

ON THE **CUTTING EDGE** Diabetes Care and Education

DIABETES AND TOUGH ECONOMIC TIMES

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Message from the Theme Editor: Susan Yake, RD, CD, CDE, CLC
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Changes in the economy hit everyone. Our patients face the difficulties of managing a chronic disease with fewer resources, particularly less money and less health insurance. As registered dietitians we are practiced in connecting patients with appropriate help. But are we equipped to face the really tough times? Do we have resources for those who have lost jobs, lost health insurance, or lost homes? How do we handle the stress of our own job insecurity?

The economic outlook appears grim. Unemployed Americans reached 15.3 million in December 2009 with an unemployment rate of 10% (1). Since the recession started in December of 2007, unemployment has risen by 7.6 million and its rate has doubled. Nearly 46 million Americans are currently without health insurance (2). About one out of every six U.S. residents under age 65 is uninsured for health care. During the last decade, the cost per person of health care has risen over 40 percent. The National Coalition on Health Care estimates that nearly seven million Americans will lose their health insurance coverage during 2009 and 2010 (3).

The number of people covered by private insurance is decreasing; both Medicaid and Medicare increased enrollment by 14% between 2007 and 2008 (4).

In 2008, 7.3 million or 9.9% of children were uninsured with 15.7% of children in

poverty uninsured (4). The Hispanic population is the most likely to be uninsured. In 2008, over 30% of Hispanics (14.6 million) were not covered by medical insurance; 10.8% (21.3 million) of non-Hispanic Whites and 19% (7.3 million) Blacks were uninsured (4).

This issue of *On the Cutting Edge* explores the challenges we are facing in these tough economic times. We begin probing these challenges with an interview with Richard LeMieux who went from wealthy to homeless quite unexpectedly. He opens our eyes to that misunderstood world and provides us with tips on helping the homeless.

Cotton Sarjahani, RD, tackles the challenge of getting nutritious food to all populations. Hailing back to the early "victory gardens," he introduces us to the concept of "civic dietetics" and provokes us to think "outside the box" in our dietetic practices.

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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.

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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.

Our patients cannot learn to eat well to manage their diabetes if they do not have access to food. Kaitlin Hammond, RD, walks us through the programs that are available to help people get enough to eat. Cathy Franklin, MS, RD, explains the changes that have occurred in the Women, Infants and Children Program so that we can help our clients utilize this resource.

Before we can connect our patients to the appropriate resources, we need to know if our patients are struggling with poverty. But, how do we ask them? Gail Brandt, EdD, RD, provides us with helpful interviewing techniques to elicit appropriate information from patients without embarrassing them. Patti Geil, MS, RD, FADA, CDE and Tami Ross, RD, CDE, have created a ready-to-copy patient handout to help guide our patients to eat healthy on a lean budget.

Schools also face difficulties in economic downturns and students often need our help in eating healthfully and managing a chronic disease. Dora Rivas, MS, RD, SNS, discusses the achievements of one school district in Texas in meeting special dietary needs of students. She offers suggestions for working with school districts to ensure that the nutritional and special dietary needs of students with diabetes can be met. Virginia O'Kelly, RD, CDE shares her experience working in a federally-qualified health center that serves primarily low-income Caucasians and Spanish-speaking Hispanic farm workers. Jeffrey Walker, PharmD Candidate, and Michael Fischer, Dietetic Intern, have provided concise information on patient assistance programs that are currently available.

Sandra Parker, RD, CDE, and Julia Walters, RD, CDE, graciously share their story of how the economy took away their dream jobs and what they did to recover.

We hope that this issue will provide you with tools and resources to enhance your practice as well as

increase your awareness of new career opportunities.

The theme team for this issue included Johanna Dwyer, DSc, RD, Jan Norman, RD, CDE, Kelly D. Horton, MS, RD, CD, OTCE Editor Nell Stuart, MS, RD, LD, CDE, and OTCE Associate Editor Elizabeth Quintana, EdD, RD, LD, CDE. I would also like to acknowledge the Hunger and Environmental Nutrition (HEN) Dietetic Practice Group for their outstanding contribution to this issue of *OTCE*. Kelly D. Horton, the current HEN Chair, provided creative inspiration and guidance throughout the whole process; HEN members Cotton Sarjahani, RD and Kaitlin Hammond, RD, contributed articles; and Alison Harmon, PhD, RD, LD, Kim Prendergast, MPP, RD, and Caroline Webber, PhD, RD, served as reviewers.

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Suddenly Homeless, In Search of the Next Meal

An Interview with Richard LeMieux from the Willow Foundation

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Richard LeMieux is an activist and advocate for the homeless in Bremerton, Washington, and founder of the Willow Charitable Foundation which was created to fill gaps in funding for local service organizations that work with homeless people.

Susan: How did you get involved advocating for the homeless?

Richard: Seven years ago I lived out of my car for 3 years and I lived in a church for 1 year. Before I became homeless, I had a dream life: owning a home with a hot tub, three boats, and nice cars. I was a sports writer for 17 years and traveled the world. Then my once-thriving business had a downturn and I lost everything. I wrote about it in my book (1).

In the past, I never looked the homeless in the eyes or saw their heart and soul. I did not think it could happen to me. I did not care. Only when I got there did I realize my own inadequacy and found out who I was. Now I do not view it as a problem, but an opportunity to help someone.

Susan: What was it like being homeless?

Richard: The first 6 months I lived like I was on some sort of vacation. I

could get a meal at McDonalds for \$3. I parked my car at the Clearwater Casino and waited until after 9:00 p.m. when the food was free. I was lost as to what to do. When you first become homeless, it is psychologically devastating and you are in a state of depression and shock causing chemical changes in your body. You lose your identity. Then you start looking for resources for help. I found those resources from other people on the street and from the group that would gather for breakfast at The Salvation Army. We shared a camaraderie hearing one another's problems and helping where we could. I survived on daily miracles like finding a place to eat, to take a shower, or to keep warm. I would go to the library to read a book on cold days.

Breakfast at Sally's is the book I wrote about my experiences at the Salvation Army (1). Life begins with breakfast which is served at noon at the Salvation Army. It is hard to get any meals before then because Sally's and the churches only serve lunch and dinner. The people who come for the meals here in Bremerton mostly live in their cars, out in the woods, at a homeless shelter for men called the Benedict House or the St. Vincent de Paul Women's Shelter. The budget for the meals at the Salvation Army is

38¢ a meal so they rely on donations such as government commodity foods, day-old donuts, and newly-expired sandwiches from vending machines. Sometimes we have oatmeal and cut-up apples. It is pretty much the same whether you are in Bremerton, Saint Louis, San Francisco or New York.

The first time I went to a soup kitchen was to God's Kitchen at the Family of God Lutheran Church. Chicken and mashed potatoes were served. I was so hungry and it was so good that I gulped it down and asked if I could get seconds. The woman serving the meal said, "Yes, if you eat your salad." I learned fast. Mary Ann at God's Kitchen cooks the best lasagna in the world, better than the meals I ate in the finest restaurants in Rome. The most wonderful and compassionate women fix these meals for us. Other foods served by the local churches are turkey, beef and spaghetti—a wide variety of food 5 days of the week. On the weekends some of the homeless have problems getting to the sites where meals are served because of cutbacks in the public transportation system.

Susan: Did you know of anyone with diabetes living on the street?

Table. What Dietetic Practitioners Can Do for the Homeless or Uninsured with Diabetes

Action	Impact on Person With Diabetes
Volunteer at a community health clinic, emergency shelter, soup kitchen, or on National Homeless Person's Memorial Day (1st one was December 21, 2009); offer nutrition education to shelter or soup kitchen staff about dietary needs of homeless clients with diabetes.	Provides MNT or diabetes education for someone who may not otherwise be served; raises dietary awareness of food providers working with clients with diabetes.
Barter your MNT or diabetes education services for a service your client can provide.	Helps someone gain control of their diabetes without the person feeling like they have been given charity.
Organize a food drive or serve on the board of a food bank.	Specifies food items for the needs of those with medical conditions such as diabetes or heart disease.
Start a Willow Fund at work, church or your organization (2).	Pays co-pays for medical care, maintains health with reduced need for emergency care thus saving medical costs and reducing long-term medical complications.
Purchase gas cards or bus tokens and donate them to the Salvation Army.	Provides clients transportation to meals and medical appointments.
Plant a row of vegetables in your garden for the food bank or soup kitchen or help care for the community garden.	Stretches the budget to feed more people nutrient-rich foods.
Donate new socks and tarps to the homeless coalition.	Promotes dry, clean feet, which mean better foot care.
Donate clothing, especially professional clothing.	Helps in job search.
Donate to the scholarship funds of the YMCA and YWCA.	Allows a person to participate in exercise programs and also to take a hot shower.
Collect complimentary soaps, shampoos and toiletries from hotels and donate them to your local homeless coalition.	Enables clients to take care of personal hygiene needs (especially important for job interviews).
Actively participate in public policy by donating to ADAPAC, attending the ADA's public policy workshop, writing letters or visiting lawmakers regarding nutrition and healthcare issues.	Encourages direct involvement with the authorization and appropriation of government programs related to health and nutrition that serve the poor.
Volunteer to help a homeless person fill out paper work to qualify for government programs or refer them to a case manager or social worker who can do so.	Helps them gain access to food, medical care and income needed to provide for basic needs.

ADAPAC = American Dietetic Association Political Action Committee; MNT = medical nutrition therapy; YMCA = Young Men's Christian Association; YWCA = Young Women's Christian Association.

Richard: Yes, one of them did not take care of himself and he died. Another got help from the Kitsap Community Resource and Salvation Army who referred him to Peninsula Health, our local public clinic that serves the poor and underinsured. If he needed to keep his insulin cool, he would put ice in a bag.

Another problem for those with diabetes is wet feet, especially if it has been rainy. There may be no opportunity to dry out the shoes if it is the only pair. Other problems include wearing the wrong-sized shoes, not having an extra pair of socks or wearing socks that may have holes in them. People on the street tend to wait until they are real sick before they get medical care.

Susan: What are some of the barriers to getting health care?

Richard: Barriers are transportation and the cost of co-pays which are usually \$20. Homeless people generally get \$333 per month here in Washington on the state welfare program, plus the support they get from food stamps. By the end of the

month the money runs out. Many of the homeless have problems filling out paperwork to qualify for government programs. For instance, if they failed to complete a tax return they will not qualify for government assistance. I was one of the few who had a car. Some days I was the taxi and some days I was the ambulance ride to the hospital emergency room. The Willow Fund named after my dog was started to pay the co-pay for the Peninsula Health Clinic in an effort to cut back on the use of the emergency rooms.

Susan: What are some of the changes you have seen in recent years?

Richard: Twenty years ago most of the homeless were drug- or alcohol-addicted men on the street who had lost their teeth. Now women with children are the fastest growing group of homeless, making up about 25% to 27%. When I speak about poverty at the schools, I ask the children who are homeless to raise their hands. I am always surprised to see how many there are.

The last 4 years have brought an increased awareness of the needs for food and housing for the homeless. There are more new people becoming homeless every day—living in conditions like those in a Third-World country.

Susan: How can we help?

Richard: It takes a large support system with people acting like a mother and father to get someone off the streets. You have to love the person and find ways to help him or her. The good news is since the recession, people are more attuned

and therefore more compassionate, and willing to help. They are pulling together to take steps to end homelessness as we know it. Next time you see a homeless person, look them in the eye and say a kind word.

Whatever your talents are, try to use them at least 1 day a month to make a difference. We are at our best when we are helping other people. This simple act has the capacity to positively impact your town, state and country in many ways. I use my talent as a fundraiser for the Willow Foundation (2). We raised enough money to open the Willow Mission in Buffalo, NY, a homeless shelter and soup kitchen. You can donate food, clothing, money or your time.

I also serve on the board of the local food bank. I remember that the first time I went to a food bank they gave me canned food. I did not have a can opener so I was unable to eat it. Now when a homeless person comes to the food bank, they are asked if they have a can opener. Some food banks, such as the Thurston County Food Bank in Olympia, WA (3), offer special food packages for the homeless and for people who have diabetes. Registered dietitians can serve as advisers for the special nutritional needs of those with medical conditions. You can donate produce from your own yard or get involved in a gleaning program gathering fruits and vegetables that would otherwise go to waste.

Our local Kitsap Continuum of Care Coalition has a pamphlet called *56 Ways to Help the Homeless in Kitsap County* (4) listing ideas from the homeless on the best ways to help

them. Other localities have similar publications.

Susan: Thank you, Richard, you have been most enlightening. I found a similar list from the National Coalition for the Homeless (5) online.

Summary

To help people in need, sometimes we need to go beyond our traditional scope of dietetic practice (Table). We stretch our imagination and seek creative solutions to problems. We become engaged. We become better people and practitioners. While helping others, we are transformed.

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Civic Dietetics, Community Gardening and Food Recovery

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Edible Gardening

Theodore Roosevelt once said, “Do what you can, with what you have, where you are.” Mr. Roosevelt’s quote is especially meaningful in a depressed economy. Growing some of our own food—commonly referred to as “edible gardening”—requires only healthy soil, clean water, sunlight, seeds, and a bit of human labor. These easily accessible resources can produce delicious, healthy, fresh and local produce. Edible gardening, as a means to supply locally grown, fresh produce, has long been part of human nourishment. This spring, both the White House and United States Department of Agriculture (USDA) announced that they would be planting Victory Gardens with most of the produce going to local food pantries (1,2). The San Francisco City Hall has also followed suit (3).

Food Recovery

Another means to making the most of what we have during economic turmoil is food recovery. Food recovery involves taking excess food production from food service institutions and restaurants, and diverting this food to local food pantries and food banks to feed hungry members of the community. The food recovered must meet criteria of the Bill Emerson Good

Samaritan Food Donation Act of 1996. In 1995, around 5.4 billion pounds of food were lost at the retail level with approximately half of that amount being fresh produce and dairy products (4). During the same year, approximately 91 billion pounds of food were lost by consumers and foodservice, with fresh fruits and vegetables accounting for nearly 20% of the loss (4). A substantial portion of the losses can be attributed to expiration dates, food spoilage and excess production. It is not uncommon for restaurants and institutions to prepare more food than is needed during meal shifts, leaving an excess of perfectly edible and mostly nutritious food that may not be served again. Under the Bill Emerson Good Samaritan Act of 1996, institutional and retail food donors are absolved of liability for food donations to food pantries and food banks that meet certain criteria (5). Most restaurants and institutions aim to prepare high-quality food that usually includes lean protein, whole grains and/or fresh produce—all of which are crucial components of a healthful diet.

Whole foods that are minimally processed with little packaging are integral to a healthful and sustainable diet (6). Most food banks or food pantries contain

nonperishable, highly-processed foods that serve to provide calories but very little nutrients. While these foods are advantageous for shelf-life, they are not the whole foods that public health professionals recognize as essential for a healthful diet. Because processed foods have an extended shelf-life, rarely does one see fresh produce or lean proteins in a food pantry or food bank—much less local, seasonal and organic produce. Both edible gardening and food recovery have the ability to increase access to whole foods.

Civic Dietetics

Wilkins (7) introduced the concept of “civic dietetics” as “bridg(ing) the gap between traditional dietetic practice and nontraditional areas such as local, state and federal policy; community economic development; and food system assessment to address food and nutrition problems.” Registered dietitians (RDs) in every sector of practice have an opportunity to positively influence the health of their communities through civic dietetics. Advocating and working to initiate community gardens and food recovery efforts are two examples of how RDs can practice civic dietetics in their communities. While these efforts are especially critical during tough

continued on page 8

economic times, they are appropriate for any RD who seeks to improve the health of his or her community at any time.

Literature Review

Journalist and professor Michael Pollan (8) refers to the new Victory Garden movement as a means to achieve “victory over high food prices, poor diets and a sedentary population.” The Environmental Protection Agency (EPA) has a “food waste recovery hierarchy” that lists food recovery (listed as “Feed Hungry People” as the second option, the first option being “Source Reduction”) when dealing with excess food (9).

During the original Victory Garden movement initiated by Eleanor Roosevelt, approximately 40% of the fresh produce eaten in the United States was produced by some 20 million edible gardens across the country (8). Given the opportunity, edible gardening can be a significant contributor of nutritious food in all populations. Beyond the question of food production is the question of food consumption. In other words, will the produce be consumed simply because it was produced? Researchers have shown that participants in a community garden are likely to consume more fresh vegetables and less sweet snacks than non-gardeners (10), and that an increase in fruit and vegetable intake is associated with a decrease in development of certain chronic diseases (11). McCullum provides an extensive review of the literature addressing sustainable agriculture and its relationship to human nutrition and health (12). In this review, McCullum addresses increased fresh produce consumption and community gardening; community gardening

and ties to community; community gardens and low-income populations; and community gardening and physical activity. Holben suggests that RDs can play a leadership role in increasing food security in communities and lists community garden development as a way in which this can be done (13). California Healthy Cities and Communities listed the following factors as important to a successful community gardening project: commitment of local leadership and staffing, involvement of volunteers and community partners, and availability of skill-building opportunities for participants (14).

A study conducted in 2008 found that excess production accounted for 187.5 pounds of food waste per meal in an all-you-can-eat facility (15). Situations like this are not uncommon (15). Food recovery is an alternative that can simultaneously reduce waste and nourish a human being. The San Francisco Commercial Food and Organics Recycling case study is one model for a city-run food recovery effort. In 1999, 3,000 tons of food were re-distributed in the community, of which approximately 500 tons were fresh, edible produce (16).

In Practice

RDs have many opportunities to aid in implementing community gardening and food recovery efforts in their communities, regardless of the setting. Partnering with area nonprofits, churches, student groups and other volunteers to plan, organize and implement a community garden on or near your facility is a good example of a project or initiative in which an RD can take the lead. RDs can advise patients or clients on the many health (and

economic) benefits of edible gardening and point them to resources such as the American Community Gardening Association’s Web site (www.communitygarden.org) or Barbara Damrosch’s, *The Garden Primer*.

Another “outside the box” educational method for encouraging a healthful diet addresses food waste. Addressing food waste in your facility and/or with your patients and clients will prove to be economically beneficial and will also hopefully prevent edible, nutritious food from going to waste. If your facility does not currently have a food recovery program, work with colleagues and community members to begin laying the foundation. The EPA’s *Waste Not, Want Not: Feeding the Hungry and Reducing Solid Waste Through Food Recovery* is a comprehensive guide on how to initiate and implement a food recovery program in restaurants and institutions. Organizing a community meeting and providing local foodservice and retail companies with these resources and a suggestion of a community-wide effort would be an example of civic dietetics. Moreover, coming from an RD, these suggestions will not only hold credibility, but also enhance the RD’s relationship with the community.

The high-quality fresh food that results from the aforementioned efforts will be helpful in nourishing patients and clients with diabetes. The leafy greens produced during the spring and fall can provide a low-calorie, low-sodium source of vitamin K, magnesium, potassium and B vitamins. Carrots in the summer and fall provide beta-carotene to the diet. What matters most is that low-income patients and clients with diabetes have access to

fresh produce, lean proteins and whole grains as a result of these efforts.

Conclusion

During tough economic times we must be innovative and creative in our approaches to getting nutritious food to all populations. Community gardening and food recovery are two proven approaches to help reach this goal. Each approach can provide nutritious food for populations who need it most. Consistently acknowledged as the nation's "food and nutrition experts," RDs have been given both respect and responsibility. The respect RDs have garnered allows for effectiveness in improving public health at the local, state and national levels. The responsibility given to RDs calls for us to be engaged in the eating environment, the food and agriculture system and the policies associated with them.

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CPE CREDIT ANSWER KEY

See the CPE credit self-assessment questionnaire on page 31.

1. D
2. C
3. C
4. D
5. E
6. F
7. D
8. C
9. D
10. D
11. A
12. D

Getting Enough to Eat: Public and Private Food Assistance Programs

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Abstract

Diabetes is expensive. Purchasing food to support a healthful diet is just one of the costs associated with managing the disease. Diabetes health care providers can refer patients to public and private food assistance programs to relieve financial burdens in tough times. Participation in some programs may require specialized diet instruction to accommodate foods that might not regularly be part of a patient's diet. Registered dietitians can also lend their expertise to expand nutritious options at local emergency food assistance organizations.

Introduction

In the current economic climate, a growing number of people are forced to make difficult decisions about how to spend their money. For most, spending categories include rent, electricity, transportation, food and recreation. People with diabetes must consider additional costs; medical visits, medications, blood glucose meters, test strips and healthful foods are no less expensive and no less important when money is scarce. This article addresses eligibility requirements and nutritional quality of various food assistance programs that can assist patients who are financially struggling. Registered dietitians (RDs) can direct their patients to these food assistance programs to support a healthful diet and help relieve some of their economic strain.

Food Assistance Programs and Eligibility Requirements

Many public and private food assistance programs are available to low-income families and individuals. Relevant public food assistance programs and their income eligibility requirements are summarized in Table 1 (1). Public assistance programs vary in the degree of assistance provided, populations served and types of food offered. The Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps, serves all ages. Programs targeting children ages 18 years and younger include the National School Lunch Program (NSLP), the School Breakfast Program (SBP), the Special Milk Program (SMP) and the Summer Food Service Program (SFSP) (2-4). The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides assistance to mothers and young children, while commodity distribution programs like the Commodity Supplemental Food Program, the Food Distribution Program on Indian Reservations (FDPIR) and The Emergency Food Assistance Program (TEFAP) reach out to populations of all ages (5-8). In addition, Farmers Market Nutrition Programs are available to WIC participants and seniors in over 45 states (9).

All public programs listed in Table 1 use income thresholds ranging from

100% to 185% of the federal poverty guidelines to determine eligibility. Table 2 shows four monthly income thresholds commonly used to determine eligibility (10). Notice that a single-person household earning \$1,670 per month (approximately \$771 every two weeks) is at 185% of the poverty level. A small increase in earnings could jeopardize crucial assistance without providing enough income to cover the cost of the lost benefits. Diabetes providers may encounter patients who are financially struggling but do not qualify for public programs because their incomes exceed 185% of poverty.

Fortunately, many private organizations offer assistance to individuals who may not qualify for public assistance but are experiencing low food security because of financial constraints. Food banks and pantries that do not participate in TEFAP are not limited by government guidelines and may set income thresholds above 185% of poverty or eliminate income requirements altogether. Food banks and pantries that offer commodities through TEFAP must adhere to the government income eligibility guidelines. However, such organizations may offer emergency assistance at least once before verifying program eligibility.

Other programs such as Angel Food Ministries and SHARE Food Network

Table 1. Public Nutrition Assistance Programs (1)

<p>Supplemental Nutrition Assistance Program (SNAP) (2)</p>	<p>Formerly known as the Food Stamp Program, SNAP helps families purchase food at the grocery store for home preparation. Eligibility guidelines require that gross income must not exceed 130% of poverty and net income must not exceed 100% of poverty. Those eligible for SNAP benefits are also qualified to receive SNAP-Ed nutrition education to encourage healthy food and lifestyle choices.</p>
<p>School Meal Programs (3)</p>	<p>The National School Lunch Program (NSLP), the School Breakfast Program and the Special Milk Program offer low-cost or no-cost meals and food items to children in public and private nonprofit schools as well as residential childcare centers. Children living in households earning 130% of poverty or lower qualify for free meals, while those living in households earning between 130% and 185% of poverty are eligible for reduced-price meals. All children are eligible to purchase meals regardless of income.</p>
<p>Summer Food Service Program (SFSP) (4)</p>	<p>SFSP is designed to replace school meals during the summer. The program is typically offered at day camps, parks, churches and community centers in areas where 50% of the children attending the local schools qualify for free or reduced-price meals. The program is available to all children ages 18 years or less regardless of income as program eligibility is most often determined by geographic location.</p>
<p>Special Supplemental Nutrition Program for Women, Infants and Children (WIC) (5)</p>	<p>WIC offers nutritious food packages for pregnant, breastfeeding and postpartum women as well as children up to age 5 who are at risk of malnutrition. Additionally, WIC clients receive nutrition education to make healthy food and lifestyle choices. Income eligibility accommodates incomes up to 185% of poverty.</p>
<p>Commodity Supplemental Food Program (CSFP) (6)</p>	<p>CSFP provides nutritious commodities on a monthly basis to low-income seniors, and women and children not participating in WIC.</p>
<p>Food Distribution Program on Indian Reservations (FDPIR) (7)</p>	<p>Commodities are also available to low-income households living on Indian reservations and Native American families living near reservations and in Oklahoma through FDPIR. Income eligibility is set at just above 100% of poverty.</p>
<p>The Emergency Food Assistance Program (TEFAP) (8)</p>	<p>TEFAP makes commodities available to individuals through local organizations like food banks and soup kitchens. States are allowed to adjust income criteria to make certain that only households in the most need are served. In Texas, eligibility is defined at 185% of poverty and below. Check with your state for specific guidelines.</p>
<p>WIC and Senior Farmers Market Nutrition Programs (9)</p>	<p>WIC participants and seniors with incomes at or below 185% of poverty are eligible to receive cash vouchers for fresh, unprepared, locally grown produce and herbs. Participants receive \$10-\$30 per year to obtain food from farmers' markets, individual farmers or roadside stands approved by the State agency implementing the program.</p>

pool member resources to leverage purchasing power, effectively acting as cooperatives (11,12). Such programs have no income eligibility requirements, but participation may be limited by the geographical constraints of the organizations. Angel Food Ministries has 5,200 host sites nationwide while SHARE Food Network serves only Maryland, Virginia and West Virginia. Membership costs average approximately \$25 each month

depending on the organization. Members receive one delivery of food at 38% to 71% of the retail cost of the items. Both organizations accept SNAP benefits so SNAP recipients can leverage their food dollars by participating in these programs.

Food Availability and Diet Quality

Among all public and private food assistance programs, SNAP provides the most freedom of choice by

allowing participants to buy grocery items as well as seeds and plants to produce food for home consumption (2). Despite the freedom to purchase healthful foods, SNAP participants, like most Americans, under consume vegetables, whole grains and healthy oils, but over consume sodium (13). To encourage positive food behaviors among SNAP participants, the government provides funding for SNAP Education (SNAP-Ed). Through SNAP-Ed, individuals eligible for

SNAP benefits can receive nutrition, cooking, food safety and food resource management education (14). SNAP-Ed implementation varies by state but is commonly administered by local agencies such as Cooperative Extension, food banks and county governments. Messages must focus on public health and disease prevention and cannot include medical nutrition therapy (MNT). Therefore, participants with diabetes often receive generalized nutrition information in place of the individualized diet planning that is classified as MNT.

School-year and summer-meal programs for children must follow strict meal patterns outlined by the Guidelines for Meals and Snacks of the U.S. Department of Agriculture (3,4,15). Lunch and supper meals must include 8 oz of fluid milk, ¾ cup (total) of fruits and/or vegetables, one serving of grain and 2 oz of meat or meat alternative. This has the potential not only to deliver high nutritional quality but also to be “carbohydrate-rich” depending on fruit, vegetable and meat alternate choices. For example, one meal could include bread served with a sweet spread, fruit canned in heavy syrup, starchy vegetables, milk and finally beans as a meat alternative.

The newly revised WIC food package aims to include foods with specific nutrients important for mothers and children (5). WIC food packages are described in more detail in another article in this newsletter on page 17.

Commodity distribution programs offer various foods throughout the year, and the availability may depend on the ordering decisions of those operating the programs locally (6-8). A list of available commodities can be found online at each program’s Web site. The senior and WIC Farmers Market Nutrition Programs offer fresh produce and herbs that are locally grown and available at farmers’ markets and individual farmers’ and

Table 2. Gross Income Thresholds Commonly Used in Food Assistance Programs 2009-2010 (10)

Household Size	100% Poverty	130% Poverty	185% Poverty	200% Poverty
1	\$903	\$1,174	\$1,670	\$1,806
2	\$1,215	\$1,579	\$2,247	\$2,430
3	\$1,526	\$1,984	\$2,823	\$3,052
4	\$1,838	\$2,389	\$3,400	\$3,676
5	\$2,150	\$2,794	\$3,976	\$4,300
6	\$2,461	\$3,200	\$4,553	\$4,922
7	\$2,773	\$3,605	\$5,130	\$5,546
8	\$3,085	\$4,010	\$5,706	\$6,170
Each Additional Member	\$312	\$406	\$577	\$624

roadside stands approved by the state agencies that implement the program (9).

While some food pantries provide prepackaged food boxes with various donated foods, others offer a client-choice model in which individuals get to select the foods they find useful. Some models are complex and are arranged like grocery stores with maximum client freedom. Other models offer a selection between two different foods at a time. For example, a client may have the option to choose between rice and pasta, and then choose between diced tomatoes or canned green beans and so on. Angel Food Ministries and SHARE Food Network also provide choices for members by posting the monthly menu on their Web sites so that members can preview items before signing up (11,12). Viewing the food list in advance offers recipients the opportunity to make advance meal plans to ensure the food does not go to waste.

Clinical Application

Understanding food assistance opportunities is valuable for dietetics practitioners. RDs should discern the degree of food-choice freedom afforded to the individual by considering where and how a patient obtains food as well as the resources

available for food purchase. Nutritional intervention should be tailored to assist patients in maximizing healthful foods while minimizing costs. Someone who relies on prepackaged food assistance may receive unfamiliar foods and therefore benefit from recipes and instructions on incorporating specific foods into a suitable meal plan. Someone who receives SNAP benefits may be helped by food resource management and meal planning education to maximize food purchasing power from month to month.

In addition to tailoring nutritional advice, knowledge of food assistance programs can assist diabetes care providers in referring patients to programs that fit their needs. Many patients who struggle to put food on the table may earn well over 185% of poverty and be ineligible for participation in public programs. Clinicians have the opportunity to educate patients about private programs that may be an option for them.

RDs also have the unique opportunity to offer to private programs their expertise with food package preparation, meal planning and nutrition education. The Washington Food Coalition (WFC) is an excellent example of an

emergency food assistance program. A publication developed by the WFC includes a section on food and nutrition that highlights best practice emergency assistance programs that respond to community needs in the following ways:

- building relationship with farmers and food growers to increase the amounts of fruits and vegetables offered
- accommodating individuals with special diets or food preparation equipment limitations by providing customized food packages
- responding to requests for staple foods from ethnic groups
- limiting distribution of foods considered to be of low nutritional quality

Food banks, pantries and soup kitchens vary in size and may be unable to afford nutrition staff to implement the strategies mentioned in the report. Reaching out to local organizations to develop specialized food packages, meal plans or nutrition education for people with diabetes can strengthen the resources for patients and improve overall community health.

Summary

Diverse opportunities exist for patients in need of food assistance. Public and private options offer varying degrees of support for people of all ages. Many patients may qualify for public programs, and private programs are available for those who do not. Diabetes care providers should become familiar with the programs to make referrals and provide diet instruction that supports food resource management principles that help clients stretch their food dollars. Finally, RDs can act as advocates for their patients and community. By collaborating with local programs, dietitians can help their clients optimize food choices and improve their health through food distribution and nutrition education.

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Interviewing Low-Income Clients

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Introduction

Low-income patients often face additional challenges that may not be obvious to the registered dietitian counseling them. These patients may live in neighborhoods without supermarkets. They may have long commutes to work leaving them without enough time to prepare meals. They may lack budgeting, shopping and food preparation skills. In addition, they may deplete their food supply before it is time for more resources to be available. If these patients have insufficient knowledge of community resources and how to access them, then the end of the month can be quite challenging.

Interviewing Tips

Registered dietitians are often at a loss as to how to elicit client information without being offensive or seeming to be condescending. When interviewing low-income clients, consider adapting the following statements and questions to elicit important information.

- **Describe your kitchen.**

You will learn if the patient has the standard appliances. If not, you will

need to modify your recommendation for food preparation. Ask if your patient receives Women, Infants and Children (WIC) or Senior Farmers' Market program vouchers to supplement the diet.

- **Does your refrigerator's freezer keep ice cream hard?**

If the answer is "No" then you should not suggest purchasing or preparing food in bulk and freezing. The food will not last very long and maintain quality and safety.

- **Where do you usually shop for food?**

You will learn if your patient has access to a supermarket or full service grocery store. If not, your patient may be relying on small local convenience stores, with a limited selection and high prices.

- **Some fast food restaurants are starting to provide nutrition facts. What information will help you select foods?**

This question may reveal if your patient eats at fast food restaurants. Through probing, you can find out what foods are selected. Then you can offer healthier alternatives.

- **It is getting more common for people to run out of food before the end of the month. If this happened to you what would you do?**

You will find out if your patient does run out of food and is aware of community resources to help.

- **How do you rate yourself as a cook?**

Cooking as well as knowing how to prepare a budget, shop and properly store foods are skills acquired through mentoring and practice. Find out if your patient has these skills. If not, the patient may not know how to prepare foods at home and must rely on convenience foods and fast food restaurants.

The ready-to-copy educational material on the next page is available at www.dce.org/members/publications/OTCE to download and print.

Diabetes Care and Education

a dietetic practice group of the
American Dietetic
Association



Healthy Eating on a Lean Budget: Top Ten Saving \$strategies for People with Diabetes

Limit impulse purchases. Go to the store with a shopping list – and stick to it!

Buy in season. Blueberries are a cheap treat in the summer but practically an investment once it's fall. Consider growing some of your own produce as well.

Use coupons. Sign up for your supermarket's shopper discount card too.

Purchase sale items in bulk. Use the same main ingredient and dress it up differently. Turn ground beef into chili, burritos and a topping for baked potatoes. Plus, freeze some beef for the weeks to come.

Buy generic. Follow this rule except when you know a certain brand is of higher quality. A major national brand of sliced Swiss cheese recently sold for \$4.49 per half pound versus \$3.49 for the store brand.

Think whole foods. The more processed foods you buy, the higher the price. Even a banana in pricey New York City only costs a quarter whereas a small candy bar costs at least 75 cents.

Do it from scratch. You pay more for convenience. Grate your own cheese and shred your own lettuce.

Shift those portion sizes. Use pricey meats as an accent, not the main event. For instance, skip the pork chops and cook up a pork stir-fry.

Load up on beans. Meat is expensive. A pound of 85% lean ground beef costs \$3.29. A 1 pound can of black beans? A mere 50 cents!

Shop at wholesale food stores. Some examples include Sam's Club or Wal-Mart Superstores. Make sure you know prices, though, to guarantee a savings.

From: *Diabetes Meals on \$7 a Day – or Less!* (used with permission.)

Patti Geil, MS, RD, CDE and Tami Ross, RD, CDE

American Diabetes Association, 2007 (2nd Edition)

Available on www.amazon.com or www.diabetes.org

Changes to the Women, Infants and Children Program with Implications for Diabetes Management

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Abstract

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) implemented a new federal rule that may have a positive impact on the prevention and management of diabetes for its participants. The foods included in the WIC program are now lower in calories, saturated fats and cholesterol; higher in fiber; and more nutrient dense. WIC policies have been strengthened to be more supportive of breastfeeding. These changes may benefit women and children with diabetes and women with gestational diabetes, as well as contribute to the prevention of obesity and related chronic diseases.

Introduction

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) recently implemented a new federal rule to improve the diets of their participants. WIC foods are now lower in calories, saturated fats and cholesterol and higher in fiber. They include foods with higher nutrient density, such as fruits, vegetables and whole grains. WIC has long been a strong supporter of breastfeeding. The new food rule will further strengthen the program's already robust breastfeeding promotion efforts (1). Because low-income women and children are at

higher risk for obesity and diabetes than the general population, these changes will promote the prevention and management of diabetes for WIC participants in tough economic times (2-4).

Program Overview

For over three decades, WIC has been a key component of the national nutrition safety net provided by the federal government. WIC serves pregnant, breastfeeding and postpartum women as well as children up to age 5 years from families with household incomes at or below 185% of the federal poverty level. The goal of WIC is to provide children a healthy start from the prenatal period until age 5 years, a period critical for children's growth and development (5). WIC works adjunctively with other programs, such as Medicaid and the Supplemental Nutrition Assistance Program, which have higher income eligibility criteria in some states. WIC is provided by 90 state agencies (50 states, 34 Indian Tribal Organizations, and 6 territories) at over 10,000 clinic sites. In fiscal year (FY) 2008, 8.7 million women, infants and children participated in WIC per month. The federal funding was \$6 billion, with more than 46,000 retailers accepting WIC checks (6). Many more women and children are eligible for and

participate in WIC as a result of the recent downturn in the economy. In FY 2009, the monthly average participation rate as of July was 9 million with an approved FY 2009 funding of \$6.86 billion. For FY 2010, Congress has approved a 5% increase in funding in anticipation of increased need.

The WIC program improves the health of women, infants and children through a unique combination of services including nutrition risk assessment, nutrition education and counseling, breastfeeding promotion and support, referrals to health care and other social services and checks for specific nutritious foods. With the new food rule, WIC is expected to be even more effective in the prevention of obesity and related chronic diseases.

Changes in WIC Foods

Another significant change allows participants to purchase fruits and vegetables. Higher fruit and vegetable intakes are known to be associated with lower rates of obesity (7-9). Lower income families tend to consume fewer servings of fruits and vegetables (10,11). Also introduced into the program are whole grains, which include whole wheat bread, corn tortillas, brown rice, oatmeal, bulgur wheat and barley.

Higher whole grain consumption is associated with improved insulin sensitivity and reduced risk of developing type 2 diabetes (12). WIC now must ensure that at least one half of the total number of breakfast cereals on a state agency's authorized food list have whole grain as the primary ingredient by weight.

Allotment of the WIC food package staples has now been reduced.

In most states WIC participants previously could choose milk with any fat level from whole milk to skim milk. With the new food rule, women and children over age 2 years can select only lower fat milk—2 percent or less. Some states have mandated that milk purchased by WIC must be 1 percent or less. Whereas previously WIC participants could substitute milk for up to 4 pounds of cheese in their monthly allotment, now, cheese substitution is restricted to only 1 pound. More cheese is allowed if a health care provider determines it is needed for a specific medical diagnosis such as lactose intolerance. Some other changes that potentially affect obesity and diabetes prevention and management are listed in Table 1.

The WIC Program and Breastfeeding

Research over the past 15 years has heightened awareness of the importance of breastfeeding for lifelong health and disease prevention including reducing the risk of obesity and diabetes. A study by Moreland and Coombs suggested that *not* breastfeeding is associated with a 40% increased risk for maternal and child type 2 diabetes (13); another study showed a 25% increase in risk for obesity in children (14). Children who are not breastfed are at higher risk of increased rates of infections, diarrhea, sudden infant death

syndrome, asthma and childhood leukemia (15). Mothers who do not breastfeed are shown to have higher rates of type 2 diabetes and breast and ovarian cancer (15). A 2009 study of nearly 140,000 women found that women who breastfed for a minimum of 1 year were 10 to 15 percent less likely to have diabetes, hypertension, high cholesterol, and cardiovascular disease than those who never breastfed (18).

The cost of not breastfeeding is estimated to be \$475 per nonbreastfed infant in the first year of life (16) and \$12 billion per year related to premature deaths and other diseases and conditions (17).

A top priority of the WIC program is to increase the number of new mothers who exclusively breastfeed their infants for a minimum of 6 months. The American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for 6 months and breastfeeding with complementary foods for at least 1 year. AAP also supports hospital practices that protect exclusive breastfeeding and discourage distribution of free formula. Early formula use is associated with lower breastfeeding rates and early weaning (19). The new food rule renews WIC's efforts to support exclusive breastfeeding by discouraging formula use in the early weeks for breastfeeding infants. WIC educates mothers on the importance of exclusive breastfeeding to their child's health as well as the negative impact of formula on breast milk production. The new food rule does not allow breastfed infants younger than 1 month of age to receive formula from WIC without a thorough evaluation of their need for breastfeeding support and problem resolution. Lastly, the new food rule provides the most volume

and diversity of food to exclusively breastfeeding mothers. The value of the monthly food package for these women provides an economic incentive for exclusive breastfeeding. These incentives are highlighted in Table 1.

Conclusion

In addition to improving access to more healthful foods, the new rule strengthens WIC's focus on breastfeeding. The new food rule provides an opportunity to improve the health of low-income women, infants and children, while preventing obesity and related chronic diseases.

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Table 1. Examples of Food Package Changes to the Women, Infants and Children Program (Effective October 2009)*

	Exclusively Breastfeeding Women		Nonbreastfeeding Postpartum Women		Children	
	Before	Now	Before	Now	Before	Now
Milk	28 qt	24 qt, 2% or less only	24 qt	<i>16 qt 2% or less only</i>	24 qt	<i>16 qt 2% or less only</i>
Cheese	Up to 4 lbs	1 lb only	Up to 4 lbs	<i>1 lb only</i>	Up to 4 lbs	<i>1 lb only</i>
Eggs	2 dozen	2 dozen	2 dozen	<i>1 dozen</i>	2 dozen	<i>1 dozen</i>
Juice	336 oz	144 oz	192 oz	96 oz	288 oz	128 oz
Cereal	36 oz	36 oz, <i>state agency's list must contain half whole grain choices</i>	36 oz	36 oz, <i>state agency's list must contain half whole grain choices</i>	36 oz	36 oz, <i>state agency's list must contain half whole grain choices</i>
Peanut butter (pb)/dried beans	18 oz pb or 1 lb dried beans	18 oz pb and 1 lb dried beans (or 36 oz pb or 2 lb dried beans)	18 oz pb or dried beans	18 oz pb or dried beans	18 oz pb or dried beans	18 oz pb or dried beans
Whole grains	None	16 oz	None	None	None	32 oz
Fruits and vegetables	1 lb carrots	<i>\$10 in cash value vouchers</i>	None	<i>\$10 in cash value vouchers</i>	None	<i>\$6 in cash value vouchers</i>
Tofu	None	Up to 4 lbs may substitute for milk	None	Up to 4 lbs may substitute for milk	None	With prescription may substitute for milk
Soy beverage	None	May substitute all milk for soy beverage	None	May substitute all milk for soy beverage	None	With prescription may substitute for milk
Canned fish	25 oz tuna	30 oz tuna or other as allowed by each state (salmon, sardines)	None	None	None	None

* Changes that increase healthful foods to help prevent or manage obesity and diabetes are italicized. Changes that are incentives for breastfeeding are in bold. Key: qt = quart; lb = pound; oz = ounce; pb = peanut butter

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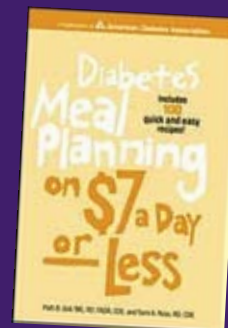
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Book Review

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***Diabetes Meals on \$7 a Day-Or Less! How to Plan Healthy Menus without Breaking the Bank.*
2nd ed. By Patti B. Geil, MS, RD, CDE, FADA, and Tami A. Ross, RD, LD, CDE; Alexandria, VA:
American Diabetes Association; 2007.**

Have any of your patients said that it costs too much to eat healthfully? The solution can be found in the new edition of *Diabetes Meals on \$7 a Day-Or Less!* which provides plenty of ideas on how to eat better on a budget. Using the American Diabetes Association nutrition recommendations, the book guides the readers through penny-wise meal planning, creative cooking, thrifty shopping tips, growing a garden, and even eating out on a lean budget. The book calls this approach "Pyramid Penny-Pinching." Whether it is learning how to make do-it-yourself 100-calorie packs at half the cost or finding the best buys in the supermarket, this book is for those of us who want to save money on food and improve our health. The recipes include a cost analysis along with the nutritional breakdown and exchange values. They include such delicious items as Tropic Slushy, Feisty French Onion Soup, Caribbean Sunrise Smoothie, Hawaiian Quesadillas and Chocolate Lovers' Frozen Mousse.



Addressing Dietary Needs of Students in a Difficult Economy

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Abstract

Growing up in South Texas in a family with diabetes-related medical issues, and now as a food service director and registered dietitian, I am sensitive to the needs of students with special dietary concerns, particularly students with diabetes. Our school meal patterns allow students and parents to work alongside the school nurse and cafeteria staff to ensure that special dietary needs are met. Managing diabetes is a challenge, especially in these difficult economic times. However, certain resources are available which help patients make healthy meal choices and control blood glucose levels. This article explores how one school district has addressed special dietary needs of students and how registered dietitians can work with school districts to ensure that the nutritional and special dietary needs of students with diabetes are met even in uncertain economic times.

Background

The Centers for Disease Control and Prevention (CDC) prevalence data released in 2008 estimates that diabetes has affected 24 million people in the United States. This is approximately 8% of the population. Another 57 million people are estimated to have prediabetes (1). In Texas, as of 2008, 1.7 million people were affected by the disease, which

is 9.7% of the adult population of the state (2). It is estimated that 186,300 people in the youth population aged 20 years and younger have diabetes, with 13,000 new cases of type 1 diabetes being reported each year. Based on data from the SEARCH for Diabetes in Youth study, the overall prevalence of diabetes in the youth population is 22 cases per 100,000 children. Although type 1 diabetes is the form of the disease primarily affecting those younger than 20 years, the increasing incidence of obesity is resulting in an increase in type 2 diabetes cases. Although the number of people aged 18 years or less with type 2 diabetes has increased in recent years as in the rest of the country, representative data are not available for the state of Texas (2-4).

The guidelines of the U.S. Department of Agriculture (USDA) make it possible for children of parents who are unemployed, have low income, or have large families to qualify for free or reduced-priced meals. Child nutrition programs are subsidized for those families in need within 185% of the poverty guidelines. Students who qualify under the supplemental nutrition assistance programs (SNAP) are entitled to benefits under the school nutrition program. The guidelines are modified annually for changes in the cost of living (5).

According to results in the School Nutrition Association's comprehensive "School Nutrition Operations Report: The State of School Nutrition 2009," nearly 60% of districts increased their school lunch prices this year to keep up with the cost of preparation (6). Dallas Independent School District (DISD) figures show an increase in the number of students qualifying for free and reduced-priced meals by 1% each year for the last 6 years. In 2008, the increase was 2%. This indicates that more students are accessing school meals during difficult economic times.

Diabetes in Dallas Independent School District

Currently, more than 200 students are documented as having a diagnosis of diabetes in DISD. Of these, approximately 10% have type 1 diabetes. This is reflective of the trends in the general population (7). This may be because of greater incidence of type 2 diabetes in minority populations, complacency in the community regarding the obesity issue, or, despite the current focus on the obesity epidemic, misunderstanding of the impact of obesity on health. For that reason outreach programs and services continue to be of dire need. DISD is working to improve services and programs by adding nutrition professionals to the food and child

nutrition program staff. The increase in dietary needs over recent years has led the department to hire a full-time registered dietitian to work with nurses and parents in helping parents make proper selections for their students.

Currently DISD offers a free online cafeteria menu planning tool that allows parents and students to make informed choices. They are able to view the nutritional content of their virtual cafeteria tray relative to the USDA standards for calories, protein, fat, carbohydrates and other nutrients.

Typical School Nutrition Program Meal

All DISD schools offer breakfast and lunch daily. Breakfast includes various breakfast items as well as assorted fruit, 100% fruit juice, and skim and low-fat milk. DISD follows the nutrient standard menu planning system. Students may choose two or three items from the breakfast menu. Lunch includes a choice of entrée, canned/ fresh fruit and vegetables, and flavored or unflavored milk. Students may select up to one entrée, three sides dishes and milk.

Modification for Diabetes-Friendly Meals

The meals of a student with diabetes are very similar to a regular meal. The meal plan for students with diabetes is part of their diabetes management plan (DMMP) developed by the child’s personal health care team, parent/guardian and school nurse. The degree to which the student is monitored with regard to menu selection is based on that student’s individualized DMMP. When accommodating for students with diabetes, various modifications can be made aimed at the individualized carbohydrate needs. Based on the DMMP some students may require the addition

Table. Sample Meals and Carbohydrate Counts

Breakfast	Carb (g)	Mid-a.m./p.m. Snack	Carb (g)	Lunch	Carb (g)
Cheerios (3/4 c)	14	String cheese (1 oz)	0.5	Grilled cheese sandwich	32
2% Milk (1/2 pint)	12	Apple (5 oz)	14	2% milk (1/2 pint)	12
Banana (medium)	27			Orange (medium)	16
Turkey sausage patty	0.2			Carrots and celery sticks (1 oz)	2
				Vanilla pudding cup	22
Total	53.2 g		14.5 g		84 g

c=cup; g=gram; oz=ounce

of a morning and/or mid afternoon snack. A typical snack consists of 15 grams (g) of carbohydrate which can be a piece of fruit and string cheese, a carton of unflavored milk, crackers and cheese, or a small bowl of (unsweetened) dry cereal.

When the student chooses to eat meals prepared at school, selections are made based on the grams of carbohydrates per meal in their DMMP (see Table). Parents and students can choose from numerous menu offerings or obtain assistance from school staff trained in carbohydrate counting.

Sample breakfast options:

- Cold cereal, muffins, sausage and biscuit
- Fresh fruit, canned fruit, fruit juice
- Unflavored, flavored 1% low-fat milk

Sample lunch options:

- Steak fingers, macaroni and cheese, or grilled chicken caesar wrap
- Veggie salad, broccoli, mashed

- potatoes, and/or fruit salad
- Bread, rolls, and/or crackers
- Fresh fruit or pudding cup
- Flavored or unflavored milk

Sample carbohydrate distribution:

- Breakfast: 55 g
- Midmorning or midafternoon snack: 15 g
- Lunch: 85 g

Recent Changes in School Nutrition Affecting Diabetes Care

Over recent years the trend in school nutrition has shifted toward ready-to-eat entrees and individually-wrapped items. While ensuring consistency in quality of foods being prepared, it also may provide consistency in nutrient composition and portion control. Food safety concerns and limited equipment and facilities in schools have also prompted a shift toward more processed items. However, prompted by increasing rates of childhood obesity as well as diabetes, food service directors across the country are now including more

whole grain products, fresh fruits and vegetables, salads and low-fat dairy options on menus (6). All of these are important components of a healthy meal for children with and without diabetes. Although the cost of convenience and prepackaged foods is higher, the overall cost of the meal is offset by reduced labor costs, and reduced need for equipment and facilities. In some cases it is more cost effective during these times when funds are more limited. The pre-portioned items may help the students with diabetes with portion control. Despite the higher food prices, the cost to the student of a complete school meal is still less than that of bringing lunch from home, especially for lower-income households. For example, households of four with incomes between \$28,665 and \$40,793 are eligible to receive free or reduced-priced meals. Thus, families with incomes between 130% and 185% of the poverty index can receive a nutritious meal at low to no cost. This financial support allows families to better manage the higher cost of healthy foods (8).

Advice to Dietetic Practitioners Working with School Districts:

Not all schools have registered dietitians on staff, so it is important that food service professionals work collaboratively with education and health communities to coordinate the care of students with special dietary needs. The following are some best practices (9,10):

- 1 Providing parents, school nurses and students with readily available nutritional information to assist in menu planning
- 2 Making available menu options that help students make wise food choices. This is true for all students, including

those with other special dietary needs as well

- 3 Providing regular in-service training for staff who share responsibility for children with diabetes
- 4 Utilizing nutritional analysis software programs that facilitate menu planning for students
- 5 Developing cooperative working relationships with all stakeholders, such as the school nurses, cafeteria supervisors and physicians
- 6 Participating in individualized education plans and collaborating with campus staff as necessary to help students successfully manage their diabetes
- 7 Utilizing state and local district wellness policies to reinforce healthy options in food vending machines

Training for School Nutrition Professionals

An essential part of helping students manage their diabetes is to empower school nutrition professionals with the information necessary to participate in their care. Organizations like the American Diabetes Association are great resources for free information and training materials. The following are key points that should be included in any diabetes awareness training (11,12):

- 1 Disease background and the role that obesity plays on early onset of the disease
- 2 Signs and symptoms of hypoglycemia which may require treatment
- 3 Review diabetes meal planning, including basic carbohydrate counting

Registered dietitians are an essential part of school nutrition programs during these difficult economic

times. They provide a broad scope of expertise in the areas of menu planning, food procurement and nutrition education, as well as diet consultation and guidance. These services will be critical in the coming years with an increase in demand for services to students with diabetes and other special dietary needs.

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Working with Low-income Clients: The Make a DIF Story

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Providing diabetes education and services during economically difficult times is challenging even for the seasoned educator. Ideas are presented in this article for developing resources that address the needs of people with diabetes in a community health clinic serving primarily low-income Caucasians and Spanish-speaking Hispanic farm workers.

I work in a community health clinic with 10 years experience as a certified diabetes educator (CDE) and 20 years of experience in a community health setting in North Central Washington state. My clinic has grown over the past 20 years from 50 to 267 employees, including 11 physicians, 5 dentists and 9 mid-level practitioners. Our clinic is a Joint Commission–certified clinic serving 21,529 patients. During harvest season (June–November) this population increases to almost 40,000 as a result of migrant and seasonal farm workers and their dependents moving into the area. We have approximately 1,500 active patients with diabetes and an additional 300 transient patients with diabetes during the harvest season. I supervise a department with three employees: two registered nurse (RN) CDEs and one medical assistant who is also certified as a “Living a Healthy Life

with Chronic Illnesses” master trainer (1). In my position as the diabetes education supervisor, I report directly to the clinic manager, who is an RN. I also serve on an internal Quality Improvement Committee. You can read more about our clinic and the population we serve at <http://www.cvch.org>. I am also involved in a state-wide diabetes collaborative.

Our diabetes department was formed 10 years ago by the clinic’s chief executive officer, whose team coined the program’s acronym, “Make a DIF” (Diabetes Intervention & Follow-up). We are part of the clinic medical team and involved in interdepartmental decision-making processes. Our goal is to educate patients and provide support for the medical staff in diabetes self-management and related issues. In addition, my department works closely with our outreach department and a community-based network, the Wenatchee Area Network for Diabetes, which provides free educational opportunities.

We have several unique programs that address the mission of increasing health awareness in special populations such as migrant workers, low-income patients, low-literacy patients and native Spanish speakers. The health of our migrant population

is extremely important to our agriculture-based economy. Keeping farm workers healthy has a direct impact on the cost and reliability of the food supply and, therefore, the health of our communities.

Unique Barriers to Diabetes Education and Care

Helping our patients overcome barriers is an ever-present challenge. Over 60% of our migrant workers are monolingual Spanish and have a fourth-grade education. When working with a low-literacy population, we choose simple educational approaches, such as using pictures and stories and teaching the plate method as a low-cost meal planning approach. An example of a healthy plate can be drawn on a large paper plate for just the cost of paper plates. We also purchase Idaho Plate Method materials because they are extremely popular with our educators and patients (2). We use food guide mini-posters from the Washington State Dairy Council.

The number of uninsured individuals is skyrocketing, and patients without insurance pose a substantial challenge to our clinic. This group seeks care at the last possible moment. Because diabetes complications often progress slowly or even go unnoticed, by the time a patient is feeling bad enough to seek help, complications may be more difficult and costly to treat. Getting patients scheduled with the help of a patient assistance person is the first step toward evaluating which support programs might be available to the patient.

Physical and mental disabilities can be another big barrier to overcome when trying to educate our patients. Many of our patients with diabetes are on a government insurance plan because

of some type of disability. We have a large number of chronic pain patients who have poor eating habits, very low food budgets and the inability to exercise to the extent necessary to control their diabetes. These patients need self-management coaching in small steps that emphasize lifestyle behavior changes (3,4). Stanford University's Chronic Disease Self-Management Course is an excellent program that lends itself to the grant funding process because its successes are well documented (1). Another popular educational tool in our clinic is the Merck Conversation Map Program (5), which is free and can be a fun and interactive way to enhance existing diabetes self-management curriculum.

Locating low-cost insulin, oral medications and test strips is a crucial form of assistance we try to provide to our patients whenever possible. Insulin is very expensive around the world so some investigation regarding costs in a patient's home state or country is critical to choosing the right insulin. Migrant workers, for example, need a low-cost supply of medications so that they can go from one community to the next and get assistance easily. An online medication assistance program can be helpful to a patient who moves frequently. Glucometer strips are not consistently available in countries like Mexico, and can be very expensive when paying out of pocket. Urine glucose strips can be used as a lower-cost option. An online health record greatly reduces the possibility of incorrect prescriptions for migrant patients.

Our Limited Resources for Diabetes Education

Performing a community assessment is necessary to identify all available patient resources in the area.

Federally qualified health centers (FQHCs) like ours have been helping low-income patients for years. However, since the recession began in October 2008, we have been inundated with patients who have not been doing even the most basic diabetes self-management, and also cannot get care at private health clinics because they are unable to pay. The sliding fee, available at all FQHC health centers, is a very practical way to help our low-income patients. Patients pay based on income and family size. Offering a sliding fee allows many to receive medical care that they would otherwise not be able to afford while still paying some portion of their care. Pricing on several oral hypoglycemic agents, insulin and blood glucose monitoring supplies is very reasonable within the community health clinic setting.

Community health workers, known in our clinic as "promotores," are key to our clinic's success (6-10). We currently have two part-time promotores and an Americorp volunteer working to educate our Hispanic community. Our promotores and volunteers provide information as well as education topics such as diabetes prevention, smoking cessation and vaccination. They are extremely effective in encouraging non-English-speaking patients to visit the clinic for preventive care. Navigating the healthcare system can be daunting when language is a barrier and these unsung heroes make a significant difference in the lives of many of our patients.

Our clinic has established a Helping Hands Fund. This fund, created by our employees, accumulates employee donations through automatic payroll deductions and employee fundraising activities. Helping Hands resources are used for clinic patients who are

unable to pay for their medical or dental bills. The Helping Hands Fund is a clear example of the altruism of our medical and nonmedical staff.

Grant money funds our clinic's "No-Charge" diabetes self-management education group in English and Spanish to all patients. Patients learn techniques to improve everything from patient-doctor communication to nutrition. For example, we provide "Veggie Vouchers" for \$2 at our local farmers' market which encourages patients to buy fresh produce. Locally-grown produce tastes better, is less expensive, and the farmers often give a little extra when they know a customer is low-income. Many farmers' markets now take food assistance cards (previously known as food stamps). This is a good use of tax dollars in supporting both the local economy and healthy eating habits.

Fostering business partnerships is advantageous for building community support. Companies, including Novo Nordisk, Abbott and Lifescan have been generous in providing educational grants for our community events. An annual "expo" is a popular method of community education, and we draw people in with incentives. Many companies offer online educational grant opportunities.

In our area, various clinics and community partners have teamed up to provide free or low-cost services. One clinic provides a comprehensive American Diabetes Association-recognized diabetes self-management program; another clinic offers classes in Spanish; the Young Men's Christian Association (YMCA) offers a program for patients with prediabetes; Gold's Gym offers a free class for people to begin exercising; and our senior center offers foot care and beginning level exercise groups.

We are able to offer a limited number of patients a no-cost group retinal screening eye examination by a local ophthalmologist. Programs are also available through churches and United Way agencies that offer direct assistance to people in need.

Advice for Diabetes Educators

In these challenging times, diabetes educators have their work cut out for them. Listed below are a few suggestions that might lighten your load.

- Be active in your area's diabetes health care programs. Finding funds and low-cost supplies is easier when you are networking with state and national diabetes collaboratives.
- Be a patient advocate for self blood glucose monitoring. If the health care provider instructs a patient without insurance or assistance to test four times a day, negotiate on behalf of the client for something reasonable and affordable.
- Do not let patients live on sliding-scale insulin alone. Sliding-scale insulin is associated with poor glycemic outcomes (11). When appropriate, advocate for using insulin-to-carbohydrate ratios and teach carbohydrate counting.
- Be a patient advocate for affordable medication regimens. Work collaboratively with the patient's health care providers and your local pharmacists to prescribe medication plans that the patient can afford to follow.
- Have a list of operating hours and addresses for your local food banks and farmers' markets and find out what they offer. People who volunteer at the food bank are often given selection priority, or if volunteering on a local farm, they can trade work for food. The clients get exercise and free food

while socializing with others.

- Work out deals at your local YMCA or gym for exercise opportunities. Encourage people to take the bus. Help your patients estimate how much they will save in gas so they can buy healthier food instead.

In summary, I encourage educators to complete a community assessment to determine what services and partnerships are available in your area. Give your administrators the data they need to look at your services in terms of cost savings and not just income from direct reimbursement. Form community networks for incentive programs and educational events, which can be locally sponsored. Finally, use your ADA Diabetes Care and Education listserv as a valuable source of information.

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Patient Assistance Programs for Diabetes Medications

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In general, patients need to meet these requirements:

1. Patient must not be covered by private or public health insurance/prescription coverage
2. Patient's income must be $\leq 200\%$ of the Federal Poverty Guideline for the size of household (see Table; different in Alaska & Hawaii)
3. If *eligible* for Medicare but *not* enrolled, then patient is *ineligible* for most programs
4. If *eligible* for Medicare Part D but *not* enrolled, then patient *may still be eligible* for some programs

• **Amylin Pharmaceuticals – Byetta** (exenatide), **Symlin** (pramlintide)

- 1-800-330-7647 or www.amylin.com/products/reimbursement.cfm
- 6-month supply at no cost
- New application every 6 months
- Must be a legal U.S. citizen
- Must meet an undisclosed income guideline
- Eligible patients receive a pharmacy card that can be used once per month

• **Bayer – Precose** (acarbose)

- 1-866-575-5002 (application sent to physician's office)

- Up to 90-day supply at no cost, with 3 refills
- New application every 12 months
- Must be a legal U.S. resident
- Must be *ineligible* for any federal/state programs (incl. Medicare Part D, Medicaid, etc.)
- Must meet an undisclosed income guideline
- Eligible patients have medication sent to provider's office

• **Eli Lilly** – insulin vials [**Humulin**, **Humalog** (aspart)], **glucagon**

- **"Lilly Cares"**:
1-800-545-6962 or www.lillycares.com
- Up to 120-day supply at no cost
- New application & financial information every 12 months
- Must be a legal U.S. citizen
- Must be *ineligible* for Medicare Part D
- Must be *under* 65 years old
- Must meet an undisclosed income guideline
- Eligible patients receive medication from manufacturer (except for insulin, in which case patient receives coupons); shipped to provider

Table Poverty Level Chart

SOURCE: 2008 POVERTY CHART

Family Size	100%	133%	150%	200%	250%	300%
1	\$10,830	\$14,404	\$16,245	\$21,660	\$27,075	\$32,490
2	\$14,570	\$19,378	\$21,855	\$29,140	\$36,425	\$43,710
3	\$18,310	\$24,352	\$27,465	\$36,620	\$45,775	\$54,930
4	\$22,050	\$29,327	\$33,075	\$44,100	\$55,125	\$66,150
5	\$25,790	\$34,301	\$38,685	\$51,580	\$64,475	\$77,370
6	\$29,530	\$39,275	\$44,295	\$59,060	\$73,825	\$88,590
7	\$33,270	\$44,249	\$49,905	\$66,540	\$83,175	\$99,810
8	\$37,010	\$49,223	\$55,515	\$74,020	\$92,525	\$111,030
For each additional family member	\$3,740	\$4,974	\$5,610	\$7,480	\$9,350	\$11,220

- **GlaxoSmithKline – Avandia** (rosiglitazone), **Avandaryl** (rosiglitazone/glimepiride), **Avandamet** (rosiglitazone/metformin)

1. **“Bridges to Access”:**

1-866-728-4368 or

www.bridgestoaccess.gsk.com

- Pick up first 60-day supply at pharmacy for \$10 copay, followed by up to 4 additional 90-day refills, up to 1-year supply
- New application every 12 months, new financial information every 6 months
- Must be a legal U.S. resident
- Must have an “advocate” handle process on his/her behalf (a healthcare worker involved in the patient’s care)
- Income must be ≤ 250% of poverty guideline
- Eligible patients receive vouchers for the medication

2. **“GSK Access”:** 1-866-518-4357 or www.gsk-access.com

- Offers up to a 1-year supply at no cost
- New application & financial information every 12 months
- Must be enrolled in Medicare Part D and have spent \$600 on medications through Medicare Part D plan this year

- Income must be ≤ 250% of poverty guideline
- Eligible patients receive a pharmacy card, good for 1 year

- **Merck – Januvia** (sitagliptin), **Janumet** (sitagliptin/metformin)

1. **Merck Patient Assistance Program:** 1-800-994-2111 or

www.merckhelps.com

- 90-day supply at no cost, with 3 refills
- New application every 12 months
- Must be a legal U.S. resident (not necessarily citizen)
- Income must be ≤ 400% of poverty guideline
- Eligible patients receive medication (shipped to either patient or provider)

2. **Merck Prescription Discount Program:** 1-800-506-3725 or

www.argushealth.com/merck_consumer_enrollment/MerckEnrollment

- 10-20% off medications
- New application every 12 months
- Regardless of age or income (but must not have public/private prescription drug insurance)
- Eligible patients receive a pharmacy card

- **Novartis – Starlix** (nateglinide)

- Up to 1-year supply at no cost
- Must be a legal U.S. citizen

- **Novo Nordisk – insulin vials or FlexPens (Novolin, NovoLog, Levemir), Prandin** (repaglinide)

- 3-month supply at no cost for eligible patients
- The medication must be sent to the physician’s office

- **Pfizer – Glucotrol** (glipizide), **Glucotrol XL** (glipizide XL), **Glyset** (miglitol), **Diabinese** (chlorpropamide)

- Up to a 90-day supply at no cost
- Must be a legal U.S. citizen
- Income must be ≤ 200% of poverty guideline
- Most medications must be sent to physician’s office
- Also have a *discount program* utilizing a discount card, offering up to 32% off for those with income ≤ 300% of poverty guideline, and up to 15% off for those with income > 300% of poverty guideline

continued on page 28

- **Sanofi Aventis** – insulin vials or SoloStar pens [**Lantus** (glargine), **Apidra** (glulisine)], **Amaryl** (glimepiride)
 - Offers up to a 1-year supply, depending on medication
 - Must be a legal U.S. resident (not necessarily citizen)
 - Income must be $\leq 250\%$ of poverty guideline
 - The medication must be sent to the physician's office

- **Takeda – Actos** (pioglitazone), **ActoPlus Met** (pioglitazone/metformin), **Duetact** (pioglitazone/glimepiride)
 - 1-800-830-9159 or www.tpna.com/responsibility
 - 90-day supply
 - Must be a legal U.S. resident (not necessarily citizen)
 - Income must be $\leq 300\%$ of poverty guideline
 - Medication can be shipped to either patient or physician

Other Patient Assistance Programs

- Needy Meds [www.needymeds.com]
 - RxAssist [www.rxassist.org]
 - Great centralized resource
 - Patient Assistance [patientassistance.com]
 - Great centralized resource, free (non-profit organization)
- All Web sites accessed December 2009.

Patient Assistance Programs for Diabetes Supplies

Michael Fischer, BS
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 West Virginia University
 Morgantown, WV

MANUFACTURER	CONTACT INFORMATION	FINANCIAL ASSISTANCE PROGRAM
ABBOTT	www.abbott.com www.abbottpatientassistancefoundation.org (800)222-6885	The Abbott Patient Assistance Foundation Diabetes Care Patient Assistant Program offers assistance on blood glucose testing supplies to low-income patients in the United States.
BAYER	www.simplewins.com (800)998-9180	Patient Assistance Programs for medication, control solution, log books, and batteries.
LIFESCAN	www.lifescan.com customerservice@lifescan.com (800)227-8862	Lifescan does not offer a patient assistance program at this time. Rebates and trade-in allowances are available to lower the cost of meters to customers.
ROCHE	www.roche-diagnostics.us (888)788-7921	Roche Diagnostic Corp. Patient Assistance Program offers Accu-Chek glucose test strips at no cost for up to 90 days to those who are eligible for the program.
HOME DIAGNOSTIC	www.prestigesmartssystem.com cs@hdidiabetes.com (800)803-6049	TRUEcare™ Support Program requires enrollment for participation.

Generic low-cost blood glucose meters and supplies present another option. For example, Walmart brand ReliOn meters cost as low as \$9 each and test strips (50-count) cost \$20.

All Web sites accessed February 2010.

Case Study: Recovering from Job Loss

Sandra A. Parker, RD, CDE
Julia K. Walters, RD, CDE
Grand Rapids, MI

Introduction

What happens when you have finally found your niche, your true calling, your job of a lifetime and suddenly the job ends? The answer is that you find yourself in company with many colleagues who no longer have jobs because of the poor economy and are searching for a job as fulfilling as the one they lost.

As members of the Diabetes Care and Education dietetic practice group, we have been asked to share our stories. We, Julie and Sandy, are both registered dietitians (RDs) and certified diabetes educators. We worked together on the same diabetes outreach team for 7 years and were both laid off in 2009. Our team led community projects ranging from professional education and consultation to tailoring diabetes education and awareness for diverse populations.

Quality Projects

One of our core activities was working with primary care offices to implement the chronic care model by creating patient registries and tracking standards of care for people with diabetes. In 2002, the United States Deputy Secretary of Health recognized our statewide program as a best practice in diabetes community health (1). Other core activities included developing and presenting professional education programs for

health professionals and working with community partners on special projects. We had the freedom to be very creative with our projects. One notable project was our Native American storyboard display used in outreach activities at Pow-Wows in the area. The storyboard was designed by a local, award-winning, Native American artist, Candi Wesaw and is based on the story, "Through the Eyes of the Eagle" (2). The display sets the stage for interactive discussions and storytelling using the Eagle book series developed for children (3). This work led to our diabetes outreach network's inclusion as a resource in the 2002 Institute of Medicine publication, "Speaking of Health: Assessing Health Communication Strategies for Diverse Populations."

Economic Downturn

In 2007, the state of Michigan faced severe budget cuts and continued grant funding for the diabetes outreach network was not guaranteed in time for our hospital to keep its doors open. Our team was then reassigned to a new project and renamed the HealthLink Diabetes Support Team. We built a specialized service for the four community health centers that are part of Saint Mary's Health Care in Grand Rapids, MI. These centers provide services to various groups such as the homeless, low income, Spanish speaking, and migrant workers. Our assignment

was to improve diabetes outcomes, decrease emergency room visits and decrease diabetes complications that require hospitalizations.

In 2008, the Michigan economic downturn and a large increase in costs, due mainly to emergency room and hospitalization costs of uninsured patients, forced our hospital to restructure services and lay off many employees. Ironically, our HealthLink Diabetes Support Team, which worked to reduce those same costs, was among the many services our hospital had to close.

Here are our stories of survival and reinvention after losing our jobs. Although we started at the same place, our individual paths took us to new and interesting/different places.

Sandy's Story *Getting the News*

It was not a total surprise when our director brought us the sad news that our project had to end. Our hospital, like most employers in Michigan, was facing hard economic times. Cost-cutting measures were in place for months. We knew that our project, even though it was aimed at cutting costs, was not generating any revenue and would likely be cut at some point. Fortunately, our employer provided us with severance packages that gave us time to organize our finances and search for new work.

Networking

We had the advantage of a vast network of colleagues throughout Michigan. A colleague in the Michigan Department of Community Health gave me a few ideas on whom to contact and told me she would refer me to others. Almost immediately, I received an e-mail from the Michigan Public Health Institute (MPHI). After learning about my community contacts and my experience with the Stanford Chronic Disease Self-

continued on page 30

Management Program (4), MPHI offered me the opportunity to consult with them in expanding the program in my region. As a consultant for MPHI, my work is similar to my previous work as the project director and team leader for the diabetes outreach and HealthLink teams.

Fulfillment

The work I do for MPHI with the Stanford Chronic Disease and Diabetes Self-Management Programs is on the frontline of health care reform discussions, in particular the patient-centered medical home. I believe that the community health arena is where the most impact on our nation's health can be made. Evidence-based community programs can enhance our efforts as RDs to help our patients make lifestyle changes to prevent or manage chronic diseases.

Positive Thinking

The moral of my story is that all of the experience, knowledge and passion that you have for a job is not lost if that job suddenly ends. It is possible to start afresh and use your energy and skills to further your career in new ways. This will not only bring you fulfillment but also benefit those you serve.

Julie's Story

Job Loss

My first major job in dietetics lasted over 19 years at a leading teaching hospital in Cleveland, OH. When I left, it was by choice to relocate to my home state of Michigan. My, how things have changed in terms of longevity at a single workplace! The position I was fortunate to find—working with Sandy—was probably the job of a lifetime. Working in community health was quite a shift from hospital dietetics, but it was also energizing. I enjoyed my work! Being part of a dedicated, professional team was the very best aspect of my job. So when the economic downturn affected that team, the loss of those

connections was like experiencing a death. My initial reaction was fear and sadness. Those feelings can become paralyzing if you let them.

Research, Renew, Regroup

It was coincidental and helpful that I attended our state dietetic spring conference shortly after my job ended. The conference allowed me to connect with colleagues who were supportive of my job search and who helped to get the word out that I was looking for a new job. Also, a few of the topics of the conference involved RDs in private practice as well as the patient-centered medical home (5) and opportunities for RDs working in physician offices. These lectures led me to think about new ideas. I seriously considered starting my own business and began connecting with local providers in my small town to explore potential opportunities. I also joined the Nutrition Entrepreneurs dietetic practice group (<http://www.nedpg.org>), which provided a wealth of information and the opportunity to join a very helpful listserv. After researching on how to start my own practice, my perspective changed from that of an employee to that of a business manager.

Networking and Job Creation

What led to my current job were my connections in my previous place of employment. Because of the people who knew my abilities and personal qualities, a job was created that would allow me to work in the setting of physician offices as a registered dietitian and certified diabetes educator. Information I learned about the patient-centered medical home as well as the research I had done on medical nutrition therapy and the business model all came together to help me prepare for this position. I am eternally grateful for the opportunity, and look forward to growing in this new role.

My words of advice are:

- Stretch yourself
- Consider new opportunities
- Think of how you can generate or save revenue for the place where you work and imagine that you are in charge of the bottom line
- Wherever you are, work with passion and integrity; people notice and remember

Closing Comments

Our journeys in finding new work were different, but our paths intersect frequently. We stay in touch with our former team members. We would love to have our “dream” team back, and maybe some day we will. But for now we help each other out by volunteering, giving advice when asked, and providing a listening ear when needed. When you love what you do, the positive energy you radiate makes good things happen.

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3. Centers for Disease Control and Prevention. Eagle books travel to communities throughout the U.S. Available at: http://www.cdc.gov/diabetes/pubs/eagle_exhibition.htm. Accessed December 9, 2009.
4. Stanford Patient Education Research Center. Chronic Disease Self-Management Program. Available at: <http://patienteducation.stanford.edu/programs/cdsmp.html>. Accessed December 9, 2009.
5. Lipscomb R. Understanding the patient-centered medical home. *J Am Diet Assoc*. 2009;109(9):1507-1508.

After reading this issue of *On the Cutting Edge*, "Diabetes in Tough Economic Times" please answer the following single-answer, multiple choice questions. For each question, select the one best response.

Indicate your responses on the answer form on page 32. Compare your answers with the answer key on page 9. Four (4) hours of continuing professional education units (CPEUs) have been approved by the Commission on Dietetic Registration (CDR). CPE eligibility is based on active DCE membership status from June 1, 2009 to May 31, 2010. **DCE members receive credits by either self-reporting that they have completed the post-test at www.dce.org (or) sending the completed answer sheet within one year of the publication of this OTCE to:**

Beth Sponseller, MS, RD, CFT, CDE
708 E. Erica Court
Spokane, WA 99208

NOTE: If you submit an online submission to the DCE Web site, then you do not need to submit the paper self-assessment answer form. DCE members are encouraged to complete the online submission. This issue's answer sheet must be returned by March 31, 2011. You will be notified ONLY IF the 4.0 continuing professional-education hours have NOT BEEN APPROVED. Continuing professional education credits will be reported to CDR, but you must keep a record of your continuing education. Please record these hours on your Learning Activities Log, and retain the certificate of completion in the event you are audited by CDR. Outcome-oriented objectives are available on the DCE Web site at www.dce.org. Note: The certificate of completion is valid when the accompanying Continuing Professional Education Questionnaire is successfully completed, submitted to, and recorded by DCE/ADA.

CPE Credit Self-Assessment Questionnaire

- 1) Food Recovery does and should involve:
 - a. Edible gardening donations
 - b. Taking excess food from food service institutions and diverting it to local food pantries
 - c. Cooperation of retail and food service institutions
 - d. All of the above
- 2) Before the Bill Emerson Good Samaritan Food Donation Act, the percentage of food lost as fruits and vegetables was _____ % at the retail level and _____ % at the food service level.
 - a. 20, 10
 - b. 30, 15
 - c. 50, 20
 - d. 60, 25
- 3) The National School Lunch Program sets the qualifying level for free lunch at _____ % of poverty level and reduced-priced lunch at _____ % of poverty.
 - a. 100, 130
 - b. 120, 150
 - c. 130, 185
 - d. 150, 200
- 4) Certain food programs such as Angel Food Ministries and SHARE Food Network have memberships at approximately \$ ____ each month that allows members to receive a delivery of food at _____ % to _____ % of retail costs.
 - a. 10, 22-50
 - b. 15, 33-61
 - c. 20, 42-63
 - d. 25, 38-71
- 5) The Supplemental Nutrition Assistant Program (SNAP) has the benefits of:
 - a. Nutrition education (SNAP-Ed)
 - b. Ability to purchase seeds
 - c. Ability to purchase plants
 - d. A & B
 - e. All of the above
- 6) Which of the following phrases would help you obtain client information to assist them utilize food efficiently without being offensive?
 - a. Describe your kitchen.
 - b. How do you rate yourself as a cook?
 - c. Where do you shop for food?
 - d. Does your refrigerator keep ice cream hard?
 - e. A and B
 - f. All of the above
- 7) Changes in WIC foods include the:
 - a. Allowance to purchase fruits and vegetables
 - b. Addition of whole grains
 - c. Selection of only lower fat milk
 - d. All of the above
- 8) WIC's new rule strengthens their focus on:
 - a. Pre-conception
 - b. Teenagers
 - c. Breastfeeding
 - d. Rural locations
- 9) Over the years, the trend in school nutrition has shifted toward:
 - a. Ready-to-eat meals
 - b. Individually wrapped items
 - c. Catered meals
 - d. A and B
- 10) When working with low-income clients, it is important to assess:
 - a. Cost of medication
 - b. Benefit of blood glucose monitoring
 - c. Utility of insulin doses
 - d. All of the above
- 11) Performing a community assessment is necessary to identify all available patient resources in an area.
 - a. True
 - b. False
- 12) To qualify for patient assistance programs:
 - a. The patient must not be covered by private or public health insurance
 - b. Income must be <200% of the Federal Poverty Guideline
 - c. The patient is eligible for Medicare but not enrolled
 - d. A and B
 - e. All of the above

Diabetes Care and Education Dietetic Practice Group

DIABETES AND TOUGH ECONOMIC TIMES

Spring 2010, Volume 31, Number 2

SELF-ASSESSMENT ANSWER FORM

Read the self-assessment questionnaire on page 31 and select the one best answer for each question.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

DCE members receive credits by either self-reporting that they have completed the post-test at www.dce.org or sending the completed answer sheet within one year of the publication of this *OTCE* to:

Beth Sponseller, MS, RD, CFT, CDE
708 E. Erica Court
Spokane, WA 99208

Record CPEUs online at
[www.dce.org/members/
record_my_cpeu_credits.asp](http://www.dce.org/members/record_my_cpeu_credits.asp)

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Form must be postmarked by March 31, 2011 to be valid. CPE eligibility is based on active DCE member status from June 1, 2009 to May 31, 2010.

Name _____

ADA No. _____

Address _____

City, State, ZIP _____

E-mail _____

Attention: If you are at the end of a five-year CDR reporting period this year, CPE forms requiring processing need to be postmarked by April 30, 2010 to meet the CDR deadline of May 31, 2010.



Have You Moved?

If you have recently moved or had a change of name, please update your membership information with the American Dietetic Association (ADA) to ensure that you don't miss out on any DCE newsletters or other communications. Because ADA maintains our address data, you must notify the association directly before you move, or your DCE newsletters may be delayed. To update your member profile information you may:

- **Use ADA's Web site (www.eatright.org) and new Member Profile secured server.** Using your member ID number and Web password, which was provided to you on your ADA membership card, view your existing member profile at the Online Business Center, make necessary changes, and submit changes to update ADA's records immediately.
- **Print a change-of-address form from ADA's website (www.eatright.org/addresschange.html),** complete the form, and fax (312.899.4899) or mail to American Dietetic Association, Attention: Membership Team, 120 South Riverside Plaza, Suite 2000, Chicago, IL 60606-6995.
- **Mail in the Change-of-Name and/or Address Card** found in the back of each *Journal of the American Dietetic Association*.
- **E-mail changes** to the ADA Membership Team at membership@eatright.org.

Certificate of Completion

Diabetes and Tough Economic Times
Spring 2010, Volume 31, Number 2

TITLE OF PROGRAM

DATE OF COMPLETION

American Dietetic Association

COMMISSION ON DIETETIC REGISTRATION CPE ACCREDITED PROVIDER

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3/31/2011

DATE

Submit this copy to state licensure board, if applicable.

Certificate of Completion

Diabetes and Tough Economic Times
Spring 2010, Volume 31, Number 2

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DATE OF COMPLETION

American Dietetic Association

COMMISSION ON DIETETIC REGISTRATION CPE ACCREDITED PROVIDER

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II CPE level

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3/31/2011

DATE

Submit this copy to state licensure board, if applicable.

Retain this copy for your records.

NOTE: This certificate of completion is not valid until the accompanying Continuing Professional Education Questionnaire is successfully completed, submitted to, and recorded by ADA.

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