New Diabetes Nutrition Therapy Recommendations: What You Need to Know

Alison B. Evert, MS, RD, CDE, and Jackie L. Boucher, MS, RD, CDE

The American Diabetes Association (ADA) has long recognized the integral role of nutrition therapy in overall diabetes management and recommends that each person with diabetes receive an individualized eating plan that has been developed in collaboration with his or her health care provider (HCP).1 To ensure that members of the health care team are providing up-to-date, evidence-based clinical practice recommendations, the ADA issues official position statements on scientific or medical issues related to diabetes. Recently, the ADA published a position statement titled “Nutrition Therapy Recommendations for the Management of Adults With Diabetes.”2 These recommendations replace those in previous position statements. This article reviews the development process for the 2013 nutrition recommendations, shares highlights from those guidelines, and discusses priority topics in the publication.

Trustworthy Clinical Practice Guidelines/Position Statements

The 2013 ADA nutrition statement was written at the request of the ADA Professional Practice Committee. In August 2012, the ADA convened a committee of nutrition experts in clinical practice and research, as well as other members of the diabetes health care team (a registered nurse/advanced practice nurse practitioner, a physician, and a pharmacist) to review the scientific literature and develop recommendations. The multidisciplinary committee followed the Institute of Medicine (IOM) Standards for Trustworthy Clinical Practice Guidelines.3 Based on the IOM standards, conflict of interest disclosures were obtained before confirmation of appointment of the co-chairs and the members of the committee/writing group. Development of the position statement was funded from ADA general revenues and not with any corporate or industry financial support.

Evidence-Based Diabetes Nutrition Therapy: Development of the Recommendations

The committee’s work on the position statement began with an introductory conference call. The group reviewed an outline for the statement and assigned sections to specific members. Committee members were instructed to conduct thorough literature searches and create evidence tables for all of the topics included in the statement. Inclusion criteria for research studies providing evidence included:

- Adult subjects with a diagnosis of diabetes in an ambulatory or outpatient setting
- Published in English
- ≥ 10 participants
- Retention rates > 80%

Study design preference in ascending order included:

- Systematic review
- Randomized, controlled trial
- Clinical controlled study
- Prospective observational study
- Cross-sectional observational study
- Case-control study
Meal studies were excluded. Other exclusion criteria included research in individuals with:
- Prediabetes/metabolic syndrome
- Gestational diabetes/pregnancy
- Poor health status/diabetes complications or critical illness

The ADA’s “Macronutrients, Food Groups, and Eating Patterns in the Management of Diabetes: A Systematic Review of the Literature,”4 published in 2012, served as a foundation for development of the new position statement. However, three crucial components of diabetes nutrition therapy were not addressed in this systematic review: effectiveness of diabetes nutrition therapy, energy balance, and healthful eating patterns in people with diabetes. For these three topics and others not included in the 2012 systematic review, PubMed data searches were conducted for articles published from January 2001 through April 2013. A table listing the supporting research for each recommendation is available online at http://professional.diabetes.org/nutrition.

A grading system developed by the ADA and modeled on existing methods was used to clarify and codify the evidence that forms the basis for the recommendations.1 Depending on the quality of evidence, recommendations were assigned ratings of A, B, C, or expert opinion or expert consensus (E) based on no evidence from clinical trials (Table 1).1 All of the 2013 recommendations and their corresponding evidence grades can be found in Table 2.

The recommendation development process continued with a face-to-face meeting of the entire committee, one subgroup writing meeting, numerous teleconferences, and multiple revisions via e-mail communications. The document received a comprehensive external review by leading diabetes nutrition clinicians and researchers in the United States. The statement was then reviewed and approved by the ADA Professional Practice Committee before being submitted to the ADA Executive Committee for final approval.

### Definitions: Diabetes Medical Nutrition Therapy Versus Diabetes Nutrition Therapy

A notable difference between this statement and previous ones is the use of the term “nutrition therapy” instead of “medical nutrition therapy” (MNT). MNT is an evidence-based application of the nutrition care process provided by a registered dietitian/nutritionist (RD/N) and is the legal definition of nutrition counseling by an RD/N in the United States,3 whereas the IOM defines nutrition therapy as the treatment of a disease or condition through the modification of nutrient or whole-food intake. Therefore, nutrition therapy has a broader definition than MNT.6

Nutrition therapy research included in the 2013 position statement was conducted around the world by a wide variety of nutrition professionals, as well as physicians and registered advanced-practice nurses. HCPs administering nutrition interventions in studies conducted outside the United States did not provide MNT as it is legally defined.2 Thus, the term “nutrition therapy” was adopted in an effort to be more inclusive of the range of health professionals providing nutrition interventions and to recognize the broader definition of nutrition therapy. However, the unique academic preparation, training, skills, and expertise of RD/Ns make them the preferred members of the health care team to provide diabetes MNT.1 Table 3 summarizes the Academy of Nutrition and Dietetics Evidence-Based Nutrition Practice Guidelines—recommended structure for the implementation of MNT for adults with diabetes.7

### Diabetes Nutrition Therapy Is Effective

Review of the research conducted during the past decade reveals that diabetes nutrition therapy continues to be an effective management strategy for improving glycemic control and other metabolic parameters such as cholesterol and blood pressure levels. Effective nutrition therapy interventions can be provided either in one-on-one sessions with an RD/N or in group diabetes education classes.7,15

Research demonstrates that diabetes nutrition therapy can lower A1C levels by 0.3–1% in people with type 1 diabetes,11,16–18 and people with type 2 diabetes can achieve A1C reductions of 0.5–2%.9,10,19–32 Implementation of nutrition therapy in people newly diagnosed with type 2 diabetes who had an A1C of ~ 9% resulted in a decrease of ~ 2%,13 whereas newly diagnosed people who had an A1C level of ~ 6.6% experienced a decrease of 0.4%.8 In both instances, reductions were significant and clinically meaningful.34

### Table 1. Evidence Levels

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Description</th>
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| A              | • Clear evidence from well-conducted, generalizable, randomized, controlled trials that are adequately powered, including:  
  o Supportive evidence from well-conducted, randomized, controlled trials that are adequately powered |
| B              | • Supportive evidence from well-conducted cohort studies, including:  
  o Supportive evidence from a well-conducted case-control study |
| C              | • Supportive evidence from poorly controlled or uncontrolled studies, including:  
  o Evidence from randomized, clinical trials with ≥ 1 major or ≥ 3 minor methodological flaws that could invalidate the results |
| E              | • Expert consensus or expert opinion |
Even in people with uncontrolled type 2 diabetes of ~ 9 years' duration, implementation of nutrition therapy significantly decreased A1C by ~ 0.5%, which was more cost-effective than adding a third medication.9

Because of the relationship between body weight (i.e., adiposity) and insulin resistance, weight loss has been recommended as a strategy for obese and overweight people with type 2 diabetes.3 Prevention of weight gain is also important.2 Modest weight loss has been shown to improve glucose15,36 and blood pressure,35–40 increase HDL cholesterol,35–37,39–41 and decrease triglyceride levels,15,36,39–42 especially in those with newly diagnosed type 2 diabetes.

Effective nutrition therapy strategies for people with type 2 diabetes should emphasize reduced energy intake along with simplified meal plans such as healthful food choices or education on portion control. To achieve modest weight loss, intensive lifestyle interventions (physical activity, counseling about nutrition, and behavior change) with ongoing support are recommended. Unfortunately, because of the progressive nature of type 2 diabetes, physical activity and nutrition therapy may not be effec-

<table>
<thead>
<tr>
<th>Topic</th>
<th>Recommendation</th>
<th>Evidence Rating</th>
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<tbody>
<tr>
<td>Effectiveness of nutrition therapy</td>
<td>Nutrition therapy is recommended for all people with type 1 and type 2 diabetes as an effective component of the overall treatment plan.</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>Individuals who have diabetes should receive individualized medical nutrition therapy (MNT) as needed to achieve treatment goals, preferably provided by a registered dietitian familiar with the components of diabetes MNT.</td>
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<tr>
<td></td>
<td>- For individuals with type 1 diabetes, participation in an intensive flexible insulin therapy education program using the carbohydrate-counting meal-planning approach can result in improved glycemic control.</td>
<td>A</td>
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<tr>
<td></td>
<td>- For individuals using fixed daily insulin doses, consistent carbohydrate intake with respect to time and amount can result in improved glycemic control and reduce the risk for hypoglycemia.</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>- A simple diabetes meal-planning approach such as portion control or healthful food choices may be better suited to individuals with type 2 diabetes identified with health literacy and numeracy concerns. This may also be an effective meal-planning strategy for older adults.</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>People with diabetes should receive diabetes self-management education according to national standards and diabetes self-management support when their diabetes is diagnosed and as needed thereafter.</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>Because diabetes nutrition therapy can result in cost savings (B) and improved outcomes such as reduction in A1C (A), nutrition therapy should be adequately reimbursed by insurance and other payers (E).</td>
<td>B, A, E</td>
</tr>
<tr>
<td>Energy balance</td>
<td>For overweight or obese adults with type 2 diabetes, reducing energy intake while maintaining a healthful eating pattern is recommended to promote weight loss.</td>
<td>A</td>
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<tr>
<td></td>
<td>Modest weight loss may provide clinical benefits (improved glycemia, blood pressure, and/or lipids) in some individuals with diabetes, especially those early in the disease process. To achieve modest weight loss, intensive lifestyle interventions (counseling about nutrition therapy, physical activity, and behavior change) with ongoing support are recommended.</td>
<td>A</td>
</tr>
<tr>
<td>Optimal mix of macronutrients</td>
<td>Evidence suggests that there is not an ideal percentage of calories from carbohydrate, protein, and fat for all people with diabetes (B); therefore, macronutrient distribution should be based on individualized assessment of current eating patterns, preferences, and metabolic goals (E).</td>
<td>B, E</td>
</tr>
<tr>
<td>Eating patterns</td>
<td>A variety of eating patterns (combinations of different foods or food groups) are acceptable for the management of diabetes. Personal preference (e.g., tradition, culture, religion, health beliefs and goals, and economics) and metabolic goals should be considered when recommending one eating pattern over another.</td>
<td>E</td>
</tr>
</tbody>
</table>

*continued on p. 124*
Table 2. Nutrition Therapy Recommendations, *continued from p. 123*

<table>
<thead>
<tr>
<th>Topic</th>
<th>Recommendation</th>
<th>Evidence Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbohydrates</td>
<td>Evidence is inconclusive for an ideal amount of carbohydrate intake for people with diabetes. Therefore, collaborative goals should be developed with individuals with diabetes.</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>The amount of carbohydrate and available insulin may be the most important factor influencing glycemic response after eating and should be considered when developing the eating plan.</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>Monitoring carbohydrate intake, whether by carbohydrate counting or experience-based estimation, remains a key strategy in achieving glycemic control.</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>For good health, carbohydrate intake from vegetables, fruits, whole grains, legumes, and dairy products should be advised over intake from other carbohydrate sources, especially those that contain added fats, sugars, or sodium.</td>
<td>B</td>
</tr>
<tr>
<td>Glycemic index (GI) and glycemic load (GL)</td>
<td>Substituting low GL foods for higher GL foods may modestly improve glycemic control.</td>
<td>C</td>
</tr>
<tr>
<td>Dietary fiber and whole grains</td>
<td>People with diabetes should consume at least the amount of fiber and whole grains recommended for the general public.</td>
<td>C</td>
</tr>
<tr>
<td>Substitution of sucrose for starch</td>
<td>Although substituting sucrose-containing foods for isocaloric amounts of other carbohydrate may have similar blood glucose effects, consumption should be minimized to avoid displacing nutrient-dense food choices.</td>
<td>A</td>
</tr>
<tr>
<td>Fructose</td>
<td>Fructose consumed as “free fructose” (i.e., naturally occurring in foods such as fruit) may result in better glycemic control compared to isocaloric intake of sucrose or starch (B), and free fructose is not likely to have detrimental effects on triglycerides as long as intake is not excessive (&gt; 12% of energy) (C).</td>
<td>B, C</td>
</tr>
<tr>
<td></td>
<td>People with diabetes should limit or avoid intake of sugar-sweetened beverages (from any caloric sweetener including high fructose corn syrup and sucrose) to reduce the risk for weight gain and worsening of cardiometabolic risk profile.</td>
<td>B</td>
</tr>
<tr>
<td>Non-nutritive sweeteners (NNSs) and hypocaloric sweeteners</td>
<td>Use of NNSs has the potential to reduce overall calorie and carbohydrate intake if substituted for caloric sweeteners without compensation by intake of additional calories from other food sources.</td>
<td>B</td>
</tr>
<tr>
<td>Protein</td>
<td>For people with diabetes and no evidence of diabetic kidney disease, evidence is inconclusive to recommend an ideal amount of protein intake for optimizing glycemic control or improving one or more cardiovascular disease risk measure; therefore, goals should be individualized.</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>For people with diabetes and diabetic kidney disease (either micro- or macroalbuminuria), reducing the amount of dietary protein below usual intake is not recommended because it does not alter glycemic measures, cardiovascular risk measures, or the course of glomerular filtration rate decline.</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>In individuals with type 2 diabetes, ingested protein appears to increase insulin response without increasing plasma glucose concentrations. Therefore, carbohydrate sources high in protein should not be used to treat or prevent hypoglycemia.</td>
<td>B</td>
</tr>
</tbody>
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*continued on p. 125*
### Table 2. Nutrition Therapy Recommendations, continued from p. 124

<table>
<thead>
<tr>
<th>Topic</th>
<th>Recommendation</th>
<th>Evidence Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total fat</strong></td>
<td>Evidence is inconclusive for an ideal amount of total fat intake for people with diabetes; therefore, goals should be individualized (C). Fat quality appears to be far more important than quantity (B).</td>
<td>C, B</td>
</tr>
<tr>
<td><strong>Monounsaturated fatty acids/polyunsaturated fatty acids</strong></td>
<td>In people with type 2 diabetes, a Mediterranean-style eating pattern rich in monounsaturated fatty acids may benefit glycemic control and cardiovascular risk factors and can therefore be recommended as an effective alternative to a lower-fat, higher-carbohydrate eating pattern.</td>
<td>B</td>
</tr>
<tr>
<td><strong>Omega-3 fatty acids</strong></td>
<td>Evidence does not support recommending omega-3 (EPA and DHA) supplements for people with diabetes for the prevention or treatment of cardiovascular events.</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>As recommended for the general public, an increase in foods containing long-chain omega-3 fatty acids (EPA and DHA) (from fatty fish) and omega-3 linolenic acid is recommended for individuals with diabetes because of their beneficial effects on lipoproteins, prevention of heart disease, and associations with positive health outcomes in observational studies.</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>The recommendation for the general public to eat fish (particularly fatty fish) at least two times (two servings) per week is also appropriate for people with diabetes.</td>
<td>B</td>
</tr>
<tr>
<td><strong>Saturated fat, dietary cholesterol, and trans fat</strong></td>
<td>The amount of dietary saturated fat, cholesterol, and trans fat recommended for people with diabetes is the same as that recommended for the general population.</td>
<td>C</td>
</tr>
<tr>
<td><strong>Plant stanols and sterols</strong></td>
<td>Individuals with diabetes and dyslipidemia may be able to modestly reduce total and LDL cholesterol by consuming 1.6–3 g/day of plant stanols or sterols typically found in enriched foods.</td>
<td>C</td>
</tr>
<tr>
<td><strong>Micronutrients and herbal supplements</strong></td>
<td>There is no clear evidence of benefit from vitamin or mineral supplementation in people with diabetes who do not have underlying deficiencies.</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>• Routine supplementation with antioxidants such as vitamins E and C and carotene is not advised because of a lack of evidence of efficacy and concern related to long-term safety.</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>• There is insufficient evidence to support the routine use of micronutrients such as chromium, magnesium, and vitamin D to improve glycemic control in people with diabetes.</td>
<td>C</td>
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<tr>
<td></td>
<td>• There is insufficient evidence to support the use of cinnamon or other herbs/supplements for the treatment of diabetes.</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>It is recommended that individualized meal planning include optimization of food choices to meet recommended dietary allowance/dietary reference intake for all micronutrients.</td>
<td>E</td>
</tr>
<tr>
<td><strong>Alcohol</strong></td>
<td>If adults with diabetes choose to drink alcohol, they should be advised to do so in moderation (≤ 1 drink/day for adult women and ≤ 2 drinks/day for adult men).</td>
<td>E</td>
</tr>
<tr>
<td></td>
<td>Alcohol consumption may place people with diabetes at increased risk for delayed hypoglycemia, especially if they are taking insulin or insulin secretagogues. Education and awareness regarding the recognition and management of delayed hypoglycemia is warranted.</td>
<td>C</td>
</tr>
<tr>
<td><strong>Sodium</strong></td>
<td>The recommendation for the general population to reduce sodium to &lt; 2,300 mg/day is also appropriate for people with diabetes.</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>For individuals with both diabetes and hypertension, further reduction in sodium intake should be individualized.</td>
<td>B</td>
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</tbody>
</table>
Table 3. Academy of Nutrition and Dietetics Evidence-Based Nutrition Practice Guidelines7

The Academy of Nutrition and Dietetics Evidence-Based Nutrition Practice Guidelines recommend the following structure for the implementation of MNT for adults with diabetes:

- MNT should be provided in a series of three to four encounters with an RD lasting from 45 to 90 minutes each.
- The RD should determine whether additional MNT encounters are needed.
- The series of encounters should begin at diagnosis of diabetes or at first referral to an RD for MNT for diabetes and should be completed within 3–6 months.
- At least one follow-up encounter is recommended annually to reinforce lifestyle changes and to evaluate and monitor outcomes that indicate the need for changes in MNT or medication(s); an RD should determine whether additional MNT encounters are needed.

- With regard to carbohydrates, the recommendations advise that people with diabetes should choose nutrient-dense, high-fiber foods, as opposed to processed foods with added fat, sugars, and sodium.71,72
- Also new, the 2013 guidelines specifically call for the avoidance of sugar-sweetened beverages (SSBs; sweetened with any caloric sweetener including sucrose and high fructose corn syrup) to reduce the risk for weight gain and worsening of cardiometabolic risk profile.7 SSBs include soft drinks, fruit drinks, iced tea, energy drinks, and vitamin water containing sucrose, high-fructose corn syrup, or fruit juice concentrates. The evidence for this recommendation is abundant from studies in individuals without diabetes; there is little reason to suspect that the diabetic state would mitigate the adverse effects of SSBs.73–77 The ADA nutrition recommendations also advise that the use of non-nutritive sweeteners has the potential to reduce overall calorie and carbohydrate intake if substituted for caloric sweeteners without compensation by intake of additional calories from other food sources.78

In another change from the 2008 ADA nutrition recommendations, the limit for sodium is given as 2,300 mg/day—the same as for the general population.79–81 Alternate individualized sodium targets are recommended for patients with both diabetes and hypertension.65,82 Previously, the recommendation had been < 2,000 mg/day for all diabetes patients.

Regarding the use of vitamin and mineral supplements and herbal products, the literature review revealed a predominance of short-term, small, human studies (i.e.,
limited number of study participants) or animal studies. These studies are often poorly designed, making it difficult to prove efficacy based on their findings. Unfortunately, results from such studies are frequently extrapolated to clinical practice. Based on its review of existing literature, the committee concluded that the benefit of pharmacological doses of supplements is unknown. Similarly, evidence does not support recommending omega-3 supplements for people with diabetes as a way of preventing or treating cardiovascular disease.

Practical Application of the New Recommendations

In an effort to help translate the position statement’s recommendations into clinical practice, the writing group included for the first time in the 2013 statement a table titled “Summary of Priority Topics.” This table provides evidence-based nutrition management talking points that can be used by all members of the health care team. Topics include nutrition strategies for all people with diabetes and coordination of care with different classes of diabetes medications, including fixed-dose or basal-bolus insulin regimens, insulin secretagogues, incretin mimetics, and others.

The new position statement does not include sample meal plans because research conducted during the past decade has provided evidence that individualization is a key element of effective eating plans for people with type 2 diabetes.

Summary

A variety of eating patterns and meal-planning approaches can be effective for achieving individual metabolic goals for adults with diabetes. To eat well, it is best to eat nutrient-dense foods (i.e., fiber-rich foods that offer high levels of nutrients in appropriate portion sizes). Nutrition therapy goals should be developed collaboratively with individual diabetes patients. These goals should be based on assessment of individual patients’ current eating patterns, personal and cultural preferences, access to healthful food choices, and willingness and ability to make changes in food and beverage choices, as well as their metabolic goals. Ideally, an eating plan should be developed early in the course of the disease in collaboration with an RD/N or through participation in a diabetes self-management group education class. Ongoing follow-up with a diabetes HCP is crucial for success; diabetes is a disease that is largely self-managed by patients who require professional support. Recommendations also may need to be adjusted over time based on changes in patients’ life circumstances, preferences, and disease course.

Acknowledgment

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