

# Women's Health *REPORT*

A QUARTERLY PUBLICATION OF WOMEN'S HEALTH DIETETIC PRACTICE GROUP

## FNCE® 2014 SPOTLIGHT SESSION SUMMARY: Behavioral and Nutrition

### Strategies for Women's Long-Term Weight Loss Maintenance By Jeremy D. Akers, PhD, RD



*Barbara Millen, DrPH, RD, FADA and Jeremy Akers, PhD, RD presented a spotlight session at FNCE® in October 2014 examining potential mechanisms of unsuccessful weight loss maintenance and recommended methods to assist in designing successful strategies for middle-aged and older women. Dr. Millen is the President of Millennium Prevention, Inc. and the Director of the Boston Nutrition Foundation, Inc. Prior*

*to their founding, Dr. Millen was Professor and Founding Chair of the Graduate Programs in Medical Nutrition Sciences at the Boston University School of Medicine and Director of the Framingham Nutrition Studies. She is also Past-Chair of the WH DPG. Dr. Akers has focused his career in weight management and the nutrition and behavioral theories associated with it. He is Assistant Professor of Dietetics and the Graduate Program Coordinator for the Department of Health Sciences at James Madison University in Harrisonburg, VA. He holds a certificate in Childhood and Adolescent Weight Management, and is a current member of the Weight Management and Sports, Cardiovascular, and Wellness Nutrition DPGs.*

#### INTRODUCTION

Overweight and obesity is an epidemic that is not diminishing. It is estimated that two out of every three adult women in America are overweight, while more than one-third of these women are obese (1). Researchers estimate that if previous trends continue, almost half the United States population will be obese by 2020 (2, 3). Obese women are at increased risk for cardiovascular disease, hypertension, diabetes, dyslipidemia, metabolic syndrome, gallstones, osteoarthritis, sleep apnea, and certain forms of cancer (4, 5).

Contrary to the perception that many middle-aged and older women are underweight and malnourished (6), the number

of obese women has noticeably increased in the past decade (7, 8). Between 2011 and 2013, approximately 72% of women ages 40-59 years old and 69% of women 60 years or older were classified as overweight or obese (1). Obesity and aging can lead to the aforementioned risks and multiple health complications including decreased physical function, frailty, and

the concerning patterns of the weight gain. Adult men and women have different patterns of weight gain. Men enter young adulthood somewhat heavier than women and men's weight gain gradually tapers off, whereas women gain considerably in their twenties and thirties, continue to gradually gain into their seventies (a full decade longer than men), before their weight begins to decline as octogenarians (9). Framingham researchers have estimated that women will gain 18 or more pounds in adulthood and will develop a considerable amount of visceral fat – the more metabolically active type of fat that is a major risk factor for metabolic syndrome, cardiovascular disease, and diabetes (9). The increasing rates of obesity and overweight in this population and the lack of age-specific health promotion efforts have important implications for medical and social services (6, 7). Thus, middle-aged and older women are a high-risk population warranting special attention.

Researchers suggest that even modest weight loss at the individual level can have substantial effects on overall population health: 3-5% loss of initial weight results in clinically meaningful health improvements, while 5-10% loss is optimal (10, 11). However, losing weight and maintaining weight loss can be a significant challenge (12, 13). As weight gain in the United States increases, so does the number of individuals who lose weight and then regain the amount lost. Following successful clinically-based weight loss programs, 30-35% of weight lost is regained in the first year after treatment (14), yielding only a 20% success rate for losing at least 10% body weight and for maintaining that loss at least one year (15). The American Heart Association/American College of Cardiology/The Obesity Society (AHA/ACC/TOS) Guideline for the Management of Overweight and Obesity in Adults suggests that maintenance of weight lost at a 5-10% level is achievable at one year, with success decreasing in year two at 3-5% of initial weight loss (10).

#### DIFFICULTIES MAINTAINING WEIGHT LOSS:

##### Potential Mechanisms

As mentioned previously, maintaining a clinical weight loss often proves challenging. There could be numerous behavioral, physiological, and biological mechanisms that stand in the way of "lifetime" weight loss maintenance. This section will highlight some of these potential mechanisms. [For a more thorough review of adipose cellularity, endocrine function, neural mechanisms and energy metabolism, please read Ochner's 2013 article in *Physiology and Behavior* (16).]

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**FROM THE CHAIR** Lisa Hamlett Akers, MS, RD, IBCLC, RLC

Welcome to the winter issue of *Women's Health Report*. I don't know about you, but time seems to be flying by these days. It is hard to believe that our 2014-2015 membership year is half over already!

Our DPG leadership has been very busy this year. Among the many things that have transpired behind the scenes is the development of our new innovative website ([www.womenshealthdpg.org](http://www.womenshealthdpg.org)). Our DPG's Immediate Past-Chair, Kathleen Pellechia, and her team worked very hard over the past calendar year to launch the website. Please take a minute to visit, if you haven't already. We think that you will be very pleased with the outcome. Thank you to Kathleen and her team for taking on this labor-intensive project.

Our leadership is also working to develop many of the processes, systems, and documents that help our DPG continue to run seamlessly. We met in person at FNCE 2014® for a half-day meeting, which is always a treat since we don't often have this opportunity. It is wonderful to work with and for such a talented group!

Overall WH had a wonderful turnout for FNCE 2014®. There were nearly 100 members who pre-registered, and many more who registered at the event. Our DPG Spotlight Session titled *Behavioral and Nutrition Strategies for Women's Long Term Weight Loss Maintenance* was a hit! The session focused on evidence-based methods to assist in designing successful weight loss maintenance strategies for middle-aged and older women. If you weren't able to join us "live," I hope that you enjoy the feature article of this issue, which offers a summary of the session. This issue also features an article written by a member of our DPG leadership, Sarah Borowicz, who offers insight into what her experience was like as a FNCE® first-timer. Perhaps these pieces and the other conference-related updates and photos in this issue will increase your excitement to attend FNCE® in 2015!

I hope that you have wonderful winter season, and I look forward to continuing to serve you!

**FNCE® HIGHLIGHTS**

**(Top LF)** From left: WH Leadership at the DPG Membership Booth – Kathleen Pellechia (Past Chair), Rita Kashi Batheja (Reimbursement), Sarah Borowicz (Awards), Maria Bournas (Nominating Committee Member), Lisa Akers (Chair), and Gail Frank (Treasurer).

**(Below LF)** From L to R: Rita, Lisa Eaton Wright (Chair of the Academy's Legislative and Public Policy Committee), and Denise Andersen (WH House of Delegates Rep).

**(Below RT)** From L to R: Maria Bournas, Dina Lipkind (Nominating Committee Chair), and Ginger Carney (Membership Retention).



**Adipose cellularity**

As individuals gain weight, their adipocytes (fat cells) increase in size. Once the diameter of an adipocyte has reached maximum capacity, the cell creates another adipocyte. Thus, excess weight gain has the propensity to increase both the size and number of adipocytes. Here lies the problem with a clinical weight loss: the size of the adipocyte decreases, while the number of adipocytes does not (17). This could lead to increased storage capacities for over-ingested energy-containing nutrients, decreased utilization of fat for energy, and decreased concentrations of leptin (satiety-activating hormone) (16).

**Endocrine function**

After initial weight reduction, levels of the circulating mediators of appetite that encourage weight regain after diet-induced weight loss may not revert to the levels recorded before weight loss. In addition to potential reduction of leptin concentrations, gastrointestinal hormones may become altered. Researchers have detected increased levels of the hormone ghrelin (induces hunger) and decreased levels of peptide YY and cholecystokinin (both of which promote satiety) in weight-reduced individuals (16).

**Neural mechanisms**

Most successful weight loss programs include caloric and/or macronutrient restriction, and the suggested meal plans usually do not include energy-dense or highly palatable foods. Obese individuals may experience increased dietary restraint and inhibitory neural responsivity throughout treatment programs, related to caloric restriction and the concept of “forbidden foods.” After completing these types of programs, there is potential for increased reward-related neural responsivity (a heightened sense of reward from restricted food) or decreased inhibitory anticipatory responsivity (a blunted response to restricted foods leading to increased consumption for the response to occur). As such, the outcomes may be an increase in both food intake and the desire to consume more energy-dense foods (16).

**Estrogen**

Weight gain and menopause have been loosely associated in research, and a definitive correlation has yet to be determined. The mechanism here could be the decline in fat free mass, the reduced energy expenditure, or the disinhibited eating patterns. Some researchers speculate that estrogen may be a contributing factor. In rodent models, decreased estrogen levels result in increased body weight, reduced physical activity, and increased appetite (18, 19). With the addition of estrogen hormone therapy in these rodent models, weight gain slowed and metabolic rate increased (18, 19). Springer’s review focused on the evidence connecting estrogen to leptin receptors to reduce food intake and adiposity while increasing energy expenditure in rodent models (the data was inconclusive in humans) (20).

**Energy metabolism (16)**

During a successful weight loss intervention, individuals decrease total body mass; however, their total daily energy expenditures decline as well (21, 22, 23). This is due to reductions in resting metabolic rate and to the cost of physical activity. Simply put, it takes less energy to move a smaller body, and a weight-reduced individual needs fewer calories to maintain weight. In a 2011 study, Beavers reported that during a weight loss trial, the fat-free mass and fat mass of postmenopausal women were both lower immediately

after loss of body weight. For every 2.2 pounds of fat mass lost there was 0.6 pounds of fat free mass lost. However, of the women that experienced some weight gain, fat mass was regained at a greater degree than lean mass. In this case, for every 2.2 pounds of fat mass gained there was only 0.26 pounds of lean mass gained. Since fat mass is less metabolically active than lean mass, energy expenditure would not increase in proportion to weight regain (24). Weight loss is more about energy restriction, maintaining weight loss may be more about increasing energy expenditure to a level that can be matched by energy intake.

**Behavior**

There are many behavioral factors that predispose individuals to weight regain. In order for a weight loss to be a permanent change, behavioral changes need to occur. However, many people are not able to maintain these lifestyle changes, and they revert back to previous lifestyle choices. During a weight loss intervention, individuals are usually motivated – intrinsically or extrinsically, and are driven by achieving set goals. It is difficult for individuals to remain motivated if there are no continued goals (i.e., additional weight loss). It is also difficult for individuals to maintain food and caloric restrictions and high levels of physical activity.

The National Weight Control Registry (NWCR) is the largest, longest study of weight loss maintainers, with over 10,000 current registrants that have been successful at losing at least 30 pounds and keeping it off for at least one year. Researchers have identified key behavioral identifiers of unsuccessful maintainers from self-reported data (25, 26). They found that the individuals most likely to gain weight after successful weight loss interventions consume a higher fat diet, are more likely to binge eat, and show reduced energy expenditure through physical activity. Weight gainers also reported greater decreases in dietary restraint, increases in hunger, and dietary disinhibition associated with internal cues (i.e., feelings, self-worth).

**EMERGING RESEARCH IN WEIGHT LOSS MAINTENANCE**

Even though maintaining weight loss may seem extremely difficult and potentially impossible, there are many individuals who are successful. A primary responsibility of the RDN is keeping current with emerging weight loss and weight loss maintenance guidelines (4) and evidence-based research. Literature reports many different methods for weight loss; however, there seems to be several emerging strategies for weight loss maintenance. Several of these useful strategies for counseling weight loss maintenance clients are discussed below.

**Continued regular contact with clients**

A variety of studies and guidelines published from AHA/ACC/TOS Guideline and the Academy’s Evidence Analysis Library (EAL) have shown that continued contact with clients helps promote weight loss maintenance (4, 27, 28). The EAL guidelines state that “for weight maintenance, the RDN should schedule medical nutrition therapy encounters at least once every month over a minimum of one year. Research shows that higher frequency comprehensive weight maintenance interventions yield more client success (27).” Although face-to-face interventions are more effective in weight loss retention (29, 30) the use of telenutrition interventions (via the Internet, telephone and text messaging) involving the RDN are potentially effective options (31). However, further studies on specific telenutrition interventions for weight maintenance are needed (31).

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**Dietary factors**

During a weight loss intervention, changing dietary habits is extremely important in providing the necessary energy restriction needed to promote weight loss. Maintaining those behaviors may prove challenging, so it is important to educate the client on small sustainable dietary changes. Below are several key points and dietary strategies that may assist in a client’s lifestyle change.

- Because energy requirements decrease proportionally with a decrease in body mass, energy requirements are lower after weight loss than before. ACC and Adult Weight Management guidelines recommend providing the client with a revised calorie diet that is based on new weight and physical activity levels (4, 27).
- Successful weight loss maintainers report:
  - o consuming a low-energy (~1380-1800 kcal per day) and low-to-moderate fat diet (20-30% of total calories) (29, 30, 32);
  - o increasing daily fruit and vegetable intake (potentially 7-10 servings per day) (33, 34, 35);
  - o increasing daily water intake to 16.9 fluid ounces 30 minutes before breakfast, lunch, and dinner (33);
  - o regularly consuming breakfast > 6 days per week (36);
  - o reducing snacking frequency to one to two snacks per day (36);
  - o limiting the number meals eaten at restaurants to 2.5 times per week, and at fast-food restaurants to < 1 time per week (37);
  - o increasing intake of fiber-rich and nutrient-dense foods (38);
  - o maintaining consistency with dietary patterns (e.g., limiting “cheat” days) (39).
- Involving the client in the treatment and goal setting is instrumental. A long-term dietary plan should be personalized and include the client’s likes and dislikes. The RDN needs to teach the client how to design his/her own meal plans, and how to adjust calorie needs based on energy expenditure.

**Physical activity**

Regular physical activity is the most consistent predictor of successful weight loss maintenance. Self-reported data from the NWCR show that successful maintainers participate in high levels of physical activity, averaging almost four miles per day. The American College of Sports Medicine’s Position Stand on Appropriate Physical Activity Intervention Strategies for Weight Loss and Prevention of Weight Regain for Adults suggests that “more physical activity is better” for successful weight maintenance. Despite the lack of strong evidence, successful weight maintenance is likely associated with approximately 60 minutes of moderate intensity walking per day (40). This recommendation is consistent with AHA/ACC/TOS recommendations of 200-300 minutes per week (4), and literature that suggests greater than 2,500 kcal expended per week (37, 41, 42, 43). The most frequent mode of exercise is walking; however, RDNs should recommend various opportunities for physical activity. It is important to understand clients’ capabilities and preferences to help prescribe activities and/or routines that are sustainable. In addition, physical activity does not have to be performed in one daily session. Clients should be encouraged to increase levels of Activities of Daily Living (e.g., park further distances from entrances, increase gardening time, mall walk, take the stairs, play with grandchildren, etc.).

**Behavioral factors**

The following are self-reported and trial-based behavioral strategies that may be useful in working with weight loss maintenance clients.

- The Relapse Prevention Model and the Problem Solving approach are both widely used in weight loss maintenance counseling.
  - o Relapse Prevention teaches clients how to anticipate and cope with potential relapses. This model helps the client understand that lapses in treatment are part of the process. It also addresses potential barriers and how best to overcome them (44, 45, 46, 47).
  - o The Problem-Solving Approach helps the client address potential barriers and develop a systematic plan with goals to overcome any barriers (46).
- Successful weight loss maintainers report:
  - o limiting the amount of time spent watching television to less than 10 hours per week (48);
  - o daily self-weighing (4, 29, 33, 49);
  - o self-monitoring of food consumption (13);
  - o daily tracking of steps taken (33);
  - o encouraging family and friends to provide social and interactive support (29, 32, 50).

**SUMMARY**

A major challenge in weight management is helping individuals avoid regaining weight once they have lost it. It seems there are mechanisms that may cause individuals, especially older females, to be unsuccessful at maintaining a weight loss. The RDN should be aware of a client’s physiological and behavioral factors contributing to weight regain, and reassess his/her energy requirements to achieve energy balance at a new, lower-level of body weight. This is why it is essential that RDNs are champions for “lifetime” weight loss maintenance.

Using a team-based approach, the RDN should continue the care for reduced-weight individuals by using evidence-based strategies and individualized care. The RDN should be knowledgeable about the guidelines and current literature regarding dietary, activity, and behavioral treatment options, but also must understand the complexities and the challenges that face each client. As the nutrition experts, we need to walk into each counseling session knowing that weight loss maintenance is a journey not a destination.

**Resources for the Registered Dietitian Nutritionist**

**2013 Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society** Copies available at: <http://www.cardiosource.org/> and <http://www.nhlbi.nih.gov/health-pro/guidelines>

*The ACC and AHA collaborated with the National Heart, Lung, and Blood Institute and stakeholder and professional organizations to develop clinical practice guidelines for assessment of cardiovascular risk, lifestyle modifications to reduce cardiovascular risk, management of blood cholesterol in adults, and management of overweight and obesity in adults.*

**National Weight Control Registry** <http://www.nwcr.ws/>  
*The NWCR is the largest prospective investigation of successful weight loss maintenance, tracking over 10,000 individuals who have lost significant amounts of weight and kept it off for long periods of time. The NWCR was developed to identify and investigate the characteristics of individuals who have succeeded at long-term weight loss. The website includes how to join, success stories, and published research.*

**Resources for the Registered Dietitian Nutritionist**

**Academy of Nutrition and Dietetics' Evidence Analysis Library 2014 Adult Weight Management (ADW) Evidence-Based Nutrition Practice Guidelines** <http://www.andeal.org/topic.cfm?menu=5276>  
*The Academy's ADW is an executive summary of major recommendations and practice guidelines evaluating and treating overweight and obese adults.*

**The Millennium Prevention™ HealthMain** <http://www.healthmain.com>  
*HealthMain is a web-based integrated lifestyle framework to control preventable health problems, including overweight and obesity, hypertension, heart disease, diabetes and certain cancers.*

**Relapse Prevention: An Overview of Marlatt's Cognitive Behavior Model** <http://pubs.niaaa.nih.gov/publications/arh23-2/151-160.pdf>  
*A manual outlining the theory behind and application of the Relapse Prevention model.*

**CDR Certificate in Adult Weight Management** <http://www.cdrnet.org/weight-management-adult-program>  
*This program is designed to produce providers of comprehensive weight management care who also know when and how to refer patients to other specialists.*

**2009 Position of the American Dietetic Association (now the Academy of Nutrition and Dietetics): Weight Management** <http://www.eatright.org/About/Content.aspx?id=8382>  
*Using the Academy's Evidence Analysis Process and Evidence Analysis Library, this position paper presents data and recommendations for weight management. (\*Please note that this position paper is out of date and is currently in the process of being redeveloped.)*

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As a new dietetics professional, I attended FNCE® 2014 as a first-timer, a newbie, a rookie. I had no expectations other than the obvious anticipation of 'seemingly' long sessions while sitting in cold auditoriums with thousands of unknown faces milling around with their own agendas. As I made my way down the winding stairs and escalators for the opening session, I anticipated a large formal hall packed to the edges with attendees, and a standard welcome and intro-

duction. After stepping off of the escalator, however, what I heard and saw before me was not what I had imagined. Did I attend a conference or concert?

I was instantly struck by a wave of cheers, music pouring through the room, and a stage dressed in neon lights—a fantastical sight filled with excitement and giddiness like a freshly popped champagne bottle, uncontrollable fizz pouring down the sides. Every chair appeared filled, the walls painted with people. A petite woman in a red hot dress with a fireball personality to match drew my attention. The President of the Academy, Sonja L Connor MS, RDN, LDN, was an inspiration. The enthusiastic reverberation of her words echoing off

the walls was enough to convince me I'd pursued the right career, and that my place was in that auditorium.

Approximately 9,300 individuals attended this year's conference. Somehow, I managed to recognize at least one person everywhere I went, or if not, I'd make a new friend. Even when crowded onto the escalators or pushing our way through the crowds at the Expo, everyone I encountered – from experienced professionals to students – was inviting and engaging. The exhibit hall itself was more like a labyrinth where the hardest decision was choosing which direction to go and which aisle to take. The maze of vendors coupled with the bustle of interest and excitement at the hottest new trends made me feel as if I was on a busy New York City sidewalk with paper boys at each corner shouting "Extra! Extra! Read all about it!" I was overwhelmed, to say the least. As a reprieve from that excitement, the educational sessions were informative and offered a variety of topics all could enjoy.

FNCE® is a multi-dimensional opportunity. It allows you not only to build your network of professional resources, gain insight on the development of dietetics practice, nutrition therapy, and the food industry's advancements influencing our population's food choices, but also to gain friends who share your same passion for food and its relationship to our health. The good number of credit hours offered is nothing to scoff at either! Attending FNCE®, in my opinion, is an absolute must.

### REDESIGNED EVIDENCE ANALYSIS LIBRARY (EAL) WEBSITE

The new website has launched.

Features of the updated site include:

**Improved Organization** - Quick view of all EAL projects

**Easier to Navigate** - Less clicking to access project content

**Evidence analysis questions organized by steps of the Nutrition Care Process within each project**

**Updated EAL Tutorial Modules**

**Quick links to popular pages like EAL Orientation Tutorial and other resources**

The EAL is a complimentary benefit to all Academy members. Visit the new site at <http://www.anddeal.org/>.

### Overheard at the FNCE® 2014 DPG/ MIG Showcase Booth in Atlanta...

*"Women's Health DPG is providing me with knowledge I can one day use with my future clients. I had the opportunity to enjoy FNCE this year because of the stipend I received from Women's Health."* – **Ty-Anne Tench**; Student Stipend Winner from Auburn University, Auburn, AL

*"I have been a member of WH DPG for over 12 years. It's been a privilege and a benefit learning as well as sharing my strengths in vegetarian nutrition for women's health through the life cycle."* – **Gita Patel**; MS, RDN, CDE, LD, CLT; greater Boston area

*"Women's Health DPG has been a great resource for me over the years. I love that all of the members are supportive of each other and always willing to help each other."* – **Maria Bournas**; MS, RD; Chicago, IL

*"FNCE has been really inspiring, from the informative sessions to the diversity of people I met, as well as learning about all the interesting new opportunities in dietetics."* – **Dina Lipkind**; MS, RD, CDN; NYC



*A sitting area and the private nursing rooms available to mothers at FNCE®.*

Once again, Women's Health Dietetic Practice Group was offered the opportunity to assist in the Mothers' Room at the Food & Nutrition Conference & Expo™ (FNCE®) 2014. This year, the Mothers' Room provided a quiet and relaxing space for 41 breastfeeding mothers to nurse their infants or pump breast milk. The Mothers' Room has been available to breastfeeding mothers at the conference since it was started in 1991 to accommodate the needs of members, Academy staff, presenters, speakers, and women who work at the Expo. As the number of mothers served by the Mothers' Room has grown each year, so have the space and services provided. This year, the specially-prepared space in the Georgia World Congress Center had 12 private rooms, as well as a breast pump holding area, refreshments for mothers, and a freezer and refrigerator to store expressed milk. The Mothers' Room was available throughout the day on Saturday and each day until the end of the conference on Tuesday. More than 160 visits by mothers occurred over the four days.

Each year the organization of the Mothers' Room is a collaborative effort of the Academy of Nutrition and Dietetics, the Public Health/Community Nutrition Practice Group, the Women's Health Practice Group, the Pediatric Nutrition Practice Group, and the Academy affiliate in the FNCE® host city. The services provided for mothers could not have been provided without the generous support of numerous volunteers and the financial sponsorship of Medela, Inc. and General Mills Inc. This year, Nicole Larson, PhD, MPH, RDN (Past-Chair, PHCNPG), did an outstanding job as the 2014 Mothers' Room coordinator. Many thanks go to partners, volunteers, and sponsors on behalf of the many appreciative mothers who benefited from their efforts. Additionally, a special thank you is due to Bonnie Bradley, the Chair of the Public Health/Community Nutrition Practice Group, for her efforts to organize the space and volunteers onsite in Atlanta.

*Adapted with permission from the Public Health/Community Nutrition Practice Group.*

### **DPG Volunteers**

- |                     |                    |
|---------------------|--------------------|
| Lisa Akers          | Benita Long        |
| Judy Bodner         | Shannon Looney     |
| Ginger Carney       | Dominica Nichols   |
| Mayra Crespo        | Kathleen Pellechia |
| Phyllis Crowley     | Megan Puryear      |
| Serena Fuller       | Christine Rivera   |
| Catherine Holly     | Kay Sisk           |
| Judy Klavens-Giunta | Brittney Stuard    |

### **Student Host Program Volunteers**

- |                   |                   |
|-------------------|-------------------|
| Tammy Baranowski  | Susanna Dysart    |
| Shennie Barroso   | Sarah Galicki     |
| Stefanie Brockner | Letal Garber      |
| Lindsey Brumlow   | Yasmine Junqueira |
| Stefanie Dove     | Jana Wolff        |



*Refreshments provided for mothers by the Mothers' Room sponsors.*

### **Partnerships**

- Women's Health Practice Group
- Pediatric Nutrition Practice Group
- Student Host Program – Academy of Nutrition and Dietetics
- Meeting Services Team – Academy of Nutrition and Dietetics
- Georgia Academy of Nutrition and Dietetics

### **Sponsors**

- Medela, Inc.
- General Mills, Inc.

If you would like to learn more about the Mothers' Room, please [click here](#) to watch a YouTube clip of Phyllis Crowley, the Public Health/Community Nutrition Practice Group Treasurer, showcasing the space at FNCE® 2013.

**The issues:** Political changes due to mid-term elections, and the status of pending pieces of legislation and change to the payment landscape for nutrition and dietetic services.

**The strategy:** Speak with one voice.

This quarter was filled with learning, reflecting and planning for the future of women's health issues and the role of the RDN. The payment landscape for reimbursement is changing and it is a crucial time for the RDN to determine how the future of dietetics will look. This has also been a politically active quarter with federal, state and local elected positions being hotly contested.

No matter the outcome of the elections, RDNs should make it a priority to educate incoming freshmen and veteran incumbents, at both state and federal levels, on the current public policy issues that keep our profession and expertise visible.

**Speak with one voice:**

- First, connect with the new or veteran legislator(s) in your area, and learn his/her positions on health, food, and nutrition issues that directly affect the role of the RDN. A great place to start is his/her website, focusing on his/her personal position statement.
- Second, work with your Academy affiliate to facilitate a meeting with these decision makers, and educate them on the role and function of the RDN. It does not matter what segment of industry in which you work, what matters is advocating for the profession as a whole – speaking with one voice.
- Third, prior to your meetings with these individuals, educate yourself on the issues that affect you as an RDN, and frame them constructively.
  - For example, Nebraska stakeholders are participating in the discussion and decision-making process through the legislative resolution (LR422) to optimally reduce the state's healthcare costs and improve quality of care for Nebraskans. This will ultimately affect issues of reimbursement, insurances, healthcare delivery systems including telemedicine, and the formation of medical teams under Patient Centered Medical Homes or Accountable Care Organizations.
  - Arm yourself for these conversations with the resources provided to you on the Academy's website, found under the Public Policy tab's Talking Points that prioritize the issues into two categories: Community Issues and Professional Issues. A resource that would be helpful in this scenario is "Strategic Investments for Long-term Health Cost Savings."
- Finally, harness the power of the Evidence Analysis Library and the new Academy of Nutrition and Dietetics Health Informatics Infrastructure (ANDHII) for evidence-based data that supports your position. In pursuit of your advocacy, begin collecting

evidence-based data that supports your position. Be sure to upload your research data to ANDHII at [www.andhii.org](http://www.andhii.org) to ensure it can be accessed by other RDNs for their own advocacy efforts.

If you would like to become more involved in grassroots advocacy, please visit the [Academy website](#), log in as a member, and select the Public Policy tab (or link directly from the [WH DPG website](#)). Here you can learn about the public policy priorities and issues that affect your profession, and arm yourself with talking points and letters that can be used with your representative or senator. You also have the option to contact your Academy affiliate directly for more guidance and inspiration.

So please remember the theme to *speak with one voice*, because...  
**"If Dietetics is your profession, then Policy should be your passion!"**

## HOUSE OF DELEGATES UPDATES

**By Denise Andersen, MS, RDN, LD, CLC, WH DPG Delegate**

The House of Delegates (HOD) conducted two mega issue dialogues on October 17-18, 2014 in Atlanta, GA. One of the issues was regarding business and management skills, and the other involved current issues of preceptor shortage and limited supervised practice positions.

As a result of these dialogues, two motions were passed by the House:

1. **Motion #1:** The HOD requests that the House of Delegates Leadership Team establish a task force with representation from DPGs, as well as internal and external stakeholders. The task force will review all of the HOD input from the dialogue session to develop a plan to assist members and students with building, enhancing and utilizing skills and knowledge related to business and management. The plan will be developed with minimal impact on the Academy's budget. This plan will be submitted for review by the HOD in May 2015.
2. **Motion #2:** The HOD requested the Speaker communicate all of the input generated by the HOD to the Accreditation Council for Education in Nutrition and Dietetics (ACEND), the Commission on Dietetic Registration (CDR), and Nutrition and Dietetic Educators and Preceptors (NDEP) for their plan in addressing these two critical issues facing the profession. ACEND, CDR and NDEP will report to the HOD on progress made to address these issues in spring and fall 2015.

All materials related to the Fall 2014 HOD Meeting, including the updates from various Academy organizational units and outcome materials, can be accessed online by members: [www.eatright.org/hod](http://www.eatright.org/hod) > [Fall 2014 HOD Meeting](#) > [Meeting Materials](#).

## REGISTERED DIETITIAN NUTRITIONISTS ARE DRIVERS IN THE FORMULA TO REDUCE HEALTH DISPARITIES OF WOMEN

By Gail Frank, DrPH, MPH, RD, CHES

The Eighth Annual National Conference on Health Disparities (NCHD) was held in Long Beach, CA, November 5-8, 2014. A major focus was reducing health disparities while sustaining and strengthening healthy communities. Two vibrant messages from keynote speaker James Clyburn, Honorable Representative from South Carolina, were: “We have to put people in a better place and need a new formula;” and “Of all forms of injustice, the injustice of healthcare disparities is the worst.”

It is evident that RDs/RDNs are essential to any new formula for women’s health care and nutrition, and there are many disease states on which we should focus our attention. If we take a closer look at diabetes in particular, there is a disproportionate prevalence among adults with 16.1% in American Indians and Alaska Natives (some rates are higher among particular tribes), 12.6% in African Americans, 11.8% in Hispanics/Latinos, and 8.4% in Asians – compared to 7.15% in non-Hispanic Whites (Centers for Disease Control and Prevention, 2011).

The causes of disparities in chronic diseases are multifactorial and complex, requiring solutions which address different drivers (Peek, Cargill, & Huang, 2007). Since RDs/RDNs are among the drivers that can help reduce these disparities, nutrition care must be tailored

to the individual’s specific health problems, and be appropriate to his or her culture and food literacy level. Likewise, RDs/RDNs have a role in prescribing or advising doctors on the correct nutrition therapies to control glucose, blood pressure, cholesterol levels and body weight.

Among the posters presented at the NCHD, I had the opportunity as Co-Project Director, along with my graduate students and colleagues, to share two that presented data from the community-based participatory research we are conducting at California State University, Long Beach: “The Role of Acculturation among Latinas and Their Knowledge of Healthy Lifestyle Behaviors and Physical Activity Recommendations” and “Dietary Intake is Associated with Physical Activity among Latino Adults.”

WH DPG members should consider submitting abstracts for presentation and attending the Ninth Annual National Conference in fall of 2015 (location to be announced). To learn more about this topic, review MedlinePlus: Health Disparities <http://www.nlm.nih.gov/medlineplus/healthdisparities.html>.

## REIMBURSEMENT UPDATES

By Rita Kashi Batheja, MS, RDN, CDN, FAND

### 1. FREE WEBINAR! *The Ins and Outs of the Physician Quality Reporting System*

The Physician Quality Reporting System (PQRS) is a reporting program that uses a combination of incentive payments and negative payment adjustments to eligible professionals –including RDNs – who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries.

Currently, RDNs who participate in PQRS and successfully report on quality measures for services furnished during 2015 will be able to avoid negative payment adjustments for services provided in 2017.

To learn more, a recording of this free webinar, as well as slide handouts and CPE certificate, are available on the Academy’s PQRS page: <http://www.eatright.org/Members/content.aspx?id=6442478742>. While this webinar discusses PQRS reporting requirements for 2014, the information on the measures reportable by RDNs and how to report them remains current. Continuing Professional Education credits (1.5) are available.

For the most up-to-date information about the PQRS, refer to the Academy website at [www.eatright.org/mnt](http://www.eatright.org/mnt).

### 2. NEW! *Coding and Billing Handbook: A Guide for Program Directors and Preceptors*

The Academy of Nutrition and Dietetics Coding and Coverage Committee is proud to announce that the Coding and Billing

Handbook: A Guide for Program Directors and Preceptors is now available and ready for use with dietetic interns. This tool (free to Academy members, \$40 for non-members) includes vocabulary, sample case studies, recommended resources and other materials for use in supervised practice programs to help interns achieve competency in coding and billing for nutrition services. The content may also help RDNs new to coding and billing for MNT services to set up and implement processes in both health care facilities and private practice.

Download your copy today: <https://www.eatright.org/shop/product.aspx?id=6442482726>

## 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@womenshealthdpg.org](mailto:info@womenshealthdpg.org).

## 2015 WOMEN'S HEALTH DIETETIC PRACTICE GROUP LEADERS

### Executive Committee

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Heather Goesch, MPH, RDN, LDN

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Please send any questions or comments to [info@womenshealthdpg.org](mailto:info@womenshealthdpg.org)



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