizations, Patient Centered Medical Homes, Medical Neighborhoods, employers, community centers, and others. It is critical to recognize that the identity of the payer is blurring.

Standard 3 was changed from Access to Evaluation of Population Served
- Why this is significant: As the population of people living with diabetes in the United States has soared to an astounding 30.3 million per recent CDC statistics, this begins the important pivot diabetes educators need to make to a population health approach. Integrating diabetes education with medical management and embedding it at the point of care (which may be virtual) improves access, clinical outcomes, and cost effectiveness. Technology enabled services, if evidence based, offer the opportunity to extend the reach and effectiveness of the care team enabling individualized, contextualized on-demand diabetes education, support and care, cost effectively, for an entire population. The resulting patient-generated health data, when leveraged, can facilitate meaningful connection of the patient with their own care team, informing focused two-way conversations, true shared decision making, and more timely therapy optimization (3).

Standard 4 was changed from Program Coordination to Quality Coordinator Overseeing DSMES Services
- Why this is significant: In keeping with the change from program to services, the emphasis here is in assuring the provision of a service that delivers value to all stakeholders, including first and foremost, the individual living with diabetes. The role of the Quality Coordinator includes collecting and evaluating data to identify gaps in services, provide feedback on performance of the services, and to identify needed improvements in the services offered. Technology enabled solutions support population management as well as practice and quality improvement initiatives.

(continued on page 12)
Standard 5 was changed from Instruction Staff to DSMES Team

- Why this is significant: With the emerging demand for diabetes education in the primary care environment, in the workplace, and in the community, the diabetes educator has an opportunity to step up to serve as the expert consultant in guiding other members of the health care team in providing relevant, contextualized diabetes care and education services, in some cases, leveraging technology-enabled solutions to meet the patient where they are and in the way they desire to learn.

As diabetes educators we need to rethink how, when, and where we deliver diabetes education services in our rapidly transforming health care environment (4). The updated standards begin to pave the way. The challenge to educators everywhere is to see and seize the unprecedented opportunity to step up and lead the way. The time is now.

References:
As registered dietitian nutritionists (RDNs) and diabetes educators, we have a professional responsibility to our patients to practice evidence-based medicine. As this body of evidence grows with the inclusion of additional research, some commonly held notions need to be reexamined.

Check your current counseling recommendations against the following myths and facts:

**Myth: People with diabetes should eat a diabetic diet.**

**Fact: There is no ideal eating plan for diabetes.**

The days of calculating predetermined percentages of carbohydrate, protein, and fat for our patients with diabetes are gone. In 2013, the American Diabetes Association’s Nutrition Therapy Recommendations for the Management of Adults with Diabetes reiterated this fact, stating there is no optimal mix of macronutrients and that their distribution should be based on individualized assessment of current eating patterns, preferences and metabolic goals (1).

In 2015, a similar recommendation to individualize macronutrient distribution was published in the Academy of Nutrition and Dietetics Evidence Analysis Library (EAL) (2). Of the studies meeting inclusion criteria for the EAL’s systematic review, there was no significant effect on A1C, independent of weight loss, for differing amounts of carbohydrate (39% – 57% of energy) and fat (27% – 40% of energy), independent of weight loss (3). Carbohydrate, fat, and protein recommendations can be individualized within the recommended energy intake and aligned with the patient’s preferences.

Understandably, patients will expect specific guidance from you. A useful strategy is to encourage blood glucose monitoring before and after meals to determine how much carbohydrate an individual can tolerate without causing hyperglycemia. In general, blood glucose monitoring should be used strategically to help patients learn if their treatment plan – including their food, medication, and activity – are working in synergy.

**Myth: People with diabetes should count carbs.**

**Fact: Carbohydrate counting is not for everyone.**

While carbohydrate is unequivocally the nutrient that most impacts blood glucose, counting carbohydrate grams is not necessary for glycemic management in all people with diabetes. The evidence shows that carb counting is particularly useful for people with type 1 or 2 diabetes on meal-time insulin or insulin pumps. In this population, use of carb counting with insulin-to-carb ratios led to an A1C reduction of 0.4% to 1.6% in a three to six months period, and an increase in quality of life for up to 44 months without significant change in weight (3).

For those who take fixed insulin doses or insulin secretagogues, carbohydrate consistency is important for glycemic control and hypoglycemia prevention. However, carb consistency can be taught through carb counting or simpler methods such as the use of food lists or the plate method. People on other medications or lifestyle therapy do not have a hypoglycemia risk, but may still benefit from monitoring carb intake to achieve glycemic goals. In all patients, motivation to carb count and numeracy skills should be considered before recommending carb counting.

(continued on page 14)
Myths & Facts about Nutrition Therapy for Diabetes
(continued from page 13)

Myth: Sweets are off limits for people with diabetes.
Fact: Sweets can fit into the eating pattern.
The 2015 Dietary Guidelines for Americans specifically emphasized a need to limit added sugars (4). However, added sugars are not off-limits for all Americans, or even those with diabetes. The evidence shows that foods sweetened with nutritive sweeteners such as sugar, honey, and molasses have no effect on A1C or insulin levels when substituted isocalorically for other carbohydrates (3). Teaching patients how to trade sweets for other carb sources can empower them to enjoy special occasions and favorite foods without leading to hyperglycemia.

Myth: People with diabetic kidney disease (DKD) need to restrict protein.
Fact: There is no need for protein restriction with DKD.
In the EAL’s systematic review, the amount of protein (range 0.7 to 1.1 g/kg/day) had no effect on glomerular filtration rate (GFR), independent of weight loss (3). Therefore, protein restriction does not need to be a standard part of nutrition therapy for those with DKD.

Myth: A low fat-diet will prevent heart disease.
Fact: The type of fat matters more than the amount.
Consistent with the 2015 Dietary Guidelines, the recommendations for people with diabetes are to modify the type of fat consumed (4). Decreasing saturated and trans fat while increasing unsaturated fat may reduce total and LDL cholesterol, a cardiac risk factor (3). To accomplish the shift in quality of fat, provide patients with concrete examples of food substitutions. For example, snacking on nuts instead of cheese, or sautéing in oil instead of butter, can help achieve a better balance of fat types.

In general, focusing on the overall eating pattern may be more useful than focusing on any single nutrient. For example, studies evaluating the Mediterranean eating pattern show promise for delaying addition of diabetes medication (5) and decreasing risk of CVD events (6).

Myth: People with diabetes need to eat three meals and two to three snacks per day.
Fact: Meal frequency and timing can be individualized.
For those who take insulin or insulin secretagogues, carbohydrate intake should be timed to avoid hypoglycemia. For all others, frequency and timing of meals and snacks can be more flexible and carbohydrate intake can be more variable. Particularly in light of high rates of obesity among people with type 2 diabetes, it is important to dispel the myth that snacks, which may add excess calories, are needed to manage diabetes.

Myth: Cutting 500 calories per day will lead to one pound of weight loss per week.
Fact: Weight loss recommendations have evolved.
Among obese patients, weight loss remains a therapeutic goal. However, newer weight prediction models have been studied and seem to debunk the notion that a daily 500 calorie deficit will lead to one pound of weight loss per week (7). In counseling patients on expected weight loss, we may need to shift away from the prevailing wisdom that a daily deficit of 500 calories will result in one pound of weight loss per week, as it is not the reality for many patients. Further, for those who do lose weight, maintenance of weight loss continues to be a challenge and requires more research to find effective approaches.

In terms of glycemic management, the evidence shows that reducing energy intake can lead to significant reductions in A1C of 0.3% to 2.0% in adults with type 2 diabetes, as well as improvements in medication adjustments and quality of life (3). The foundational components of any weight loss intervention are calorie reduction, exercise, and behavior modification, with frequent touchpoints with health care professionals or trained lay people. The LOOK AHEAD trial provided solid evidence of the effectiveness of this approach, achieving an 8.6% weight loss among people with diabetes after one year (8).

Meanwhile, newer options for pharmacotherapy have entered the marketplace and the evidence for metabolic surgery continues to mount. In fact, the 2017 American Diabetes Association’s Standards of Medical Care in Diabetes moved to a stronger recommendation for pharmacotherapy or metabolic surgery at lower BMI thresholds of 27 kg/m2 and 30 kg/m2, respectively (9). RDNs and diabetes educators should be familiar with the latest obesity management approaches.

Want more?
Compare your counseling recommendations with the EAL’s latest recommendations in the Diabetes Type 1 and 2 Evidence-Based Nutrition Practice Guideline for Adults at www.andeal.org/topic.cfm?menu=5305.
Families with Diabetes under Poverty Threshold

Diana L. Malkin-Washeim, PhD, MPH, RD, CDE, CD-N
Bronx, NY

The United Nations (UN) adopted the Convention of the Rights of the Child (CRC) in 1989 (1). The CRC helps shape the way we view children, creates a safe environment and protects all children from neglect, exploitation and abuse. These provisions also include that every child enjoy the highest attainable standard of health (2).

Diabetes and Poverty

There are 1.25 million Americans living with type 1 diabetes (T1D) including approximately 200,000 children under 20 years old. Five million people in the U.S. are expected to have T1D by 2050, including nearly 600,000 youth (3). An estimated 387 million people have diabetes worldwide, of which T1D accounts for between 5% and 10%. However, the prevalence of T1D is increasing worldwide (4). Alongside the rise of diabetes, there is an increased rate of obesity and type 2 diabetes (T2D) among children (5,6).

In September 2017, the U.S. Census Bureau reported that the national poverty rate decreased 0.8 percentage points (7). In 2015, more than 43 million people lived below the poverty threshold in the U.S. and of this population, 14.5 million were children (4). The poverty threshold reflects the estimated number of Americans living in poverty each year, and poverty guidelines refer to the corresponding eligibility for specific federal programs (9,10).

Americans spend less than 10% of their income on food (8). According to the Foundation for International Community in 2016, three billion people live on less than $2.50 per day and more than 1.2 billion live in extreme poverty, living on less than $1.25 per day (8). 40 million children worldwide live without adequate shelter and 270 million children have no access to health services.

(continued on page 16)
Families with Diabetes under Poverty Threshold (continued from page 15)

Poverty over time
The poverty rate for Americans has fluctuated from 22.4% in the 1950s to as low as 11.1% in the early 1970s, and reaching a peak level of 15.2% in the 1980s before dipping to 12.7% in 2016 (12,13) (see Graph 1).

Weight Among Children
Since 1980 the prevalence of obesity has doubled in more than 70 countries, with a greater increase of obesity occurring in children than that of the adult population. In 2015 there were approximately 108 million children living with obesity worldwide (5). The Centers for Disease Control and Prevention (CDC) reported that “during 2000–2010, the overall prevalence of obesity among young low-income children in Women, Infants and Children (WIC) increased significantly” (see Graph 2). It appears that there is a linear relationship established between poverty rates and obesity among low-income children in WIC over time (see Table 2). Since the 1970s, children with obesity in the U.S. have more than tripled, and currently, one in five school-aged children (ages 6 – 19) has obesity (14).

Food Patterns
Food patterns change over time due to the environment, such as natural disasters, culture, housing, economic, and political events. Food patterns have shifted worldwide over the last 50 years (1961 – 2011) (see Graph 4).

In the U.S., there was a shift of total calories (from 2882 to 3641) (see Graph 5).

Fruits and vegetable consumption has not changed significantly, remaining at 8% of total calories consumed. The U.S. consumes more meat than any other country second to China, with poultry reported as the fastest growing preferred meat of choice (15).

Psychosocial
Given the cost of food, housing, utilities, health insurance, and the portfolio of diabetes technology that has entered mainstream healthcare in recent years, it is imperative that every child and their family not only survives but also thrives. Both T1D and T2D include multiple modifiable and non-modifiable risk factors that can impact their mental health. These include: weight, dietary indiscretions, and high blood pressure (modifiable) and family history and ethnicity (non-modifiable) (17). Additionally, families could experience elevated stress due to food insecurity, limited financial resources, unemployment, and other disruptive life events such as incarceration, shelter living, transient housing, and mental health conditions (18). When a family is living under the poverty threshold and their child is diagnosed with diabetes, it sets the stage for multiple challenges which could include those mentioned above, as well as anxiety, depression, eating disorders, control issues, and even more added stress. The latter can influence mental and emotional well-being of the entire family. Stress alone can also affect
In the US, there was a shift of total calories (from 2882 to 3641) (see Graph 2).

Graph 2. U.S. 1961 – 2011

- Total Calories: 2194 to 2870
- Sugar & Fat Calories: 270 to 327
- Produce Calories: 1085 to 1296
- Grain Calories: 361 to 272
- Meat Calories: 345 to 570

Worldwide 1961-2011

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Psychosocial

Given the cost of food, housing, utilities, health insurance and the portfolio of diabetes technology that has entered mainstream healthcare in recent years, it is imperative that every child and their family not only survive but also thrive. Both T1D, an autoimmune disease dependent on insulin and T2D, relative to multiple risk factors that include family history, weight, dietary indiscretions, high blood pressure and ethnicity, elevate stressors on families that may already have multiple stressors, such as food insecurity, limited financial resources, unemployment and other disruptive life events such as incarceration, shelter living, transient housing and mental health.

The body’s physical status inducing the onset of headaches, muscle pain or tension, sleeping too much or too little, general feelings of illness, fatigue, discouragement, irritability, depression, restlessness, lack of concentration, and memory loss. The child with diabetes and their sibling(s) may experience symptoms that are out of character, such as withdrawing from friends and family, eating too much or too little, acting out in anger, drinking alcohol to excess, smoking tobacco, and using drugs.

In addition, feeding practices may be affected by poverty in homes where parents are not practicing “responsive feeding practices” between the child and caregiver; this specifically has been associated with the development of poor dietary habits and/or increased childhood obesity.

Food insecurity impacts a child’s health long term and can negatively affect development, physical functioning and behavior. According to the American Academy of Pediatrics, children living in food insecure households are more likely to experience “stress, depression and anxiety; worse overall health; more hospitalizations when three years old or younger; iron deficiency; lower bone density in preadolescent boys; obesity due to lack of access to healthy foods; lower cognitive skills; developmental problems affecting school performance; and malnutrition that can lead to diabetes, hyperlipidemia and cardiovascular disease later in life.” The time period after diagnosis can be challenging for families. There are feelings that may include denial, depression, anger, shock, sadness, fear and guilt. Children may fear of punishment in that they did something wrong.

Strategy Tips for Families: Remind, Encourage, and Participate

1. Learn about diabetes while taking the time to acclimate to diagnosis and reinforcing positivity
2. Participating in supplemental assistance programs: Supplemental Nutrition Assistance Program (SNAP), Welfare or Temporary Assistance for Needy Families (TANF), Medicaid and Children’s Health Insurance Program (CHIP), Public Housing (affordable apartments for low-income families) and the Housing Choice Voucher Program (Section 8) (a family may find their own place and use a voucher to pay for all or part of the rent)
3. Sharing diabetes knowledge with friends and family
4. Taking control over their diabetes management
5. Joining a support group
6. Exploring available resources, e.g., diabetes camp
7. Encouraging feelings-focused dialogue and discussion
8. Being emotionally present, for example, asking what specifically the child or family member(s) would like to work on
9. Asking the child or family member(s) if they have or are experiencing any fear(s)
10. Avoiding blame placement
11. Focusing on the child as a whole person and not someone with diabetes

(continued on page 18)
Families with Diabetes under Poverty Threshold
(continued from page 17)

12. Encouraging the exploration and use of mental health resources

Screening/Assessment Tool
Conducting a thorough assessment will help screen for psychosocial issues, prevalent socioeconomic influences and nutrition deficiencies, which can include the following components:

A. A 24-hour dietary recall (provides a snap-shot in time)
B. Asking questions including: 1) Are you feeling down, sad or hopeless (Yes or No)? 2) Do you have little interest or pleasure in doing things (not at all, several days per week, or nearly daily)? and 3) Have your sleep patterns changed (none or too little sleep or too much sleep)?
C. Asking caretaker questions including: 1) Who do you live with? and 2) Do you have a para or care-taker?
D. Asking questions including: Are you receiving public assistance, e.g., child support, SNAP and/or social security disability?
E. Identifying families with young children as being at risk for food insecurity by asking food insecurity questions: 1) Within the past 12 months have you worried whether your food would run out before you got money to buy more? and 2) Within the past 12 months has the food you bought lasted? If no, did you have money to get more? (20,23) (Answers include often true, sometimes true, or never true)
F. Asking social support questions: 1) Who checks in on you? and 2) What is your biggest fear regarding diabetes? (These two questions may open up a dialogue about social services and what level of support there is from family and friends)

We can support our children with diabetes and their families living under the poverty threshold in the provision of community resources, education and social support. As professionals, we need to maintain our code of ethics which is to support and promote high standards of our professional practice for the benefit of clients and the public (24).

References
8. Foundation for International Community (FINCA). World Poverty. http://www.finc.org/campaign/world-poverty?gclid=Cj0KEQiAwMLDBRDC_h.r9sMVQ_88BEiQA6zuAQ-L0Ag7U4bkJSrn_9ET_1DOua9_T8peSObEmiriWXicaAeEkB8HAQ. Published 2016.
HOT OFF THE PRESS!

The eatrightpro website has been updated with new information on MDPP Medicare Diabetes Prevention Program.

- Beginning April 1, 2018 Medicare beneficiaries with prediabetes who also have elevated body mass indices (≥ 25 kg/m² and ≥ 23 kg/m² in Asian populations) have a new benefit with coverage for diabetes prevention services…

- Please find complete information here:
  http://www.eatrightpro.org/resources/payment/medicare/medicare-diabetes-prevention-program

- CMS Physician Fee Schedule for 2018 is now online.

- December 2018 MNT provider

COMING SOON IN FEBRUARY 2018

- RDN payment schedule calculations
An important action alert we were asked to contact our legislators about was the **Academy’s Centennial Resolution**, the congressional resolution responsible for the commemoration of the Academy’s Centennial that occurred in 2017. Although no longer open, this alert may reopen for the house. It is important for us to know that this resolution marks the hundredth year of our Academy’s existence. Imagine what the Academy, known originally as the American Dietetic Association, was like upon its 1917 inauguration. Here are some pictures FNCE® featured this year in honor of the Academy’s centennial celebration.

**Hurry up and wait!** That seems to be a good motto in the advocacy world! I would like to tell you that a lot has happened in the nutrition and diabetes policy and advocacy world in the 115th Congress, but that is not exactly true. It seems that much happens in one area while very little in others. Since the summer and our last edition of newsFLASH, we have had one definite success and several “hurry up and waits.”

**The big success this fall was the passing of the National Clinical Care Commission Act (S. 920).** Responsible for the coordination and leverage of various federal programs related to diabetes, the National Clinical Care Commission Act was signed into law on November 2, 2017. The Academy will continue to work with the bill’s sponsors and the presidential administration alike to ensure federal programs provide the most efficient and effective care for people with diabetes and related diseases.

**The National Clinical Care Commission Act** will establish a 23-member commission comprised of individuals from both public and private sectors under Health and Human Services. The commission’s purpose within this AACE-spearheaded initiative is to evaluate and subsequently provide improvement-driven recommendations for the coordination and leveraging of federal programs regarding the care of people with diabetes. DCE submitted several members as potential candidates to help serve on these critical commission-related committees. I hope that we will see some DCE members included!

Does the message below look familiar to you? If not, I hope it will soon. This is the electronic mail message sent to our DCE electronic mailing list to notify all members of open action alerts and offer legislative contact information.

**TAKE ACTION**

Go to: [www.eatrightpro.org/action%20center](http://www.eatrightpro.org/action%20center) and follow the guidance below:

1. Go to the gray “Click to Start” button on the AND Action Alert page.
2. Login or Register.
3. Read and send the letter to “all” or “edit one, two, or all” by clicking on the pencil icons depending on if you would like to modify a letter or send as is.
4. Copy and paste from one letter to another, if you wish.
5. Don’t forget to scroll down to save your edits.
6. Click SEND.
7. Pat yourself on the back! YOU DID IT!

1917 – 1920
Lulu G. Graves, head dietitian at Lakeside Hospital in Cleveland, Ohio, served as the first president of the American Dietetic Association.

**October 18 – 20, 1917**
Lenna F. Cooper, director of the training school of the Battle Creek
Attendees will meet Capitol Hill staff 9 a.m.-3:30 p.m. with a lunch briefing for congressional staff at noon (attendees are invited). The day will end with a 4-6 p.m. reception cosponsored by ANDPAC and ObesityPAC to honor legislators who have championed efforts to promote patient access to obesity care.

Example of an Advocacy Day Schedule:
9 – 10 a.m. Meeting for those participating in Hill visits
10 – 11:30 a.m. Congressional briefing
Noon – 3:30 p.m. Hill visits

Sanitarium in Michigan, and Lulu Graves, supervisor of dietitians at Lakeside Hospital in Cleveland, organized the first conference of dietitians in Cleveland, Ohio.

On October 31, 2017, the Senate passed S. Res. 75. Its companion measure, H. Res. 161, is actively gaining support in the House of Representatives. You can help secure the support of your representatives by asking them to cosponsor this exciting measure.

A second piece of legislation to know about is the Preventing Diabetes in Medicare Act. The U.S. House and Senate recently introduced the bipartisan Preventing Diabetes in Medicare Act (H.R. 3124/S. 1299), which will allow a dietitian or nutrition professional to provide MNT services for prediabetes. Look for opportunities this spring to let members of Congress know that you support them in improving health care access and reducing health care costs associated with diabetes among Medicare beneficiaries.

Another important action alert is to ask our Senators and House representatives to Co-Sponsor the Treat and Reduce Obesity Act. The bipartisan Treat and Reduce Obesity Act of 2017 (H.R. 1953; S. 830) will allow a registered dietitian nutritionist or other qualified nutrition professional to provide intensive behavioral counseling services for Medicare beneficiaries with obesity. This bill’s most recent congressional action took place in the House of Representatives on April 17, 2017 with Ways and Means Committee bill referral to the subcommittee on Health. Do you know who your House representative is? Let your members of Congress know where you stand and urge them to support this bill to improve health care access while reducing health care costs.

Congress is currently working on the reauthorization of the Farm Bill, which reauthorizes two effective nutrition education programs: SNAP Nutrition Education and Obesity Prevention grants (SNAP-Ed) and the Expanded Food and Nutrition Education Program (EFNEP). These education programs coordinate and create synergies to maximize reach and attempt with limited funding to meet the need for nutrition education messages responsible for empowering families to make healthy choices.

Be sure to check the Academy’s Farm Bill recommendations and action alerts that will be opening this spring! These programs provide targeted and effective nutrition education that encourages families to make lasting behavioral changes and build the skills needed to manage limited resources while working towards achieving economic self-sufficiency beyond the short time that typical SNAP recipients utilize said benefit.

The Academy strongly supports the necessity of pairing nutrition assistance programs with strong and comprehensive nutrition education programs. Thank you for taking action to ensure that SNAP-Ed and EFNEP continue to provide innovative and effective nutrition education to those families looking to make long-lasting healthy choices.

Last, but not least, I would like to tell you a bit about the DCE Legislative Activity Award. This year at FNCE®, I had the pleasure of awarding Charlotte A. Hayes, MMSc, MS, RDN, CDE, ACSM-CEP with the DCE Legislative Activity Award. Charlotte’s DCE membership and professional tenure spans nearly three decades and is highlighted by prominent positions of dedicated Academy service, including: Legislative and Public Policy Committee member and Committee Chair (2015); active leadership in developing relationships with key legislators during her many Hill visits during PPW; and Georgia Diabetes Coalition member and Chair (2013). Congratulations Charlotte! Thank you for your service!

If you know someone who is an active DCE member and has served in nutrition related public policy activities, please consider nominating them. The deadline for submitting nominations is February 15, 2018. For more details and to request and application go to: http://www.dce.org/get-involved/awards/legislative-activity/.

Quarterly Advocacy Day: February 27, 2018
Academy members will have the opportunity to inform policymakers about the importance of the Treat and Reduce Obesity Act (TROA) along with the Obesity Care Advocacy Network (OCAN).
BOOK REVIEW

What to Do When Your Partner Has Diabetes: A Survival Guide

Elizabeth (Libby) Downs Quiroga, MS, RD, CDE
Grand Rapids, MI

This book is a unique little gem. Although written primarily for the partners of those with type 1 diabetes (T1D), there is undoubtedly very useful information for those who have partners with type 2 diabetes; it can furthermore be argued that health care professionals could greatly benefit by reading it. Diabetes touches every part of life and subsequently, family members often play a major role in the diabetes management of a loved one. Often overlooked as a subject worth exploring, What to Do When Your Partner Has Diabetes: A Survival Guide covers a broad range of incredibly useful topics. The contents are written with sharp understanding and sensitivity of those who have lived through diabetes diagnosis, treatment and disease management. Co-Author Nicole Johnson’s personal experiences are also shared throughout the text in meaningful and thoughtful ways with respect to difficult situations.

The book opens with established and topical research, including the authors’ own, and quickly defines the essential distinction between partner caretaking and social control. Readers are provided tips including safe conversation starters when attempting to navigate their role as a supportive partner. While offering advice on being supportive, there is also text dedicated to validating the support partner in their difficult role. Throughout its entirety, What to Do When Your Partner Has Diabetes: A Survival Guide offers “partner perspective” and “partner advice” boxes with respectively real and practical experiences. It also makes the point to include humor, because if used well, laughter can go a long way.

The book is organized into ten chapters, all with the central theme that communication is paramount and lends importance to making time for quality conversations. Although there is some overlap between chapters, as with anything on the subject of diabetes, a lot of what is articulated is how to approach situations gracefully in order to be supportive. The alternative to such would risk a challenging interaction defined by unsupportive confrontation and even potential negligence.

“The Relationship Balancing Act” examines when, if at all, to engage with day-to-day diabetes matters while also recognizing that there may be times when the supportive partner must take full control (for example during occurrences of low blood sugar). There is also deliberate conversation about how to manage conflict by avoiding tempting behaviors. Take for example, this Partner Advice Box: “Make an agreement to use a time-out during an argument if either of you suspects blood sugar may be high or low. Treat it if necessary and later return to the discussion.”

“Managing Your Fear” offers some major pearls of wisdom and reflection. This chapter starts with the importance of identifying when your fear is warranted and when your fear
is irrational. It then discusses creating a method of communication with your partner regarding his/her health like CGM sharing tools. Also covered is the importance of learning how to use glucagon and developing an ability to recognize physical signs of low blood sugar. One piece of advice offered: “If your partner is using a CGM and often doesn’t hear the device alarm at night, place the receiver in a glass tumbler or cup. When the receiver alarms, the sound will be amplified by the glass.”

“Diabetes can become the third partner in a relationship and so it is beneficial to maintain open communication.”

“Depression—Both Your Partner’s and Yours” delves into the world of diabetes and depression. This chapter highlights studies that have successfully demonstrated a correlation between diabetes and depression. The authors go on to explore how to recognize symptoms and the importance of reaching out to trained health professionals. “Diabetes burnout” is also discussed, as well as an online tool that is recommended to further help understand the distress of the partner.

“Trief and colleagues have found that couples’ beliefs about the quality of their relationships, and how close they felt to their partner were associated with blood sugar control.”

“Our motivations are right but we, as partners, should be careful to avoid feeling it is necessary to insert ourselves just because we have concerns.”

Without spoiling anything for future readers, there are tips included on dealing with alcohol, complications, discrimination, exercise, food, sex, pregnancy, travel, and aging. “The T1D Partner Perspective” shares stories written by T1D partners, and the last chapter, “Diabetes Can Empower You” is dedicated to diabetes and empowerment. The book closes with a much appreciated appendix full of helpful diabetes organizations and resources to help steer readers in the right direction.

“Diabetes education is the best medicine to treat your fears of diabetes. Consider joining your partner in a diabetes education class.”

Nicole Johnson, DrPH, MPH, MA is most well known for being Miss America 1999 but she is also a renowned speaker who researches quality of life and psychosocial issues. She lives with type 1 diabetes. Lorraine Stiehl has been a diabetes partner and patient advocate for many years and has dedicated herself to the cause. More can be read about the authors in their book.

“Our motivations are right but we, as partners, should be careful to avoid feeling it is necessary to insert ourselves just because we have concerns.”

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“All relationships have some degree of conflict — it is to be expected. Determining how you know when you are having relationship challenges versus diabetes challenges can be difficult.”

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HAVE YOU READ?

Melissa Brown, RD, PhD
Rachel Kaunas and Kaneen Gomez-Hixson
West Hartford, Connecticut
University of Saint Joseph Dietetic Interns


In Spring 2017’s issue of Diabetes Spectrum, Guest Editor Melinda Maryniuk curated five articles dedicated to healthy eating patterns comprised by the Research to Practice section. Topics addressed included the Mediterranean Diet, Dietary Approaches to Stop Hypertension (DASH), vegetarian/plant-based diets, mindfulness and a summary of the latest NDEP Diabetes Survey findings. A section summary of each follows below.


The author summarized evidence from research on the potential health benefits of a Mediterranean-Style Eating Pattern (MEP) for individuals in the management or prevention of diabetes. All studies were done within the Mediterranean region and used subjects with type 2 diabetes. Although there has yet to be a standard definition for the Mediterranean Diet, the basic outline of the diet is following an eating pattern that encourages high-quality foods (i.e. fruits, vegetables, olive oil and fish) and limits the use of foods high in sodium, sugar and unhealthy fats. The majority of the studies showed that the MEP has the potential to improve glycemic control and reduce cardiovascular risk factors in individuals with type 2 diabetes and also stimulate a protective effect against the development of type 2 diabetes in those at risk. Further, the majority of the studies showed that the combination of the MEP and an awareness of portion sizes and total energy intake can be a beneficial intervention for type 2 diabetes management and prevention.


Given that individuals with diabetes have a greater risk for developing hypertension, the author determined that the DASH diet can be an appropriate diet pattern for people with diabetes to manage or prevent hypertension. Blood pressure reduction is promoted through foods that are low in fat and salt, as well as foods high in potassium, calcium, magnesium, fiber, and protein. In addition, whole grains, fat-free and low-fat dairy, vegetables, fruits, nuts, poultry, and fish are encouraged. Although some elements of the DASH diet may need to be modified to address the individualized needs of those with diabetes, such as calorie distribution from macronutrients, research has demonstrated relevant health benefits for diabetes management and prevention. This includes decreased insulin resistance, weight control, improved blood lipids, blood pressure and A1C. For women with gestational diabetes, it was found that the DASH diet could lower insulin use, reduce cesarean rates and lower birth weights. Since the DASH diet promotes a healthy eating pattern aligned with the dietary guidelines, it is an appropriate option for individuals with diabetes.


Kaneen Gomez-Hixson
The author reviewed the impact of vegetarian diets on diabetes with regard to management, prevention, incidence of type and a comparative analysis to non-vegetarians. Findings in a variety of studies include lower incidences of type 2 diabetes, lower A1C, reduced risk of diabetes-related neuropathy pain, improved cardiovascular disease risk factors, and improved renal function in individuals who followed a vegetarian diet. Regarding the previously stated outcomes, the lowest risks were found in people who adhered to vegan diets. Improved weight status, high intake of dietary fiber, plant protein and the absence of meat, egg-derived protein and saturated fat is likely the mechanism for the reduced risk. Therefore, while vegetarian diets encompass several diet types, research indicates that vegetarian diets, especially vegan diets, can be effective tools for diabetes prevention and management.


The author discusses how mindful eating can be included as a part of diabetes self-management education. Helping individuals learn skills to become aware of internal and external triggers to eating, preventing automatic eating, and eating in response to hunger and satiety cues could help prevent dysregulated eating. Studies found that mindful eating has the potential to prevent weight gain, promote weight loss, and significantly improve A1C. Therefore, mindful eating may be a beneficial addition to diabetes self-management education (DSME) to help people with diabetes meet their self-management goals and make their eating experiences more enjoyable.


This article provides the most recent findings from a survey from the National Diabetes Education program for diabetes self-management education and support (DSMES). The psychosocial and emotional aspects of self-management were assessed among people with diabetes (PWD, people told by their doctor or health professional that they had diabetes). Over 50% of PWD reported that they were not confident in their ability to manage blood glucose levels while most PWD reported some distress with managing their diabetes. Most PWD reported engaging in self-management activities such as exercise (“vigorous activity”, 35%; “more exercise”, 76%; “light/moderate activities”, 89%), diet (“following meal plan”, 82%) and taking diabetes medication (84%) six months prior to survey participation. The most common self-management tools reported were paper calendars and diaries or journals used for tracking diabetes-related activities. Neither electronic-based tools nor social media outlets were found to be a significant influence. Only 7% of PWD reported regularly seeing a diabetes educator and physicians were the most-cited source of diabetes management advice.


Compared to the U.S. population as a whole, the prevalence of diabetes is 17% higher in adults living in rural areas because of barriers to care. This systematic review of literature focused on video conferencing telehealth models and how such could be adapted to improve diabetes care in rural communities. The identified benefits of telehealth technology include reduced costs, enhanced convenience, and improved access to specialty health care and quality care. Several studies furthermore found benefits across increased patient empowerment, improved self-management and adherence to diet. Improved glycemic control and A1C levels were also shown. Although further research is needed to determine standard telehealth guidelines for safe and effective practice and appropriate reimbursement for these services, telehealth technology is a useful tool to help improve access to diabetes education and specialty care to individuals in rural settings.


The fear of hypoglycemia has become a barrier for the achievement of normoglycemia in the hospital setting, and further was an obstacle to the hospital-established goal of 90% compliance of the hypoglycemia protocols. Hypoglycemia is defined as a blood glucose level less than 70 mg/dL with short and long-term risks including adrenergic responses,
HAVE YOU READ? 
(continued from page 25)

central nervous system responses, cardiac arrhythmias, increased hospital stay and mortality. A key element of existing hypoglycemia protocols in hospitals is the “Rule of 15”, where the patient with hypoglycemia is given 15-20g of glucose followed with a recheck of the blood glucose level 15 minutes later. If the patient is still hypoglycemic, the process is repeated. The recheck is essential for treating unresolved hypoglycemia. It is therefore important to determine a protocol that encourages adherence to this step. A pilot study compared two interventions. The first required patient care technicians (PCTs) to stay in the room with the patient for the entire 15 minutes and then complete the recheck. The second utilized a timer to alert PCTs and nurses when it was time for a recheck. The timer group had an average compliance of 84% which was significantly higher than the 52% compliance achieved by the PCTs that were asked to stay in the patient room. A suggested reason why the compliance was higher in the timer group is that it is too difficult for PCTs to remain in the patient room. A summarized version of the standards are:
1) Providers shall have a defined mission statement and goals;
2) Providers will accept stakeholder and expert input to improve services;
3) Providers will assess and understand the population they serve to aid in diminishing barriers to care;
4) Providers will appoint a quality coordinator to ensure DSMES services and corresponding standards are properly implemented;
5) Requirement of at least one facilitator who is an RN, RDN, or PharmD with training in diabetes education;
6) The curriculum will be evidenced-based with measurable outcomes that are tailored to serve the individual participant;
7) Participants will have a hand in developing their own DSMES plan; and
8) Participants will be made aware of their access to ongoing support and can decide on which resources work best for them;
9) Providers will monitor and evaluate the effectiveness of educational interventions; and
10) The quality coordinator will monitor the quality of services and identify gaps in the program.

These updated standards are applicable to educators in many practice areas, but are particularly important in establishing a path for diabetes educators to position themselves as leaders.


This article makes a compelling argument for transitioning from the typical diabetes self-management education and support (DSMES) standards to cost-effective eHealth tools that better fit into an ever-changing technological world. Using this platform, eEducators use patient-generated health data to create a feedback loop that enables patients to receive individualized treatment plans. The ultimate goal is to improve diabetes outcomes. Additionally, the article introduces the FDA-cleared BlueStar diabetes coaching application, the first of its kind as mobile prescription therapy, which delivers the AADEd7 Self-Care Behavior Diabetes Education Curriculum.


In this systematic review and meta-analysis of 24 clinical trials, researchers sought to examine how increases in serum 25(OH)D levels, via vitamin D supplementation, affect the fasting plasma glucose (FPG), homeostatic model assessment of insulin resistance (HOMA-IR), and HbA1C of those with type 2 diabetes. Researchers concluded that a minimum dose of 100 μg/d (4000 IU/d) can result in significant increases in serum 25-hydroxyvitamin D levels and may ultimately help to significantly lower serum FPG, HbA1c, and HOMA-IR.


In this post hoc analysis of the 2002 Diabetes Prevention Program clinical trial, researchers aimed to investigate the correlation between caloric intake and body weight in order to analyze macronutrient intake as a predictor for weight loss. The article concluded that an increased consumption of high fiber carbohydrates and low amounts of total and saturated fat, combined with overall calorie reduction, promotes weight loss in those at high risk for type 2 diabetes.


A review of sixty studies on the effectiveness of dietitian-provided type 1 and type 2 diabetes medical nutrition therapy (MNT) and nutrition interventions was conducted to update the evidence-based practice guidelines featured in the Academy of Nutrition and Dietetics Evidence Analysis Library. Through this systematic review, the strength of the effectiveness of MNT provided by RDNs on five areas was determined. These five areas are glycemia, cardiovascular (CVD) risk factors, weight management, medication use and quality of life. Also, two secondary questions regarding frequency of encounters with an RDN and types of MNT interventions were analyzed. The review concluded that there is strong evidence in support of MNT’s role in improving and maintaining HbA1c and decreasing fasting blood glucose levels. Additionally, MNT showed strong promise in decreasing the dosage or usage of glucose-lowering medications. What’s more, MNT had a positive effect on quality of life when nutrition counseling was initially provided 3 to 6 times with follow-ups thereafter using individualized treatment plans. On the other hand, MNT showed mixed results on total cholesterol, LDL, HDL, blood pressure, and triglyceride levels. The same mixed results occurred with BMI and waist circumference.


This article reviewed 40 diabetes medical nutrition therapy (MNT) studies for integration into the interventions portion of the Nutrition Care Process. Nutrition practice guidelines were generated and categorized under rating systems based on quality of the evidence (e.g. strong, fair, weak, consensus/expert opinion and insufficient evidence) and whether or not said guidelines apply to all members of the target population (imperative) or only under specific circumstances (conditional). Overall, the evidence to support MNT provided by RDNs as an effective approach to diabetes management is strong and illustrates the unique skills of the RDN.
In a parallel, double-blind, randomized clinical trial the investigators added to the knowledge gap and tried to shed light on the effect of non-nutritive sweeteners on blood glucose. The study subjects were male volunteers with normal glycemia who underwent a four-week screening period, followed by the 12-week intervention period and concluded with a four-week follow up. The subjects consumed either placebo or ~333 mg sucralose (encapsulated) at meal times (3x/day) and various tests of glycemic control were subsequently measured on a weekly basis with oral glucose tolerance tests (OGTT) measured one to two times during each period. Results reveal no statistically significant differences or clinically meaningful differences between the control group (placebo) and the intervention group (sucralose) over baseline for the glycemic measures (HbA1c, fasting blood glucose, insulin, C peptide, time to peak levels of blood glucose or return towards basal levels in OGTT). The authors conclude that there is no evidence to suggest that non-nutritive sweeteners such as sucralose have any effect on glycemic control.
which I desperately wanted to contribute. The problem was I didn’t have the traditional background for transplantation research. I was a registered dietitian pursuing a nutrition science doctorate with very little experience beyond absorption studies in small bowel transplantation but Cristiana didn’t care. What was important to her was the will, dedication and genuine caring for the cause. The rest she could teach me – and that she did. Through my PhD experience and post-doctoral training under her mentorship, to my knowledge, I became the first and only registered dietitian trained to isolate and transplant human pancreatic islet cells as a surgically-induced treatment option for individuals with T1DM. This incredible experience allowed me to work with patients from all perspectives: pre-transplant, peri-transplant and post-transplant while being given the opportunity to simultaneously utilize my nutrition, metabolism and diabetes knowledge. Since then I have remained in the field researching methods to improve islet transplantation as well as pursuing other beta cell expansion techniques. Today, as a faculty member at the University of Saint Joseph in West Hartford, CT you will find me splitting my time between the lab and the classroom, as well as serving as the Director of the Athlete Nutrition Advising Program. To some the combination of diabetes research and performance nutrition may seem like a strange pairing, but to me it makes perfect sense: both involve nutrition, energetics and metabolism! The favorite part of my current position is being able to bring both my investigative and clinical experiences into the classroom to share with the students. I can provide realistic examples of how research findings form the foundation of evidence-based practice.

What are some of your interests outside of diabetes education? With the little bit of free time that I have, I prefer to spend it with my family and friends doing a variety of different things and staying as active as possible. For years I trained in taekwondo and was able to achieve 3rd degree black belt and instructor status. I absolutely love it and wish I could dedicate more time to it. I also really enjoy traveling around to watch my niece and nephew play sports.

What is the best advice you give to your students so they can be successful as RDs? Think outside of the box and do not let anyone tell you that you can’t do something – even if it is a non-traditional path for dietitians!

Thank you to Dr. Melissa Brown for sharing her passion and experience with us!

DCE Members:

Remember we all need 2 CEU credits related to ethics

If you missed the Dietitians and Ethical Dilemmas by Dianne Polly, JD, RDN, LD, FAND, then you can access the recorded webinar via the DCE website or this link:

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mniester@umich.edu

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dm2rdcde@gmail.com

Academy Diversity Liaison
Constance Brown-Riggs, MSEd, RD, CDE, CDN
constance@eatingoufully.com

DCE SUPPORT SERVICES

DCE Webmaster
Aurimas Adomavicius
aurimas@devbridge.com

DCE Web address
www.dce.org

DCE Copy Editor
Lindsay Parnell
Imparnell@gmail.com
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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 involved in DCE, let us know. You may email the appropriate contact listed below.

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

If you are interested in the above opportunity, contact:
Patricia Davidson, DCE, RDN, CDE, LDN, FAND
E-mail: pdavidson@wcupa.edu

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If you are interested in a writing opportunity, contact:
Britt Rotberg, MS, RDN, LD, CDE, BC-ADM
E-mail: britt.rotberg.dce@gmail.com