Purpose
• Increase awareness of the prevalence of liver disease among women and current gender-specific research.

Objectives
• Develop an understanding of the diagnostics, treatment, and prognosis of the various types of liver diseases.
• Recognize the importance of nutrition and lifestyle in relation to the most common forms of liver disease.
• Become familiar with current medical nutrition therapy recommendations.

Introduction and Summary
The prevalence of liver disease is increasing, particularly in women. While liver disease affects both men and women, the medical and life-long health impact on women appears to be unique. Research on the impact of liver disease on women is focused on protocols and management to promote early diagnosis and initiate effective treatment to improve patient outcomes.

Prevalence of Liver Disease

in Women
Compared to men, women are more likely to have acute liver failure, autoimmune hepatitis, biliary cirrhosis, and drug-induced liver disease; however, women have a decreased risk of malignant liver tumors, viral hepatitis, and liver transplant. Additionally, women have a slower rate of disease manifestation of cirrhosis and hepatitis C than men. Survival rate of alcoholic liver disease and liver cancer are the same for both sexes.1

Alcohol and Drug Induced Liver Disease (ALD and DLD)
Among those over the age of 26, alcohol dependence is twice as common in men as in women; however, women appear to be more affected by the toxic effects of alcohol on the liver, with damage developing more rapidly in women than men.1,2 The severity of alcoholic liver disease in women is multifactorial; a study involving more than 107,000 women from the United Kingdom suggests that high BMI and high consumption of alcohol increase the risk of disease.3 Additionally, endotoxin levels, estrogen receptor concentrations, and gene expression in women appear to contribute to the severity of alcoholic liver disease. Women seem to be twice as sensitive to alcohol-induced liver toxicity with a lower amount of alcohol consumption in comparison to men. Preliminary research suggests that rapid toxicity in women may be attributable to variations in estrogen levels, BMI, body fat percentage, and the menstrual cycle.4,5 Socially, alcohol consumption among women has increased for many reasons, including the decrease in cost of alcohol in relation to financial earnings, easier access to alcoholic beverages in grocery stores and gas stations, and the societal acceptability of routinely drinking alcohol in public.4

Drug-induced liver disease (DLD) is due to rare, adverse reactions caused by an individual’s immune response to a drug like acetaminophen. In a study by the Acute Liver Failure Study Group, out of 133 patients diagnosed with drug-induced hepatotoxicity, 71% were women; notably, bioavailability, metabolism, and excretion of drugs in women play a role in disease progression.1,6

Nonalcoholic Fatty Liver Disease (NAFLD)
Nonalcoholic fatty liver disease, commonly known as NAFLD, is the most prevalent form of chronic liver disease with an estimated 34% of adults in the United States diagnosed.8 NAFLD occurs when fat accumulates abundantly in the liver cells of patients who do not use alcohol in excess. This build-up of fat is known as steatosis. While the liver naturally contains fat, clinical steatosis is diagnosed if the liver contains more than 5-10% fat.9-11 NAFLD is referred to as a “disease of lifestyle,” as the risk factors include obesity, lack of physical activity, hyperlipidemia, and type 2 diabetes. Furthermore 60-80% of NAFLD patients have diabetes and/or are obese.12 Interestingly, livers affected by NAFLD and alcoholic liver disease appear extremely similar under a microscope. For both types an estimated 10% will progress to cirrhosis.1,7,13

Continued on page 3
As we embark on a new exciting year, we introduce our first issue of the membership year packed to the brim, offering practical and applicable resources to better accommodate our female population, covering topics such as liver disease and alcohol consumption, along with additional CDR updates to our professional portfolio. We hope our quarterly publication helps launch your nutritional expertise into the next century.

For those of you who were in Chicago celebrating the Academy’s centennial, a huge thank you for stopping by the WH DPG showcase and attending our featured spotlight session-PCOS: Beyond Hormones and Hot Flashes. A grateful shout-out to our magnificent presenters, Angela Grassi and Lynn Monahan, who offered an impressive session. This session was so well attended that an overflow room was created to accommodate attendees! Thank you Angela and Lynn for sharing cutting-edge research that can be readily applied when working with this population!

If you haven’t already, please check out the WH DPG social media outlets! Over the next few months, any WH DPG member who shares WH DPG info/articles via Facebook, who retweets or tags @WomensHealthDPG, #WHDPG, or who encourages a fellow RDN to join the WH DPG, will be entered into a quarterly raffle to win an Amazon gift card! Pictures taken during FNCE® at any WH DPG related event also count, so tag away.

Thank you to all the contributors to this newsletter and to all of you for contributing every day to the wonderful world of women’s health; we have some pretty amazing members that continue to inspire!

FROM THE EDITOR  Kathleen Pellechia, MS, RDN

Hello WH DPG Members,

I am excited to kick off another year of the Women’s Health Report! This issue features a cover article on “Women and Liver Disease: Role of Nutritional Interventions” by Carey Stites, MS, RD, LD, CPT. It is becoming more evident that differences exist in not only the rates at which men and women develop certain diseases, but in optimal strategies for disease management and treatment. As dietitians, it is essential that we understand, as best we can, the role of gender in disease prevention, diagnosis, and management. This article is approved for one continuing education credit.

This issue also includes a discussion of the latest recommendations for alcohol consumption for women, and a Q&A on the new Professional Development Portfolio (PDP) system.

For those of you who attended FNCE, I hope you were able to make connections and expand your learning opportunities. We will be sharing highlights from the conference in upcoming issues.

As always, we welcome your suggestions for future issues and especially love having our members contribute content. Contact me at publications@womenshealthdpg.org with comments or ideas.

Warm regards,
Kathleen

FROM THE CHAIR  Katie Leahy, MS, RDN, LD

We’re on the web!
www.womenshealthdpg.org
Data on NAFLD in women appears conflicting. Some research suggests women are 1.5 times more likely than men to be diagnosed with NAFLD, while other research indicates no gender connection. To date, the possible genetic link to NAFLD development remains undefined; however, research points to an increased disease prevalence in those of Hispanic, Native American, and Asian descent.

Nonalcoholic Steatohepatitis (NASH)
Nonalcoholic steatohepatitis (NASH) is a more damaging form of NAFLD in which the trifecta of liver injury, inflammation, and steatosis occurs in non-alcoholic patients. A study conducted by the Third National Health and Nutrition Examination Survey from 1988-1994 found that of 1,266 patients with NASH, 64% were female (age not disclosed), resulting in more women developing severe thickening and scarring of the liver versus men.

Preliminary population-based studies reveal estrogen may serve a protective role in preventing NASH in women. More post-menopausal women over the age of 50 have a form of NAFLD versus women under 50 producing ample estrogen. Ultimately, further research is needed to identify a possible link between estrogen and decreased risk of NASH in women.

Viral Hepatitis: Hepatitis C
Hepatitis, whether viral or genetic, is inflammation of the liver. A well-known form of viral hepatitis is hepatitis C, which typically affects baby boomers born between 1946 and 1964. Research notes that women clear the hepatitis C virus (HCV) faster than men. Risk factors for hepatitis C include intravenous drug use, blood transfusions prior to 1991, hemodialysis, working in health care, and sexual transmission through unprotected sex or multiple partners. Estrogen may protect women against fibrosis of the liver in viral hepatitis and slow the progression. In a study of 251 women, 121 were post-menopausal, and 65 of those post-menopausal women received hormone replacement therapy (HRT). The 65 women on HRT therapy showed a lower rate of fibrosis compared to post-menopausal women not on this treatment protocol.

Gestational Diabetes and Liver Disease
During the years of 1985 and 1986 across four U.S. cities, 1,115 black and white women who gave birth to one child were studied. These women did not have diabetes or any type of liver disease. Of these women, 124 were diagnosed with gestational diabetes mellitus (GDM) during the course of the pregnancy. Twenty-five years later, 75 of the 124 GDM women acquired NAFLD. The researchers concluded the women with GDM during pregnancy were more than twice as likely to develop NAFLD later in life. Notably, these women were also more likely to be overweight, suggesting importance of medical nutrition therapy in the management of GDM and NAFLD.

Nutrition and Lifestyle in Relation to the Most Common Forms of Liver Disease
Certain liver diseases specifically parallel diet and lifestyle habits. NAFLD is the most prevalent known liver disease directly related to obesity. As one of the most common causes of liver problems in industrialized areas, NAFLD is related to excess body weight and poor lifestyle habits. Both excess body weight and poor lifestyle habits contribute to the development of NASH.

A study of 129 patients with NAFLD followed for almost 14 years found that death from cardiovascular disease was more likely than death from liver complications. Additionally, the death rate for patients who developed NASH during the study was twice as high as the death rate in those with only NAFLD.

With nutrition therapy as the first line of treatment for patients, clinicians must be aware of the nutritional risk factors and medical nutrition therapy protocols for improving patient outcomes.

Excess Caloric Intake
Obesity and excess caloric intake are directly associated with NAFLD in adults. Research states 80% of adults categorized with class 1 or class 2 obesity and 90% with class 3 obesity have NAFLD; across all cases, 36% of those cases progress to NASH. Class 1 obesity is defined as a BMI of 30 to <35, class 2 as a BMI of 35 to <40, and class 3 as a BMI of 40 or higher. Excess caloric intake and inactivity forces the liver to store fat, which is not a primary function of this organ. This can lead to the development of NAFLD. Additionally, studies citing energy intake among patients with NASH show an increased consumption of calories, fat, and simple sugars.

Common practice for nutrition intervention in treatment of NAFLD includes weight loss and a reduction of sugar intake. According to recent data, a 5–10% weight loss in patients with NAFLD can decrease fat accumulation in the liver. Additionally, patients are encouraged to reduce sugar consumption by controlling the intake of baked goods, desserts, sodas, snack foods and cookies. The consensus is that daily sugar intake should be less than 10% of total daily calories.

Excess Fat Intake
Excess fat intake, especially saturated fat, is an important risk factor for NAFLD and NASH due to the associated increase in calories and body fat. A survey showed NAFLD patients typically consume more saturated fat than healthy patients. The same survey revealed NAFLD and NASH patients had a higher consumption of total fat than healthy patients. Additionally, the intake of polyunsaturated fatty acids was lower in patients with NAFLD; researchers suggest the deficiency may be a contributing factor to the development of NAFLD.

Most patients require a meal plan specifically designed by a registered dietitian nutritionist based on the clinical course and medical diagnosis. For patients with NAFLD, a recommendation of total fat intake of 25 to 30% of total daily calories is often a starting point and is generally an improvement from the patient’s previous intake. Saturated fat intake of more than 7% of caloric intake should be avoided for patients with NAFLD. A food recall is an extremely valuable tool for clinicians in order to evaluate current eating patterns and recommend appropriate nutrient parameters for clinical improvement.

Eliminating whole milk, full-fat cheese, butter, fried foods, high-fat meats, and packaged foods, and replacing foods high in saturated fat with foods rich in omega-3 fat (e.g., salmon, tuna, and flax), are often suggested for patients with liver disease such as NAFLD and NASH.

Sodium and Fluid Restrictions
Medical nutrition therapy for patients with liver disease typically involves a restriction of sodium intake and fluid. Sodium affects fluid retention in patients and with excess fluid intake can lead to edema.
and ascites from portal hypertension. Portal hypertension is the increase in blood pressure in the portal venous system due to the inability of blood to flow through the damaged liver. This results in ascites, which is the accumulation of fluid in the abdominal cavity. In most cases, patients are instructed to consume no more than 2 grams of sodium and 6-8 cups of fluid (48-64 ounces) per day.17,18

Liver Disease and the Prevalence of Malnutrition

Research suggests 20% of patients with early-stage liver disease and 60% of those with late-stage liver disease are malnourished.19 Malnutrition can be defined as deficiency of vitamins A, D, and E, as well as thiamine, or as clinically diagnosed protein-calorie malnutrition.5,12,19 Malnutrition is common in patients with certain liver diseases, such as ALD or DLD, due to the presence of fluid gain seen in most of these patients. While often overlooked, the process of screening patients with known liver disease for the presence of malnutrition is vital to improving patient outcomes.

For many years, clinicians assumed the degree of malnutrition versus patient alcohol consumption directly affected the degree of liver disease. New research, however, suggests the alcohol itself causes the liver disease even in patients with a balanced diet who consume excess alcohol. Studies show hospitalized patients consuming a nutritious daily diet developed fatty liver when carbohydrates were replaced with alcohol while protein and fat remained the same. 20

Malnutrition in patients with liver disease results from a variety of factors affecting nutritional status, which can include loss of appetite with reduced oral intake, inadequate digestion, impaired nutrient storage, or malabsorption of nutrients. Additionally, the presence of ascites, or the abnormal accumulation of fluid in the abdomen resulting from liver disease, provokes early satiety for patients when attempting to eat. Patients with ALD may forego food altogether, choosing instead to consume alcohol and limit interaction with the outside world. Under medical supervision, the nutrition care plan may include a low-sodium diet, fluid restriction, specific protein recommendations, and intake of small, frequent meals. 19

Summary

Data suggests differences between women and men in risk factors, clinical manifestations, treatment protocol, and prognosis for liver diseases such as ALD, DLD, PBC, NAFLD, NASH, and HCV. Proposed explanations for these differences, based on limited evidence, include variances in hormones and genetic factors, suggesting gender-specific treatments could be valuable in the clinical management of liver disease. Generally speaking, however, the most common forms of liver disease can be effectively managed with appropriate medical nutrition therapy including a reduction in calorie, fat, and sugar consumption as directed by a registered dietitian nutritionist.

References

14. Kennedy, M. New analysis shows that women who develop diabetes while pregnant are likely to develop fatty liver disease. The Hospitalist. 2016;4:15-16.

Educational Resources for Dietitians


our vision

“Optimizing the future of women’s health at all ages.”
A glass of wine with dinner, a beer at the baseball game, or a celebratory drink with friends at the bar all seem like normal, harmless habits. But what about two glasses of wine? Three beers? Four drinks? It’s clear that women who drink more than moderate amounts of alcohol, defined by the Dietary Guidelines for Americans as up to one drink per day for women, have increased health risks. However, studies have also identified benefits to alcohol within the recommended limits.

Based on several studies, alcohol in moderation may lower the risk of coronary heart disease in women, especially those over the age of 55.\(^1\) This makes sense, because the active ingredient in alcohol – ethanol – promotes the production of HDL.\(^2\)

Depending on the patient, then, suggesting a glass of wine with dinner may be healthful. However, the benefits must be weighed against the risks.

Women process alcohol differently than men. Women on average have less water per pound of body weight than men, as they typically have less lean mass. Therefore, when alcohol is consumed and it disperses in the body’s water, the ratio of alcohol to water is higher, increasing the toxic effects on women’s organs.\(^1\) Even one drink effects women more rapidly and more severely.

Moreover, even one drink per day can increase breast cancer risk in women who are post-menopausal or have a family history of the disease.\(^1\) Given that heart disease is the number one killer in the United States,\(^3\) though, risks of moderate drinking should be weighed against potential heart-health benefits.

Consuming alcohol above identified moderate levels can result in higher blood pressure and direct damage to the essential organs.\(^2\) In addition, alcohol consumption of greater than four drinks per day, or eight drinks in a week, can lead to alcohol dependence, and an increased risk of liver disease, breast cancer, and several other forms of cancer.\(^1\) Alcohol dependence often runs in families, thus obtaining a family history of alcoholism is an important step in the counseling process. If a patient has a family history of alcoholism, avoid recommending wine as a protective measure for their heart.

The drawbacks of over-consumption aren’t only limited to the long-term and can impact more than the woman herself:

- Fifty percent of all fatal car accidents are alcohol related. Other injuries are also more common with alcohol consumption, as decision-making and motor skills are impaired. Alcohol can also interact with medications, increasing the side effect of drowsiness.\(^1\) Make sure to review a patient’s medications before recommending any alcohol consumption.
- In the US, nearly half of all pregnancies are unplanned.\(^4\) There is no recommended safe amount alcohol for women who are pregnant or who are trying to become pregnant. A woman could get pregnant and not know it for 4-6 weeks, during which time key fetal development is already occurring. Fetal alcohol spectrum disorders, which include a range of physical and mental problems for the infant, are preventable if women do not consume alcohol during pregnancy.

As of 2015, 60% of women in the US drank at least one drink each year. Of those, 5.3 million drank alcohol in a way that threatened their health.\(^5\) That is a lot of women putting themselves in the way of preventable illness and injury. Addressing alcohol consumption, binge drinking, and alcoholism with all patients who report it as part of their daily intake is essential for the dietetics practitioner.

So, can there be benefits to wine, beer or even spirits? Definitely. One drink every few days (or even every day) could be a boon to heart health. However, if controlling consumption becomes too difficult, or other risk factors exist, the best way to protect the heart and all-around health is to abstain from alcohol entirely.

**References**


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**ATTENTION ALL WOMEN’S HEALTH DPG MEMBERS**

Our survey regarding Health and Wellness has been completed! Listed below is the wording that was sent out with our survey.

> The Academy House of Delegates has embarked on a new process for capturing member insight on key issues impacting the profession. Women’s Health is seeking your thoughts on the future ideal state of Wellness and Prevention and the RDN’s and NDTR’s role in this segment of our profession. Please answer this short 6 question survey. Thank you in advance for your participation in this survey and your ongoing commitment to the Women’s Health DPG.

We are happy to report that we do have WH DPG members who are employed in Health and Wellness, and would like to ask if any of you would be willing to write an article for a new section on Health and Wellness in our newsletter. You can write about your careers and how you got started working in Health and Wellness. This is an exciting time for all Academy members as we head into our Second Century.

Interested WH DPG members should contact: Denise Andersen MS RDN LD CLC, WH DPG Delegate for the Academy’s House of Delegates. My email address is: dandersster@gmail.com.
COMMISSION ON DIETETIC REGISTRATION (CDR) INCORPORATES ESSENTIAL PRACTICE COMPETENCIES: Revised Professional Development Portfolio (PDP) Recertification Process By Karen Lacey, MS, RDN, CD

Karen Lacey is a Senior Lecturer Emerita and Former Director of the Dietetic Programs at the University of Wisconsin-Green Bay. She is a past-president of the Wisconsin Academy of Nutrition and Dietetics and most recently served as a Commissioner on the Commission for Dietetic Registration (CDR). She currently chairs the Competency Assurance Panel (CAP), a subcommittee of CDR that oversees the Professional Continuing Education for registered dietitians and dietetic technicians. CAP developed the newly revised Professional Development Portfolio process utilizing practice competencies.

Her awards and recognitions include: Academy’s Outstanding Dietetic Educator Awards for Didactic Program and Dietetic Internship, the Wisconsin Academy of Nutrition and Dietetics’ Outstanding Dietitian and the Academy’s Medallion Award.

Since 1969, when registration was first established with a mandatory continuing professional education unit (CPEU) requirement, CDR has been committed to ongoing enhancement of the recertification process to support practitioners’ competence. The most recent revision resulted in the PDP process moving away from goals and learning need codes to using practice competencies and performance indicators to create each new 5-year learning plan.

This revision was first implemented in June 2015 by newly credentialed practitioners beginning their first 5-year cycle. In June 2016, practitioners who were recertifying began using the process, and each year a new group will develop their next 5-year learning plan with the revised process. By June 2020, recertification with essential practice competencies will be fully implemented.

Given the new recertification process, practitioners have raised many questions. For example: What does this mean for how learning plans are created? Will I have to take the RD or DTR exam over again? Can the new plan meet my needs if I am not currently working or what if I want to change jobs?

Rest assured that the revised process addresses these concerns, and in fact many prefer the updated process. Below are a series of common questions and answers about key changes to the process and what you can expect from using essential practice competencies.

1. Why did CDR make these changes? The transformation of the PDP process away from goals and learning need codes to competencies and performance indicators helps address regulatory changes and expectations of regulatory bodies such as the Department of Health and Human Services (which administers HIPAA) and the Joint Commission. These groups and others have raised standards for demonstrating professional competence in practice for nutrition and dietetics practitioners. The use of practice competencies better reflects not only the knowledge, but also the skills, judgment, and attitudes necessary to perform duties in a competent manner. Along with the Code of Ethics, Standards of Practice, and other Academy resources, the new competencies will further enhance the overall quality of dietetics practice.

2. What are competencies? A competency is a set of defined behaviors that provide a structured guide enabling the identification, evaluation, and development of behaviors in an individual. The Essential Practice Competencies for CDR-credentialed nutrition and dietetics practitioners define the knowledge, skills, judgment, and attitude requirements throughout a credentialed practitioner’s career, across practice settings, and within focus areas. They are broad and encompass a wide variety of learning needs. They have also been validated by practitioners so that they accurately reflect what is vital to practice and in the best interest of the public.

3. Do I need to retake the RD or DTR exam? The transition to this competency-based system DOES NOT require re-examination.

4. How are the competencies organized? The overall competency framework is divided into three interconnected parts. First, there are 14 spheres that define the areas in which practitioners act, work, or have influence. Examples include such areas as communications, education and counseling, clinical care, and community and population health. Second, within each sphere are the competencies that describe expected performance or behaviors. These competencies replace the goal statements. Third are performance indicators that define the level of expected performance. These replace learning need codes. Last in this framework are practice examples intended to help practitioners apply competencies in day-to-day performance.

The entire list of all of the spheres, competencies, performance indicators, and practice examples can be found and downloaded from the CDR website in the document entitled “Essential Practice Competencies for the Commission on Dietetic Registration’s Credentialed Nutrition and Dietetics Practitioners.”

5. How do I use these competencies and performance indicators to create a new learning plan? The current PDP system asks you to reflect on your past, current, and possible future employment and professional experiences, and then to write goals and select learning need codes to address your learning plan. The revised system utilizes an online Goal Wizard, accessed via your usual log-on to the CDR website, www.cdrnet.org, and then the MyCDR page. The enhanced Goal Wizard will walk you through a number of computerized steps in which you reflect, assess, and ultimately create a new learning plan. Steps include defining your practice; reflecting on day-to-day activities; assessing the skills, knowledge, and judgment that you demonstrate; identifying interests and future work; and mandatory learning and required ethics. You will be able to develop a complete personalized competency profile listing all the competencies that relate to your professional status and performance. From this list, you will then be able to select which competencies best describe your desired learning plan for the upcoming 5-year recertification cycle.

There are a number of resources on the CDR website that can help prepare you for using this new Goal Wizard. You can access these resources via the home page link to PDP and Competencies Information; then Practitioners. Once on the practitioner’s information site, there are webinars, videos, and frequently asked questions (FAQs). One of the most helpful resources is a demo version of the Goal Wizard entitled the Dream Wizard that will take you through simulated steps of the Goal Wizard.

Continued on page 11
Future Practice
HOD Fact Sheet

House of Delegates Spring 2017

For over a decade, the Academy has collectively worked towards a vision of future education and practice that will elevate the profession and its practitioners. Some areas such as nutrition and dietetics education and practice competencies have already begun shifting to this vision, and other changes will be implemented over the next several years and decades. In addition, the Academy has just now entered its Second Century further emphasizing the importance of elevating the nutrition and dietetics profession.

Meeting Objectives:
Delegates and Meeting Participants will be able to:
1. Share current efforts underway by the Academy and its organizational units to identify and meet the needs of the Second Century workforce.
2. Create a vision of a Second Century workplace.
3. Generate ideas to close the gap between current and future practice.
4. Recognize skills and professional development needed for current and future practitioners.

Mega Issue Question

How can credentialed nutrition and dietetics practitioners elevate the profession, expand opportunities, and enhance practice for the Second Century?

Introduction
The Academy, the Council on Future Practice (CFP), Accreditation Council for Education in Nutrition and Dietetics (ACEND) and Commission on Dietetic Registration (CDR) have each investigated the current and future landscape to determine education and practice opportunities.

Realities
- One of the themes in a supplement from the CDR Workforce Demand Study noted, “Too many in the profession see dietetics as a job rather than a profession and are not ready to step up to the challenge of change.”
- There is a shortage of health workers globally, while demand for health services jobs are expected to increase.
- RDNs are the mostly highly trained nutrition practitioners and represent a workforce of 100,000 credentialed professionals. Yet, they are underrepresented in careers in global health, resulting in an unfulfilled potential to accelerate progress in improving nutritional status of all people around world.
- Advancing entry level educational requirements for the RDN and NDTR will have implications in areas such as scope of practice, standards of practice, professional regulations, reimbursement, and professional competence.

“*If the profession is not moving forward, it is being left behind.*
Adapted from the 2013 CFP Consensus Report
CFP Change Drivers

1. Food Becomes Medicine in the Continuum of Health
2. Aging Population Dramatically Impacts Society
3. Accountability and Outcomes Documentation Become the Norm
4. Population Health and Health Promotion Become Priorities
5. Consumer Awareness of Food Choice Ramifications Increases
6. Embracing America’s Diversity
7. Technological Obsolescence is Accelerating
8. Creating Collaborative-Ready Health Professionals
9. Tailored Healthcare to Fit my Genes
10. Simulations Stimulate Strong Skills

Stakeholder Feedback

ACEND interviewed stakeholders representing healthcare administration (pharmacy, nursing), deans of allied health colleges, employers of less traditional roles (communications, marketing, and management), physicians, educators in allied health graduate programs, and researchers regarding their needs with employment of current and future practitioners. Below are the themes that emerged from these interviews.

ACEND’s Environmental Scan with Stakeholders

- There is an increased focus on disease prevention and integrative healthcare, and the need for more knowledge in emerging areas such as genomics, telehealth, behavioral counseling, diet order writing, and informatics.
- This work requires that health care professionals work more interprofessionally.
- Employers indicated the need for improved communication skills in nutrition and dietetics practitioners and an improved ability to understand the patient’s community and cultural ecosystem.
- Practitioners need to be able to read and apply scientific knowledge and interpret this knowledge for the public. Employers also expressed a desire for stronger organizational leadership, project management, communication, patient assessment, and practice skills.
- Many of the stakeholders identified gaps in current competencies in areas of research, communication, leadership/management skills, cultural care, interprofessional work, basic food and culinary preparation, and sustainability.
- Employers indicated that more time might be needed in the preparation of future nutrition and dietetics practitioners to assure application of knowledge and demonstration of skills needed for effective practice.
- Stakeholders identified the importance of associate and bachelor level prepared graduates for roles in community health, wellness, and management.
- Employers identified the need for preparing undergraduates with transferable skills in leadership, business and management, and expressed the need for faculty prepared at the doctoral level.
Current Education and Credentialing Updates

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<th>Credentialing</th>
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<td>Process Changes</td>
<td>• CDR changed the degree requirement for dietitian registration eligibility, from a Baccalaureate degree to a Master’s degree, effective January 1, 2024.</td>
<td>• ACEND proposed a model for future nutrition and dietetics education with new graduate level standards to prepare generalist and specialist dietitians for these future roles.</td>
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| Current Updates | • CDR launched the Essential Practice Competencies. These are applicable to all credentialed nutrition and dietetics practitioners.  
  • By the 2020 cycle, all credentialed nutrition and dietetics practitioners will be on the competency-based system. | • In 2016, ACEND released a first draft of standards and opened a public comment period. The public comments were reviewed.  
  • In February 2017 ACEND released a revised draft of the Future Education Model Accreditation Standards for Associate, Bachelor and Master Degree Programs in Nutrition and Dietetics. |
| Practitioner Action Items | • Learn more about the Essential Practice Competencies.  
  • Seek higher levels of continuing education that advance skills and practice. | • Stay informed by reading the ACEND UPDATE. **The current dialogue will focus on future practice, but it is important for practitioners to understand the work being done in the areas of education.** |

Strategic Direction

- The Essential Practice Competencies are just one step in preparing the profession for the changing landscape, trends, and other forces driving practice.
- Practitioners are seeking opportunities to advance practice and expand services. Many active projects and initiatives support this need.
- Credentialed nutrition and dietetics practitioners can help fulfill the changing needs in society.
- The Academy continues to build an organizational infrastructure to help advance the profession and the Second Century work.

The Academy is entering its Second Century and there are many exciting opportunities to advance the profession. Six Second Century opportunity categories have been identified.

Six Second Century Opportunity Categories

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<tr>
<td>Food and Nutrition Security</td>
<td>Ensure all people have reliable access to culturally appropriate, nutrient-dense food and clean water now and in the future by building resilient food systems and prioritizing actions to prevent and divert wasted food throughout the value chain.</td>
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<tr>
<td>Prevention and Health Care</td>
<td>Improve health outcomes and decrease health disparities by accelerating the shift to a preventive health care model and using new technologies to individualize nutrition care.</td>
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<td>Global Workforce Capacity</td>
<td>Grow the number of trained nutrition professionals and dietitians globally, and embed nutrition knowledge broadly to increase nutrition capacity and reach global health goals.</td>
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<tr>
<td>Environment, Behavior, and Choice</td>
<td>Create a culture and environment that support health and wellness through relevant and appealing solutions for all places where people spend their time – home, work, schools, and communities.</td>
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<tr>
<td>Research and Standards</td>
<td>Implement models of trusted, public-private collaboration to accelerate high-quality nutrition research, metrics and standards creation, and open-access platforms for curating research and reporting outcomes.</td>
</tr>
<tr>
<td>Investment</td>
<td>Accelerate progress and explore collaborations to drive investment in nutrition outcomes.</td>
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Empower Yourself with Nutrition Informatics:
Informatics in Nutrition Certificate of Training Program

Through an innovative blend of technology and information, nutrition Informatics is increasingly vital to nutrition care across all areas of practice. This online program enables nutrition professionals to apply the best informatics concepts to improve the care of those utilizing a patient centered, team approach to coordinated care.

The Level 2 program consists of five separate modules that build on each other:
- **Module 1:** Overview of Informatics at the Academy, Academy Resources and Tools
- **Module 2:** “Data Follows the Patient”: Interoperability, Patient Generated Data, Protected Health Information, Security and Ethics
- **Module 3:** Communications: Current Capabilities and Future Endeavors: Social Media, Telehealth, the Direct Project, and Blue Button
- **Module 4:** Nutrition in Electronic Health Records (EHR) and Health Information Technology
- **Module 5:** Analytical Skills: Data Big and Small

Academy members enjoy a reduced rate of **$24 for each module** or may complete all five modules and earn **10.0 hours of CPEUs for $120**.

Start improving your nutrition care today! Learn more at [www.eatrightPRO.org/onlinelearning](http://www.eatrightPRO.org/onlinelearning)

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**FNCE® ON-DEMAND**

FNCE® On-Demand (synchronized audio and PowerPoint screen captures) from the 2017 Food & Nutrition Conference & Expo™ are now available. Don’t miss out on important research and key learning objectives from the meeting attended by thousands of your colleagues.

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2017 WH DPG AWARDS

Each year at FNCE ® the WH DPG gives out awards to its members. For 2017, two awards were presented:

Excellence in Practice in Women’s Health
The purpose of the Excellence in Practice in Women’s Health Award is to recognize a member of the Women’s Health Dietetic Practice Group (WH DPG) who has exhibited outstanding service, dedication and/or innovation to the field of women’s health nutrition.

Recipient: Helen Lane, PhD, RD
Helen obtained her BS from University of California, Berkeley; MS from University of Wisconsin, Madison; and PhD from University of Florida, Gainesville. She worked at the VA hospitals in Madison Wisconsin and Gainesville Florida. She was assistant and associate professor of nutrition and dietetics at University of Texas Health Science Center, Houston, and professor of food science and nutrition at Auburn University. Her research was on antioxidant selenium and prevention of breast cancer and had students completing research with WIC and school lunch. She worked for NASA/Johnson Space center as the chief nutritionist and senior scientist in health and human performance. She served on Institute of Medicine (including dietary recommendations for women in the military) and NIH committees. For the dietetics profession, she was a district president, director of the Texas Academy Foundation, chair of Texas nominating committee, chair of the Academy Position Committee, a member of the House of Delegates, chair of the Committee for Professional Development, chair of Dietetics Practice-Based Research Network Oversight Committee, and member of Council on Research along with treasure of Research and Vegetarian DPG. She has over 100 peer-reviewed publications, has edited four books, and has two patents. She received the Texas Distinguished Scientist award and is the senior scientist Emeritus at NASA.

Emerging Professional in Women’s Health
The purpose of this award is to recognize a member of the DPG who has exhibited interest and initiative in the area of women’s health.

Recipient: Kendra Tolbert, MS, RDN, CDN, CLC, CHC
Kendra is a private practice dietitian and writer. She helps women and couples prepare for pregnancy and improve their fertility.

Kendra lives by the quote, “People don’t care how much you know until they know how much you care,” and believes compassion and a listening ear are two of the most powerful medicines.

Prior to starting her own practice, Kendra worked as a consultant for non-profits and as a nutritionist in acute care, food assistance programs, and outpatient clinics. A lifelong learner, she’s constantly digging into books and research about aromatherapy, herbalism, women’s health, spirituality, movement, and nutrition.

Kendra is also a certified lactation counselor and certified aromatherapist. She holds a master of science in nutrition and public health from Teachers College, Columbia University.

Congratulations to Helen and Kendra and thank you for your contributions to our DPG and to the profession!

COMMISSSSSION ON DIETETIC REGISTRATION. Continued from page 6

6. How do I log activities if not using learning need codes? In the Activity Log, instead of linking your activities to learning need codes as you have done in the past, you will now align the activities to your performance indicators. The last step of the process, addressing Professional Development Evaluation requirements, also remains unchanged. However, you will need to reflect on how the learning has or will impact your practice instead of merely stating what you learned. This is consistent with the emphasis on professional continuing education that demonstrates competency in practice.

7. Where can I find the complete list of possible CPE activities? Are there any changes in requirements? The number of hours required remain the same as always: 75 for RD/RDN and 50 for DTR/NDTR. It is extremely important, however, to periodically review the PDP Guide, available on the CDR website. This guide is updated annually and provides detailed information on the various types of continuing education as well as important dates and deadlines. If you have further questions or concerns, you can contact CDR staff.

Congratulations again to Rita K Batheja, MS, RDN, CDN, AFMCP, FAND, WH DPG Reimbursement Coordinator, for receiving a 2017 Medallion award from the Academy of Nutrition and Dietetics.

The Academy of Nutrition and Dietetics’ Medallion Awards, given each year since 1976, honor Academy members who have shown dedication to the high standards of the nutrition and dietetics profession through active participation, leadership, and devotion to serving others in nutrition and dietetics, as well as allied health fields.
The Academy Presents the **Transforming Vision into Action Award**

**Honoring Outstanding Contributions to the Dietetics Profession**

The Council on Future Practice is pleased to introduce the Transforming Vision into Action Award. This award recognizes RDNs, NDTRs and their teams whose innovative programs transform a vision into nutrition and dietetics practice and/or education with future-focused outcomes.

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**2017-2018 WOMEN’S HEALTH DIETETIC PRACTICE GROUP LEADERS**

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**Please send any questions or comments to**
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**Transforming Vision into Action Award**

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