

# Renal Nutrition Forum

A Peer Reviewed Publication of the Renal Dietitians Dietetic Practice Group

Volume 29 • Number 4

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## Niacin: A Method of Control for Hyperphosphatemia in Chronic Kidney Disease Stage 5 Patients

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**This article has been approved for 1.5 CPE units. The online CPEU quiz and certificate of completion can be accessed in the Members Only section of the RPG web site via the My CPEU link. In addition, this CPE offering is available to current RPG members only and the expiration date is November 15, 2011.**

### Introduction

Hyperphosphatemia is a reoccurring and difficult obstacle to overcome within the Chronic Kidney Disease (CKD) stage 5 population. This condition, most often presenting as part of renal disease, has increased due to the number of individuals with poorly controlled co-morbidities of diabetes, heart disease and hypertension. Left untreated, and with phosphorus (P) levels ranging above 5.5 mg/dL, patients are at risk for a multitude of health issues. These include cardiovascular disease as a result of heart, visceral and peripheral artery calcification, secondary hyperparathyroidism, and advanced bone disease with soft tissue calcification (1). It has been estimated that at least 40 to 50% of all patients undergoing

dialysis treatment suffer from some type of renal osteodystrophy (2). Statistically, cardiovascular disease is the number one factor for mortality in renal disease patients (1). Current medical therapies consist of adequate dialysis sessions for removal of P from the bloodstream, a focus on patient education to control dietary intake of P and P binder medications (1). A less researched and newer area of interest is the use of niacin as a method to control hyperphosphatemia. This article will explore current research with niacin used to alleviate hyperphosphatemia in the CKD stage 5 population.

In 2006, the National Kidney Foundation revised the Kidney Disease Outcomes Quality Initiative guidelines to reflect current recommendations for the prevention and treatment of bone and mineral disease. Goal ranges were determined for serum P values and treatment approaches outside of these ranges were discussed for different stages of CKD. CKD stage 5 is one of those stages. It is defined as a glomerular filtration rate of 15 or less with need of hemodialysis or peritoneal dialysis. Within this defined group, it is a goal for P levels to be maintained between 3.5 and 5.5 mg/dL (3). CKD stage 5 typically requires an average P restriction of 800 to 1000 mg per day; with this number varying depending on the amount of protein needed for each individual. If dietary restriction and adequate dialysis are not sufficient for P control, a variety of P binders can be prescribed for improved serum P management (3).

### Niacin Reduction of P

In recent years, research has correlated a

Renal Nutrition Forum is published quarterly (summer, fall, winter, spring) as a peer-reviewed publication of the Renal Dietitians Dietetic Practice Group of the American Dietetic Association.

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Articles about successful programs, research interventions, evaluations and treatment strategies, educational materials, meeting announcements and information about educational programs are welcome and should be emailed to the editor by the next deadline.

#### Future Deadlines:

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# From the Editor's Desk

## Megan Sliwa, RD, LDN

Editor



It is hard to believe how time has flown in 2010! As this issue of the Forum goes to print, I am heading back from a great ADA FNCE Meeting in Boston (November 6-9, 2010). The Renal Dietitians Executive Committee met all day on Saturday to discuss current activities, review the operating budget and plan for 2011. RPG also hosted a networking breakfast on Sunday. I hope you had the opportunity to attend FNCE, connect with colleagues and friends and to attend many of the renal-focused sessions. I hope you came back as inspired and re-energized as I did.

As you look ahead to reading this issue of the Forum, I invite you to enjoy the variety of topics available in this publication. The Feature Article by Stacey Phillips, RD provides an interesting approach to treating hyperphosphatemia with niacin supplementation while Eileen P. Newman, MS, RD and Anna Zawislanski, MPH provide an update on the National Kidney Disease Education Program's CKD Diet Initiative. Beyond that, you'll find a compelling article on Ethical Decision Making in Dialysis by Kathleen M. Madigan, MS, RD, LDN, CSR, MBA and an article on stretching beyond your usual comfort zone when counseling patients (a reprint from the Weight Management DPG). I encourage you to review the calendar of upcoming events for the remainder of the year and throughout 2011 for possible conventions to attend.

I hope you will enjoy this issue of the Forum. In 2010-2011, whether your feedback is positive or negative, I'm interested in hearing it. The editorial team welcomes your comments and suggestions for future issues as well. And if you've recently attended an interesting seminar or read an article and thought it was something you'd

like to try, it is likely that fellow members of the RPG would agree and are interested in learning more. Alternatively, if you encounter a great case study or research you'd like to share with other members, please submit your articles and reviews to the editorial team for review.

Between now and the Spring Forum, the editorial committee will be finalizing the next e-supplement of patient education handouts, composed entirely of handouts submitted by RPG members. The handouts include handouts about snacks appropriate for renal patients, along with some that are pediatric focused. Some are very picture-oriented to be easier to use with multiple populations. As an additional benefit, they will be translated into Spanish as well.

Please be sure your email address on file is up-to-date with the ADA so you can receive this and other e-announcements. The Spring Forum will be published in electronic format only again in 2011; the overall feedback for this format has been positive and the cost savings to the RPG budget significant.

As always, I'd like to thank all of the volunteers that helped make this publication happen: the authors for their experiences and contributions, the peer reviewers for their expert knowledge and our CPEU test writer for all of her hard work. I'd also like to thank the editorial committee for their multiple reviews to make this the valuable reference that it is. Have a good holiday season and a great start to 2011! ♦

**Welcome**  
to our new Advertising Editor!  
**Emily Cutler, MS, RD, LDN**

# Feature Article....

relationship between niacin supplementation and a decrease in high P levels in renal patients. In a healthy individual, the renal tubules are responsible for eliminating excess P from the body. As renal disease progresses and the glomerular filtration rate of the kidneys declines, the normal kidney function of P filtration decreases (4,5). Researchers have been able to identify a transporter within the intestinal and renal tubule lining which is partially responsible for the amount of phosphate absorbed. This transporter, known as type IIb sodium-dependant Pi co-transporter (NaPi-2b), is inhibited by the presence of nicotinamide, and therefore limits the amount of P absorbed when this vitamin is present (4,5).

Different forms of niacin have been studied as to their effect on P blood levels. Niacin is known as nicotinic acid while nicotinamide or niacinamide is the amide of nicotinic acid. The conversion from nicotinic acid to niacinamide is not a direct process. While each is readily absorbed in the body, nicotinic acid is only able to function in the coenzyme forms of nicotinamide adenine dinucleotide (NAD) or nicotinamide adenine dinucleotide phosphate (NADP) in the cells for the processes of glycogenolysis, fatty acid metabolism and tissue respiration (6). Figure 1 shows the difference in the chemical structures of each.

Both positive and negative side effects of the two different

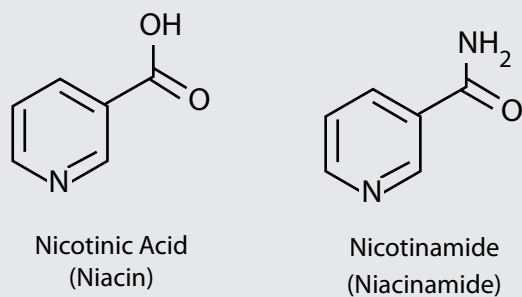
are gastrointestinal distress and potential thrombocytopenia (7). In studies examining niacin effects, it was found that a dose of aspirin taken before the nicotinic acid can counteract the flushing symptoms (8,9). Conflicting research exists too, in support that liver damage may be caused by administration of niacin. Experts acknowledge that more research is needed, but that timing of the supplement and not exceeding the recommended therapeutic dose of niacin may help to limit liver damage (10). Reaction to this supplementation in diabetic patients also remains controversial. It has been recognized that the benefits on the lipid profile are more valuable than the slight decrease in glucose control (11). Finally, older research is more supportive of niacin causing gastrointestinal upset and blurred vision. More recent research suggests that monitoring patient tolerance and providing lower doses of the supplement cause only minor incidence of these reactions amongst study participants (8,12,13).

## Decrease in Hyperphosphatemia with Niacin Supplementation

With understanding of how nicotinamide can inhibit the NaPi-2b transporter within the intestine and renal tubule lining, research has been completed on this aspect of control. A focus has been placed on determining the exact dose of the supplement which can help with P control in the CKD stage 5 patient. Table 1 summarizes each study, the number of participants, duration of trial, and results at the completion of each of the trials.

Six different human clinical studies have identified niacin as a beneficial source in limiting hyperphosphatemia in CKD stage 5 patients. The earliest of these trials examined the serum P values of hemodialysis patients in response to increasing levels of nicotinamide over a three month period of time. Sixty-five individuals were initially given a dose of 500 mg per day of nicotinamide. Every two weeks this dose was increased by 250 mg until P level goals of less than 6.0 mg/dL were obtained (14). Conclusive results indicated that most individuals consumed an average of 1080 mg/day of niacin. With this supplementation, P decreased from  $6.9 \pm 1.5$  mg/dL to  $5.4 \pm 1.3$  mg/dL. Being one of the earlier trials focusing on this supplementation, researchers proposed that more trials would be necessary to add validity to their results (14). In a similar study, researchers in India looked at control of hyperphosphatemia while supplementing 34 hemodialysis patients with 375 mg of extended release nicotinic acid daily for eight weeks. Phosphorus levels were measured two weeks into the study and if hyperphosphatemia remained, then the dose was increased to 375 mg nicotinic acid, given twice daily with meals. At the end of the study, average P levels had decreased from  $7.7 \pm 1.5$  mg/dL to  $5.6 \pm 1$  mg/dL (15). Researchers cited failure to consider dietary

**Figure 1**  
Chemical Structures of Niacin



forms used to control hyperphosphatemia have been identified with niacinamide having less potential harmful side effects. Positive results of use of the nicotinic acid include the decrease of low density lipoprotein cholesterol and an increase in high density lipoprotein (HDL) cholesterol. As cardiovascular disease is the leading cause of death in CKD stage 5 patients, this benefit is recognized as a valuable finding (1). Potential negative side effects of this form include flushing, abnormal liver function tests, thrombocytopenia, an increase in insulin resistance, gastrointestinal disturbances with nausea, vomiting and irritation of pre-existing stomach ulcers, and in rare incidences blurred vision with macular edema (7). With the niacinamide form, most common side effects

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P intake, limited number of participants and short trial duration as study limitations (15). In contrast to previous trials, the effect of niacin on P levels was concurrently studied with examination of the effect on HDL levels in a third trial. This particular study included the use of Niaspan, a prolonged release nicotinic acid, (Abbott Laboratories, North Chicago, IL) after a two week washout period from either a calcium or aluminum based P binder. Initially, 20 patients started the study, but only 11 finished due to symptoms of flushing, weight change or hypotension. Participants were given a starting dose of 375 mg per day. Every two weeks, until 12 weeks had passed, this dose was increased to levels of 500, 1000, 1500 or 2000 mg per day depending upon patient tolerance and response in terms of P levels. Results indicated a decrease in average P levels of participants from  $7.2 \pm 0.7$  mg/dL to  $5.8 \pm 0.75$  mg/dL. The average dose needed for P control was  $1470 \pm 110$  mg/day of Niaspan. Along with the lowered P levels, Niaspan supplementation additionally increased HDL levels (16). Authors indicated that future studies determining the relationship of niacin with P and HDL would benefit from a longer trial period and a greater number of study participants (16).

Following these early research trials, three other trials have been completed since 2008 and confirmed similar results as previous studies. In a randomized, double-blind placebo-controlled trial, 33 dialysis patients were subjected to average levels of 500 to 1500 mg per day of niacinamide or to placebo supplementation over an eight week time frame. At the end of the eight weeks, a two week washout period took place. Individuals were then restarted on supplementation for another eight weeks, opposite of what they had been receiving during the initial trial period. Phosphorus levels of the treatment group decreased from 6.26 to 5.47 mg/dL in comparison with the placebo group where levels rose from 5.85 to 5.98 mg/dL (17). Final results again proved that the niacin supplement lowered serum P levels but researchers questioned the potential effects of non-compliance with taking the prescribed supplements as a set back with findings. Additionally, they suggested that an expanded time trial is needed to determine more valid benefits and potential side effects (17). Next, researchers used nicotinic acid supplementation in three hemodialysis and six peritoneal dialysis patients over eight months. Individuals were started on a dose of 500 mg per day of nicotinic acid with this dose increasing to 1000 mg per day by month three. At the start of the study, P levels were measured to be  $6.46 \pm 0.53$  mg/dL. Laboratory values were re-measured at month four and were  $4.37 \pm 0.63$  mg/dL. By the conclusion of the trial, P levels had significantly dropped in all participants and were at levels of  $3.94 \pm 0.76$  mg/dL (18). Researchers found that an average of 1 g/d nicotinic acid was well tolerated amongst the participants (18). Issues that may have

affected study conclusions were the limited number of participants and no follow-up period of P measurements after the trial completion. One final study supporting the use of niacin for control of phosphorus levels was completed with 15 peritoneal dialysis patients during an eight week trial period. Seven patients were used as control subjects. The other eight participants were supplemented with 250 mg of niacinamide twice daily. After two weeks, this amount was increased to 500 mg, twice per day. At week four, 750 mg, two times per day, was given. Although this trial's study population was not as large as previous trials with hemodialysis patients, levels of serum P still decreased by approximately  $0.7 \pm 0.9$  mg/dL (19). One major drawback was that only six of the eight supplemented patients completed the trial. Similar to earlier trial conclusions, more participants and a longer trial time frame were recommended to assist with validating the results (19).

## Current Methods of P Control

Current methods to combat high P levels in renal patients include adequate dialysis sessions, dietary education and the use of prescribed P binders. A typical hemodialysis patient will complete three sessions per week, ranging from three to five hours depending on patient needs. It is estimated that each dialysis treatment removes approximately 800 mg of P (1). As the typical American consumes more than 1000 mg of P per day with simply meat and dairy intake, it is evident how dialysis alone could be considered deficient for adequate removal of P. For those patients requiring higher protein amounts once on dialysis or consuming foods with hidden P additives, 1000 mg is a low estimate of P intake (1). Malnutrition must be avoided, therefore it is important to prescribe adequate amounts of calories and protein for each individual patient while adhering to P goals (20).

Patient education is another key factor in current methods of controlling hyperphosphatemia. The renal diet is comprised of many other restrictions such as sodium, fluid, calcium, and potassium, making adherence difficult for the patient. Several studies demonstrate the importance of re-educating patients on a regular basis in areas that may not be well understood. In one of the studies, a simple survey consisting of ten questions regarding high P levels, P binders and understanding behind medical treatment of hyperphosphatemia was given to 117 patients. Of the participants, approximately 74% were lacking in dietary education of high P foods. A little over half were unable to demonstrate knowledge about the harmful effects and symptoms of uncontrolled P levels (21). The major finding from this particular study indicated that even with regular counseling related to food and medications, there still remained a barrier between learning the information and applying it in one's lifestyle (21). Two additional research studies



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examined the role of more intense dietary education on control of hyperphosphatemia. Both sets of trials concluded that the goal of controlling P could be obtained with regular diet education along with dietary and lifestyle changes (1,22).

Multiple types of P binders exist and are available to be prescribed for P management. Available P binders include: iron containing compounds, aluminum hydroxide, resin-based binders, sevelamer carbonate, calcium-based binders and lanthanum carbonate (4, 5, 18, 23, 24). Each of the binders, while having a positive effect on P control, has its own set of potential drawbacks. Many of the iron containing compounds remain under clinical research to determine a safe dose. Early trials have resulted in diarrhea (5). Aluminum binders are used only under special, short-term conditions due to risk of toxicity, lack of identified safe dose and risk of neurological impairment, osteomalacia and anemia (4,18). Much like the iron containing compounds, resin-based binders remain under clinical investigation. Current trials demonstrate the side effects of constipation and abdominal distention with oral use (5). Of the calcium based binders, sevelamer carbonate and lanthanum carbonate, recommendations vary in regards to which is the most beneficial to be used amongst the renal patient population (23). The calcium based binders, typically calcium acetate or calcium carbonate, may be the most affordable. One problem with these medications is the potential deposit of the calcium and P product in the soft tissues. Experts argue that the expense and quantity of pills needed with the sevelamer carbonate and lanthanum carbonate can contribute more to noncompliance (5,24). A study determining pill burden and adherence to prescribed P binders was undertaken by researchers (25). After data collection from 233 dialysis patients, the mean number of pills taken per day averaged 19, with half or more of these pills being P binders. As the number of pills increased, compliance decreased with an estimate of only 38% of the population studied taking their medications as prescribed (25). Overall, the best method of controlling hyperphosphatemia with P binders remains a very controversial topic and is often determined depending on physician preference. It is apparent that adequate dialysis, dietary compliance and consistent medical therapy each play a major role in maintaining P levels within recommended guidelines.

## Discussion/Recommendations for Practice

Based on the reviewed research, it appears that the use of niacinamide to promote P control for CKD stage 5 patients should be considered as an alternative or addition to current therapies of adequate dialysis, dietary education and the existing P binder prescriptions. Non-adherence is one of the largest contributors to hyperphosphatemia within this population. Missing dialysis sessions, dietary consumption of foods that contain evident or added P

and not regularly taking prescribed P binders with meals are just a few of the reasons causing hyperphosphatemia and the progression of bone and mineral disease (22). Use of niacinamide may help to reduce this growing problem by decreasing the number of pills being taken. It may also decrease the cost associated with P control methods.

In each of the six reviewed studies, the patients responded well to varying doses of niacin and serum P levels decreased. In the two trials that provided the average amount of niacin needed to maintain goal levels of P, intake fell between the ranges of 1000 mg to 1600 mg per day (14,16). None of the trials provided a maximum dose of more than 2000 mg per day, suggesting that a safe and beneficial dose of niacin supplementation ranges between 1 to 2 grams per day. Careful monitoring of the patient should be of concern when starting a patient on niacin supplementation to determine the individual's personal tolerance level (7). Fewer negative side effects have been found with the niacinamide or extended release nicotinic acid supplementation making these the more recommended forms. Upper limits for intake have been recommended at 35 mg NE for adults 18 years of age and older (26).

Niacin supplementation should not be prescribed to all renal patients. In many of the studies, patients that are pregnant or those with a medical history of liver disease, peptic ulcer disease, gout or cancer were excluded because of the potential for harmful side effects (15,17,18). Minimal symptoms were seen amongst trial participants. This suggests that the preliminary side effects noted with niacin supplementation may not present with the amount of niacin being given or in the time frame of supplementation. Of the symptoms noted with nicotinic acid supplementation, a few individuals were limited by flushing, weight loss, hypotension, diarrhea, thrombocytopenia or a skin rash (15-17). In order to determine the seriousness of these conditions, larger and longer trials are needed to increase knowledge and understanding.

The number of trials determining the effect of either nicotinic acid or niacinamide on hyperphosphatemia is easily the largest limiting factor in this area of research. Each of the six studies evaluated note the importance of future research in determining validity of the results (14-19). Another limitation of the studies included length of the trials. Many of the trials took place over a time frame of two to three months, with only one being completed after eight months. With a short time frame for completion, results could be further validated with a longer trial period. A follow-up measurement of P levels following trial completion would also be of benefit. This would allow researchers to determine if the supplementation was the main factor in decreasing P levels or if other trial influences need to be considered (18). One additional limitation was the number of study participants. The largest num-

**Table 1**  
Summary of Trials Examining Niacin Effect on P Levels

Author(s)	Study Subjects	Study Duration	Results
Takahashi and colleagues	65 hemodialysis patients	12 weeks	Decreased P levels with niacin supplementation
Sampathkumar and colleagues	34 hemodialysis patients	8 weeks	Lower P levels following treatment
Muller and colleagues	19 hemodialysis patients 1 peritoneal dialysis patient	12 weeks	Improvement in P level after supplementation
Cheng and colleagues	33 hemodialysis patients	8 weeks treatment, 2 weeks washout period, 8 weeks placebo	Treatment group saw improvement in P levels. Placebo group had slight increase in P levels.
Valencia and Cruz	3 hemodialysis patients 6 peritoneal patients	8 months	Significant improvement in P levels at 8 months
Young and colleagues	15 hemodialysis patients (8 treatment and 7 control)	8 weeks	Decrease in P levels of treatment group. Increase in P levels of placebo group.

ber of individuals studied was 65 and three of the other five studies were limited to 20 or less participants. Several patients in each of the trials did not complete the full trial. Less disputed results could be obtained in trials with a larger number of participants (14-19).

Strength of study designs were reflected in the outcomes. Each of the trials proved the initial hypothesis that P levels would decrease with the addition of niacin supplementation. The least amount of P improvement was seen in the eight week trial where only six peritoneal patients finished the study (19). A much larger difference was noted in those patient supplemented with nicotinic acid over an eight month time frame (18). Also of original concern, were the side effects of gastrointestinal distress, altered liver function tests and flushing with the nicotinic acid supplementation. Results from the studies were supportive in the fact that many of these symptoms did not appear or were not of significance in a majority of the individuals completing the trials (6).

Due to the limited amount of research on niacin supplementation and control of hyperphosphatemia, future research includes many possibilities. Most needed at this time are longer trials with a larger number of participants to determine the validity of earlier trials. It would also be of interest to determine if niacin effects differ between those on hemodialysis in comparison with those undergoing peritoneal dialysis.

## Conclusion

Hyperphosphatemia and bone and mineral disease are ongoing and growing problems amongst patients with CKD stage 5. Until this problem can be better controlled, dialysis patients with

chronic hyperphosphatemia will continue to be at an increased risk for mortality from cardiovascular disease. Current therapies of dialysis, education and medications can help decrease this problem. New alternatives such as niacin supplementation should be further researched and examined as to their role and contribution in prevention of hyperphosphatemia and therefore bone and mineral disease. ♦

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*Thank You...*

*Our Thanks* to all of our clinical peer reviewer members who made this issue possible:

**Eileen Katz, MS, RD, LD**

**Mary Sundell, RD, LDN, CCRP**

**Desiree DeWaal, MS, RD, CD**

**Sara Erickson, RD, CSR, LDN, CNSC**

*Thank You* also to:

**Amy Hess-Fishl, MS, RD, LDN, BC-ADM, CDE**

for providing our test questions.

*Additional Thanks* are extended to:

RNF Managing Editor **Stacey Phillips, RD**; web site editor

**Cathy M. Goeddeke-Merickel, MS, RD, LD**;

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for proof copy review.

## Addressing the Growing Need for Chronic Kidney Disease (CKD) Medical Nutrition Therapy in Primary Care Settings: Update on the National Kidney Disease Education Program's CKD Diet Initiative

**Eileen P. Newman, MS, RD and  
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**This article has been approved for 1.5 CPE units. The online CPEU quiz and certificate of completion can be accessed in the Members Only section of the RPG web site via the My CPEU link. In addition, this CPE offering is available to current RPG members only and the expiration date is November 15, 2011.**

Since its inception in 2001, the National Kidney Disease Education Program (NKDEP) has worked to improve the early detection and treatment of chronic kidney disease (CKD). Approximately 23 million Americans aged 20 and older may have CKD, and that number is expected to rise with the increasing rates of diabetes and hypertension, the two leading risk factors for CKD (1). Although usually considered a specialist's disease, early CKD can be managed in the primary care setting and integrated into existing care for patients with diabetes and hypertension. However, CKD remains poorly managed, in part because clinicians, including Registered Dietitians (RDs), feel inadequately educated. Despite the fact that Medicare provides coverage for three hours of CKD Medical Nutrition Therapy (MNT) in the first year and two hours in subsequent years, the benefit is underutilized, with only 9,486 RD Medicare providers enrolled (2). For these reasons, NKDEP developed a CKD Diet Initiative to fill the need to provide simplified and accessible professional and patient education materials, to train general practice dietitians to counsel people with CKD, and to facilitate referrals for CKD MNT from primary care physicians.

NKDEP initiated this effort with a roundtable discussion with members of the Renal Practice Group (RPG) to obtain insights into the barriers to counseling CKD patients who are not on dialysis. The participating renal dietitians reported that RDs who do not practice renal education daily may not be as familiar with the specific challenges of the renal diet and need refresher training from RDs experienced in CKD MNT. In addition, they commented that primary care providers need to be educated on the importance of MNT and the need for referrals for CKD. The participants encouraged NKDEP to develop an agenda that helps to improve CKD patient outcomes by encouraging strategies that can be initiated by dietitians (3).

Subsequent to the initial roundtable discussion, NKDEP conducted in-depth interviews and held two focus groups with RDs across nine practice areas. The participants reinforced the original comments from the roundtable discussion and provided feedback on patient and provider training materials. The comments also informed the development of an overall strategy for NKDEP's CKD Diet Initiative to improve MNT to CKD patients. This article is intended to update the RPG on these activities.

### New Research Activities

After the initial roundtable discussion, NKDEP held in-depth telephone interviews with RDs from nine different dietetic practice groups (DPGs) to gain insight into current practice outside the experience of the renal dietitian. Many of the general practice dietitians (GPDs) who participated in the interviews reported that they had limited experience with CKD but had seen an increase in CKD patient referrals. As a result, they expressed a need for an update/refresher course on how to assess and provide MNT to CKD patients. They also reported a need for simple patient education materials available from one source; they often had to access materials from many different sources and found that the reading level for their patients was usually too high. Many recommended that NKDEP develop a professional guide on the CKD diet, and simple, easy-to-read materials for lower literate patients.

### Strategy of the NKDEP CKD Diet Initiative

Based on in-depth interview findings, NKDEP developed an overall strategy for the initiative. Goals included: development of easy-to-read patient education and training materials; training GPDs to provide CKD MNT as part of their care of patients with diabetes and/or hypertension in primary care practice; and educating primary care practitioners on the importance of CKD MNT and making referrals to RDs, when appropriate.

Both of the subsequent focus groups, composed of renal and GPDs who had varying experience with CKD MNT, discussed



## NKDEP CKD Nutrition and Diet Materials

These free, downloadable, and reproducible materials are designed to provide key information about CKD and diet for RDs and their patients. The patient materials are written below a seventh grade reading level.

### For RDs:

**Chronic Kidney Disease and Diet: Assessment, Management and Treatment** - an overview guide on treating CKD patients who are not on dialysis.

### For CKD Patients Who Are Not on Dialysis:

**Eating Right for Kidney Health: Tips for People with CKD** – a handout about the basics of nutrition in CKD.

**Nutrition Tips for People with CKD** – individual handouts on:

- Sodium
- Protein
- Phosphorus
- Potassium
- Food-label reading

**Your Kidney Test Results** – a useful tool for assessment and education about test results with patients.

**Visit NKDEP at [www.nkdep.nih.gov](http://www.nkdep.nih.gov) to view and download these materials free of charge.**

ways to implement the proposed strategy. They supported a Certificate of Training in CKD Diet Management program, similar to the American Dietetic Association's (ADA) Certificate in Training in Weight Management program, as an effective avenue for training. They suggested both online and in-person training to minimize travel time and cost. Although many commented that a formalized mentoring program was hard to implement and maintain, they encouraged post training support, such as an online CKD community to discuss decision support and patient self-management issues. They also noted there was a need to develop a "business case" to help RDs "sell" the idea of referrals to primary care practitioners who manage CKD patients who are not on dialysis.

## Decision Support and Patient Self-Management Materials

After the initial telephone interviews, NKDEP developed a suite of nutrition resources for managing patients with CKD. These materials included a simplified decision support guide for the RD (provider tool), and easy-to-read self-management handouts for the RD to use with the CKD patient. To provide feedback on the first set of materials, NKDEP conducted a focus group with a representative from each of the nine DPGs interviewed earlier. The goal was to find an RD from each practice area with experience in CKD. Recruitment proved to be difficult, confirming an earlier finding that not many RDs are practicing CKD MNT.

The focus group participants had positive feedback on the materials. They liked the simplicity of the provider tool and the reading level of the patient materials and they recommended that NKDEP develop fact sheets on single nutrients to enable MNT sessions focusing on individual nutrients (phosphorus, potassium, etc), in addition to the overview handout for patients who would only be seen once. Also, they commented that material will be needed to address cultural food preferences for the diverse populations they serve. To improve the provider tool, they suggested more details on dietary intervention, a more functional layout, and an organization that reflects CKD disease progression.

As a result of the focus group findings, NKDEP revised patient materials and created new ones. The resulting guide for patients provides a quick overview of the diet components. While intended to be used by RDs, this handout can also be used by primary care providers to introduce the basics of the CKD diet changes before making a referral. To help patients understand their lab test values and why the changes to the diet are being recommended, NKDEP developed a "Kidney Tests Report Card" that provides simple explanations of the common tests and room for the provider to enter the latest values. Enabling continuity of care, this customizable handout can also be used by other members of the health care team to provide updates on test results or answer the patient's questions. NKDEP also developed a series of individual fact sheets on sodium, protein, phosphorus, potassium, and the food label. All patient materials are written between a fifth and seventh grade reading level.

In addition, NKDEP transformed the tool for professionals from a narrative format into a tabular design, organizing its content into the following categories: assessment, slowing progression, and reducing complications. As much as possible, the information in the tool is evidence-based, drawing upon the ADA Evidence Based Library for CKD and existing literature. However, since data is limited for CKD patients not on dialysis, many

# Advances in Practice....

*“Some RDs with many years of experience are not comfortable with the renal diet. There are so many things that are involved with the renal patient. It’s not just a low-sodium diet. It’s being able to see all different disease states and knowing how to treat.”*

NKDEP Focus Group Participant

*“I’m starting to get referrals for CKD patients more regularly.”*

NKDEP Focus Group Participant

*“CKD is unidentified and we need to alert physicians of the need for referrals to dietitians.”*

NKDEP Focus Group Participant

of the recommendations for CKD are extrapolated from renal replacement therapies literature. Before finalizing the materials, NKDEP conducted additional reviews by RDs practicing CKD MNT and their patients. The completed materials can be accessed on the NKDEP website at [www.nkdep.nih.gov/ckd\\_nutrition](http://www.nkdep.nih.gov/ckd_nutrition).

## Next Steps

To address the need for a CKD update/refresher for registered dietitians, NKDEP is developing training materials which ADA will adapt as an online Certificate of Training in CKD (expected to launch in mid 2011). Administered through the ADA Center for Professional Development, the online program will include interactive activities, case studies, assessments, and the CKD business case. Both ADA members and non-members will be able to earn continuing professional education units and, upon successful completion of an assessment, will earn a Certificate of Training in CKD Diet Management. The ADA will review the web-based modules with members of the RPG as part of the developmental process. All supplemental materials developed by NKDEP as part of this collaboration will be publicly available online.

Next, we will explore developing an online CKD community

### **Dietetic Practice Groups included in the In-depth Interviews and Focus Groups:**

- **Medical Nutrition Practice Group**
- **Clinical Nutrition Management**
- **Healthy Aging**
- **Renal Dietitians**
- **Nutrition Entrepreneurs**
- **Diabetes Care and Education**
- **Dietetic Educators of Practitioners**
- **Dietetics in Health Care Communities**
- **Public Health/Community Nutrition**

forum to allow RDs and other members of the multidisciplinary health care team to discuss and post comments with fellow practitioners. In addition, we will be working with the Dietetic Educators of Practitioners Practice Group to interest students in renal practice and expand training curricula. Also, NKDEP will encourage referrals to RDs for CKD MNT as part of its forthcoming online matrix of suggested curriculum activities for the new six-hour Kidney Disease Education benefit from the 2008 Medicare Improvement for Physicians and Providers Act.

NKDEP will develop linguistic and cultural adaptations of the patient materials to allow RDs to use them with non-English speaking clients and to address the need for cultural food preferences. We will likely develop additional patient education fact sheets in the future and are open to suggestions for future topics from RDs who use the materials.

We look forward to a continued collaboration with RPG members on all aspects of the NKDEP Diet Initiative. We hope that they will participate in the Certificate of Training in CKD Management Program and encourage other RDs not working in the renal field to also participate. If you have comments or suggestions, please contact Eileen Newman, MS, RD, NKDEP Associate Director at [Eileen.newman@nih.gov](mailto:Eileen.newman@nih.gov).

We acknowledge the participants in the interviews and focus groups for sharing their time and expertise to help NKDEP refine the overall strategy and develop the provider and patient materials. We thank the ADA for their assistance in recruitment for the focus groups through the DPGs and for supporting the NKDEP CKD Diet Initiative and the Certificate of Training in CKD Diet Management program. ♦

## References

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2. CMS/OFM’s and CMM’s Unique Physician Identification Number database/classification by ORDI. December 2009. Available at: [http://www.cms.gov/DataCompendium/15\\_2009\\_Data\\_Compendium.asp#\(Table VI.13b—Medicare Physician and Other Practitioner Registry by Specialty\)](http://www.cms.gov/DataCompendium/15_2009_Data_Compendium.asp#(Table VI.13b—Medicare Physician and Other Practitioner Registry by Specialty)), Accessed May 2010.
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# Member Spotlight

## **Maureen McCarthy, MPH, RD, CSR, LD**

*Recipient of an RPG educational stipend for the 2010 International Congress on Nutrition and Metabolism in Renal Disease in Lausanne, Switzerland*

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This article will report on several topics presented at the 15<sup>th</sup> International Congress on Nutrition and Metabolism in Renal Disease, which convened in Lausanne, Switzerland, on May 25 to 28, 2010. The Congress represents the bi-annual meeting of the International Society of Renal Nutrition and Metabolism which provides a unique opportunity to hear reports on cutting edge research and clinical practice in all stages of chronic kidney disease (CKD) as well as all modalities of replacement therapy. It brings together researchers and clinicians, primarily physicians and dietitians, from around the world whose practices include nephrology nutrition.

## **Adiponectin as A Marker for CKD**

In a plenary session devoted to “Obesity and Adipokines in CKD,” Peter Stenvinkel, MD, of Sweden spoke on adiponectin (ADPN) in CKD. He subtitled his talk “Dr Jekyll or Mr Hyde?”. ADPN, a 30kD polypeptide, is secreted by adipocytes. Levels increase with decreased renal function. ADPN is known to have strong anti-inflammatory and anti-atherosclerotic properties, but is also associated with insulin resistance, diabetes mellitus type 2, and cardiovascular disease. It seems to promote wasting and high levels are a marker for increased risk of sudden death related to cardiovascular issues in hemodialysis patients. There is considerable research demonstrating altered levels of ADPN in patients on dialysis and post-kidney transplant. Much more basic research is needed to determine practical applications of ADPN levels and potential nutrition interventions to reduce high levels.

## **Obesity In Transplant Candidates**

Isabelle Binet, MD, from Switzerland, presented an excellent lecture on obesity in transplant recipients during a scientific session on metabolic challenges in renal transplantation. Her conclusion was to challenge the practice of European transplant centers in declining patients with body mass index (BMI) greater than 30 for transplant. When BMI is >35, and certainly when it is >40, it may be appropriate, in her opinion, to deny transplant because of obesity. Transplant candidates need thorough, individualized evaluations, and clinicians need better strategies to identify risks in obese end-stage renal disease (ESRD) patients who present for transplant evaluation.

## **Other Topics**

Here are some brief summaries of a few other talks, with the name of the presenter:

**Carla Avesani** (Brazil)—Basal energy expenditure (BEE) is lower in CKD patients compared to healthy controls. Diabetes, hyperparathyroidism, and inflammatory stressors are just a few factors that may increase BEE.

**Nathan Levin** (United States of America (USA))—The Dialysis Outcomes and Practice Patterns Study has reported huge variability in use of water-soluble vitamin supplements in ESRD patients. The USA leads the way, and Japan shows very low utilization but has good statistics for dialysis survival.

**Vincenzo Bellizzi** (Italy)—See <http://clinicaltrials.gov/ct2/show/NCT00323713> for information about an ongoing prospective randomized clinical trial of very low protein diet (0.35 g/kg/day) vs. a low protein diet (0.55 g/kg/day), both with the addition of keto-analog amino acids, at multiple Italian centers. This study is enrolling subjects with CKD stages 4 and 5, not on dialysis. The primary end-point is the start of renal replacement therapy or patient death.

**Flavio Vincenti** (USA)—The prevalence of new-onset diabetes after transplant (NODAT) and other metabolic issues may explain why there is no evidence of improved long-term survival in kidney transplant recipients. Vincenti suggests more emphasis on treating NODAT, weight gain and cardiovascular issues post-transplant with the same intensity now used to address acute rejection. NODAT accelerates graft loss for reasons that are so far unknown, but newly developing immunosuppression regimens may be part of the answer.

**William Mitch** (USA)—His work on the activation of the ubiquitine-proteasome system in CKD is well-known. He is now looking additionally at the effect of CKD on a group of cells called satellite cells (stem cells for muscle; required to maintain muscle mass). CKD seems to suppress satellite cells, resulting in muscle fibers that fail to grow normally.

## **16th International Congress, 2012**

The next Congress will take place in Honolulu, Hawaii, from June 21 to 25, 2012. Based on my experience in Lausanne, I strongly encourage all of my colleagues in nephrology nutrition to consider attending this event. It was extremely stimulating to hear discussions among respected experts from the USA, as well as world leaders such as Peter Stenvinkel from Sweden, Denis Foque from France, Lillian Cuppari from Brazil, and many others. The interaction with peers from around the world is an incomparable and stimulating opportunity. ♦



# Ethical Decision-Making in Dialysis

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As renal dietitians and as individuals, we make ethical decisions on a daily basis. Sometimes, they may be as simple as right versus wrong. Other times, we may need to incorporate an ethical decision-making tool known as the Four Guiding Principles. They are used innately, even without knowing them by name. The four guiding principles are: autonomy, beneficence, nonmaleficence, and justice.

Autonomy is the ability to be self-governing and self-directing. As individuals, we have both the right and the freedom to make decisions for ourselves. Beneficence is doing good and avoiding harm. It can be an action that takes place for the benefit of another. Nonmaleficence is the opposite of beneficence, it is do no harm. This is not absolute and must always be balanced against beneficence.

Understanding these guiding principles and how to use them in a variety of situations is essential in today's environment. In the field of healthcare ethics, right and wrong is not always clear, so it is often in the eye of the beholder.

Lastly, there is justice, the act of treating an individual fairly and without bias. This requires a high standard of behavior. Why should we practice ethical behavior? First and foremost, we have a responsibility to ourselves. If we are not able or willing to incorporate ethical behavior in our own lives, we will not be successful at incorporating the guiding principles to help others. Next, we have a responsibility to others, including our patients. They need to know that we are capable of acting in their best interest. We also have a responsibility to our dialysis facilities and our companies or corporations. Lastly, we have a responsibility to our stakeholders. With so many people involved, there is no doubt that ethical dilemmas will arise.

In our everyday work performance, we are faced with many situations where ethical decision-making is critical. End of life, transplant candidacy, achieving outcomes, quality of care, vendor relations, the Health Insurance Portability and Accountability Act (HIPAA), and caring for the difficult or disruptive patient are a few of the most common situations that require ethical decision-making skills. Understanding the four guiding principles and balancing them against each other helps us to understand the moral implications of each choice.

## End of Life Decisions

Practicing in a dialysis facility allows us continuity of care

as well as an avenue to build a trusting relationship with patients. As an active member of the healthcare team, we are actually in an ideal position for patients to come to us for help with end of life decisions. In this situation a struggle between autonomy and beneficence can present. Informed consent, medical futility, respect for life and patient self determination are issues that must be addressed. As long as medical and emotional needs are being addressed and the patient is competent, if he or she chooses to stop treatment, autonomy is the guiding principle followed and the patient's wishes should be respected. We have to look at the principle of beneficence from the point of view that what the patient's family, friends, and caregivers feel is in their best interest, may not be what the patient feels is in his/her best interest regarding quality of life.

## Transplant Candidacy

Determining transplant candidacy is harder than ever from an ethical perspective. Cadaveric transplants involve issues of respecting the life that has been lost, making sure the organ is given to the best possible match, and compliance. The stakes become even higher when live donations are involved. There are more and more directed – living related, directed – stranger, and non-directed – general pool transplants taking place. While respecting the autonomy of the recipient, we cannot lose sight of the sacrifice of the donors. As we address a patient's compliance, as well as mental and physical stability, we may find that our primary ethical responsibility doesn't always lie with our patient. Coercion and guilt must also be addressed. The guiding principles in conflict are beneficence versus nonmaleficence. We must look at the fine line between doing good and not doing harm. There may be times when a live transplant isn't in the best interest of the donor.

## Meeting Regulations, Requirements

We all know that achieving outcomes benefits patients as well as meets facility, corporate and regulatory requirements. This in itself is not an ethical dilemma. Naturally, we want what is best for our patients. So, why do we feel pulled when our patients can't achieve these outcomes? There are patients, who no matter how hard they try, can't achieve the desired outcomes. There are also patients that choose to not be adherent and therefore won't achieve the desired outcomes. How we choose to handle these situations is what can lead to ethical dilemmas. It is important to recognize that our responsibility is to educate and encourage patients to be adherent with diet and treatment. For those that can't or won't, we need to accept, without giving up. We must respect the patient's autonomy even when we know it is not in his or her best interest.

# Ethical Decision-Making....

There is no doubt that the role of the renal dietitian has changed over the years. There is more documentation than ever before. Dietitians are finding themselves spending a considerable amount of time dealing with insurance issues. We find ourselves wearing many hats at times to help control cost.

This doesn't have to be an ethical issue, but can easily become one if we allow it to happen. Yes, we have many responsibilities, but we must always remember that our patients need to come first. We must find a way to juggle all responsibilities within reason and be there for our patients. We must do the right thing for the right reason! Don't compromise on patient care. When we do make that compromise, our patients lose.

## Vendor Relations

The way we interact with vendors has also changed over the years as well. What was once thought of as friendly interactions has many legal and ethical implications today. Vendor relationships are now heavily focused on avoiding inducements. These are items, subsidies or other non-contractual benefits received from a vendor that could improperly influence decision-making. Ethical conflicts can arise through gifts, focus groups and educational meetings. We must be careful when saying yes to focus groups and even receiving samples. We cannot promote one product over another across the board. We must keep each individual patient's best interest in mind.

## Patient Privacy- HIPAA

HIPAA or the Health Insurance Portability and Accountability Act was enacted in 1996. It was intended to help keep everyone's health information private. In some ways, it has hindered care, while in others it has been a major benefit. At the heart of HIPAA is patient autonomy. Without permission from the patient, legal guardian, or power of attorney, information cannot be shared unless there is a signed waiver. Any violation of this is an ethical issue, as well as a legal issue. Patient autonomy must be respected even when it is in the best interest of the patient to share that information with a family member or friend. As renal dietitians, we readily share report card information with spouses or other family members when asked by them, especially when they have been the ones responsible for meal planning. Without written permission from the patient, we cannot share that information.

**Table 1**  
Ethical Decision Making

Principles	Meaning	Real-World Example
Autonomy	Self-governing Self-directing	Choice to withdraw from dialysis
Beneficence	Do good	Transplant
Nonmaleficence	Do no harm	Transplant donor related via coercion
Justice	Treat fairly and without bias	Treating the difficult patient; while keeping in mind the rights of others and vendor relations

## Challenging Patients

Without a doubt, we have all had to provide care to a difficult or disruptive patient at one time or another. We must remember to ask: 1- Why are we here?; 2- What is our goal?; and 3- Who's needs have to be met?. It is important to recognize whether the patient is reacting out of fear or if he/she is being manipulative. If the answer is fear, it may be more important to put the immediate need of the patient over the needs of the facility as a whole at that moment. If it is manipulation, the needs of the facility override the autonomy of the patient. Autonomy, beneficence, nonmaleficence and justice may all be in conflict when a scenario such as this exists.

When it comes to practicing ethical behavior, the answers may be very clear at times and very vague at other times. It is important that we be as well educated in the area of healthcare ethics as possible. We should also be willing to examine our own value systems from time to time in order to understand our own basic ethical beliefs. ♦

Reference: *The American Heritage Dictionary, 4<sup>th</sup> Edition*.  
Houghton Mifflin Company. 2009.

For additional reading, see  
**[www.eatright.org/ada/files/ADA\\_CDR\\_  
Code\\_of\\_Ethics\\_Reading\\_List.pdf](http://www.eatright.org/ada/files/ADA_CDR_Code_of_Ethics_Reading_List.pdf)**

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# Counseling For Behavior Change

## “Push the envelope” of your counseling skills

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Reprinted with permission from *Weight Management Matters* Newsletter of the Weight Management DPG Summer 2010.

“Push the envelope” means: *To attempt to extend the current limits of performance. To innovate, or go beyond commonly accepted boundaries.*

It was first used in mathematics, then aeronautics where it refers to finding the limits of safety with respect to speed, altitude and other factors. In order to find those limits, test pilots gradually expand the parameters and observe the results. We can use this same principle to advance our skills, and fortunately, our work does not put us at physical risk.

### A simple process for skill advancement

1. Pick one skill or technique to work on
2. Experiment/practice
3. Review how it went (with a supervisor or colleague if possible)
4. If it worked, practice until it's a habit
5. Repeat

We all have habitual behavior patterns. This is certainly true in counseling and education sessions. These “ruts” are handy and may help us remember to include everything that's important. There is always another level of effectiveness we can achieve by pushing outside our comfort zone and trying new language or skills. At first it will feel strange or even a little scary, but this does not make it wrong. It simply means you are not accustomed to this language or approach.

When you are ready to push your envelope, find ways to keep a safety net. For example, make a step-by-step plan and choose to practice only one specific change at a time. The boxes below have a suggested format to follow and some skills to focus on.

If you are not sure what to work on, audio-record a client counseling session. Then listen to it with an ear for technique or language modifications. As you practice with clients, suspend judgment about whether you will incorporate this new behavior in

### Counseling skills to push yourself into

- Including more **open-ended questioning**:  
“What about this new diagnosis concerns you most?”  
After giving education, “What is your response to all this?”
- **Remaining silent** after an open-ended question to allow a client to think and respond
- Including more **affirming** statements:  
“Thank you for coming in today.”  
“I can see that you are a persistent person when you set your mind to something.”  
“You have already made some great changes.”
- Reflecting **out loud** rather than just in your head
- Stopping to **ask your client for direction** in a session:  
“Here is a list of topics we could discuss. Which, if any, are you interested in today?”  
“What do you already know about cutting back on saturated fat? And what do you need from me?”  
“Are we covering what you need?”
- **Summarizing** the change talk you have heard:  
“I hear that you are tired of trying to lose weight. You know it will help keep your blood sugar down and you would like to get back into smaller clothes. You have made a few changes recently. You are now walking at lunch with your friend and you and your husband are eating out less often. You know how to keep food records and are going to do this at least on the weekends because that is when your routine falls apart. You have decided to stop bringing the big bottles of soda home. Have I missed anything?”
- Holding back a tendency to **self-disclose**
- **Asking permission** before providing advice:  
“I have some ideas for those situations. Would you like to hear them?”  
“I have a pamphlet that lists the foods highest in sodium. Would you like it?”

your work. Just do it and attend to what happens next.

When you stretch yourself and practice new skills, it *will* feel weird and awkward. That is not the way to decide whether to keep doing it or not. So, how can you tell if this new way of interacting with clients is a good idea? If it gets easier as you practice it, this shows that you can choose to add it to your bag of tricks. If it does not get any more comfortable after practicing a few times, there are



# Counseling For Behavior Change....

two possible reasons. Either this technique is not your style or you may not be ready to take it on. If you are willing, give it another whirl in a few weeks or months.

The other important thing to attend to is the results when you practice this new skill. Do your clients respond differently? Is it effective? Do you feel any more or less tired or competent?

To continue advancing your skills, repeat this process over and over and over. There is no such thing as an envelope that cannot be pushed. ♦

## Counseling for Behavior Change

"As nutrition professionals, it is easy to lapse into our comfort zone when it comes to counseling patients. Developing new counseling skills and testing them with clients is an important part of our professional development and improving care." –Bonnie Jortberg, MS, RD, CDE

## Suggested reading

1. Kellogg M. Counseling Tips for Nutrition Therapists: Practice Workbook. PA: KgPress. 2006, 2009.
2. Kellogg M. Counseling Tip #73 Recording Sessions. [www.mollykellogg.com/TipsList](http://www.mollykellogg.com/TipsList)
3. Rosengren D. Building Motivational Interviewing Skills: A Practitioners Workbook. NY: Guilford Press, 2009.

## New: CKD Nutrition Practice Guideline

### Announcing the Chronic Kidney Disease (CKD) Evidence-Based Nutrition Practice Guideline!

This new guideline contains systematically developed recommendations, based on scientific evidence, and is designed to assist practitioners on the appropriate nutrition care for adults with CKD. Among the guideline's 38 CKD recommendations, are bone-mineral density assessment, and protein, energy, phosphorus, calcium, and vitamin D recommendations.

To view the CKD Guidelines, visit [www.eatright.org](http://www.eatright.org) and under *For Members* tab, click on Evidence Analysis Library in the left side menu panel.

## 2011 Board Certification for a Specialist in Renal Nutrition

**Application Form:** <http://www.cdrnet.org/PDFs/RenalApplicationForms.pdf>

Examination Dates	Application Deadlines (postmarked)
May 9-27, 2011	February 21, 2011
November 1-21, 2011	August 15, 2011

**To become a Board Certified Specialist in Renal, you must first complete the eligibility application and successfully meet the following minimum criteria:**

- Current Registered Dietitian (RD) status with CDR.
- Maintenance of RD status with CDR, for a minimum of 2 years from original examination date (by the time of the specialty examination date).
- Documentation of 2,000 hours of practice experience as an RD in the specialty area within the past five years (by the date the application is due). Please note: certain education and professional experiences can be used as a substitution for the required 2,000 specialty practice hours up to a maximum of 40% (800 hours).

# Older Americans Act

**Angela B. Sader, MBA, RD, LD**

DHCC Public Policy Coordinator

Email: [Angela.sader@goldenliving.com](mailto:Angela.sader@goldenliving.com)

Reprinted with permission from *Connections*, the Dietetics in Health Care Communities DPG Newsletter Summer 2010.

In looking forward to the future, one of the next legislative activities that will be facing us as a profession will be in 2012 when Congress is scheduled to consider the reauthorization to the Older Americans Act. During reauthorization, Congress can make amendments to the standing law.

In 1965 Congress passed the Older Americans Act (OAA) in response to concerns by policymakers about a lack of community social services for older persons. The original legislation established authority for grants to states for community planning and social services, research and development projects, and personnel training in the field of aging. The law included the creation of the Administration on Aging (AoA) to administer the newly created grant programs and to serve as the Federal focal point on matters concerning older persons. Grants are allocated to the states and territories by a formula based on their share of the population aged 60 and over. Since then many other services through federal programs have been created for older individuals. However, the OAA remains the primary provider and vehicle for delivery of social and nutrition services for this population and their caregivers.

The OAA is broken into sections and authorizes three different nutrition programs under Title III C1, C2, and NSIP.

- Title III C1 - Congregate Nutrition Services
- Title III C2 - Home-Delivered Nutrition Services
- NSIP - Nutrition Services Incentive Program which is a funding program to encourage efficient service provision through the provision of cash or commodities to States and Tribes based on the number of meals served in the previous year.

Title VI provides grants to Tribes, Tribal Organizations and public and nonprofit private organizations representing Native Hawaiians for the provision of nutrition services, supportive services and family caregiver services that meet the unique cultural needs of this population.

Total Title III Funding for Nutrition Services during the past five years is as follows:

FY 2005	\$718,696,000
FY 2006	\$714,578,000
FY 2007	\$735,070,000
FY 2008	\$758,003,000
FY 2009	\$809,743,000

In review of possible revisions for the program the American Dietetic Association has provided the following recommendations:

The Title III C Nutrition Program and its goals meet those of the Older Americans Act and the Administration on Aging, helping older Americans stay in their homes and communities and avoid unnecessary nursing home placement. However, Title III C can be improved to achieve the full potential of nutrition services to prepare for the burgeoning numbers of boomer clients while balancing the current needs of today's very frail population. Title IIIC can be transformed to better address the nutrition-related health and well-being of older persons, increase agency accountability and reporting, build program capacity, and achieve positive program and client outcomes cost effectively.

ADA recommends the AoA:

- Develop and fund a Nutrition Resource Center. The function of this center would be to help the aging network improve programmatic operations including implementation of best practices, capacity building, broadening coordinated care linkages, resource and information sharing, problem solving, cost containment and multidisciplinary collaboration interactions;
- Develop and promote a strong evidence-based nutrition and health component; through programs that include targeted nutrition screening, assessment, nutrition counseling and education. Build a model evidence-based chronic disease self-management program around a structured nutrition program, e.g. DASH diet, a randomized control trial for successful management of hypertension in older persons;
- Consolidate Titles III C1 and III C2 into a single Title III C that will fund both congregate and home-delivered nutrition services and allow greater flexibility at the state and local levels to target funds to best meet the needs of older adults at the community level;
- Fully fund Title IIIC and invest in the opportunity to use funds not only to serve the current population in need but also to transform congregate nutrition sites and home delivered nutrition services into desired models to meet

# Older Americans Act

the needs of the growing numbers of older individuals seeking to remain healthy in their communities.

- Eliminate dollars allowed to be transferred out of Title IIIC.
- Increase funding for Title III B and Title III C in order to ensure adequate funds to provide services for older individuals who need them;
- Increase the numbers of RDs and/or persons with comparable expertise at the local, regional, state and federal levels to increase availability and to support provision of cost-effective nutrition services, especially as programs try to balance the needs and expectations of the aging population with those of the currently very frail older adult;
- Maintain nutritional health and reduce food insecurity through provision of Title III C and VI meals that meet established nutritional standards;
- Improve state and local area plans by including nutrition-related community needs assessment addressing functionality, food security and depression;
- Conduct individual client assessments to reduce potential for nutrition risk and provide appropriate solutions;
- Collect strong and relevant outcomes data that relate to nutrition program measures;
- Fully fund Title VI, to promote the delivery of supportive services, including nutrition services to American Indians, Alaskan Natives, and Native Hawaiians that are comparable to services provided under Title III.

As we continue to move to a more home based focus with long term care intended as the last step in care rather than the first it is important that we are an asset to our clients through understanding the services that are available and the growing opportunities for us to be of continued value to our communities in which we serve.

Below you will find resources to help you in this endeavor.

- <http://www.nctreasurer.com/compsup2004/sectionb/93.045-2004.pdf>
- <http://www.tcs.org/law/oa/reauth.htm>
- <http://www.aoa.gov/>
- <http://www.elderguru.com/what-is-the-older-americans-act-oaa-and-what-does-it-do/>
- <http://www.federalgrantswire.com/special-programs-for-the-agingtitle-iii-part-cn nutrition-services.html> ♦

## Don't Miss Out!

**Is your information, including your current email address, updated with the ADA?**

RPG wants to make sure you're receiving e-announcements as the Spring 2010 Forum will be published again in electronic format only.

## RPG BY THE NUMBERS....

**Members:** 2,321

**RPG Web site page requests:**

11,017 in August

8,656 in July

9,142 in June

**Top 3 Pages/Downloads  
(by number of requests):**

*Members only:* 35,722

Website Poll: 11,555

My CPEU section: 9,186

*Top 2 Referring sites:*

Google: 6554; Webmail.aol.com: 1,034

**Top 2 Browsers (Number of requests):**

Internet Explorer 1,173,880; Firefox 87,425

# Calendar of Events

## January 2011

### *NATCO 2011 Symposium for Advanced Transplant Professionals*

Westin Diplomat  
Hollywood, FL  
January 14-16, 2011  
<http://www.natco1.org>

## February 2011

### *ADA PPW*

Grand Hyatt Hotel  
Washington, DC  
February 6-8, 2011  
<http://www.eatright.org/ADAPAC/>

### *Annual Dialysis Conference*

Phoenix, AZ  
February 20-22, 2011  
<http://som.missouri.edu/Dialysis/>

### *CRRT 2011 Conference (Continuous Renal Replacement Therapies)*

San Diego, CA  
February 22-25, 2011  
<http://www.crrtonline.com>

## March 2011

### *2011 CST Annual Scientific Conference*

Fairmont Mont-Tremblant  
Tremblant, Quebec  
March 2-5, 2011  
<http://www.cst-transplant.ca>

## April 2011

### *National Kidney Foundation 2011 Spring Clinical Meetings*

MGM Grand  
Las Vegas, NV  
April 26-30, 2011  
<http://www.kidney.org/news/meetings/clinical/index.cfm>

## April/May 2011

### *American Transplant Congress 2011*

Pennsylvania Convention Center  
Philadelphia, PA  
April 30-May 4, 2011  
<http://www.atcmeeting.org/2011/>

## June 2011

### *ADA Leadership Institute (Invitation Only)*

Scottsdale, AZ  
June 9-12, 2011  
<http://www.eatright.org/leadershipinstitute/>

### *2011 Joint International Congress of ILTS, ELITA & LICAGE*

Valencia, Spain  
June 22-25, 2011  
<http://www.iltis.org>

## September 2011

### *ADA Food & Nutrition Conference & Expo*

San Diego, CA  
September 24-27, 2011  
<http://www.eatright.org/fnce/>

## November 2011

### *American Society of Nephrology*

### *ASN Renal Week 2011*

Pennsylvania Convention Center  
Philadelphia, PA  
November 8-13, 2011  
[http://www.asn-online.org/education\\_and\\_meetings/](http://www.asn-online.org/education_and_meetings/)

### *2011 Organ Donation Congress*

### *11th Congress of the International Society for Organ Donation and Procurement*

Buenos Aires, Argentina  
November 27-30, 2011  
<http://www.tts.org>



# Renal Dietitians Chair Message

**Kathleen M. Madigan, MS, RD, LDN, CSR, MBA**

RPG Chair



The autumn issue is a reminder that the Food & Nutrition Conference & Expo (FNCE) recently took place. I hope many Renal Practice Group (RPG) members were able to attend. This year, we were capable of offering an RPG Member Buffet Breakfast on Sunday, November 7<sup>th</sup> at the Westin Waterfront Hotel. It was a great opportunity to network and get to know one another. For new renal dietitians, this served as a chance to gain knowledge from more experienced renal dietitians. As well, the more experienced renal dietitians also had the opportunity to learn from the newer renal dietitians.

If you haven't been on the [www.renalnutrition.org](http://www.renalnutrition.org) web site for a while, take some time to check it out. Cathy M. Goeddeke-Merickel, MS, RD, LD does a great job in keeping the web site

up-to-date and easy to use. Please complete the RPG Opinion Poll as we value and appreciate your thoughts and suggestions. There are Articles of Interest and Legislative Updates to help keep you informed. Also, the Links and Resources section could lead you to information on sites that you may not know exist.

I hope everyone takes the time to read the *Renal Nutrition Forum*. Stacey Phillips, RD, Megan Sliwa, RD, LDN and Sara Erickson, RD, CSR, LDN, CNSC do a great job in providing articles focused on the most current and cutting edge information in our field. It is also a great way to earn CPEUs.

As we all know, bundling is almost upon us. Are we ready? As the updates are becoming available, it seems to be less alarming. Yes, we will definitely need to change the way we have been doing things, but change can be good. We need to stay informed and positioned to handle the changes ahead. ♦

**Don't forget to access the RPG News section for announcements and valuable references**  
**<http://www.renalnutrition.org/>**

## Web Site Extras

Visit RPG's web site: [www.renalnutrition.org](http://www.renalnutrition.org) for helpful professional and patient resources

### Exciting New Updates:

New Webinar Section: A series of 4 webinars with approved CPEUs per webinar are offered on topics covered on the CSR Exam for Renal.

**Check the web site for additional webinar offerings later this year!**

### Have you used your New Member Benefit: Online CPEU recording?

#### Access the My CPEU link via

[http://www.renalnutrition.org/members\\_only/my\\_cpeu.asp](http://www.renalnutrition.org/members_only/my_cpeu.asp)

#### Access the Calendar/Meetings section for a comprehensive list of CPEU opportunities and upcoming conferences

[www.renalnutrition.org/calendar/index.php](http://www.renalnutrition.org/calendar/index.php)

#### Access the RNF Patient Education E-Supplement

[www.renalnutrition.org/members\\_only/insert.php](http://www.renalnutrition.org/members_only/insert.php)

#### Access to Award/Meeting stipend info

[www.renalnutrition.org/members\\_only/awards.php](http://www.renalnutrition.org/members_only/awards.php)

#### Renal Nutrition Forum Pt Education Handouts

[www.renalnutrition.org/members\\_only/insert.php](http://www.renalnutrition.org/members_only/insert.php)

#### Access to Articles of Interest

[www.renalnutrition.org/members\\_only/interest.php](http://www.renalnutrition.org/members_only/interest.php)

#### Access to current & archived Renal Nutrition Forum issues

[www.renalnutrition.org/members\\_only/feature.php](http://www.renalnutrition.org/members_only/feature.php)

#### Evidence Analysis Library (EAL) information and tips for using this valuable resource

[www.renalnutrition.org/members\\_only/resources.php](http://www.renalnutrition.org/members_only/resources.php)

#### For more information about the Certification Specialty Exam in Renal (CSR)

[www.renalnutrition.org/faq/index.php](http://www.renalnutrition.org/faq/index.php)

Member input & suggestions are a vital part of improving our member resources such as the web site. Please submit your ideas and suggestions to Cathy M. Goeddeke-Merickel, Web Editor via [cmgmerickel@gmail.com](mailto:cmgmerickel@gmail.com)

*"Never underestimate the power of dreams and the influence of the human spirit. We are all the same in this notion. The potential for greatness lives within each of us."*  
Wilma Rudolph

# CRN Chairperson Message

## Karen Wiesen, MS, RD

NKF-CRN Chair

The time has come for me to write my final message as Council on Renal Nutrition (CRN) Chair. For many years I have had the opportunity to be involved with CRN at the national level wearing many hats. I started as a Regional Representative in 1999 thinking that would be the extent of my participation but little did I know where that would lead. It is with mixed feelings that I write this last note, as I am proud of all we have accomplished but am also looking forward to a little rest as I step down into immediate past Chair in February 2011.

During my term I kept in mind some lessons learned from one of my early mentors: There is no "big I" and "little you" and when you take on a job, do it right and do it well. Any organization, whether it is the CRN or Renal Practice Group (RPG), is not run by one person. It takes a team effort. There are many things competing for our time at work and home these days but making the commitment to get involved, whether nationally or locally, is important to further advance the profession of the renal dietitian and to make our voices heard. It has been my pleasure and honor to serve as CRN Chair for the past 2 years and to work with so many talented, enthusiastic and dedicated individuals within CRN

and RPG. The 2nd edition of *The Clinical Guide to Nutrition Care in Kidney Disease*, our current CRN/RPG publication collaboration is now in the editorial review stage and planning for a new joint project is underway. I would especially like to thank the members of the CRN Executive Committee who have served with me during my term. CRN and RPG will continue to collaborate on future joint projects that will support and serve as a resource for the renal dietitian.

On February 28, 2011 it will be my honor to turn the gavel over to Lisa Gutekunst, MEd, RD, CDN, CSR who will be a dynamic leader, a strong advocate for the renal dietitian and continue the joint ventures between CRN and RPG. Please join me in welcoming Lisa as the new Chair of CRN. ♦

## WHO WILL BE THE RPG FUTURE LEADERS?

Online voting of 2011-2012 officers will begin February 1 - March 3, 2011.

More details will be available via electronic communications.

## SPACE FOR COMPANY ONLINE ADS NOW AVAILABLE!

Rotating and exclusive banner ads on  
**[www.renalnutrition.org](http://www.renalnutrition.org)**  
Viewable by non-members and members

Contact RPG Ad Editor  
Emily Cutler, MS, RD, LDN at  
[emilycreamers@aol.com](mailto:emilycreamers@aol.com) for details

## Additional CPEUs

**AAKP HealthLine**, a new educational program developed by AAKP that is a FREE, one-hour conference call designed to educate on a variety of topics affecting kidney patients and their families. Conference calls feature kidney healthcare experts from across the country and provide patients and/or healthcare professionals with the convenience of gaining knowledge from the comfort of their home or office. Time is provided at the end of each call for participant questions. Contact the Program Manager at 813-636-8100 x42 or visit our Web site <http://aakp.org/events/HealthLine/> to see upcoming topics.

# 2010-2011 RPG Executive Committee

**Mission:** Renal dietitians dietetic practice group is leading the future of dietetics by promoting and supporting its members working in nephrology nutrition.

**Vision:** RPG members are a valued source of expertise in nephrology nutrition.

## OFFICERS:

### Chair

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### Immediate Past Chair

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#### Area VI/Legislative /Reimbursement Chair

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## RNF Guidelines for Authors

**Article length:** Article length is determined by the Editor for each specific issue. The feature article (including abstract) is approximately 3000 words (not including tables/graphs). Other articles are usually 1000-1500 words; member highlights and reports are approximately 400-500 words.

**Text format:** Times New Roman font, 12 point, double space.

**Tables/illustrations:** Tables should be self-explanatory. All diagrams, charts and figures should be camera-ready. Each should be accompanied by a title and brief caption that clearly explains the table, chart, diagram, figure, illustration, etc.

**References:** References should be cited in the text in consecutive order parenthetically. At the end of the text, each reference should be listed in order of citation. The format should be the same as the *Journal of the American Dietetic Association*.

### Reference citation examples:

#### Article in periodical:

Knower WC, Barrett-Connor E, Fowler SE, et al. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. *N Eng J Med*. 2002;346:393-403.

#### Book:

Institute of Medicine. *Dietary Reference Intakes: Applications for Dietary Assessment*. Washington, D.C.: National Academy Press; 2001.

#### Chapter in a book:

Walsh J. Which insulin to use and how to start. In: *Using Insulin*. San Diego, Calif.: Torrey Pines Press; 2003.

#### Web site:

Medscape drug info. Available at [www.medscape.com/druginfo](http://www.medscape.com/druginfo). Accessed Feb. 3, 2004.

**Author information:** List author with first name, middle initial (if any), last name, professional suffix and affiliation below the title of the article. Also include the primary author's complete contact information including affiliation, phone, fax and email address.

*All submissions for publication should be submitted to the editor as an email attachment (MS Word file). The feature articles from the Renal Nutrition Forum will be posted on the Members Only Section of the RPG website (password protected). Thus, please include a brief abstract along with feature article submissions.*

Megan Sliwa, RD, LDN  
Editor, *Renal Nutrition Forum*  
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## Renal Dietitians

a dietetic practice group of the



American Dietetic  
Association

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