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a dietetic practice group of the
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newsFLASH
Diabetes Care and Education

Message from the Chair

Andrea Dunn, RD, LD, CDE
Cleveland, OH

"I just want to be normal," cried my patient. In her mid-50s, she was trying to juggle weight loss and injectable medications to help manage her type 2 diabetes. Katie (not her real name) was finding it difficult to follow the consistent schedule her doctor asked of her, and her blood glucose values reflected that inconsistency.

Defining "normal" can be hard; it has different meanings for different people. Some people spend their whole lives trying NOT to be normal and reveling in how wonderfully different they are from everyone else. Then there are those who are working hard to achieve a normalcy that may be ever-fleeting.

Do you define yourself as normal? Asking Katie what normal looked like to her gave me a picture of her life. As an artist, she wanted to be able to work when the muses flowed through her, and if that meant all through the night and sleeping in half a day later, that was her normal.

> Trying to be normal day after day is exhausting!

It also meant eating out often with her husband, who frequently entertained clients for his business. She wanted to drink and eat just like everyone else without worrying about insulin, carb counts, or the timing of the meals. Katie wanted the diabetes to just disappear and leave her alone to be normal again. Life without diabetes was the "normal" she was seeking. Because diabetes wasn't "disappearing" (and she did not want to pursue gastric bypass surgery), we talked about redefining normalcy.

Mentally meeting our patients where they are at is a challenge. Just as we talk about being "mindfully present" when eating, so we must be "mindfully present" when we are with our patients. Asking the right questions, withholding judgment, and helping them come to terms with a disease that is not fitting in with the life they thought they would have is challenging. How do you make it work for you? What does "normal" look like to you?

Featured Stories

7 Book Review: *Diabetes weight loss*
9 Have you Seen? Diabeteseveryday.com
17 Meet the Chef
22 Do you want to help RDs gain national prominence?
23 Diet and lifestyle

At the Food & Nutrition Conference & Expo (FNCE) in Philadelphia in October, celebrity chef Paula Deen gave a glimpse of what her life is like with diabetes. She delighted 50 Diabetes Care and Education (DCE) members with an intimate breakfast and talk on the last day of FNCE. Focusing on the journey she has been on since receiving her diagnosis of type 2 diabetes, she stressed how she is not willing to let diabetes take away from what she enjoys of life. She struggles with finding normalcy amidst juggling her business and family, just like all people with

(continued on page 3)

*news*FLASH
Diabetes Care and Education
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MISSION
DCE members are the most valued authorities on nutrition and diabetes prevention, education, and management.

VISION
DCE members lead the future of nutrition and diabetes prevention, education, and management.

TABLE OF CONTENTS

1 Message from the Chair
4 Message from the Print Communications Coordinator
5 Message from the *News*FLASH Editor
6 Scholarship Winner Highlights Her FNCE experience
7 Book Review: *DIABETES WEIGHT LOSS Week by Week: A Safe Effective*
9 Have You Seen? DiabetesEveryday.com and the Living with Type 2 Diabetes Program?
10 Have You Read ?
17 Meet the Chef Jennifer Stack, RD, CDE, CHE
19 The Diabetes-Friendly Kitchen
21 FNCE 2012 Events
22 Do You Want to Help Registered Dietitians Gain National Prominence?
23 Diet and Lifestyle Innovations for Prevention of Cardiovascular Disease
24 Sequestration Issue Brief
26 DCE FNCE Sponsors 2012
27 2012-2013 DCE Officer Directory

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)

diabetes do. With her typical sense of southern humor, she stressed how moderation now looked to her. Never a fan of exercise, she now adds in walking sessions whenever she can and delights in how walking helps keep her blood glucose in a healthy range.

This year's closing session at FNCE was highlighted by the motivational speaker Erik Weihenmayer, who lost his vision at the age of 13 years but refused to be defined by blindness. Erik is the first blind climber in history to reach Mount Everest. He is one of fewer than 100 individuals to climb all of the Seven Summits, the highest peaks on each of the seven continents. Erik challenged us to become alchemists by taking the lead that life piles on you and turning it into gold.

Erik also stressed that leadership is contagious. At our DCE Awards Breakfast, we had a chance to honor those members who have shown themselves to be leaders. Congratulations to Legislative Activity Award winner: Sister Ladonna Woerdeman, MS, RD, LD, CDE; Distinguished Service Award winner: Linda Delahanty, MS, RD, LD; Diabetes Educator of the Year Award winner: Margaret E. Cook-Newell, PhD, RD, LD, CDE, CN; Diabetic Living's People's Choice Diabetes Educator of the Year Award winner (and *News*FLASH editor): Lorena Drago, MS, RD, CDN, CDE; Publications Award winner: Prof. Rubina Hakeem, PhD, RD, RPHN (who traveled to Philadelphia from Pakistan to receive this award); and Champion Award winner, Jacqueline K. Giovanoni, RN, BSN. The Academy of Nutrition and Dietetics also honored three of our members: Ann Albright, PhD, RD, with the Medallion Award; Wahida Karmally, DrPH, RD, CDE, CLS, with the Excellence in Practice-Dietetic Research Award; and Connie Brown-Riggs, MSEd, RD, CDE, CDN, with the Excellence in Practice-Consultation & Business Practice Award. Nominated by DCE, Rich Bergenstal, MD, was given Honorary Membership in the Academy. Thank you to these members who inspire us!

Thank you to our FNCE sponsors Animas, CanolaInfo, Daisy Brand Cottage Cheese, McNeil, and Viocare for their support.

Thanks also to those members who were able to attend our membership meeting, the reception, or the DCE booth at FNCE. It was my pleasure to get to meet so many dietetics professionals who are passionate about the role they play in educating patients, students, and other RDs and health care workers about diabetes and nutrition. We heard from our public policy staff in Washington, DC, about how much we need to speak out for ourselves and conduct outcomes studies showing the benefits of medical nutrition therapy in diabetes. These studies need to be published and have the words "registered dietitian" in the title. At FNCE, Gretchen Benson, RD, CDE, received the DCE Karen Goldstein Memorial Grant for Medical Nutrition Therapy for her research project: Controlling LDL and Blood Pressure in Adults at High Risk for Cardiometabolic Disease. Comparative Effectiveness of a Dietitian and Nurse-led Telephonic Coaching Program versus Standard Clinical Care. This award is given every other year to a DCE member. Congratulations, Gretchen! Please see the awards page on our website (http://www.dce.org/get-involved/awards/) for this and other awards that are part of your DCE benefits.

Happy 35 years of DCE! 2013 is our 35th anniversary year. The recent membership survey results reinforced the many positive benefits of DCE membership — our newsletters, electronic mailing list, webinars and website — as invaluable resources. Thank you for taking the time to complete the survey and provide us this valuable feedback. This information will also be used to shape our 3-year strategic plan. Please continue to send me your comments, criticisms, and suggestions for moving DCE into the next 35 years — and beyond!

Happy New Year! I join with the Executive Council of DCE in wishing you a healthy and prosperous 2013.

Enjoy your DCE membership? Please don't keep DCE a secret – invite a friend to join DCE. Along with free CEPUs from 3 issues of OTCE, DCE webinars are free in 2013 as part of our 35th anniversary celebration.

Are you receiving monthly email updates from DCE? If not, please check to see that your email is correct in your Academy profile. Logon at eatright.org and in the upper right corner under your name choose myAcademy to update your profile.

Message from the Print Communications Coordinator

Liz Quintana, EdD, RD, LD, CDE
Morgantown, WV

Registered dietitians (RDs) and Dietetic Technicians, Registered (DTRs) pursue a vocation of helping people. Advocacy is one avenue for helping our patients. Advocacy can be defined as working with and on behalf of clients to ensure that they receive benefits and services to which they are entitled and that the services are rendered in ways that safeguard their dignity.

Helping can empower people and encourage personal growth but can also foster and perpetuate dependence. How can we avoid that trap and encourage personal growth? We interact with our patients. We listen to their stories. In their stories, we help them to find their own strengths and their self-esteem. We advocate for patients in a way that builds self-reliance and independence.

As RDs and DTRs, we can easily identify opportunities for advocacy in our daily practice. We must first identify what our patients need and then determine how we can best meet those needs with available resources. Patients with calorie-, food-, or nutrient-restricted meal plans often find grocery shopping and dining out especially challenging. We teach them how to modify recipes, seek certain foods, translate food labels, and interpret menu items. We also offer strategies on how to request certain food items to be stocked at the grocery stores or special modifications to their menu selections when dining out.

With limited time and energy, we must determine how best to expend our efforts to provide the most benefit. Partnering with other health professionals can complement and extend nutrition care and education. Group classes provide opportunities to reach more with less. Forms and templates can make short work of routine paperwork. We can share ideas and resources via the Diabetes Care and Education (DCE) listserv. There is no need to reinvent the wheel.

Sometimes what patients need is beyond our scope of practice. Concerns can be discussed at team meetings. These weekly "huddles" sometimes defy the laws of mathematics. Collectively, the group can form more ideas and identify greater numbers of resources than any individual working alone. The sum of 2 plus 2 can indeed exceed 4!

We also must be advocates for our profession. Through active participation in our professional organization, the Academy of Nutrition and Dietetics, we help ensure that RDs and DTRs are respected team members of healthcare programs and initiatives.

The tools of effective advocacy are knowledge of community resources, knowledge of rules for key benefits/programs, and the skill of effective communication with key individuals and agencies. Make a resolution to identify and further develop and improve upon your skills in advocacy. In taking steps in building on our strengths, we can help advance community and state nutrition initiatives. We need advocates who are skillful in researching and delineating the complexity of the issues. We also need advocates who are skillful in communicating: authors, educators, orators, and negotiators. Groups involved in advocacy work have used a wide range of resources to accomplish professional goals. Advocacy is no longer limited to town hall meetings. The Internet has helped to increase the speed, reach, and effectiveness of advocacy-related communication and mobilization efforts, ultimately having a positive impact on the advocacy community.

What can DCE members do? Stay informed, be involved. RDs and DTRs have many opportunities to influence policy. Share your stories of advocacy in *News*FLASH or on the DCE Facebook page at www.facebook.com/DCEdpg. Stories can be very powerful, serving as inspirations for advancing ideas in the policy-making circles.

Message from the *News*FLASH Editor

Lorena Drago, MS, RD, CDN, CDE
Forest Hills, NY

It was a pleasure to have met so many of you at the 2012 Food & Nutrition Conference & Expo in Philadelphia in October. At the Diabetes Care and Education (DCE) Membership meeting on Saturday, October 6, DCE's chair, Andrea Dunn, RD, LD, CDE, announced that *News*FLASH is among the top five valued DCE benefits. With every issue, a cadre of contributors aims to inform and provide you with practical tools for your practice. Each issue offers a host of information, including legislative updates, book reviews, and a summary of the most current scientific research on diabetes and nutrition. We hope you use the information you receive from *News*FLASH to create presentations for patients, consumers, and health care professionals and support best practice with medical-based evidence research. Crossroads in Nutrition and Diabetes provides insight on multicultural aspects of diabetes management to develop tailored interventions that promote health behaviors and optimal diabetes self-management behaviors. One of the many DCE member benefits is being able to apply for our annual awards, educational stipends, and speaker stipends. I hope the articles written by FNCE scholarship recipients about their experiences encourage you to apply or nominate someone for the many DCE awards.

In this issue, DON'T miss reading about Chef Jennifer Stack, RD, CDE, CHE, who has successfully integrated culinary science and nutrition science. Jennifer is a professionally trained chef and an associate professor at the Culinary Institute of America in Hyde Park, NY.

*News*flash is a member benefit that we strive to make useful. We need your feedback to continue making the publication relevant to you and your practice. Please email me at Lorenamsrd@aol.com and let me know what topics *News*FLASH should examine to bring your practice to the next level.

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Scholarship Winner Highlights Her FNCE experience

Geetha Krishnan, MS, MA, RD, CDE
Bedminster, NJ

I was excited when I was informed that I had won a scholarship from Diabetes Care and Education (DCE) to attend the 2012 Food & Nutrition Conference & Expo (FNCE) in Philadelphia. I was unable to attend FNCE in the past few years and was happy for this opportunity.

Many of the sessions focused on applying current technology to nutrition and computers. For example, I attended a session on diabetes diet facts and myths. With so much confusion about how to manage diabetes and make appropriate food choices; it was refreshing to hear that the focus should be on making healthy choices rather than a do's and don'ts list. Some of the recommendations were:

- A moderate amount of sugar can be substituted for other carbohydrates in the diet.
- Balancing choices include the occasional consumption of sugar-containing foods as long as the majority of other food choices are healthy.

- Teaching patients about portion control, i.e. choosing a small piece of regular cake instead of a large piece of sugar-free cake.

The session on low-calorie sweeteners was very informative. With various sweeteners being introduced, diabetes educators need to be prepared to answer questions from our clients/patients. Nectresse™ and Stevia were some of the sweeteners discussed:

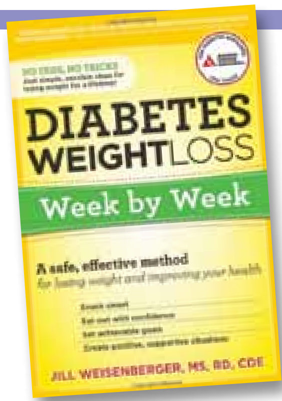
- Nectresse™ is a no-calorie sweetener extracted from the monk fruit and other natural sweeteners. Nectresse™ can be used in cooking and baking and can be purchased in many national retail stores in individual packets and in a canister.
- Stevia is a South American herb extracted from the leaves of the Stevia rebaudiana and used as a natural sweetener. Stevia is a no-calorie sweetener used in beverages and sold individually in packets.

The exhibit floor provided an opportunity to learn about new products. I was impressed with a large display of Greek yogurts with higher protein content and fewer carbohydrates compared to other varieties. Kind products have four new bars made with nuts and fruits and no more than 5 grams of sugar per serving.

From the array of new products on the exhibit floor to the poster sessions, FNCE was a positive learning experience and a great chance to meet with fellow practitioners. I will definitely attend FNCE again.

DIABETES WEIGHT LOSS Week by Week: A Safe Effective Method for Losing Weight and Improving Your Health

Peggy Zeller, RD, LD
Cleveland, OH



DIABETES WEIGHT LOSS Week by Week: A Safe, Effective Method for Losing Weight and Improving Your Health
By Jill Weisenberger, MS, RD, CDE

It seems as if every news program, magazine, or newspaper today is promoting another weight loss diet book. The diet industry is running strong and making money, but obesity statistics have not changed much. One third of adults aged 20 or older are obese, that is, 35.9 % of the population (1). Even more concerning for health professionals, is the rise in childhood obesity. Obesity now affects 17% of all children and adolescents in the United States, which is triple the rate from just one generation ago (2).

Obesity increases health risks such as heart disease, stroke, and hypertension. Diabetes and obesity are much more common with the patients with diabetes I see today compared with ones from years ago. I am amazed at how many diets clients have tried, with many losing weight but most regaining what they lost and more. I tell them that diets can work and that they will lose weight, but they generally will gain it back when they go off diet and return to old eating behaviors.

DIABETES WEIGHT LOSS Week by Week: A Safe, Effective Method for Losing Weight and Improving Your Health is not another fad diet book. In fact, it is not even a diet but a "master plan" for losing weight and keeping it off. This book provides simple, smart steps for losing weight and is filled with sound, practical advice for a lifetime of weight management and control of diabetes. The focus is on setting SMART (Specific, Measurable, Action-Oriented, Realistic, Time-limited) achievable goals, learning that weight loss is not just willpower but more about skills, and emphasizing the "haves" rather than the"have nots." Weisenberger systematically targets the behaviors that lead to weight gain, offers clear suggestions on how to replace them with healthy habits, and provides useful strategies and information. She also demonstrates how to develop and practice skills to use in the kitchen, grocery store, restaurants, social situations, and other tough situations.

Weisenberger begins with a week-by-week guide for 16 weeks that covers the basics: food knowledge, cooking skills, behavior changes, physical activity suggestions, and specific diabetic concerns. Each week has citations of useful websites and references for healthy eating from the Academy of Nutrition and Dietetics, United States Department of Agriculture (USDA), and the National Institutes of Health (NIH). The weekly guideline has many helpful tips for more plant-based and less animal intake, aiming for three or more food groups per meal, and the plate method. Registered dietitians will find much of this is a reiteration of what they are saying already to their patients.

Week 1 covers basics about calories, balanced meal plans, and the importance of keeping records (writing down can double weight loss success, according to research by NIH). Helpful examples illustrate the importance of recording as one eats rather than at the end of the day and emphasize the need to review the food diary to learn from it. Also included are references for the USDA, DASH, and glycemic index. Examples show how results improve blood glucose and cholesterol, how to burn extra calories for weight loss, and how to relieve stress to reduce heart disease risk. After each week, the author suggests action steps.

(continued on page 8)

BOOK REVIEW

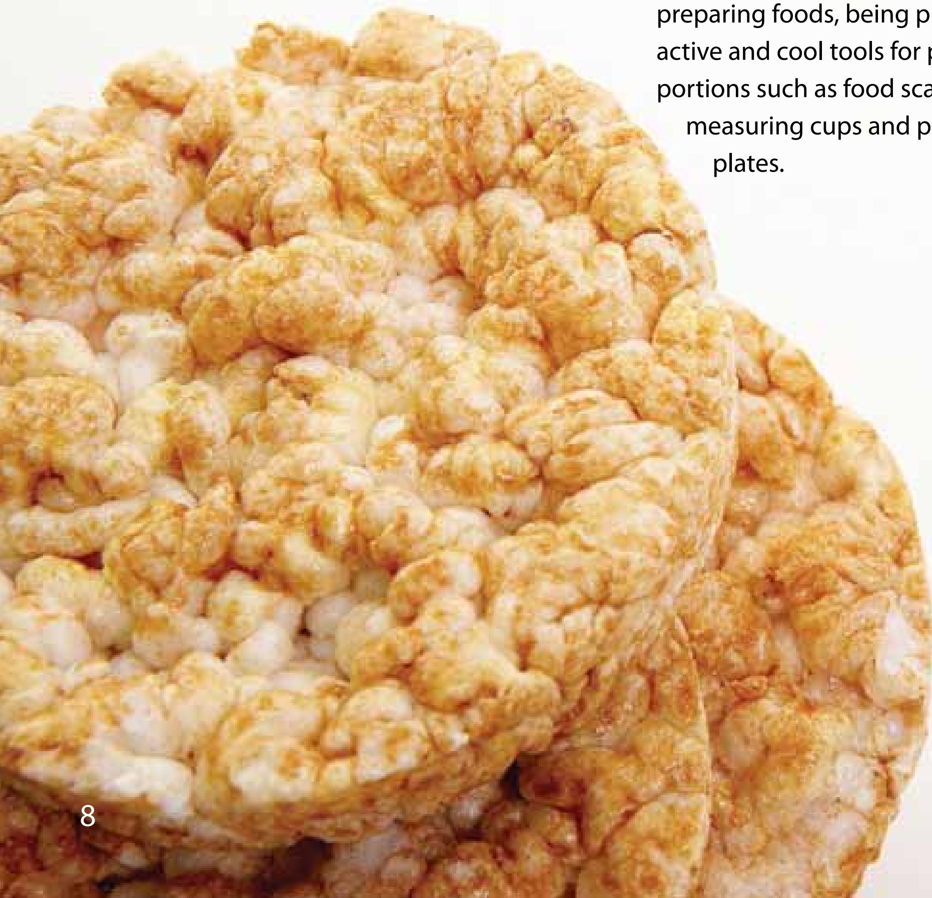
(continued from page 7)

Week 2 reviews guidelines for planning meals, how to decipher a food label, and how blood glucose values might change. The author focuses on what and why with lots of examples.

Week 3 stresses the importance of eating breakfast and what to eat, quoting the National Weight Control Registry statistic that 78% of those who lost 30 lb and kept off the weight for 1 year ate breakfast (3). This section also covers exercise and blood glucose as well as mindless eating.

Week 4 emphasizes foods that keep hunger at bay, such as water-rich foods (i.e., tomatoes, radishes, cucumbers).

Week 5 examines food swaps, calorie-trimming tips, the addition of strength training, and keeping the environment safe, with many suggestions and action steps.



Week 6 covers how to turn excuses not to do something into excuses to do something, commenting on the hard work of changing a lifelong pattern of thinking. Suggestions include becoming attuned to negative self-talk, observing the situation objectively, and planning a different response for the next time. The author offers suggestions for helpful tools in the kitchen, e.g., gravy separator, zester, oil mist pump.

Week 7 covers ideas for resetting the routine, switching environments to help break a bad habit like over-snacking at night, starting a good habit, and taming nighttime nibbles.

Week 8 offers options to manage hunger and restaurant meals and fill up on fiber.

A great section on eating out reviews various types of restaurants and where people can "GO FOR IT" on the menus at Asian, Italian, Mexican, Middle East restaurants.

Week 9 focuses on portion control, preparing foods, being physically active and cool tools for proper portions such as food scale measuring cups and portion plates.

Weeks 10 -16 discuss weekends, vacations, special occasions, and party strategies as well as progress reports, snacking suggestions, meal replacements, practicing eating mindfully, and back up plans.

The second part of the book focuses on the long term, with stress management techniques, staying out of food ruts, helpful information on limiting intake of saturated and trans fats, sodium, and ways to increase whole grains as well as managing obstacles.

Weisenberger includes real-life stories from clients in each section to show how they made changes. The appendix includes a wealth of tools: weight graph chart, goal worksheets, plate method planner, progress report sheets, USDA food patterns, a sample 7-day 1,300-kcal/day meal plan, and 21 analyzed recipes.

These helpful step-by-step guidelines direct readers toward creating healthy eating habits for a lifetime. Readers can pace themselves and receive ample tools and examples. Clients should see this as a wonderful workbook for changing to healthier and happier lifestyles for the long term.

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DiabetesEveryday.com and the Living with Type 2 Diabetes Program?

Jill Weisenberger, MS, RD, CDE
Yorktown, VA

We offer our patients with diabetes so much more than education and meal plans. We offer support, an attentive ear, recipe recommendations, individualized advice, and more. We cannot, however, offer them everything they need to be successful. Thus, we (and they) look to support groups, bookshelves, and the Internet. Because credibility is a frequent problem, we must carefully evaluate each resource with or for our patients. One website worth the look is DiabetesEveryday.com (http://diabeteseveryday.com/). Additionally, the American Diabetes Association *Living with Type 2 Diabetes,* produces supportive, informative, and credible written materials for people recently diagnosed with type 2 diabetes.

DiabetesEveryday.com is a user-friendly website that guides and supports people with diabetes. Founder Toby Smithson, RD, CDE, brings an innovative approach to diabetes support. As someone who has successfully managed her own type 1 diabetes for more than 40 years, Toby shares a connection with similarly affected people. She also has unique professional and personal insights into what effective diabetes management requires and its long-term rewards. DiabetesEveryDay.com stands apart from other sites because of its credibility, videos, radio shows, practical applications, and Toby herself. Toby's enthusiasm, warmth, and positive attitude will surely appeal to your patients. The videos address diet, exercise, medical management, motivation, and lifestyle. Among recent topics are: preparing Balsamic Tomatoes with Spinach, Managing Diabetes with Resistance Exercise, and Wearing Your Medical ID. Toby even discusses how diabetes affects her preparation for a colonoscopy. The site presents a weekly menu with recipes and a grocery list. Toby prepares recipes, which are selected from 12 books published by fellow registered dietitians, on video. While demonstrating the recipes, she also explains why the foods are especially good for individuals with diabetes. The website also includes condensed diabetes news and feature articles. Toby says her goal is to keep followers thinking about their health.

DiabetesEveryDay.com is subscriber-supported. Therefore, there are no ads of questionable products, services, or supplements anywhere on the website. Your patients and clients can enjoy a trial subscription for 60 days with no further obligation. To keep subscribers engaged, she sends a weekly email and an occasional text or voice message. Limited access to videos, recipes, and other diabetes-related information is available without a subscription. A subscription includes, weekly menus, new weekly video content, diabetes every day radio and professional guidance and coaching. Subscriptions are free for diabetes care providers Email Toby at toby@diabeteseveryday.com for details about this offer.

Subscription Prices:
- 2 months: $26
- 6 months: $60
- 12 months: $84

The American Diabetes Association's free 12-month program, *Living with Type 2 Diabetes,* is designed for those who have been recently diagnosed with the disease. However, it is equally beneficial for those who have had the diagnosis for many years but lack self-management skills or need more frequent encouragement. Enrollees receive five informational packets by mail or email.

The first packet addresses food and diet. A 32-page booklet answers the question *What Can I Eat?* It covers the plate method, carbohydrate counting, the glycemic index, reading food labels, and a description of each diabetic exchange. A 2-page article introduces eating out and offers suggestions for healthful choices in ethnic restaurants. There is a 2-day sample menu as well. This first booklet also introduces the topic of physical activity, but a subsequent packet is dedicated to the topic. Other packets cover stress and emotions and preventing complications of diabetes.

Enrollees also receive three free issues of *Diabetes Forecast* magazine and a monthly e-newsletter that includes recipes. Sign up at www.diabetes.org.

HAVE YOU READ?

Janice MacLeod, MA, RD, CDE
Chester Springs, PA

- TODAY Study Group, Zeitler P, Hirst K, Pyle L, et al. A clinical trial to maintain glycemic control in youth with type 2 diabetes. *N Engl J Med*. 2012;366:2247–2256.

  The TODAY trial randomized 699 overweight youth (ages 10 through 17) recently diagnosed with type 2 diabetes 1:1:1 to metformin, rosiglitazone with metformin, or metformin plus lifestyle interventions. The participants were followed for 3.8 years. Study results showed that metformin/rosiglitazone combination therapy was associated with a significantly lower rate of treatment failure (38.6%) than metformin alone (51.7%, *P*=0.006). The failure rate of metformin plus lifestyle intervention (46.6%) did not differ significantly from either of the other two groups, which was a substantial disappointment and underscores that lifestyle modification may have been too late or insufficient. The reasons for treatment failure and the median time to failure (a short 11.5 months) did not differ significantly across groups. Furthermore, adjusting for sex, race/ethnic group, baseline body mass index, or baseline glycosylated hemoglobin did not modify the results. Metformin plus lifestyle intervention provided greater weight loss than metformin monotherapy at 6 but not at 24 months. Insulin therapy was initiated at the time that glycemic deterioration was confirmed.

- Akers JD, Cornett RA, Savla JS, Davy KP, Davy BM. Daily self-monitoring of body weight, step count, fruit/vegetable intake, and water consumption: a feasible and effective long-term weight loss maintenance approach. *J Acad Nutr Diet*. 2012;112:685–692.

  Researchers conducted a two-group, 12-month weight loss maintenance trial to determine the feasibility and effectiveness of a weight loss maintenance intervention in 40 weight-reduced individuals. Study participants were asked to record daily body weight, step count, and fruit and vegetable intake as well as consume 16 oz of water before each main meal. Daily self-monitoring of weight, steps, and fruit and vegetable intake was shown to be effective, and the daily monitoring of water intake may provide additional benefits in long-term weight loss maintenance.

- Guildbrand H, Dizdar B, Bunjaku B, et al. In type 2 diabetes, randomization to advice to follow a low-carbohydrate diet transiently improves glycemic control compared with advice to follow a low-fat diet producing a similar weight loss. *Diabetologia*. 2012;55:2118–2127.

  This prospective, randomized, non-blind, parallel trial was conducted in 61 adults with type 2 diabetes consecutively recruited in primary care. Patients on the low-fat diet (LFD) were aiming for 55% to 60% energy from carbohydrate in contrast to the low-carbohydrate diet (LCD) group, who were aiming for 20% of energy from carbohydrate. Although weight loss was similar in both groups, both glycosylated hemoglobin and insulin doses decreased in the LCD group significantly more than in the LFD group. The authors conclude that aiming for 20% of energy intake from carbohydrates is safe with respect to cardiovascular risk relative to the traditional LFD and provides a viable treatment option.

- Milliron BJ, Woolf K, Appelhans BM. A point-of-purchase intervention featuring in-person supermarket education affects healthful food purchases. *J Nutr Educ Behav*. 2012;44:225–232.

  This randomized trial compared the efficacy of a multi-component supermarket point-of-purchase intervention featuring in-person nutrition education on the composition of food purchases with no intervention. The trial involved 153 adult shoppers in a supermarket in a socioeconomically diverse region of Phoenix, AZ. The intervention consisted of a brief education session on a point-of-purchase healthful shopping program, including posted shelf signs identifying healthful foods, sample shopping lists, and tips. Outcomes were determined through nutrition analysis of participant shopping carts. Outcomes that improved in the intervention group included

purchases of less total, saturated, and trans fat g/1,000 kcal; more fruits and vegetables; and more dark-green/yellow vegetables (servings/1,000 kcal). More extensive evaluations of supermarket interventions should be conducted to establish the evidence base regarding the potential for influencing food choices associated with decreased chronic disease incidence.

- Ye EQ, Chacko SA, Chou EL, Kugizaki M, Liu S. Greater whole-grain intake is associated with lower risk of type 2 diabetes, cardiovascular disease, and weight gain. *J Nutr.* 2012;142:1304–1313.

Whole-grain and high-fiber intake are routinely recommended for prevention of vascular diseases in humans. The aim of this study was to systematically examine longitudinal studies investigating whole-grain and fiber intake in relation to risk of type 2 diabetes (T2D), cardiovascular disease (CVD), weight gain, and metabolic problems. Authors identified 45 prospective cohort studies and 21 randomized, controlled trials (RCTs) between 1966 and February 2012. Researchers found that compared with those never/rarely consuming whole grains, those consuming 48 to 80 g/day whole grain (3 to 5 servings/day) had an approximately 26% lower risk of T2D, approximately 21% lower risk of CVD, and consistently less weight gain during 8 to 13 years of follow-up evaluations. Among the RCTs, weighted mean differences in post intervention circulating concentrations of fasting glucose and total and low-density lipoprotein cholesterol between whole-grain intervention groups and controls indicated significantly lower concentrations after whole-grain consumption. Findings from this meta-analysis provide evidence to support the beneficial effects of whole-grain intake on vascular disease prevention. Potential mechanisms responsible for the effect of whole grains on metabolic intermediates require further investigation in large intervention trials.

- Rovner AJ, Nansel TR, Mehta SN, Higgins LA, Haynie DL, LaffelLM . Development and validation of the type 1 diabetes nutrition knowledge survey. *Diabetes Care.* 2012;35:1643–1647.

The purpose of this study was to assess the psychometric properties of the newly developed Nutrition Knowledge Survey (NKS), a survey of general and diabetes-specific nutrition knowledge for youth with type 1 diabetes and their parents. A multidisciplinary pediatric team developed the NKS and administered it to youth with type 1 diabetes (n=282, 49% females, 13.3±2.9 years of age) and their parents (82% mothers). The NKS content domains include healthful eating, carbohydrate counting, blood glucose response to foods, and reading of nutrition labels. Higher NKS scores reflect greater nutrition knowledge (score range is 0 to 100%). Glycemic control in youth was assessed by glycosylated hemoglobin, and dietary quality was determined by the Healthy Eating Index-2005 (HEI-2005) derived from 3-day diet records. NKS scores (23 items) were 56.9±16.4% for youth and 73.4±12.5% for parents. The KR-20 was 0.70 for youth and 0.59 for parents, representing acceptable internal consistency of the measure. In multivariate analysis, controlling for youth age, family income, parent education, diabetes duration, and insulin regimen, parent NKS scores were associated with corresponding youth glycosylated hemoglobin values (P=0.03). Researchers conclude that the NKS appears to be a useful measure of general and diabetes-specific nutrition knowledge for youth with type 1 diabetes and their parents.

- Ranasinghe P, Jayawardana R, Galappaththy P, Constantine GR, de Vas Guynawardana N, Katulanda P. Efficacy and safety of 'true' cinnamon *(Cinnamomum zeylanicum)* as a pharmaceutical agent in diabetes: a systematic review and meta-analysis. *Diabet Med.* 2012;12:1480–1492.

These authors systematically evaluated the literature on the safety and efficacy of *Cinnamomum zeylanicum* in diabetes. They conducted a meta-analysis of studies examining the effect of C *zeylanicum* extracts on clinical and biochemical parameters. The literature search identified 16 studies on C *zeylanicum* (five invitro, six invivo, and five invivo/invitro); no human studies were identified. Invitro C *zeylanicum* demonstrated a potential for reducing postprandial intestinal glucose absorption by inhibiting pancreatic α-amylase and α-glucosidase, stimulating cellular glucose uptake by membrane translocation of glucose transporter-4, stimulating glucose metabolism and glycogen synthesis, inhibiting gluconeogenesis, stimulating insulin release, and potentiating insulin receptor activity. The beneficial effects of C *zeylanicum*

(continued on page 12)

HAVE YOU READ?

(continued from page 11)

in animals include attenuation of diabetes-associated weight loss; reduction of fasting blood glucose, low-density lipoprotein cholesterol, and glycosylated hemoglobin; increasing high-density lipoprotein cholesterol; and increasing circulating insulin. C *zeylanicum* also significantly improved metabolic derangements associated with insulin resistance. It also showed beneficial effects against diabetic neuropathy and nephropathy, with no significant toxic effects on liver and kidney and a significantly high therapeutic window. Researchers conclude that C *zeylanicum* demonstrates numerous beneficial effects both in vitro and in vivo as a potential therapeutic agent for diabetes. However, further randomized clinical trials are required to establish therapeutic safety and efficacy.

- Cohen RV, Pinheiro JC, Schiavon CA, Salles JE, Wajchenberg BL, Cummings DE. Effects of gastric bypass surgery in patients with type 2 diabetes and only mild obesity. *Diabetes Care.* 2012;35: 1420–1428.

Roux-en-Y gastric bypass (RYGB) has been shown to ameliorate type 2 diabetes in severely obese patients through mechanisms beyond just weight loss, and it may benefit less obese diabetic patients. Researchers determined the long-term impact of RYGB on patients with diabetes and only class I obesity in this study of 66 consecutively selected diabetic patients with body mass indexes of 30 to 35. Study participants underwent RYGB and were prospectively studied for up to 6 years to evaluate the primary outcome measures of safety and the percentage of patients experiencing diabetes remission (glycosylated hemoglobin [A1C]<6.5% without diabetes medication). Participants had severe, longstanding diabetes, with disease duration 12.5±7.4 years and A1C 9.7±1.5% despite insulin and/or oral diabetes medication usage. For up to 6 years following RYGB, durable diabetes remission occurred in 88% of patients, with glycemic improvement in 11%. Mean A1C fell from 9.7±1.5% to 5.9±0.1% ($P<0.001$), despite diabetes medication cessation in most patients. Weight loss failed to correlate with several measures of improved glucose control, consistent with weight-independent anti diabetes mechanisms of RYGB. C-peptide responses to glucose increased substantially, suggesting improved β-cell function. There was no mortality, major surgical morbidity, or excessive weight loss. Hypertension and dyslipidemia also improved, yielding 50% to 84% reductions in predicted 10-year cardiovascular disease risks of fatal and nonfatal coronary heart disease and stroke. This is the largest longest-term study examining RYGB for diabetic patients without severe obesity. Researchers conclude that RYGB can safely and effectively ameliorate diabetes and associated comorbidities, reducing cardiovascular risk, in patients with body mass indexes of 30-35.

- Sluijs I, Forouhi NG, Beulens JW, et al; InterAct Consortium. The amount and type of dairy product intake and incident type 2 diabetes: results from the EPIC-InterAct Study. *Am J Clin Nutr.* 2012;96:382–390.

Dairy product intake may be inversely associated with risk of type 2 diabetes, but the evidence is inconclusive for total dairy products and sparse for types of dairy products. This large prospective study investigated the prospective association of total dairy products and different dairy subtypes with incidence of diabetes in populations with marked variation of intake of these food groups. A nested case-cohort within eight European countries of the European Prospective Investigation into Cancer and Nutrition Study (n=340,234; 3.99 million person-years of follow-up) included a random sub cohort (n=16,835) and incident diabetes cases (n=12,403). Baseline dairy product intake was assessed by dietary questionnaires. Intake of total dairy products was not associated with diabetes in an analysis adjusted for age, sex, body mass index, diabetes risk factors, education, and dietary factors. Of the dairy subtypes, cheese intake tended to have an inverse association with diabetes, as did a higher combined intake of fermented dairy products (cheese, yogurt, and thick fermented milk). Although the study found no association between total dairy product intake and diabetes risk, an inverse association of cheese intake and combined fermented dairy product intake with diabetes is suggested.

- Odegaard AO, Koh WP, Yuan JM, Gross MD, Pereira MA.Western-style fast food intake and cardiometabolic risk in an eastern

country. *Circulation*. 2012;126: 182-188.

With globalization, the western-style fast food pattern of eating is becoming more common in developing and recently developed populations. Researchers examined the association of western-style fast food intake with the risk of incident type 2 diabetes (T2D) and coronary heart disease (CHD) mortality in Chinese Singaporeans. This analysis included men and women ages 45 to 74 years who enrolled in the Singapore Chinese Health Study from 1993 through 1998. For CHD mortality 52,584 participants were included and 1,397 deaths were identified through December 2009 via registry linkage. For T2D, 43,176 participants were included and 2,252 cases were identified during the follow-up interview (1999-through 2004) and validated. Chinese Singaporeans with relatively frequent intake of western-style fast food items (2 times per week) had an increased risk of developing T2D and dying from CHD relative to their peers who had little or no reported intake. These associations were not materially altered by adjustments for overall dietary pattern, energy intake, and body mass index, leading researchers to conclude that western-style fast food intake is associated with increased risk of developing T2D and CHD mortality in an eastern population. These findings suggest the need for further attention to global dietary acculturation.

- Bozzetto L, Printer A, Annuzzzi G, Costagliola L, et al. Liver fat is reduced by an isoenergetic MUFA diet in a controlled randomized study in type 2 diabetic patients. *Diabetes Care*. 2012;35:1429–1435.

In a factorial 2X2 randomized parallel-group design, 45 people ages 35 to 70 years with type 2 diabetes in satisfactory blood glucose control on diet plus metformin treatment were assigned to one of the following groups for an 8-week period: 1) High-carbohydrate/high-fiber/low-glycemic index diet (CHO/fiber group), 2) high-monounsaturated fatty acid (MUFA) diet (MUFA group), 3) high-carbohydrate/high-fiber/low glycemic index diet plus physical activity program (CHO/fiber+Ex group), and 4) high-MUFA diet plus physical activity program (MUFA+Ex group). Hepatic fat content was measured at baseline and after intervention. Liver fat content decreased more in MUFA and MUFA+Ex groups than in CHO/fiber and CHO/fiber+Ex groups, with significant (clinically relevant) effect on liver fat content for diet and no effects for exercise training or diet-exercise interaction. Researchers recommend consideration of this approach in the nutritional management of hepatic steatosis in people with type 2 diabetes.

- Cozma AI, Sievenpiper JL, de Souza RJ, et al. Effect of fructose on glycemic control in diabetes. A systematic review and meta-analysis of controlled feeding trials. *Diabetes Care*. 2012;35: 1611–1620.

Isocaloric exchange of fructose for other carbohydrate improves long-term glycemic control, as assessed by glycated blood proteins, without affecting insulin in people with diabetes. Generalization of these data is limited due to the short duration of the trials.

- Moyer VA on behalf of the U.S. Preventive Services Task Force. Screening for management of obesity in adults: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2012;157:373–378.

This is an updated statement from the 2003 U.S. Preventive Services Task Force recommendations on screening for obesity and overweight in adults. The Task Force reviewed new evidence on the benefits and harms of screening and primary care-feasible or referable nonsurgical weight loss interventions. They recommend that clinicians screen for obesity and offer or refer to intensive, multi-component behavioral intervention those patients with body mass indexes of 30 or higher.

- Ebbeling CB, Swain JF, Feldman HA, Wong WW, et al. Effects of dietary composition on energy expenditure during weight-loss maintenance. *JAMA*. 2012; 307:2627–2634.

Researchers examined the effects of three diets that differed widely in macronutrient composition and glycemic load on energy expenditure following weight loss. Among overweight and obese young adults, compared with energy expenditure before weight loss, isocaloric feeding following 10% to 15% weight loss resulted in decreases in resting energy expenditure and total

(continued on page 14)

HAVE YOU READ?

(continued from page 13)

energy expenditure. The reductions were greatest with the low-fat diet, intermediate with the low-glycemic index diet, and least with the low-carbohydrate diet.

- Gardner C, Wylie-Rosett J, Gidding SS, et al. American Heart Association Nutrition Committee of the Council on Nutrition, Physical Activity and Metabolism, Council on Arteriosclerosis, Thrombosis and Vascular Biology, Council on Cardiovascular Disease in the Young; American Diabetes Association. Nonnutritive sweeteners: current use and health perspectives: a scientific statement from the American Heart Association and the American Diabetes Association. *Diabetes Care*. 2012;35:1798–1808.

  This statement is a timely, updated, and comprehensive reference essential for registered dietitians in diabetes care.

- The *Lancet* published a comprehensive series of articles on global physical activity in July 2012. The series includes a new analysis that quantifies the global impact of physical inactivity on the world's major non-communicable diseases, reviews current levels of physical activity and trends worldwide, discusses why some people are active and some are not, provides evidence-based strategies for effective physical activity promotion, and discusses how a multi-sector and systems-wide approach that goes beyond health will be critical to increase population-levels of activity. Titles, authors, and references for several articles in the series are listed below.

  Das P, Horton R. Rethinking our approach to physical activity. *Lancet*. 2012; 380:189–190.

  Hallal PC, Bauman AE, Heath GW, Kohl HW 3rd, Lee IM, Pratt M. Physical activity: more of the same is not enough. *Lancet*. 2012;380:190–191.

  Lee IM, Shiroma EJ, Lobelo F, Puska P, Blair SN, Katzmarzyk PT. Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. *Lancet*. 2012;380:219–229.

  Hallal PC, Andersen LB, Bull FC, Guthold R, Haskell W, Ekelund U; Lancet Physical Activity Series Working Group. Global physical activity levels: surveillance, progress, pitfalls, and prospects. *Lancet*. 2012;380:247–257.

  Bauman AE, Reis RS, Sallis JF, Wells JC, Loos RJ, Martin BW; Lancet Physical Activity Series Working Group. Correlates of physical activity: why are some people physically active and others not? *Lancet*. 2012;380:258–271.

  Heath GW, Parra DC, Sarmiento OL, et al. Lancet Physical Activity Series Working Group. Evidence-based intervention in physical activity: lessons from around the world. *Lancet*. 2012;380:272–281.

  Pratt M, Sarmiento OL, Montes F, et al; Lancet Physical Activity Series Working Group. The implications of megatrends in information and communication technology and transportation for changes in global physical activity. *Lancet*. 2012;380:282–293.

  Kohl HW 3rd, Craig CL, Lambert EV, et al. Lancet Physical Activity Series Working Group. The pandemic of physical inactivity: global action for public health. *Lancet*. 2012; 380:294–305.

- Teeuwisse WM, Widya RL, Paulides M, et al. Short-term caloric restriction normalizes hypothalamic neuronal responsiveness to glucose ingestion in patients with type 2 diabetes. *Diabetes*. 2012 Dec; 61(12):3255–9.

  The hypothalamus is critically involved in the regulation of feeding. Previous studies demonstrated that glucose ingestion inhibits hypothalamic neuronal activity, although this has not been observed in patients with type 2 diabetes. Reduction of the caloric intake and weight loss are important therapeutic strategies in many patients with type 2 diabetes. The authors of this study hypothesized that caloric restriction would have beneficial effects on the hypothalamic neuronal response to glucose ingestion. Functional magnetic resonance imaging was performed in 10 male type 2 diabetic patients before and after a 4-day very low-calorie diet (VLCD) at a 3.0-Tesla scanner using a blood oxygen level-dependent technique for measuring neuronal activity in the hypothalamus in response to an oral glucose load. Hypothalamic signals were normalized to baseline value, and differences between the pre- and post-diet condition were tested using paired T-tests. Pre-VLCD

scans showed no response of the hypothalamus to glucose intake (i.e., no signal decrease after glucose intake was observed). Post-VLCD scans showed a prolonged signal decrease after glucose ingestion. The results demonstrate that short-term caloric restriction readily normalizes hypothalamic responsiveness to glucose ingestion in patients with type 2 diabetes, paving the way for larger, longer-term research.

- Manohar C, Levine JA, Nandy DK, et al. The effect of walking on postprandial glycemic excursion in patients with type 1 diabetes and healthy people. *Diabetes*. 2012 Dec; 35(12):2493–9.

Physical activity (PA), even at low intensity, promotes health and improves hyperglycemia. However, the effect of low-intensity PA captured with accelerometry on glucose variability in healthy individuals and those who have type 1diabetes has not been examined. Quantifying the effects of PA on glycemic variability would improve artificial endocrine pancreas (AEP) algorithms. Researchers studied 12 healthy control subjects (five males, 37.7±13.7 years of age) and 12 patients with type 1 diabetes (five males, 37.4±14.2 years of age) for 88 hours. Participants performed PA approximating a threefold increase over their basal metabolic rate. PA was captured using a PA-monitoring system, and interstitial fluid glucose concentrations were captured with continuous glucose monitors. In random order, one meal per day was followed by inactivity, and the other meals were followed by walking. Glucose and PA data for a total of 216 meals were analyzed from 30 minutes before meal ingestion to 270 minutes post-meal. In healthy subjects, the incremental glucose area under the curve was 4.5 mmol/L/270 min for

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(continued on page 16)

HAVE YOU READ?

(continued from page 15)

meals followed by walking compared with 9.6 mmol/L/270 min (*P*=0.022) for meals followed by inactivity. The corresponding glucose excursions for those with type 1 diabetes were 7.5 mmol/L/270 min and 18.4 mmol/L/270 min, respectively (*P*<0.001). Walking significantly affects post-prandial glucose excursions in healthy populations and in those with type 1 diabetes. AEP algorithms incorporating PA may enhance tight glycemic control end points.

- McCaffery JM, Papandonatos GD, Peter I, et al; Genetic Subgroup of Look AHEAD; Look AHEAD Research Group. Obesity susceptibility loci and dietary intake in the Look AHEAD Trial. *Am J Clin Nutr.* 2012; 95:1477–1486.

Although genome-wide association studies (GWAS) have identified consistent associations with obesity, the mechanisms remain unclear. This study sought to determine the association between obesity susceptibility loci and dietary intake. The association of GWAS-identified obesity risk alleles (FTO, MC4R, SH2B1, BDNF, INSIG2, TNNI3K, NISCH-STAB1, MTIF3, MAP2K5, QPCTL/GIPR, and PPARG) with dietary intake, measured through food frequency questionnaires, was investigated in 2,075 participants from the Look AHEAD (Action for Health in Diabetes) clinical trial. Adjustments for age, sex, population stratification, and study site were made. Obesity risk alleles at FTO rs1421085 significantly predicted more eating episodes per day (*P*=0.001), an effect that persisted after adjustment for body weight (*P*=0.004). Risk variants within BDNF were significantly associated with more servings from the dairy product and the meat, eggs, nuts, and beans food groups (*P* ≤0.004). The risk allele at SH2B1 rs4788099 was significantly associated with more servings of dairy products (*P*=0.001), whereas the risk allele at TNNI3K rs1514176 was significantly associated with a lower percentage of energy from protein (*P*=0.002). These findings suggest that obesity risk loci may affect the pattern and content of food consumption among overweight or obese individuals with type 2 diabetes.

- Young V, Eiser C, Johnson B, et al. Eating problems in adolescents with type 1 diabetes: a systematic review with meta-analysis. *Diabet Med.* 2012 Aug 22.doi: 10.1111/j.1464-5491.2012.03771.x. Epub ahead of print.

This systematic review sought to determine: 1) the prevalence of eating problems compared with peers and 2) the association between eating problems and glycemic control in young adults with type 1 diabetes. A systematic literature search was conducted via electronic databases and meta-analysis, yielding 13 studies that met inclusion criteria. Cohen's d (the mean difference score between type 1 diabetes and comparison groups) was calculated for these studies. Eating problems (both disordered eating behavior [39.3% and 32.5%; d=0.5] and eating disorders [7.0% and 2.8%; d=0.46]) were more common in adolescents with type 1 diabetes compared with peers, and both were associated with poorer glycemic control (d=0.40). In restricted analyses involving measures adapted for diabetes, associations between eating problems and poorer glycemic control remained (d=0.54). Disordered eating behavior (51.8% and 48.1%; d=0.06) and eating disorders (6.4% and 3.0%) were more common in adolescents with type 1 diabetes compared with peers, but differences were not significant. Researchers conclude that eating problems are common in this age group and recommend screening in clinics. Future research in populations with type 1 diabetes should develop sensitive measures for eating problems and interventions as well as establish predictors of eating problems.

Jennifer Stack, RD, CDE, CHE

Lorena Drago MS RD CDN CDE
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Jennifer Stack, RD, CDE, CHE, is a Culinary Institute of America (CIA)-trained chef, registered dietitian (RD), and certified diabetes educator (CDE). Jennifer teaches nutrition and food safety to culinary students and is the author of *The Diabetes-Friendly Kitchen.*

Why did you become an RD and a chef?

My mother started the ball rolling that led to me becoming an RD. She suggested dietetics as a major when I was a freshman at Bowling Green State University in Ohio. Besides the calculus and chemistry, one of the first courses I took was based in a kitchen, which gave me an odd sense of comfort, despite not having much interest or experience in cooking. I stuck with the program, completed a dietetic internship at The New York Hospital in New York City, and took the RD examination. Jump forward 10 years and I was working with a team to treat binge eating disorder at New York University Behavioral Health Programs. I had just moved into a house and was only commuting into New York City three days a week. I took a part-time job as a sales associate at Williams-Sonoma at the local mall and enjoyed the benefits of 40% off merchandise. In my first year, I spent $300 more than I made accumulating a set of All Clad stainless steel cookware and Mauviel Copper Cookware in addition to numerous other kitchen gadgets. I loved it and started to dream about going to culinary school if I won the lotto. I didn't win the lotto, but I did take out a student loan and enrolled full-time at the CIA, which was just 90 minutes north of my home. I maintained a part-time private practice in New York City providing weight control, diabetes, and eating disorder counseling during the 2-year associate degree program and graduated just 1 month after my 40th birthday.

What events in your personal/ professional life led you to become a CDE?

I completed my master's degree early in my career while working full-time in a clinical position at New York University Langone Medical Center, where I provided medical nutrition therapy and counseling to people with diabetes. Although I was qualified to take the CDE examination, I hesitated because I saw it as just more letters after my name and the cost of taking the exam seemed high to me at the time. I'm glad I went through with it and have maintained my certification despite not remaining in the clinical setting day to day. I continue to be inspired by my CDE colleagues and welcome the challenge of staying up-to-date and maintaining the certification.

What are the key messages of your book *The Diabetes-Friendly Kitchen?*

The publishing department at the CIA eased me through the process of proposing a diabetes-focused cookbook and provided a place to test recipes. I had just taken a course on Professional Food Writing and was ready to give it a try. It was essential to me that the book raise taste standards for diabetes-appropriate food. After graduating with honors from the CIA in 2003, I knew I couldn't eat" diet food" anymore and wrote this book for people who couldn't bear the thought of having to eat diet food. I created recipes that met the standards of the chefs at the CIA and food lovers. The fact that they are diabetes-friendly is an added benefit. The book guides the reader on ingredients and basic cooking techniques that are useful when preparing delicious, health-enhancing meals. In addition, it clarifies the current recommendations for carbohydrates, fats, and calories and meal planning for people with diabetes.

(continued on page 18)

MEET THE CHEF

(continued from page 17)

Can you expand on the concept of creating a diabetes-friendly kitchen?

Setting up a diabetes-friendly kitchen and learning to cook well puts you back in control when diabetes threatens your sense of well-being. Preparing your own meals makes it easier to manage your blood glucose and health. A diabetes-friendly kitchen helps you create meals that can prevent pre-diabetes from becoming a full-blown case and improves your blood glucose and health if you have diabetes. A diabetes-friendly kitchen has the ingredients and basic equipment needed for preparing meals for you or for a family. It is no different than good cooking of any kind, which is the art of producing the best flavor in any dish.

What do you suggest for my patients who often complain about having little time to cook healthy and tasty meals?

A freezer is one of the best pieces of equipment to simplify meal planning and preparation. Cooked whole grains and legumes freeze very well in individual portions and can be added to broth to create a base for building a quick meal in a bowl. Add finely shredded cabbage or greens such as Swiss chard to the steaming broth. Leftover chicken and meat from a previous meal can be added or served alongside.

Vegetables are always so hard to "get in" the diet. Can you share some tips on making vegetables part of a healthy diet?

One method of adding more vegetables to meals is creative preparation. I use a julienne peeler to make long zucchini "noodles." A daikon radish also works well with this technique. The recipe for ***Daikon Spaghetti with Chicken and Tahini Soy Dressing*** can be made with leftover chicken that is shredded and simmered in the flavorful dressing and tossed with chopped kale and the daikon "spaghetti." I include a list of 15 fabulous, flavorful vegetables that are low in carbohydrate in the book. They are on my "keep on hand" list because of their flexibility in recipes (mushrooms, celery, cucumbers), ability to hold well (cabbage, cauliflower, radishes, and fennel) or the phytonutrients and antioxidants they contain (arugula, broccoli rabe, bell peppers, and kale).

Tell us about your experience as a CIA instructor. What do you teach and do you see a change in how students connect with nutrition and good health?

I teach nutrition to students in the Culinary Arts and Baking and Pastry Arts degree programs at the CIA. Our students have a very wide range of experiences and educational backgrounds, which keeps the classroom interesting. I have had students with GEDs working alongside students with master's degrees who are coming to culinary school as career changers. Because most of the students are young and their life experiences are limited, they have a hard time understanding why someone would order healthy food in a restaurant. They assume that when a person develops a health problem requiring dietary change, he or she loses desire for good food and just follows the assigned diet. They often believe that if people are educated about food and health, they will eat healthier. Therefore, my classes address these misconceptions. In addition, they need guidance on how to find reliable nutrition information, so I often emphasize sources such as .edu and .gov over .com and try to improve their information literacy.

What else is going on in your life?

In March 2013, I am offering a diabetes-friendly cooking class for non-chefs at the CIA on some Saturdays. I am hoping to create a system that is easy for others to replicate and offer in a wide range of settings. Cooking is truly an engaging and active type of learning and certainly more fun than sitting in a classroom or a clinic. I encourage RDs to expose themselves to a very wide range of foods and to tempt their palates. I can create much more interesting and enticing recipes that are healthy because of my culinary exposure. I am also better able to relate to my clients who are passionate about food and eating and now have to deal with some dietary limitations.

Sides and Salads

Jennifer Stack, RD, CDE, CHE

Arugula and Spinach Salad with Raspberry Dressing

MAKES 6 SERVINGS

1 tablespoon red wine vinegar
1 tablespoon balsamic vinegar
¼ teaspoon kosher salt
1 cup mashed raspberries
3 tablespoons olive oil
3 cups baby spinach leaves
3 cups arugula
Freshly ground black pepper

The natural sweetness of the raspberries tastes fantastic with the slightly bitter arugula and also pairs beautifully with the spinach. The bright berry flavors are complemented by the red wine and balsamic vinegars in a vinaigrette that is extremely easy to make.

1. For the vinaigrette, combine the vinegars and salt and add the raspberries. Whisk in the olive oil.
2. Add the spinach and arugula to the vinaigrette and toss gently. When the greens are lightly coated, transfer to chilled plates, and finish with a generous grinding of pepper.

Nutritional Information Per Serving:
Calories 78, Protein 0.5 g, Carbohydrates 5 g, Fiber 1 g, Total Fat 7 g, Saturated Fat 1 g, Sodium 70 mg

(continued on page 20)

(continued from page 19)

Steamed Kale with Cashews and Raspberries

MAKES 6 SERVINGS

1½ tablespoons lemon-infused olive oil
½ small red onion, diced
6 cups packed kale leaves with stems removed
¼ cup white wine
½ teaspoon kosher salt
¼ teaspoon freshly ground black pepper
¾ cup raspberries
2 teaspoons balsamic vinegar
1 teaspoon agave syrup
3 tablespoons salted, roasted cashews, chopped

Kale is such a hearty and versatile vegetable. The salty cashews and sweet and tart flavors from the raspberries contrast with the earthy kale. The lemon-infused olive oil can be found at most grocery stores.

1. Heat the olive oil in a sauté pan over medium high heat. Add the onion and cook until soft. Add the kale, wine, salt, and pepper.
   Cover and steam, 3 to 5 minutes.
2. While the kale is steaming, toss the raspberries with the vinegar and agave syrup.
3. When the kale is soft and most of the liquid has evaporated, add the cashews and raspberries. Cook until the raspberries are heated through and serve.

Nutritional Information Per Serving: Calories 98, Protein 2 g, Carbohydrates 9 g, Fiber 2 g, Total Fat 6 g, Saturated Fat 1 g, Sodium 139 mg

Zucchini-Mushroom Griddlecakes

MAKES 9 GRIDDLECAKES

2 teaspoons olive oil
1 cup sliced cremini mushrooms
½ yellow onion, diced
1 medium zucchini, shredded
1 cup whole wheat instant baking mix
½ teaspoon kosher salt
1 tablespoon sugar
2 teaspoons Parisian fines herb mix (chives, dill, basil, tarragon, chervil)
¾ cup buttermilk
1 egg
1 ounce grated hard cheese (Parmesan works well)

Any salt-free, dried herb mixture can be used in these savory griddlecakes. Serve them with extra sautéed mushrooms on top if desired.

1. Heat the olive oil in a sauté pan over medium high heat. Add the mushrooms and sweat. When they have released some of their liquid, stir in the onion and cook until the onion is soft and translucent and mushrooms have released most of their liquid. Remove from the heat and stir in the zucchini. Set aside to cool.
2. Preheat a nonstick griddle to medium (about 300°F).
3. Combine the baking mix, salt, sugar, and herb mix. Whisk together the egg and buttermilk. Add to the dry mixture and mix to combine. Stir in the zucchini mixture.
4. Use a half-cup scoop or ladle to portion out the batter onto the nonstick griddle. Cook on both sides until golden brown. Top with the grated cheese and serve.

Nutritional Information Per Griddlecake: Calories 54, Protein 3 g, Carbohydrates 4 g, Fiber 0.5 g, Total Fat 3 g, Saturated Fat 1 g, Sodium 69 mg

DCE awards breakfast

Cecilia Sauter, MS, RD, CDE and Marion Franz, MS, RD, LD, CDE

DCE breakfast presentation FNCE 2012

Liz Quintana, EdD, RD, LD, CDE and Lisa Brown, RD, LD, CDE

FNCE gala

Ann Constance, MA, RD, CDE and Susan Rizzo, RD, LDN, CDE

Do You Want to Help Registered Dietitians Gain National Prominence?

Marla Solomon, RD, LD/N, CDE
Reimbursement Chair
Skokie, IL

The Academy of Nutrition and Dietetics is building an exciting new set of online tools: Academy of Nutrition and Dietetics Health Informatics Infrastructure (ANDHII). These tools are designed to collect and report patient outcomes and national quality improvement data. This information is not only for those practitioners who conduct research; THIS IS FOR ALL!

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- can track patient progress through monitoring and evaluation
- can keep track of patient data to create reports of individual patient progress
- can help you to analyze the overall impact of your practice and different nutrition interventions

Your patient data contribute to the national quality improvement database, providing the evidence needed to promote the value of the registered dietitian (RD) to our leaders and policymakers.

Are you ready to start using ANDHII now? No extra time to your charting will be involved; in fact, it may assist you in charting quicker with important information requested to analyze your patient's data outcome and patient behavioral changes.

The development team's goal is to make this whole process effortless so that you will be happy that you did join!

Be a participant, not an observer. If you are a dietetic manager, have your entire team become members.

For 1 to 2 years, the initial development of ANDHII will include thorough testing for information security, accuracy, and validity. Eager members can sign up to be early ANDHII testers by joining the Dietetics Practice-Based Research Network (DPBRN), a network of practicing RDs who work together to help develop research projects that are important to the profession. Joining the network is free, and signing up only takes a few minutes. Invitations will be sent to DPBRN members in the spring of 2013 for the first ANDHII pilot study.

How do you join DPBRN?

Here is how you connect: www.eatright.org. Go to the RESEARCH tab, where you will see Dietetics Practice-Based Research Network.

✓ You can participate in developing plans to address insurance and government institutions.

✓ You will be helping to promote your profession.

✓ You will help to demonstrate the value of RDs.

Be a participant, not an observer!

Diet and Lifestyle Innovations for Prevention of Cardiovascular Disease

Della B. Flanagan, RD, LD, CDE, BC-ADM
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Concord, NH

I was fortunate to attend the Academy of Nutrition and Dietetics Food & Nutrition Conference & Expo in Philadelphia this year, where I participated in the program on diet and lifestyle innovations for cardiovascular disease (CVD) prevention presented by Robert H. Ecklel, MD, and Barbara Millen, DrPH, RD, FADA. In 2012-2013, the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health expects to release five expert panel reports on CVD risk reduction in adults. The topics include: high blood cholesterol, high blood pressure, obesity, risk assessment, and lifestyle. This session focused on the process for reviewing the evidence and developing expert recommendations for the Lifestyle Work Group report, which include diet and physical activity.

Five panels are reviewing evidence for CVD risk reduction in adults: blood pressure, cholesterol, obesity, lifestyle workgroup, and risk assessment workgroup. Each of these panels reviews evidence on the assigned topic. Drs. Ecklel and Millen worked on the lifestyle workgroup. The panels and work groups use a rigorous evidence-based approach and innovative information technology to identify, review, and evaluate the scientific evidence for specific research questions. The panel formulates key clinical/scientific questions ("critical questions") of high relevance to clinical practice. The implementation workgroup will implement guidance and science review. Once these reports are completed, they will be released for public comment.

Critical topics for the lifestyle workgroup were:

1) Dietary patterns and/or macronutrient composition and blood pressure/lipids,
2) Sodium and potassium and CVD outcomes/risk factors, and
3) Physical activity and blood pressure/lipids.

For topic 1, they reviewed 3,690 articles and included 47. Eleven of the 47 were rated as good evidence, 17 as fair evidence, and 19 as poor evidence. For topic 2, they reviewed 749 articles and included 66. Of these, 36 were considered good evidence, 25 were fair evidence, and 5 were poor evidence. For the third topic on physical activity and blood pressure, they reviewed 867 papers and used 26. Sixteen were rated as good evidence and 10 as fair evidence.

This NHLBI-sponsored National Program to Reduce Cardiovascular Risk (NPRCR) will replace the National Cholesterol Education Program (NCEP), National High Blood Pressure Education Program (NHBPEP), and Obesity Education Initiative. This program fosters collaboration with partners, including the Academy of Nutrition and Dietetics and 17 other professional organizations such as the American Academy of Family Physicians, American Academy of Nurse Practitioners, American Academy of Pediatrics, American Academy of Physician Assistants, and American College of Cardiology. Many federal agencies are also involved, including the Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), and Centers for Medicaid and Medicare Services (CMS).

At this time, the evidence statement and recommendations, draft report, and federal and selected reviews are completed. The NHLBI council meeting on October 30 was followed by a 30-day public comment time. Revisions will be made and the guidelines will be finalized.

The science and framework for developing these guidelines is amazingly comprehensive. Participants at this presentation were told that there might be some surprises when the recommendations are released. The guidelines will be the same for everyone except for those with hypertension, who will be encouraged to have a lower sodium diet. The guidelines are written to inform, not to mandate.

The cosponsors for this program were the Nutrition Education of the Public Health Dietetic Practice Group (DPG) and the Women's Health DPG.

REFERENCES AND RESOURCES

NHLBI-Sponsored Clinical Guidelines: http://www.nhlbi.nih.gov/guidelines/index.htm

Millennium Prevention Inc: http://www.HealthMain.com

Sequestration Issue Brief

Summer 2012
Academy of Nutrition and Dietetics

The Situation

Last summer Congress voted not to increase the country's debt limit without a reduction in government spending. The debt limit is the amount the U.S. is allowed to borrow to pay its creditors. " Under the Budget Control Act, most Federal programs face an across-the-board cut in January 2013 if Congress does not enact a plan before then to reduce the national debt by $1.2 trillion. The Act also created a "Super Committee. This bipartisan committee of 12 members of Congress was charged to find an additional $1.2 billion in cuts over 10 years. Unfortunately the Committee did not come to an agreement and as a result, the sequestration process will be implemented on January 2, 2013. There still is an opportunity for an agreement to be reached before the end of the year. However, it is important that we are aware of the impact would be on nutrition services and interventions.

What is Sequestration?

Sequestration is Washington-speak that is being used more frequently in the media during the past few weeks. It is the term for mandatory cuts to federal programs and agencies. The process cuts funds that may have been authorized by Congress but are now prohibited from being spent. The process has been used in the past but this current sequestration will be the largest in our history; $1.2 trillion in mandatory cuts over 10 years. Half of the cuts will come from defense spending and half from what is known as nondefense discretionary (NDD) programs (we'll get to that later).

Spending Categories

The cuts outlined by the Budget Control Act are divided into three categories: mandatory defense and non-defense spending. Some members of Congress are now demanding that the Pentagon is exempt from sequestration, either by finding offsets for the defense cuts only or by making nondefense programs bear the full brunt of the $1.2 trillion in cuts. Here is a snapshot of what the cuts would be at this point in time:

Mandatory – Spending that is automatically allocated on a year-to-year basis, and cannot be changed unless by an act of Congress. Medicare will be reduced 2% in 2013 by $11 billion. This means that providers will continue to bill Medicare but will be reimbursed at a rate of 98 cents to the dollar. Other mandatory cuts amount to $5.2 billion and include: farm price supports, student loans, vocational rehabilitation, mineral leasing payments and the Social Service Block Grant (1).

Defense – Defense will be reduced by $54.7 (roughly half of total sequestration) billion in 2013 and continue with the same reductions on a yearly basis through 2021.

Non-Defense (NDD) – Money that is not mandatory or allocated for defense spending (roughly 20% of our total yearly budget). NDD will be reduced by $38.5 billion in 2013 (Medicare cuts not included). Reductions would be in every federal agency and most programs. Medicare will start to consume more of the yearly cuts to NDD. This means that in 2014 the Medicare cuts will amount for 21% of the total and 33% in 2021, meaning fewer dollars will be reduced from NDD programs. This can be seen as both good and bad as more money will be left for NDD programs but less could be left for Medicare reimbursement.

Some examples include:

- 700 fewer research grants for The National Institute of Health
- 96,179 fewer children served in Head Start
- 659,476 fewer people would be tested for HIV
- 48,845 fewer women would be screened for cancer
- 5 million fewer families served in the Maternal and Child Health Block Grant
- 30 years between inspections of surgical centers, now done every 3-4 years
- 17 million fewer meals served in Senior Nutrition

How does NDD affect communities?

NDD programs represent a large diversity of investment and partnership between government and local communities. For example, NIH cuts would hinder medical research. Based on these sequestration cuts for NIH programs, 2,500 fewer grants to universities and medical centers would be awarded, effecting research jobs in communities across America.

How does NDD affect nutrition services?

Sequestration can have a big effect on nutrition services. Medicare reimbursement rates, funding towards research, funding to school meal programs, funding to community nutrition programs, are some of the many ways these cuts

can affect how Americans live healthy lives. According to one study by Dr. Stephen Fuller of George Mason University, sequestration could cost the healthcare industry 48,000 jobs in total (2).

Where are We Now?

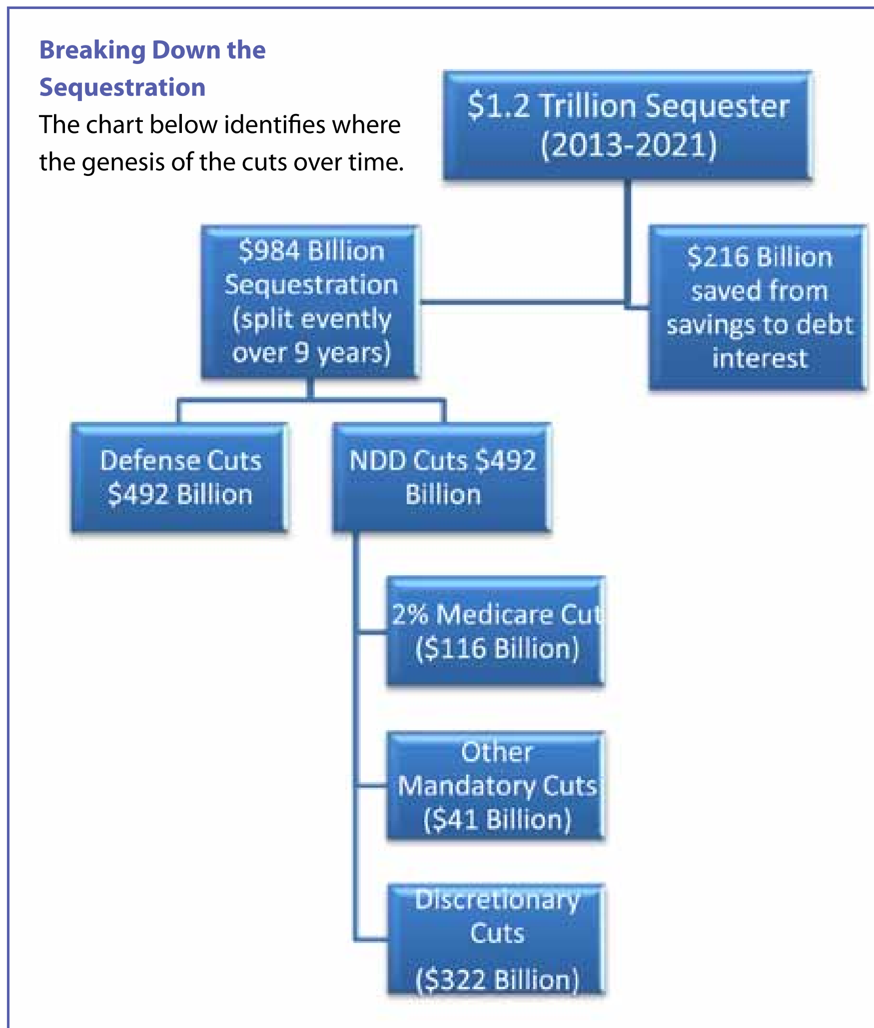
If Congress does nothing and allows sequestration to occur, defense and nondefense related programs will see a combined cut of $109.3 billion in fiscal year 2013. However, Congress still has time to act before the cuts take effect. Congress can pass a new law that overrides these cuts temporarily and then return to Washington next year to create a permanent fix.

What Action Can I Take?

- Send your member of Congress a letter or call their office. Ask them to stop sequestration, protect programs important to you and find a fair solution to solving our county's debt crisis through a balanced, long term approach.
- When you meet with your member of Congress include sequestration in the discussion and how it would impact nutrition programs and services.
- Read ERW for requests for calls to action.

REFERENCES AND RESOURCES

1. How the Across the Board Cuts in the Budget Control Act Will Work. 2012, http://www.cbpp.org/cms/?fa=view&id=3635
2. The Economic Impact of the Budget Control Act of 2011 on DOD and Non-DOD Agencies. http://www.aia-aerospace.org/assets/Fuller_II_Final_Report.pdf



Breaking Down the Sequestration

The chart below identifies where the genesis of the cuts over time.

SEQUESTRATION DEFINITION:

Washington-speak for agreed upon, mandatory cuts to government spending. This spending is what is contained in the Federal budget.

HOW SEQUESTRATION IS DIVIDED 2013-2021

$109.3 Billion/year in reductions

- $54.7 billion in non-defense
- $54.7 billion in defense
- $21.6 billion in savings to our interest on the debt

WHAT IS NDD?

NDD or "nondefense discretionary" programs are the core functions government provides for the benefit of all, e.g., medical research, education, roads and bridges, food safety, law enforcement and other critical services. NDD represents a relatively small and shrinking share of the Federal budget and our overall economy.

NDD represented 1/5th of our Federal budget and 4.3% Of our economy (GDP) in 2011. By 2022 under current law NDD will decline to just 2.5%, (The lowest level in the past 50 years), while defense would decline to 2.9%.

WHAT ARE SOME OTHER PROGRAM FUNDED BY NDD?

- The prevention and public health fund, which helps to reduce chronic disease
- Conservation efforts and agriculture research including the National Institute of Food and Agriculture (NIFA) and the Agriculture and Food Research Initiative (AFRI)
- Farmers markets and farm to school programs.
- The women, infants and children program

Thank you to our Food & Nutrition Conference & Expo 2012 Sponsors!

Animas (www.animas.com) – Provided a tour of their facility for DCE leaders

Canola Info (www.caonolainfo.org) – Our co-sponsor at our joint DCE/Weight Management DPG reception

Daisy Brand Cottage Cheese (www.daisybrand.com) – Our cosponsor at our Awards Breakfast and our joint DCE/Weight Management DPG reception

McNeil Nutritionals (www.splenda.com) – Our cosponsor at our joint DCE/Weight Management DPG reception

Viocare Technologies (www.viocare.com) – Our lunch sponsor at the Friday DCE Executive Committee meeting

Thank you to Novo Nordisk for being a Premier-level sponsor at FNCE. Special thanks for their efforts to bring Chef Paula Deen to Philadelphia, where DCE members were treated to a breakfast highlighting her new recipes from *Diabetes in a New Light* as well as culinary demonstration in the exposition hall. Paula's diabetes-friendly recipes are available at http://www.diabetesinanewlight.com.

From left to right last row: Susan Yake, RD, CD, CDE, CLC; Susan Rizzo, RD, LDN, CDE; Amy Hess Fischl, MS, RD, LD, BC-ADM, CDE; Lisa Brown, RD, LD, CDE; Andrea Dunn, RD, LD, CDE; Carolyn Harrington, RD, CD, CDE
From left to right front row: Carol Hamersky, MBA, CDE, RD; Betty Kraus, RD, CDE; Liz Quintana, EdD, RD, LD, CDE; Anne Constance, MA, RD, CDE; Amber Wamhoff, MA, RD, LD, CDE
Missing from picture: Maryann Meade, MS, RD, CDN, CDE, DPG Delegate

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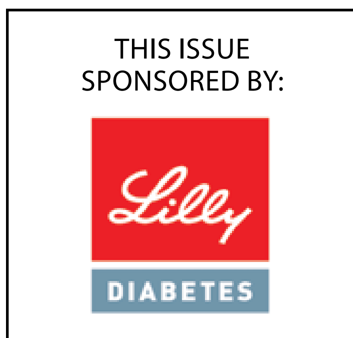

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Get Involved in DCE — We Want You!

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:
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☐ **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.

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