Diabetes and Nutrition in the Latino Community Webinar

March 21, 2012

Host: Betsy Rodriguez, CDC/NDEP Deputy Director

Guest Speaker: Lorena Drago, MS, RD, CDN, CDE

Coordinator: And the call has begun. You will be in listen only until the question and answer session. The call is being recorded today. If you have any objection you may disconnect at this time.

((Crosstalk))

Coordinator: You may begin. At this time Ma'am you may begin.

Betsy Rodriguez: Before we start our webinar, I would like to remind you a few features the Live Meeting has as well as some of the things to remember during this presentation.

We will have not - we will not use the chat feature except for technical issues.

We will not answer live questions during the presentation until the end when we arrive to the question and answer portion of the program. If you have a question during the presentation, please use the Q&A button located on the upper portion of your screen. There, type your question and press the Ask button to send. Please do not send questions to the presenter, send them privately to me at brodriguez.

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Upon receiving your evaluations you will receive a complimentary resources of It's More than Food, It's Life -- ((Spanish Spoken)) -- Nutrition Education Resources. So if you love food, or by any chance you are hungry today, I honestly can say that this is the right webinar for you at this time.

But today's webinar is brought to you by the National Diabetes Education Program ((Spanish Spoken)). My name is Betsy Rodriguez, Deputy Director at CDC NDEP Hispano/Latino Stakeholder Group and your host for this afternoon.

Our presenter today is Lorena Drago. Lorena is a Registered Dietician, Certified Diabetes Educator and Hispanic Education Specialist and maintains a private practice. Miss Drago also work as a consultant conducting lectures, stress management workshop and diabetes patient education for managed care organizations, business and individuals.

Miss Drago will discuss the role that nutrition plays in managing and preventing diabetes, as well as focusing on motivating clients for behavior change primarily in the Latino community. So without further introductions I leave you with Miss Lorena Drago. Lorena?

Lorena Drago: Thank you. Thank you and I will be happy to share this - the next 45 minutes with all of you.

The objectives of this webinar are to; state three goals of medical nutrition therapy for diabetes; describe one component of the nutritional management of diabetes; to describe at least two nutrition interventions targeting Hispanics or Latinos with diabetes -- I'm going to be using that term interchangeably throughout the conference; and highlight the NDEP's nutrition education materials.

Let me start with giving you a snapshot of Hispanic demographics. Based on the 2010 U.S. Census Survey, we can see that the Hispanic population has grown almost 56% in the United States. The largest Hispanic groups in the United States still remain Mexicans with 63%, followed by Puerto Ricans almost 10%, and then we have Other Hispanic subgroups.

And this is very important for those of you who are counseling Hispanic patients to understand that Hispanics come from many different locations and their health attitude, their culture, as well as their food preferences will vary from one group to another. The projection for 2020 is that almost - there will be a almost 20% growth in the Hispanic population.

When we look at diabetes and the racial and ethnic differences in the prevalence of diabetes in these communities we see that 6% of non-Hispanic whites, and this is based on 2010, have diabetes. When we look at Hispanics, the age adjusted rate were 9.3% of all Hispanics.

But as I was mentioning before, there is a difference in the prevalence of diagnosed diabetes among different Hispanic subgroups. So we look here, that

the highest prevalence will be for Mexican-Americans and also for Puerto Ricans and the ones that we have documented the least will be for Cubans.

Now what are the three goals of medical nutrition therapy in diabetes management? The three goals are; to achieve or maintain a blood glucose level in the normal range and of course or close to that normal as long as it is safe for the patient to do so; a lipid and lipoprotein profile that reduces the risk for vascular disease; and then the blood pressure, to maintain the levels once again, just like blood glucose, to be as close to normal as is safely possible.

And this is taken from the American Diabetes Association Clinical Practice Guidelines the - in 2008, and it has remained so even at the Clinical Guidelines of 2012.

Now how effective, when we talk about food, when we talk about management of food and diabetes, how effective is medical nutrition therapy? Well when we look at the studies that have been conducted, there is a report of A1C of roughly a decrease of 1% in Type 1 and 1 to 2% in Type 2, and this is just with meal planning and with meal modification that is specific for the person with diabetes. And this is excluding all types of medication.

So medical nutrition therapy, it is very effective in managing blood glucose, and it has also been shown to reduce LDL cholesterol 15 to 25 points, effective in reducing hypertension, and the improvement of hypertension becomes apparent in three to six months. So medical nutrition therapy is an adjunct to medication, exercise and other lifestyle modifications for the person with diabetes.

I am going to share with you some of the general medical nutrition therapy recommendations for 2008, those that was a review of all the

recommendations that exist today and every year thereafter, including 2012, there has been some modification. So I'm going to be using both recommendations.

The recommendations for the primary prevention of diabetes, so we know that not only do we have diagnosed cases of diabetes, but we also have a large percentage of individuals that might be in this pre-diabetes zone, meaning that they are at risk of developing diabetes. So the studies have shown that a moderate weight-loss -- so we're talking about 7%, sometimes even up to 10%, of their body weight -- might impact positively on an individual's risk of preventing diabetes.

When it comes to different kinds of diets, whether it's a low carbohydrate diet, a low fat calorie restricted, a Mediterranean, and even a vegetarian diet, as long as the calories are kept to sustain the person's bodyweight or achieve the weight-loss have been equally affected; of course adding physical activity, about 150 minutes per week, also increasing dietary fiber 14 grams for every 1000 calories.

And we're going to go into that a little bit more so that you can visualize when this recommendation is made, "What are we talking about when we are suggesting that individuals consume 14 grams of dietary fiber?"

The consumption of whole grains is also very important. At least half of the grains that are consumed by persons at risk of developing diabetes, and I should say almost every individual, should come from whole grains, and to limit the intake of sugar sweetened beverages -- and that has been a epidemic in the nation is the use of sugar sweetened beverages. And what we see is that there is a 26% greater risk of developing diabetes where individuals consumed sugar sweetened beverages consistently.

Now we just talked about those 14 grams of fiber for every 1000 calories. So here we have some examples of what foods contain soluble fiber. So we have 1-1/2 cup oats, we have 1 cup of cooked kidney beans, we have 1 cup of ochre, an apple, strawberries, and a cup of cooked broccoli -- all these foods contain soluble fiber.

But what I would like you to do right now, and we can go to Poll Question Number 1 is, "From those foods, which one is highest in soluble fiber?" And if you could please, okay we're going to be closing the poll so make your selections. Okay, the polls are closed now and I see that 43% selected kidney beans, and oats was the second most popular.

So let's go back to the slide and we'll see that most of you were correct. One cup of kidney beans has 6 grams of soluble fiber compared to 1-1/2 cups of cooked oats with 3 grams of fiber. Nevertheless all of these foods are healthy.

And when we think about needed 14 grams of fiber for every 1000 calories that we need, so we're talking about 28 grams of soluble fiber if a person consumes a 2000 calorie diet, so it could be easily met by a combination of fruit, vegetables, as well as beans and peas.

The other recommendation was to include multi-grains, whole grains, etcetera. What I wanted to show here is it is very difficult to distinguish what is a whole grain and what is not. In this example we have two crackers and most people will probably select the one on the right, the multi-grain cracker as the whole grain.

What happens is, what you need to do as a health care professional as well as a consumer, is to look at the ingredient list and you will see that the first

ingredient on both is enriched flour, which is not multi-grain. What multi-grain means is that at least five different grains should be added to a product in order to be called multigrain, but it doesn't mean that the product in itself is a wholegrain product.

So here at a glance, when you want to choose wholegrain foods, this is what you should be looking for when you're looking at the ingredient list. So the word Whole should be - should precede the grain, and we're talking about whole wheat, whole corn, or rice, browned rice, and then some of the maybes might be wheat flour, semolina, etcetera. They might or might not be whole grain. And definitely when you see Enriched Wheat Flour, that is not whole grain.

So these are now the recommendations for the management of diabetes. We looked at the prevention of diabetes with the weight loss, including whole grains, reduction of calories to meet that goal. And now we're looking at the recommendation for the management of diabetes.

Well the research has shown that about a 5% weight loss is associated with a decrease of insulin resistance. So again, the message should be, "Any kind of weight loss is beneficial for person with diabetes."

The other recommendation is; to monitor carbohydrate intake, foods with carbohydrate, and we will take a look at what those foods are; to limit the saturated fat to less than 7% of total calories, and we're going to see an example of how you can take this recommendation and put it into action; and also to minimize the intake of trans fats. And trans fats are those foods that contain partially hydrogenated oil as listed as one of the ingredients.

These are some examples of foods that are high in saturated fat. It might be certain cuts of meat, chocolate and ice cream -- definitely one of my favorite high saturated fat food -- and dairy products made with whole milk, and of course the usual culprits, butter, lard, pork-fat, etcetera.

So when we talk about what is that 7% of our calories when we translate it into our budget, we're talking about between 12 to 16 grams of fat per day. That should be the budget for someone that might be consuming an 1800 calorie diet, which will be perhaps what the average American would be eating. Weight reduction plans might be somewhere between 1200 to 1400 calories and the fat will be reduced.

So here we have some common foods, American cheese, cheddar, etcetera. And what I would like to know is, and we can go to poll Question Number 2, "From those foods that are listed, which foods has the highest amount of saturated fat?" And you can make your selections now. Okay and make your selections, polls are closed.

So we have one glass, 8 ounces of whole milk as our winner. And an ounce of American cheese as the runner-up. Let's go back to the slide, and for those of you that selected American cheese, you are correct; 6 grams of saturated fat, for the most part, and of course each brand might vary a bit. And a glass of whole milk was - is 5 grams of saturated fat.

So as you can see, very easily someone that is consuming one to two glasses of milk, let's say 10 grams of fat, and has a grilled cheese sandwich with two or three slices of American cheese can really go over their daily budget. So 12 to 15 grams of saturated fat per day really does not give you a lot of wiggle room.

And many times, many of our patients are limiting their egg consumption because of their cholesterol content -- and I'm referring to the yolk. But you see that one egg, including the yolk, only has 1 gram of saturated fat.

So when you're counseling you have to pay attention to the consumption of other foods that others might not feel that they need to limit from their diet, and that that might be the cause of their high cholesterol levels. A diet that is high in saturated fat will increase LDL cholesterol, and that's one of the goals of diabetes management. So pay attention to those foods in the diet.

Okay, so we talked about carbohydrates. And people talk about a low carbohydrate diet; is it better than a low fat diet, better than a Mediterranean diet? And the optimum mix of macro-nutrients really mostly should come from carbs.

And again, we talked about fruits, vegetables, beans, legumes in general, and whole grains. That's where most of the carbohydrates should be coming from, the protein and the fat will - most likely should come from lean, and also the good and the healthy fat.

So while saturated fat might need to be decreased, there are other types of fats that are considered to be healthy. But above all, the total number of calories do matter regardless of that macro-nutrient mix. And the number of calories should be appropriate for a person's age, height, weight, physical activity, medication and their blood glucose levels.

So when we look at a meal and we deconstruct that meal, we see that the meal that you have on the left, it's a mix of carbohydrates, protein and fat. Very seldom do we consume just one type of food.

And I want to focus, even though our foods come from carbs, protein and fat, I want to focus of just one component of the nutritional management of diabetes, and that will be for today's lecture, the carbohydrate in diabetes management. And the reason that I want to focus on carbohydrate is because carbohydrate in foods is what effects blood glucose levels the most. So that's the reason why that will be the choice.

So when we're talking about carbohydrate, I want to use managing carbohydrate as the primary strategy for achieving blood glucose control. And the blood glucose levels, it's a combination of how much carbohydrate a person with diabetes eats, how much available insulin they have, and that determines their blood glucose levels.

So, what is the minimum daily carbohydrate recommendation? Is it 100, 130 or 150? When we're talking about going low-carb or having enough carbs to sustain health, what would that look like? And the answer is 130, that's the American Diabetes Association recommendation.

Now what is 130? How many cups of rice can I eat for 130? How much bread can one eat with 130? Let me just give you an idea of what 130 looks like in terms of food. One cup of cooked rice -- one cup -- will have 45 grams of carbohydrate, and that's about 1/5 course. So that means that if a person has two servings, or two cups of cooked rice, that will use 90 grams of the 130 grams that are budgeted for the day.

I will just summarize some of the recommendations by the American Diabetes Association and I will just reiterate that the fiber intake is very important. When the fiber is increased in the diet that can help to manage hunger and also soluble fiber can help to manage cholesterol levels. And very high fiber diet can even help to manage blood glucose levels.

Some - the diet should be a combination of fruits and vegetables and whole grains, legumes and low fat milk and dairy products. We also talked about the amount of carbohydrate and how quickly those 130 grams might go in one day when a person counts carbohydrate.

Another recommendation is to use the glycemic index and load as an advantage. And I'm not going to go into the definition or examples, but I will just say that the glycemic index is really how quickly the blood glucose level rises depending on the type of carbohydrate that is consumed. And foods that have sugar can be substituted for other carbohydrate foods, even though they might not be as nutritious, but they can be used.

Now let me just give you a couple foods, some of the foods that may contain carbohydrate, and some of them may not. So let's go to Poll Question Number 3 and there are six foods. What I want you to do is select the food that does not contain carbohydrate. Okay let's close the poll.

Okay, so the first answer, chicken cutlets the most popular one, followed by spinach, and sugar free cookies. And let's go back to the slide, and I just want to show, the foods that are now in red, those are the foods that have carbohydrate. Chicken cutlet was the correct answer, unless the chicken cutlet is breaded or it has flour, but just a chicken cutlet that is not a food that contains carbohydrate.

Spinach might be a surprise for some of you since it is a dark green and very nutritious vegetable. Most non-starchy vegetables do have carbohydrate, however the amount is very little. I would say that when I compare one cup of cooked rice, having 45 grams of carbohydrate, if I had one cup of cooked spinach, the amount would be 10 grams of carbohydrate.

However, because there is so little amount of carbohydrate in most vegetables and people do not consume a lot of vegetables in one meal, that many meal recommendations advice not even to count these vegetables as a source of carbohydrate unless there eating very large quantities.

And I just want to remind you that sugar-free foods might be sugar-free, but they are not necessarily carbohydrate-free. Even though the sugar might not be an ingredient in that cookie or cake, there is flour, and there might be fruit added to it, or milk. And all those three foods that I just mentioned, they have carbohydrate. And that's very important to talk to people with diabetes about because they might assume that once a product says, "Sugar-free," it is equivalent to carbohydrate-free.

Now I'm moving to some nutrition interventions targeting Latinos with diabetes. I'm going to talk about traditional foods, newly acquired food traditions, nutritional counseling based on the food groups, and I'm going to share with you some of the tools that I have used in practice that I have deemed to be culturally appropriate teaching tools.

The first item will be the food differences by Hispanic groups. As I was mentioning before, just as the prevalence of diabetes is different among certain Hispanic groups, so is the countries of origin and the food prices.

So our Mexican patients with diabetes stem from different parts of Mexico. Depending on where they come from, their food, habits and preferences will be different.

Individuals that live in the Caribbean part of Mexico, let's say in the Yucatan Peninsula, will have access to different kinds of food such as fish, compared

to people that are coming from the Northern part of Mexico, especially the Central part in which goat might be a preferred meat. Corn and beans though are two of the staple carbohydrate sources.

They use seafood, poultry and pork, depending on what part of Mexico they come from. And it is ubiquitous to use chili throughout Mexico. Some places might prefer to have corn tortillas and some other places might prefer to have flour tortillas.

When we look at the countries from Central America, I am just going to focus here on the staples. As we saw in Mexico, corn and beans are the staples; those are two sources of carbohydrate. Now rice, bean and corn are staples in Central America. Pork, chicken and beef are also used as the sources of protein. And it is seasoned also with tomatoes and onions. And chilies are not used as prevalently as in Mexico.

When we look at South America it's a vast territory, so it would be very difficult to just summarize all the different foods in South America. Once again, the coastal regions will have a very different food traditions and food cultures as the inland part of the countries. Going back again to the staples that are traditional in South America; potatoes, corn and rice are staples.

Now the Caribbean, from Puerto Rico, Dominican Republic and Cuba, rice and beans are staples, but now I'm going to add something else which are starchy root vegetables, which are also predominant in the diet. So things such as cassava, taro and yams are also part of the traditional meals. And when counseling persons that coming from the Caribbean, it is very important to be aware that these are sources of starch and carbohydrates.

I wanted to mention the globalization of food. And that is because many times we assume that when a person comes from any Latin American country or region that they're only eating their traditional foods, and it's not the case anymore.

This is a McDonald's in Bogota, Columbia, so many of the younger persons from a particular country might already be exposed to some of the same foods that we are exposed here. This is a Kentucky Fried Chicken in Oaxaca, Mexico. And here we have the places where Dunkin Donuts has stores.

So we are not - we should not assume that just because someone is coming from Mexico, from Columbia, and they're coming from another region that they might not already be mixing traditional with non-traditional foods. And here we have McDonald's that is already ethnically correct, with a selection of McPinto, which is a combination of rice and beans.

So not only do we become "Americanized," but even a chain like McDonald's becomes also, should I say, "Guatamalized," and it even has fried plantains.

I am briefly going to go over what the main point of this slide. And as you can see on the left hand side you have all the different food groups. The column in the center, it says, "What you need to know," meaning as the person that is teaching diabetes education, that is bringing nutrition messages to groups and individuals of persons with diabetes or pre-diabetes. And then the right hand column is what your clients or your patients need to know and do.

So if you are not familiar with Hispanics in general, what you need to know in the Meat category is that Hispanics consume more beef than non-Hispanic whites. And what you need to share is to encourage the leaner cuts of the different foods.

Where rice and beans is prevalent, rice is much more prevalent on the plate and less beans, so it should be switched around. Fruit is also added to shakes and it's eaten and preserved in juice, etcetera. And many times it is important to differentiate real juice from juice drinks.

I also want to highlight that many times when we talk about healthy oils, such as olive oil or canola oil, that we need to emphasize to our patients that oils, even though they - some of them might be very healthy, they still have calories. And that's very important for them to know. They might think, "Well I'm just having olive oil, I'm cooking with olive oil, therefore I can use as much as I want because it's healthy."

Very important to look at nutrition labels, especially when they are using certain foods such as corn flour to cook with, choose healthier fat, and again I want to stress this, that portions matter even if the foods are healthy. Somebody might be drinking an oat beverage or eating oatmeal because they have heard that it's healthy, but one cup is - I mean, it might be healthy, but not three and four cups. And vegetables, encourage the use of vegetables in stews and soups, etcetera.

I am going to share with you a program that I spearheaded, that I developed, and it was - it's a supermarket tour for Latinos with diabetes, and how to make this program culturally competent. In this particular program I walked with a group of 10 to 12 individuals with diabetes, and some of them had pre-diabetes, to teach them about meal planning, reading food labels, etcetera.

It is very important that instead of just providing information, that the program was culturally appropriate. When we started in the Produce section, many of the handouts and food lists include starchy foods such as squashes

and sweet potatoes, etcetera. So this might be a common list of certain foods that are included.

However, translating this into Spanish might not be culturally appropriate. This is a picture of the actual supermarket where I was conducting the tour. And as you can see, the starchy vegetables that are here include things such as cassava, it also includes taro, different kinds of yam.

So when I had to culturally adapt the list, I included things such as the pumpkin, cassava, plantain, the yam and the taro. It is important to include in your handouts, even if they are in Spanish, not just the foods that are commonly traditionally listed, but the foods that the group consumes.

Same thing here, instead of just listing the breads and the different types of breads, as you can see here there is one aisle with tortillas, another aisle with tortillas, another aisle with tortillas and more carbohydrates in the form of corn flours to make different products. And of course from the floor all the way to the ceiling, rice and beans.

So it is very important to once again, and I am going to reiterate this, that when you're creating a program for Latinos, it's not just about translating the existing food list, but to incorporate those foods that are traditionally found in the Hispanic group that you're working with so that they actually know what to do.

This is again another picture of - and many of you might not know of what this is, but it's called crema, which is the sour cream equivalent which is widely used in Central America. So we have avocado, we needed to include that. So a list of traditional facts for the American population may include mayo, cream cheese, sour cream, salad dressing and oils.

But then what happens is, look at this picture, again this is pork skin. So there is this giant display of pork skin. Now if a person with diabetes that consumes pork skin, how are they going to be able to manage their pork skin and still manage their diabetes? So my fat list included crema, included pork rinds, and included avocado. Again, to make it culturally acceptable to an individual so that they know how to fit that pork rind in their meal plan.

These are some carbohydrate teaching tools for Latinos. And the population that I worked with at the supermarket, many of them were not literate in Spanish, or in English. So what I did was at the end of the supermarket, I just created a visual tool. And my goal was for them to identify the foods that had carbohydrate.

So it was a mixture of just pictures that I had copied and pasted from Google, and but it includes things such as cassava, plantains and different - and of course tortillas that are ubiquitous in the person's diet. And then I wanted to show them the foods that didn't have any carbohydrates so that they could relate to that concept during our first visit to the supermarket.

And again I included things such as chicharrón, which means pork back fat. And I also included the crema, which are the jar that you see at the right hand side, right above the avocado.

The other part of the - at the end of our presentation I wanted to make it real. We don't eat carbohydrates, protein in foods, we eat food. So what I did was I showed them a meal that had many different types of carbohydrate. And most of these patients came from El Salvador, so I wanted to create a visual that brought the foods that they're familiar with, the foods that they like to eat.

And as you can see here, we have pupusa, which is made out of corn, we had cassava, fried plantain, we had pork, we had an empanada, which is a patty, and we had two different kinds of tamale, one made out of chicken and the other one made out of corn.

So what I did was I asked them first, "Which of these foods have carbohydrate?" And I had them just point at the food or just call it out loud. And then I told them how much carbohydrate was in all the foods that they had selected. And I asked them, "Well if you have a 50 gram budget for this meal, you clearly have gone over. So what would you do to bring it to a 50 gram budget or you can change it to 75?"

And then I have the individual say, "Well, I guess I'm not going to have the pupusa, or I'm not going to have the tamale, or I'm going to eliminate." So this way they were able to think about what they would do at home. It was not just about the numbers, but it was about meal planning with real foods.

We also looked at before and after, this is the Plate Method. And we said, "Well you still can eat your rice and beans, but instead of having two scoops or two cups, maybe have one and then increase the amount of vegetables." We also looked about adding more vegetables into a meal like Aros Compoyo, less vegetables, more vegetables. We looked about food preparation. And we looked about plantains, deep fried or oven fried. And how do we teach portion control?

We look at the spoon method; how many spoons can I have of these foods in order to be balanced. And using comparisons that people were familiar with; one ounce of cheese doesn't mean much, however when I told them that 1 ounce of cheese looks like a tile of domino, especially Puerto Ricans that love to play domino, at least here in New York, they knew exactly what 1 ounce

looked like. So using, not just the light bulb and other things, but things that are meaningful to the culture.

So what questions should you ask? This is really my little quick questions that I have used and that is, "Tell me about the Top 20 foods that you buy in your house. If I went to your house right now, what would be in your pantry, what would be in your kitchen?" I asked them, "What would a Mexican/Columbian/Venezuelan, what would be in your shopping cart?" And some of the other questions that are listed there.

So the take home message is Hispanics comprise the largest minority in the United States, they're a very diverse group, their food preferences vary widely amongst the different Hispanic regions. So you better ask, "What are your Top 20 favorite foods?"

Medical Nutrition Therapy, the three goals are to; manage blood glucose levels, minimize cardiovascular disease and hypertension, the energy balance should be good, quality, wholesome food in the appropriate quantity and use culturally appropriate teaching tools. And we looked at carbohydrate as one tool to manage diabetes -- not the only one, but one that we use today.

I also want to very quickly share with you some of my favorite resources because they're colorful and they're beautiful, they're in English and they're in Spanish, and these are tailored specifically for people with diabetes. And the latest edition contains new and revised recipes, things like Spanish omelet, beef stew, red Caribbean snapper, etcetera. So these delicious recipes could be yours to distribute and to have in your clinic, in your place of business because people want to share them.

Then these are recipe cards that you can share, that you can keep, that you can keep handy, and that you can even give as gifts for simple activities that you can have. So this is Set 1, this is Set 2.

And I would say that you also have, there's something else, you have posters. You have posters that you can use in your waiting area, that you can utilize if you're having a health fair. If you're putting anything up, I think they're colorful, and look at those mouthwatering pictures.

And last but not least, these are sample ads. So if you're communicating, you're sending newsletters, if you are - anything that is printed, you can just utilize them, use them and print them.

So I am going to now, very quickly turn over the presentation to Betsy Rodriguez and she's going to explain how you can order these colorful and delicious and practical materials.

Betsy Rodriguez: Thank you Lorena. For more information or to order materials, please call our number, 1-888-693-6337 or you can visit our Web site, yourdiabetesinfo.org. You can also send me an email at bjr6@cdc.gov. This is one - don't forget to complete your evaluation please. We invite you to use the resources on our Web site at www.yourdiabetesinfo.org.

Here you will find information for people with diabetes, at risk for diabetes, health care professional, business, school and community organizations. When you click - when you are in our Web site, under the section on Diabetes Topics, you can select their recipes and you will find all the information from It’s more than food, it’s life - Más que comida es vida!, is more than 40 slides, all of them are together -- all of these resources that were in our just show to you all.

Thank you for participating in this webinar. The National Diabetes Education Program is a partnership of the Center for Disease Control and Prevention, and the National Institute of Health and - with more than 200 public and private partners. Our goal is to reduce the illness and death caused by diabetes.

And now let's move through real quick to the Q&A section. Lorena, so I'm giving you the mic so you can answer questions right now.

Lorena Drago: Okay.

Coordinator: And again, at this time if you would like to ask a question over the phone, please press star 1 at this time. Once again, to ask a question over the phone press star 1. One moment.

And the first question we have comes from (Marianne), your line's open.

(Marianne): Hello. Early on you mentioned about limiting sugar sweetened beverages. I was just wanting to point out that it seems like many sodas are actually sweetened with high fructose corn syrup, and I was wondering if you wanted to talk about the effects of that as well. And is that something that we should also let clients know they should be limiting?

Lorena Drago: Yes, thank you (Amy) for your question. The issue of course is of high fructose corn syrup having a different effect than just regular sugar. It has been highly publicized and it's controversial. I don't know enough about the subject of high fructose corn syrup for me to feel comfortable speaking about it.

However what I do know is that increasing the consumption of beverages that increases the amount of calorie consumption and also replaces other healthy foods is not a positive way to manage diabetes, or even just for a healthy person overall. So I really want to be very careful because our society wants to look for just one bad guy. So if we eliminate high fructose corn syrup, then it is okay if we utilize other sources of added sugars.

And whether there might be some documentation, some evidence that it might be harmful, then I also don't want to give the message that once a soda or a beverage doesn't have high fructose that then it can be consumed as liberal. So I would say, "Refrain from using it whether it's high fructose or not."

(Marianne): Thank you.

((Crosstalk))

Coordinator: And once again, if you would like to ask a question please press star 1. Next question we have comes from (Flora). Your line's open.

(Flora): ((Spanish Spoken)).

Lorena Drago: ((Spanish Spoken)).

(Flora): Okay. ((Spanish Spoken)) Little Rock, Arkansas. ((Spanish Spoken)) Little Rock, Arkansas?

Lorena Drago: ((Spanish Spoken)). I'm going to repeat the question for those of you that did not understand. She wanted to ask the question in Spanish, she wanted to know if there was a Spanish speaking educator in Arkansas.

The American Association of Diabetes Educators has a directory that can be utilized to identify and also to locate different educators and the languages that they speak, in different parts of the country.

Betsy Rodriguez: Yes, in the ADA - AADE Web site there is a map, it says Find an Educator. If you go to their Web site you will be able to access what are the health educators in your area, and what is the language they speak.

(Flora): Okay, well thank you very much.

Lorena Drago: ((Spanish Spoken)).

(Flora): ((Spanish Spoken)) diabeteseducator.org?

Lorena Drago: ((Spanish Spoken)).

(Flora): Okay. Well thank you very much okay.

Coordinator: And once again that's, to ask a question, star 1. The next question comes from (Patricia). Your line's open.

(Patricia): Yes, thank you. Is the PowerPoint that you used in this presentation available to the audience?

Lorena Drago: Betsy?

(Patricia): Hello?

Betsy Rodriguez: Yes, the presentation, it's going to be archived. The - actually the whole webinar is going to be archived, and the presentation will be archived as a

PDF. So that means that people will not be able to make any alterations to the presentation because our speaker - this is proprietary information of the speaker.

(Patricia): Okay. So how will we be able to access that?

Betsy Rodriguez: As soon as we finish this email, I'll be sending an email to all the webinar participants, sending the evaluation form and sending some other information, including how to access the archived webinar.

(Patricia): Thank you.

Coordinator: The next question we have comes from (Lisa). Your line's open.

(Lisa): I got my question answered. Thank you.

Coordinator: Thank you. The next question then comes from (Jean). Your line's open.

(Gabriela): Hello?

Betsy Rodriguez: Hello?

(Gabriela): Yes, this is (Gabriela), I'm calling from Indianapolis. And I'm - I see a lot of Hispanic patients and they always have a question about eating carrots. I know there is some vegetables that are starch vegetables, but I am not - I am confused about carrots. I do tell them, "I don't know about carrots." How is that as far as being a starch vegetable; is that true or not?

Lorena Drago: That's a very good question, thank you for asking it. Yes, I think overall patients feel that they stay away from carrots and also beets because they feel

they're high in sugar. And I just wanted to say that they are not included as a starchy vegetable, they are included as a non-starchy vegetable which means that 1/2 cup of cooked carrots and 1/2 cup of cooked beets on average would have approximately 5 grams of carbohydrate. So sweetness should not be the measure for the amount of carbohydrates.

Things that are not sweet, like a slice of bread or a cup of rice, will have much more carbohydrate than carrots and beets. So you should encourage your patients to consume carrots and beets as one of their vegetables of choice. But I think that giving them those numbers can really help them. And just to let them know that don't guide themselves just by how sweet a food might be, because that does not determine the amount of carbohydrate.

(Gabriela): Okay, thank you.

Coordinator: Showing no further questions.

Betsy Rodriguez: Okay so being no further questions, I thank all of you for your participation.

Coordinator: Apologize, we did have someone come in.

Betsy Rodriguez: Okay.

Coordinator: (Rita McKenzie).

(Rita McKenzie): Could you repeat the instructions for the evaluation, how to fill out the evaluation.

Betsy Rodriguez: (Rita), I will be sending an email with the evaluation form and you can...

(Rita McKenzie): Okay.

Betsy Rodriguez: ...send that to me by - to my email.

(Rita McKenzie): Okay, I'm sorry. I thought I had to go into the system. Thank you.

Betsy Rodriguez: Also you can go to the system as we speak right now to the three-page icon. You download - you click on that icon, and then from there you can download the evaluation.

(Rita McKenzie): Okay. Lorena it was an excellent presentation.

Lorena Drago: Thank you.

Betsy Rodriguez: It is in the three-page icon – Handout Button- on the upper right portion of your screen. Select the file by checking the box, press Download, and browse to a location on your computer. Then select a destination folder and click Okay. Or you can wait until I send those to all of you.

(Rita McKenzie): Okay, thank you.

Coordinator: No further questions.

Betsy Rodriguez: Well thank you very much, (Muchas Gracias) for being in our webinar. I'm hoping that this webinar was informative and you are learned what to deal - how to deal with the Latino population in diabetes.

I want to thank Lorena Drago for being our speaker for today. And I want for all of you to give her a little applause. So thank you very much Lorena. And thanks everybody.

Lorena Drago: Thank you.

Coordinator: Thank you for your participation, you may disconnect at this time.

END