Jorge Chavarro, MD, ScD and Judy Simon presented a spotlight session on nutrition and fertility at FNCE® in October 2013. Dr. Chavarro is Assistant Professor of Nutrition and Epidemiology in the Department of Nutrition - Department of Epidemiology at the Harvard School of Public Health, and is a leading researcher in the area of nutrition and fertility. Judy Simon has focused her career in women’s health. She is a clinical instructor in the Nutritional Sciences program at the University of Washington, and a clinical dietitian at the University Women’s Health Clinic providing medical nutrition therapy to women and men with infertility. Judy also owns a private practice, Mind Body Nutrition, PLLC, specializing in reproductive nutrition. She is the current chair of the Nutrition Special Interest Group of the American Society of Reproductive Medicine.

INTRODUCTION TO INFERTILITY
Infertility is defined as the inability to conceive after one year of unprotected intercourse (six months if the woman is over age 35), or the inability to carry a pregnancy to live birth. Infertility impacts 12% of women of child-bearing age (7.3 million), and approximately 10-12% of reproductive age couples in the United States (1).

The number of men and women seeking infertility treatment increases annually (1). While part of this rise is due to delayed childbearing, it is also related to the incidence of overweight and obesity (2). Excess body weight is perhaps the best characterized modifiable risk factor for subfertility (3), low semen quality (4), and adverse outcomes in couples undergoing assisted reproduction (5). In the United States, 56% of reproductive age women are overweight or obese (BMI ≥ 25 kg/m²), and approximately one-third of reproductive age women are obese (BMI ≥ 30 kg/m²) (6). Forty percent of all embryo transfers in the US are performed among overweight or obese women (6). Despite improvements in the area of reproductive technology over the past decade, success rates have stayed constant (7).

ROLE OF NUTRITION IN INFERTILITY
Research has shown that nutrition plays an important role in fertility – particularly that diet and weight are modifiable risk factors. Nutrition can improve treatment outcomes for ovulatory disorders, semen abnormalities, endometriosis, and unexplained infertility. Women who are overweight or obese based on BMI are predicted to display a greater frequency of polycystic ovarian syndrome (PCOS) and insulin resistance, which can lead to anovulation (the absence of ovulation) (8). Women with a BMI below 20 have a greater risk for anovulation due primarily to a lack of available energy to allow proper function of the hypothalamic-pituitary-ovarian axis (9), which is responsible for hormonal regulation of specific body systems, including the reproductive system.

RELATIONSHIP BETWEEN NUTRITION AND INFERTILITY
In 2007 Dr. Chavarro and Dr. Walter Willett, the Department of Nutrition Chair at Harvard School of Public Health, presented their findings based on data from the Nurse's Health Study (NHS) II. In this prospective epidemiological study, nutrition information was collected from more than 18,000 women, and eight factors were found to be associated with infertility and ovulatory disorders (10). An increased risk of anovulatory infertility was associated with diets that provided an overall higher glycemic load, and contained trans fatty acids, low-fat dairy, and animal protein sources. A reduced risk was associated with consumption of adequate folic acid, iron from non-heme sources, one high-fat dairy product daily, and vegetable protein sources. While it is important to keep in mind that the NHS was prospective, it is no less powerful to learn that through nutrition intervention women could potentially reduce their risk for ovulatory infertility.
FROM THE CHAIR  Kathleen Pellechia, RD

Happy 2014! As I write this column I am amazed that we have entered another year, but even more excited for all that’s to come for our DPG. Before we discuss that, let’s spend some time reflecting on the last few months. My focus was on the birth of my second daughter in November. We continue adjusting to being a family of four, and greatly enjoyed spending the holidays with our new little one.

Unfortunately this meant that I was unable to travel to FNCE®; however, I heard nothing but positive comments about the meeting! In addition to the events and sessions offered by the Academy, the WH DPG had a spotlight session, “Promoting Fertility via Optimal Nutrition: Nutrition in Infertility Prevention and Management” (co-planned with the Nutrition Education for the Public (NEP) DPG), and a member reception (co-planned with NEP and Pediatric Nutrition DPGs). I would like to thank USA Rice for their generous sponsorship of the member reception. Our board members also enjoyed talking with current and potential members at the DPG/MIG Showcase.

If you attended FNCE®, I hope you found it to be an enjoyable and eye-opening experience. If you missed it, we are happy to present a follow-up article on the spotlight session written by one of the presenters, Judy Simon, MS, RD, CD, CHES. Judy is a past board member of our DPG and an expert in her field. We are so appreciative of Judy and her co-speaker, Dr. Jorge Chavarro, for taking the time to present at the conference.

In addition to the article on nutrition and fertility, we have updates on public policy/legislative issues, and information from the Academy House of Delegates. We hope you find this issue to be a great start to the new year.

As we move into 2014, we will be again offering our free webinar series, so stay tuned for dates and topics. We also hope to launch our new web site in the spring! Keep warm, and keep in touch. Questions, comments, etc. can be sent to me at info@womenshealthdpg.org.

FROM THE EDITOR  Heather A. Goesch, MPH, RDN, LDN

As you know, the annual Food & Nutrition Conference & Expo™ was held in Houston this past October. More than 8000 attendees representing 50 states and 43 countries gathered to network, learn about emerging trends, see what’s new in the industry, and further their professional knowledge. Between attending educational sessions and workshops, and sampling their way through the Expo, WH members made time to visit the DPG showcase booth, attend the Spotlight Session, and socialize at the Members’ Reception. It was a grand gathering, and this issue will highlight the WH events and members in action.

The co-planned WH and Nutrition Education for the Public DPG Spotlight Session, “Promoting Fertility via Optimal Nutrition: Utilizing MNT in the Prevention and Treatment of Infertility,” was a great success. Dr. Jorge Chavarro took the podium first, highlighting nutritional and metabolic factors associated with infertility and treatment outcomes among men and women undergoing assisted reproduction. Our own Judy Simon, MS, RD, CD, CHES followed with discussion of her current clinical findings and MNT applications for this population. Keep reading for her session summary and recommendations for RDNs interested in pursuing this area of nutrition.

For the past 22 years, the conference has dedicated a space for moms to breastfeed and pump during the conference. Our DPG Membership Retention Coordinator, Ginger Carney, once again volunteered to staff the room and shares her thoughts on its continued success. Be sure to check out the snapshots taken at the Mother’s Room, and from elsewhere around the conference!

I continue to be impressed and motivated by my first FNCE® -- the best kind of ‘jet lag’. I am grateful to all who helped make the event sensational, and simply to be part of such a welcoming, ambitious, and inspiring group of professionals. If you were unable to attend and have the opportunity to next year, I look forward to making your acquaintance.

Wishing each of you best wishes for a healthy, vibrant, and prosperous 2014! As always, feel free to contact me at whdgppublicationseditor@gmail.com with any questions or concerns.
FNCE® 2013 SPOTLIGHT SESSION SUMMARY

Continued from page 1

Further research by Dr. Chavarro’s group on couples receiving assisted reproductive therapy (ART), as well as studies on males and nutrition, has found that diet, physical activity, and BMI also play a role in male fertility (11).

Key points from nutrition and infertility research
• Weight control of both partners is an important determinant of natural fertility.
• Weight control appears to be important for treatment outcomes of couples undergoing infertility treatment.
• To assess their specific roles in fertility, further research is needed on antioxidant supplementation in men, and preconception folic acid supplementation in both men and women.

ROLE OF THE REGISTERED DIETITIAN IN TREATMENT OF INFERTILITY
As a registered dietitian working with infertile or sub-fertile patients, it is important to have a basic knowledge of female and male reproduction, as well as the potential treatment modalities these patients may be undergoing. The most common diagnoses for which a patient with infertility is referred to a registered dietitian are PCOS and/or obesity. Due to the fact that many fertility clinics now limit In Vitro Fertilization (IVF) to women with a BMI < 39 kg/m² due to poorer outcomes, anesthesia risks, and difficulty visualizing embryo transfer associated with a higher BMI (12), registered dietitians in this area of practice are seeing an increase in referrals.

Other commonly seen causes of infertility include hypothalamic amenorrhea, eating disorders, endometriosis or fibroids, celiac disease (13-14), male factors (e.g., sperm production disorders, structural abnormalities, or ejaculatory disturbances), and unexplained infertility.

Reproductive nutrition assessment should include:
• Reproductive history
• Medical history
• Metabolic and reproductive labs
• Anthropometric measurements: current weight, weight history, height, waist and hip circumferences
• Energy needs/expenditure via indirect calorimetry and body composition, if available
• Usual dietary patterns and usual food/nutrient intake, including comparison with expert food-based and nutrient guidelines for health and disease risk reduction (e.g., Dietary Guidelines for Americans, IOM, etc.)
• History of dieting/eating disorders
• Food allergies/intolerances
• Medication/supplements/herbs
• Alternative therapies
• Cultural beliefs
• Socioeconomic status
• To assess their specific roles in fertility, further research is needed on antioxidant supplementation in men, and preconception folic acid supplementation in both men and women.

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FNCE® HIGHLIGHTS
(Top LF) From left: Gail Frank, DrPH, RD, CHES, Maria Bournas MS, RD, LDN, Judy Simon, Carrie Dennett, and Lisa Hamlett Akers MS, RD, IBCLC, RLC at the Members’ Reception. (Below LF) Our DPG award winners, Angela Grassi, MS, RD, LDN (WH Award for Excellence in Practice) and Carrie Dennett (WH Award for Outstanding Student). (Below Middle) Kathleen Pellechia, RD, leading the Executive Committee meeting via Skype – dedication! (Below RT) Maria Bournas, and Lisa Hamlett Akers, holding down the fort at the DPG/MIG Showcase.
SPECIAL CONSIDERATIONS FOR PCOS AND OVERWEIGHT

When working with patients who have PCOS or are overweight it is important to use the Nutrition Care Process to thoroughly assess each woman and provide MNT for successful outcomes. During these interventions it is essential to assess the woman's knowledge of her disease, the treatment, and the role of diet on decreasing insulin resistance. Weight loss of 5% can improve success with fertility (15), which is very encouraging for most women since this feels attainable to them.

In 2012 I developed Food For Fertility™ (FFF), a comprehensive seven-week program for women struggling with weight and infertility. To date, the series has been offered four times. The initial session is an individual 90-minute assessment with the registered dietician, prior to which clients have undergone metabolic lab work, and completed a 3-day food record and reproductive health history questionnaire. Each week thereafter consists of one 90-minute class followed by a 30-minute outdoor walk. Weights are monitored weekly, and waist and hip circumferences are measured prior to and after completion of the program. Client education focuses on fertility and diet, fitness, goal setting, and accountability, as well as healthy meal planning and eating habits.

A small-scale evaluation of FFF in 2013 found that average BMI decreased from 37.1 kg/m^2 to 35.8 kg/m^2 (p <0.01) during the seven weeks (16). The assessment also showed that following program completion several women conceived, and one successfully cryopreserved her eggs. Future larger-scale studies will elucidate more solid data regarding fertility outcomes.

SUMMARY

Registered dietitians interested in working with reproductive nutrition should network and provide care in conjunction with fertility and women’s health practitioners in their area. With the depth of knowledge and skills necessary to provide MNT from preconception through lactation, it is important for registered dietitians to also become familiar with the medical aspects of fertility, as patients will expect understanding of where they are in their fertility treatment.

Key responsibilities of the registered dietician

- Always screen and treat women and men for nutrition issues related to infertility: PCOS, obesity, eating disorders, endometriosis, energy availability, celiac disease, and inflammatory diseases (17).
- Aim to provide a healthy, balanced diet, which can have a positive influence on improving fertility outcomes. Emerging research suggests that women who follow a Mediterranean-style diet pattern may increase their chance of pregnancy (18-19).
- Help clients achieve a modest decrease of body weight, which can have a significant impact on improving fertility in overweight/obese women. In one trial, 90% of women resumed ovulation and 45% spontaneously conceived following a 5% weight loss (13).

PRACTICAL APPLICATIONS

Case Study #1: 27 year-old female with hypothalamic amenorrhea and infertility referred to a registered dietician September 2011.

Food- and nutrition-related history

Amy acknowledges she has exhibited disordered eating behaviors (restrictive eating and excessive exercise) since high school and never received treatment. She also reports anxiety and perfectionist traits. Amy recently completed law school, and is anxious to start a family.

After her first miscarriage she began running to overcome disordered thoughts. Amy has lost more than 30 lbs during the past year, and complains of fatigue. She has been on oral contraceptives since age 15, reporting no resumption of menses following discontinuation of contraceptives in 2010.

Current diet

1200-1300 kcal including many "diet" foods; tracks intake daily

Activity

Runs 35-40 miles weekly; does not like to take a day off

Anthropometrics

- HT 5’7”; WT 100 lbs; BMI 15.7 kg/m^2
- Lowest adult WT 94 lbs; highest adult WT 140 lbs
- RMR 1320 kcal

Biochemical data

- Leptin (> 10 ng/mL)
- Iron Panel – Ferritin (> 40 ng/mL)
- Estradiol [30-400 pg/mL]
- Serum Complement C3 (short term nutrition marker) > 40 mg/dL
- Serum Triiodothyronine T3 (long term nutrition marker) > 100 ng/dL
- Luteinizing Hormone (LH) [5-25 IU/L]
- Follicle-Stimulating Hormone (FSH) [4.7-21.5 mIU/mL]
- Vitamin D [30.0-74.0 ng/mL]
- CBC and CMP

Nutrition diagnosis

PES: Inadequate energy intake related to eating 1200 kcal/day as evidenced by a BMI of 15.4 kg/m^2 and estimated intake of 1000 kcal/day less than needs.

Intervention

Using motivational interviewing techniques Amy suggested she could limit physical activity to a 45- to 60-minute daily walk in place of her usual runs, remove all "diet" foods from her house, consume a full 3 meals and 2 snacks every day, and not track food intake during her upcoming two-week vacation. A follow-up was scheduled for the week after her vacation, and she was referred to a psychologist for a mental health evaluation.

Monitoring/Evaluation

- Weekly weights (blinded) with a registered dietician
- Weekly food exposures
- Therapy visits/coordinated care
- Reassessment of labs
- Focus on weight restoration, available energy, healthy eating habits

Outcomes

Amy reported feeling healthier, and over time became less anxious about weight and body image. She maintained a weight between 135-140 lbs, and eventually became desensitized to her weight. Her menstrual cycle still had not resumed, so her reproductive endocrinologist (RE) recommended timed intercourse and two cycles of the drug Femara (to induce ovulation). This was unsuccessful, so the RE added a Human Chorionic Gonadotropin trigger injection (to assist in releasing mature eggs from the follicles) and Intrauterine Insemination. At the same time she began another four cycles of Femara, two of which were cancelled by the RE – one due to hyperstimulation (too many follicles that could result in multiple births), and the other due to a poor response/small follicle.

Continued on page 5
She turned next to IVF treatment. The original IVF cycle yielded several good quality embryos. One embryo was transferred during the first fresh cycle, which resulted in a chemical pregnancy. The next IVF cycle was frozen and two embryos from the original retrieval were successfully implanted. Amy is currently 24 weeks pregnant with twins. She continues to meet with the registered dietitian monthly to receive nutrition and weight gain recommendations for a twin gestation. Her fetal measurements are optimal, and she is enjoying a healthy pregnancy.

**Case Study #2:** 27-year-old South Asian female referred for MNT for diagnoses of PCOS and infertility.

**Food- and nutrition-related history**

Arti is a vegetarian who consumes no eggs due to religious beliefs. Arti typically skips breakfast, consumes a granola bar or orange juice for lunch, snacks on chocolate candy bars, juice or fruit smoothies, and then enjoys a full supper of vegetarian curry, basmati rice, vegetables and lentils. She reports having gained 20 lbs since moving to the US from India one year ago.

**Current diet**

Consumes most kcal at night; diet high in carbohydrates

**Activity**

Very minimal physical activity

**Anthropometrics**

HT 5’3”; WT 162 lbs; BMI 28.7 kg/m²

Waist circumference 38.4”

**Biochemical data**

• HgbA1C – 5.5% [4.5-6%]
• Fasting Blood Sugar (FBS) – 90 mg/dl [70-100 mg/dL]
• Vitamin D – 6 ng/dl [30.0-74.0 ng/mL]
• Cholesterol – 188 mg/dl [< 200 mg/dL]
• HDL – 34 mg/dl [≥ 60 mg/dL]

**Nutrition diagnosis**

PES #1: Excessive carbohydrate intake related to knowledge deficit as evidenced by diet history and BMI.

PES #2: Physical inactivity related to knowledge deficit as evidenced by current physical activity level.

**Intervention**

Arti agreed to consume 3 meals and 2 snacks daily, distributing carbohydrates with fat and protein. She can now identify the carbohydrate content of Indian dishes, and learned how to balance carbohydrate portions. She understands how to add protein sources to meals and snacks (e.g., add soy milk and yogurt servings; use lentils, beans, edamame, and quinoa to increase protein intake and provide a low glycemic carbohydrate), and increased omega 3 fatty acid intake through sources such as nuts, ground flax, and chia seeds. She also agreed to include vitamin D supplements (50,000 IU weekly for 8 weeks) and a prenatal multivitamin and mineral to her routine. In terms of physical activity, Arti began with 15 minutes of walking daily and gradually worked up to 45 minutes daily.

**Outcomes**

Arti lost a total of 12 lbs (8% body weight over 6 months), and successfully conceived a healthy son through the use of timed intercourse. She met with the registered dietitian for an additional nutrition session during pregnancy, and her glucose tolerance test result was normal.

**REFERENCES**

Since 1991, the Mothers' Room has been available to breastfeeding women attending the Food & Nutrition Conference & Expo™ (FNCE®), as well as to Academy staff, presenters, speakers, and women who work at the Expo. In the convention center, a room is specially prepared to accommodate the breastfeeding woman and her infant. The room is quiet with private spaces available for breastfeeding or pumping. This service is a collaborative effort of the Academy of Nutrition and Dietetics, the Public Health/Community Nutrition (PHCN) DPG, the Women's Health DPG, the Pediatric Nutrition (PN) DPG, and the Academy affiliate in the FNCE® host city. Members of the Academy, including student members through the FNCE® Student Host Program, volunteer to staff the Mothers' Room throughout the conference.

This year, as in years past, I volunteered to staff the Mothers’ Room. As a representative of the WH DPG, I am proud to show our support for the many mothers who breastfeed their infants even when away from the comfort of home, or while separated from them for an extended period of time. The room – equipped with 10 private spaces in which moms could either nurse their little ones quietly, or utilize their own personal breast pumps to express milk throughout the day -- was a welcome site for the women who made use of it. Refrigerators and freezers were made available for storage of expressed milk, if needed, and pumps were securely stored in the room between sessions. In addition, snacks and beverages were provided by generous donors, so moms could enjoy refreshments while using the room.

As we have seen in the past, our fellow Academy members and others who utilized the Mothers’ Room were extremely appreciative for the accommodations provided. Many said they would not have been able to attend FNCE® without the availability of the space. I truly enjoyed meeting so many mothers who recognize the value of breastfeeding for their infants’ nutrition, and the determination to continue breastfeeding while participating in professional activities. As women’s health professionals, this is certainly something that we should always support, and I invite other WH DPG members to assist in the future. Thank you to our colleagues in the PHCN and PN DPGs for sponsoring this worthwhile and important effort!

Click here to watch a YouTube clip of Phyllis Crowley, MS, RD, IBCLC, the PHCN DPG Treasurer, showcasing the Mothers’ Room in Houston.
The issue of feeding the nation is complex, and with the many stakeholders, it is imperative that as food and nutrition experts, Registered Dietitian-Nutritionists seek to educate both the decision makers and the public. Regarding specific programs funded by the Farm Bill, there are many divergent voices making their concerns heard. While the Farm Bill Conference Committee meets in Washington, some stakeholders advocate for more funding and/or policy changes; others advocate against policy changes.

A little background about the Farm Bill:
The Farm Bill is a comprehensive piece of legislation that guides and authorizes funding for most federal farm and food policies. Every five years, Congress renews the Farm Bill through the reauthorization process – the last of which was passed in 2008. The Farm Bill covers programs that are in the non-defense discretionary spending category. Title IV of the Farm Bill covers domestic food and nutrition and commodity distribution programs. The House Agriculture Committee and the Senate Agriculture, Nutrition, and Forestry Committee have jurisdiction over the Farm Bill.

At issue are not the Farm Bill programs or the benefits, but how to continue funding and at what level. As part of the non-defense discretionary category, this is one area of the federal budget where legislators seek to reduce spending and cut costs to balance the national budget. The House’s version of the bill would seek to reduce spending by $40 billion over ten years, whereas the Senate’s version would cut only $4.1 billion over the same ten-year period. Because there is such a vast difference in proposed funding, there are multiple proposed strategies of how to implement the cuts, including: reduction of Supplemental Nutrition Assistance Program recipients and the rules covering these households; changes to the Commodities Supplemental Food program that feeds many elderly populations; and changes to the Child Nutrition Program that includes the National School Lunch Program and the School Breakfast Program. Issues that arise for the public include the cost and availability of food, the increased cost of living, and the sticker shock of the new health insurance plans associated with the Affordable Care Act’s mandate of insurance for all.

What is our role as food and nutrition experts?
First and foremost we are here to secure the health of the nation through our expertise on food and nutrition. Therefore our responsibility is not to take political sides, but to offer practical, cost-effective solutions to assist the decision makers. Sometimes those solutions may not be what our altruistic or self-interested nature could bear, but it would be the compromise that could keep the programs somewhat viable. These programs are funded through taxation, so let us advocate for the best use of tax dollars to provide the help and care for those who are most vulnerable. Now more than ever, we need to be in the conversation with our decision makers.

To get involved in advocacy and make your views known, please contact your state’s affiliate Public Policy Coordinator. You can also log on to www.eatright.org >> Public Policy >> Take Action >> Grassroots Manager, or link directly from the Women’s Health DPG website under the Policy heading. Here you can learn more about the legislative and public policy priorities, the issues affecting your profession as a Registered Dietitian-Nutritionist, as well as download talking points and letters that can be used for reaching out to your representatives.

My personal recommendation is to join with your state’s affiliate Public Policy Coordinator in making a concerted effort to not only advocate for continued funding of an issue or issues, but to bring real, practical solutions to the decision makers. **If dietetics is your profession, then policy should be your passion!**
With the inception of the Medicare Part B MNT benefit, effective 1/1/02, for Medicare Part B beneficiaries with diabetes or kidney disease, RDs must review how they provide services to these individuals in order to comply with Medicare regulations. RDs have three options for this service—(1) enroll as a provider, (2) do not enroll and do not provide MNT to Medicare patients with diabetes or kidney disease, or (3) “opt-out” of Medicare.

**Enroll**

Before submitting the provider enrollment form to the Medicare carrier, RDs must obtain a national provider identifier (NPI). Go to the Center for Medicare and Medicaid Services (CMS) Web page for NPI enrollment information.

After obtaining an NPI, RDs can enroll at any time to become a Medicare Part B provider by completing the necessary enrollment applications forms available from the local state Medicare carriers. If an RD is employed at a clinic or facility that will submit Medicare Part B claims forms and collect payment on behalf of the RD, the RD will also need to complete a reassignment enrollment form (See enrollment information included in this publication, section three.)

Example: An RD is employed by a hospital or facility that is a Medicare provider, so as part of the Medicare Conditions of Participation, the RD will provide MNT to Medicare beneficiaries with diabetes and non-dialysis kidney disease. The RD obtains a NPI, then enrolls with Medicare Part B by completing the CMS 855I form. Since the RD’s hospital billing department will submit MNT claims to the carrier for the RD who provides the service, the RD will also need to complete the CMS 855R (reassignment) form. Other outpatient RDs who will provide Medicare Part B MNT for diabetes and kidney disease also enroll with Medicare using the CMS 855I, 855R and the enrollment form for groups, CMS 855B.

**Do not enroll, but refer qualifying beneficiaries to RD Medicare Part B providers**

RDs who do not enroll in Medicare Part B, or who do not ‘opt-out’ of Medicare should refer qualifying beneficiaries with diabetes and non-dialysis kidney disease to RDs who are enrolled as Medicare Part B providers. Providing MNT to qualifying Medicare Part B beneficiaries with diabetes or non-dialysis kidney disease as a free service, or accepting full payment from the beneficiaries with either disease is not appropriate since this can be interpreted as an inducement or a kickback for services offered at the clinic or the outpatient hospital department.

Consider Medicare’s regulations for “Private Contracts” (“opt-out”)

The option to opt-out of Medicare requires serious consideration by practitioners. This option requires the RD to provide Medicare Part B carriers and beneficiaries with specific documentation stating he/she has chosen to opt-out of Medicare. Specifically, a practitioner who chooses to opt-out of Medicare must have an NPI number, sign a formal affidavit and mail this detailed statement to the Medicare carrier. The affidavit must include specific language which states that the RD has explicitly chosen this option, that he/she or the practice’s billing office will agree not to file any claims for Medicare Part B service, nor receive payment for covered services from Medicare, and that he/she agrees to enter into private contracts with Medicare beneficiaries prior to providing Medicare covered services. The affidavit must also include the practitioner’s NPI number. A practitioner who has opted-out must also enter into a private contract with each Medicare beneficiary prior to providing a Medicare Part B covered service. The private contract must contain certain detailed components and must be signed by both the RD and the Medicare beneficiary before the service is provided. RDs who opt-out (i.e., remove the single quotation marks from around the words) are bound to the two-year opt-out agreement, even if the practitioner’s place of employment changes during the two-year opt-out period.

*The information is for reference use only and does not constitute the rendering of legal, financial, or other professional advice of the Academy of Nutrition and Dietetics.*

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**GOT CASE STUDIES?**

The Women’s Health Report is looking for contributing authors to share case studies for our future publications. Please contact Editor Heather Goesch at whdpgpublications@gmail.com if you’d like to contribute.

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**SEEKING TESTIMONIALS FROM MEMBERS**

The WH DPG is looking for members to provide testimonials about working in women’s health, and on membership in the WH DPG for its new website. If interested, please email info@womenshealthdpd.org.
A WARM WELCOME TO OUR NEW EXECUTIVE COMMITTEE MEMBERS!

Assistant Editor, Stephanie Romaneiro, MS, RD, is a former nutrition editor at Prevention magazine. She recently moved to Pittsburgh from New York City, where she was the day treatment nutrition team leader for a private eating disorder treatment center. Currently she works as a registered dietitian at PNC YMCA and Shining Light Prenatal Education, and is a freelance writer.

Awards Coordinator, Sarah Borowicz has an MS in Nutrition and Dietetics from Clemson University where she completed a thesis researching Gestational Diabetes. She is currently finishing the dietetic internship, while working as a part-time dietary assistant. Her passions are prenatal/postnatal nutrition and lactation, and she is also actively pursuing the IBCLC credential.

Reimbursement Coordinator, Rita Kashi Batheja, MS, RDN, CDN is a Registered Dietitian and Integrative & Functional Medicine Nutritionist in private practice in Long Island, New York. Professionally she is active with National, Affiliate and District dietetic associations, serving on their boards in various positions.

Congratulations to the WH DPG Drawing Winners at FNCE®!

Stephanie Hart, RD, LD was the recipient of a one-year DPG membership, and Maria Gustafsson, RD a $25 gift certificate to the Academy bookstore.

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**2013-2014 WOMEN'S HEALTH DIETETIC PRACTICE GROUP LEADERS**

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