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In This Issue

Maximizing Reimbursement in a Multidisciplinary Medical Practice: Navigating the Maze of Coverage Guidelines

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This article has been approved for 1.0 CPEU unit. 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. This CPEU offering is available to current RPG members only and the expiration date is July 15, 2013.

Introduction

A sure-fire way of keeping registered dietitians (RDs) employed in a multidisciplinary medical practice (MDMP) is by third-party reimbursement for medical nutrition therapy (MNT) and diabetes self-management training (DSMT). Most insurers cover these services, but as most RDs and diabetes educators would confirm, coverage guidelines are confusing, complicated, convoluted, challenging and constantly changing! Let's clear things up with this article!

MNT is a therapeutic approach to treating and preventing medical conditions and their associated symptoms via the use of evidence-based protocols that include nutrition assessment, nutrition diagnosis, nutrition intervention, and nutrition monitoring and evaluation (1,6,10). DSMT, also known as diabetes self-management education (DSME), is a collaborative patient/provider process through which patients with, or at risk for, diabetes gain the knowledge and skills needed to modify their behavior and successfully self-manage the disease and its related conditions (4,10).

Medicare Coverage

Billing and Coding

Medicare does reimburse select providers for these two services (2, 10). Table 1 summarizes coverage guidelines in key billing and coding categories. Table 2 outlines the procedure codes required by Medicare for MNT and DSMT. Table 3 presents the Centers for Medicare & Medicaid Services (CMS) guide to rounding the time spent face-to-face with patients when using 15-minute time-based current procedural terminology (CPT®) codes. These include the three codes used for MNT: 97802, 97804, and G0270. The specific diagnosis codes that Medicare requires on pre-dialysis renal MNT claims are provided in Table 4. These tables can be used as handy desk-top references.

Telehealth

MNT telehealth services have been reimbursed by Medicare for some time. This includes individual and group MNT (HCPCS codes G0270 and G0271 and CPT® codes 97802, 97803, and 97804). In January 2011, Medicare approved payment for DSME/T benefits when delivered via telehealth (HCPCS codes G0108 and G0109).

Telehealth services use a real-time audiovisual telecommunication system as a substitute for an inperson encounter between the Medicare beneficiary and the provider located at a different site (1,3,5,6). Medicare's specific telehealth coverage guidelines for billing and payment are summarized in Table 1 (see page 18). Additional information on Medicare MNT and DSME/T telehealth is available on the Academy of

– Continued on page 3.

RPG

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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.

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From the Editor's Desk

Megan Sliwa, RD, LDN, MBA

Welcome to any new RPG Members and welcome back to any returning RPG Members! This electronic-only issue brings a variety of content, from reprints from outside journals and other DPG newsletters to member updates from the National Kidney Foundation's Spring Clinical Meetings. The feature article from Mary Ann Hodorowicz, MBA, RD, CDE provides insights to maximizing reimbursement in a multidisciplinary practice and the Advances in Practice article from the Journal of Renal Nutrition describes pica in pediatric dialysis patients. The updates from NKF scholarship recipients and EC Members include three different perspectives on lectures at this year's meeting in Washington, DC.

The first issue of this membership year includes a few changes and I'd like to take a few moments to outline them. The first is the removal of the season designation (e.g. Fall, Spring) to a simple volume and number. The second change is that each issue will have color on all pages of the newsletter; previously, the RNF would have four pages that were printed in color and the remaining would be in black and white. We hope you enjoy this enhancement! The last change is less visible to the reader, but is happening behind the scenes. We are moving from three editorial team members to four in order to increase our reach for author recruitment for original article submissions and divide the workload amongst four members.

The editorial team's goal is for you to learn from and enjoy the Renal Nutrition Forum. We welcome all feedback and encourage you to submit content. This will be my last issue, I leave the editorial team in the capable hands of Sara Erickson, RD, CSR, LDN, CNSC and the two assistant editors, Amy Braglia Tarpey MS, RD, CSR, CNSC and Jackie Termont, RD.

I wish you all the best!
Megan Sliwa, RD, LDN, MBA

Calling All Authors!

Renal Nutrition Forum Article Submissions Needed!

Have you had a unique case recently?

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For more details, please contact
Sara Erickson at: SaraEricksonRD@gmail.com

Nutrition and Dietetics (the Academy) website at *http://www.eatright.org* and on the CMS web site at *http://www.cms.org*.

Private Payer and Medicaid Reimbursement for MNT and DSME/T

The RD, educator, and/or management personnel in the practice should contact each private payer in the local area and the state's Medicaid office to obtain their specific billing, coding, and payment guidelines. Best practice management requires that providers communicate the insurer's MNT and/or DSMT coverage policies to the patient ***before*** furnishing the benefit, including the payment rate and the patient's copayment amount. The patient has the right to this information to make an informed decision about whether to receive the benefit. Meeting this requirement can be a challenge because insurers typically have multiple insurance plans within their systems, such as a health maintenance organization or preferred provider organization. This information is also required to develop the procedures for furnishing the benefits; with Medicare, this includes obtaining the patient eligibility laboratory criteria and the physician's referral before the first visit.

Forty-six states and the District of Columbia have state laws that require private health insurance policy coverage for diabetes treatment and education for select subscribers. The specific coverage guidelines can be accessed at *http://www.ncsl.org/ default.aspx?tabid =14504*. The four states that do not have a mandate or insurance requirement are Alabama, Idaho, North Dakota, and Ohio.

Some payers may also require other billing codes for MNT and DSME/T. In January 2006, the American Medical Association approved three new CPT® procedure codes that can potentially be used for nutrition education and training services (not MNT) provided by RDs and billed to private payers (Table 5) (10). Reimbursement is not only contingent on private payers' acceptance of these codes, but also on the RD's adherence to the payers' specific coverage guidelines for non- MNT nutrition services. Of note, these codes are not reimbursable by Medicare at this time. Therefore, RDs should not use them on claims sent to Medicare.

These codes are intended for use with education and training for patient self-management to treat established illnesses or diseases or to delay comorbidities. The purpose is to teach the patient (or caregivers) how to self-manage the patient's illnesses effectively in conjunction with the patient's professional health care team. An Academy task force developed a document that compares and contrasts the differences between MNT and nutrition education/ self-management training (http://www.eatright.org/mnt). Several other billing codes may be required or accepted by private payers and Medicaid plans that can be applied to MNT and DSME/T (Table 6).

Table 1. Medicare Coverage Guidelines

	Individual and Group Medical Nutrition Therapy (MNT) Initial and Follow-Up Episodes of Care: 2012	Individual and Group Diabetes Self-Management Training (DSMT) Initial and Follow-Up Episodes of Care: 2012
Coverage: In-Person	Diabetes type 1, type 2, gestational diabetes, predialysis renal disease, and for the period of 36 months following a successful kidney transplant.	Ten self-care topics included; nutrition is 1 of 10 presented as broad overview of basic concepts.
Allowed Settings	Outpatient settings that include hospital outpatient departments, private practices, federally qualified health centers, home health agencies, nursing homes, pharmacies, renal dialysis facilities, and rural health clinics.	Outpatient settings that include hospital outpatient departments, private practices, federally qualified health centers, home health agencies, skilled nursing homes pharmacies, and durable medical equipment companies.
Excluded Settings	Hospital inpatient and skilled nursing homes.	Hospital inpatient, nursing homes, renal dialysis facilities, and rural health clinics.
Utilization Limits and Format	Initial: 3 hours in first calendar year; can be repeated every 3 years. Follow-up: 2 hours in each subsequent calendar year. Cannot extend unused initial or follow-up hours into next calendar year. Format of Initial and Follow-up: Group or individual. Individualized meal and exercise plans with	Initial: 10 hours in 12 consecutive months, starting with date of first visit; once-in-a-lifetime benefit. Format of Initial: 9 of 10 hours must be provided in group, unless beneficiary meets criteria for individualized DSMT. 1 hour may be used for individual visit. Follow-up: 2 hours in each year following year in which DSMT completed.

Table 1. Medicare Coverage Guidelines - Continued

	extensive monitoring of outcomes to adjust plans and medications to meet targets. Individual visit to be minimum of 15 minutes because CPT codes 97802 and 97803 are 15-minute time-based codes. Group visit to be minimum of 30 minutes because CPT code 97804 is a 30-minute time-based code. Additional hours may be reimbursed if RD obtains documentation of medical necessity on another referral from treating physician and specific number of extra units of time is prescribed. Cannot be provided on same day as DSMT.	Format of Follow-up: Group or individual; learning barriers not required for individual follow-up DSMT. Cannot be provided on same day as MNT.
Billing Providers	*Individual providers:* Medicare provider RDs and nutrition professionals (latter has met same educational requirements as RD but has not taken national registration exam given by Commission on Dietetic Registration). Non-RD Medicare individual providers (e.g., physician) and entity Medicare providers (e.g., clinics, physician offices) may bill Medicare on behalf of Medicare provider RD, who has reassigned her/his reimbursement to practice entity. Only RD provider (or individual or entity Medicare provider billing on behalf of RD) can bill; benefit may not be subdivided for purposes of billing. Cannot be billed as "incidental to" physician's services.	*Individual* providers: RDs, qualified nutrition professionals, physicians, physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, clinical social workers, and clinical psychologists. *Entity providers:* Outpatient hospital, private health care practices, federally qualified health centers, home health agencies, pharmacies, skilled nursing homes, and durable medical equipment companies. Must be billing for other Medicare services and receiving payment. Only one individual or entity Medicare provider can bill for entire hours of training; benefit may not be subdivided for purposes of billing. Cannot be billed as "incidental to" physician's services.
	Individual and Group Medical Nutrition Therapy (MNT) Initial and Follow-Up Episodes of Care: 2012	**Individual and Group Diabetes Self-Management Training (DSMT) Initial and Follow-Up Episodes of Care: 2012**
Reimbursement	1. Must accept current geographically adjusted assigned reimbursement rate set by Medicare as payment in full. 2. Cannot bill beneficiary or secondary insurance for difference between RD's fee and Medicare payment. Text box on next page provides example.	*Non-participating* Medicare providers need not accept assignment: can bill beneficiary or his/her secondary insurance for difference between fee and Medicare's assigned reimbursement rate. However, fee is subject to Medicare's limiting charge. *Participating* providers, however, are required to accept assignment.
Beneficiary Co-Payment	Effective January 1, 2011, beneficiaries no longer required to pay MNT co-payment of 20%. Medicare pays 80% of adjusted allowed rate.	Beneficiaries are required to pay the 20% co-payment. Medicare pays 80% of adjusted allowed rate.

Table 1. Medicare Coverage Guidelines - Continued

Facility Fee	No Medicare facility fee allowed, except if furnished as telehealth.	No Medicare facility fee allowed, except if furnished as telehealth.
Quality Standards	Regulations state: *"RDs and nutritionists must use nationally recognized protocols, such as those developed by the Academy."* Also known as evidence-based nutrition practice guidelines and available at: www.nutritioncaremanual.org	Program must have accreditation from AADE or recognition from ADA; status based on program meeting the 10 National Standards for Diabetes Self-Management Education and meeting application requirements.
Beneficiary Entitlement	*Initial MNT:* Has Medicare Part B insurance and has not received initial MNT in previous 3 years. Medicare carriers now in process of meeting new requirement to allow provider access to history of beneficiary's claims. Beneficiary can call Medicare to obtain own history (1-800-MEDICARE). *Follow-Up MNT:* Has Part B insurance.	*Initial DSMT:* Has Medicare Part B insurance and has not received initial DSMT ever. *Follow-Up DSMT:* Has Medicare Part B insurance.
Allowed Referring Providers	Treating physicians who are MDs and DOs only. Qualified non-physician practitioners cannot refer (i.e., nurse practitioners, physician assistants, clinical nurse specialists).	Treating physician (MDs and DOs) and qualified non-physician practitioners can refer (i.e., nurse practitioners, physician assistants, clinical nurse specialists).
Beneficiary Eligibility: Referral	Must establish medical necessity by RD obtaining written referral for MNT from treating physician for initial and again for follow-up MNT. Referral must include diagnosis of diabetes or 5-digit diabetes ICD-9-CM diagnosis code, physician's NPI number, and other data.	Must establish medical necessity of program by obtaining written referral for DSMT from provider for both initial and again for follow-up DSMT. Referral must include diagnosis of diabetes or 5-digit diabetes ICD-9-CM diagnosis code and other data.
Beneficiary Eligibility: Diagnostic Laboratory Criteria	Documentation of 1 of 3 in chart maintained by RD for type 1/type 2 diabetes mellitus: 1) Fasting blood glucose ≥126 mg on 2 different occasions.* 2) 2-hour post glucose challenge test ≥200 mg on 2 different occasions. 3) Random blood glucose test ≥200 mg for person with symptoms of uncontrolled diabetes. *Documentation in chart maintained by RD for predialysis renal MNT: estimated glomerular filtration rate of 13 to 50 mL/min/1.73m^2	Same. * Cannot be obtained from home-based or inpatient (bedside) blood glucose meter

Table 1. Medicare Coverage Guidelines - Continued

	Individual and Group Medical Nutrition Therapy (MNT) Initial and Follow-Up Episodes of Care: 2012
Coverage: Telehealth (4)	Individual and group MNT and DSMT (initial and follow-up) can be provided as telehealth services. Telehealth services use a real-time audiovisual telecommunication system as a substitute for an in-person encounter between the Medicare beneficiary and the provider, who are at different sites. Medicare's specific telehealth coverage guidelines for billing and payment are: 1) The beneficiary must be at an "originating site" at the time the service is being furnished. 2) Originating sites must be located in a rural Health Professional Shortage Area or in a county outside of a Metropolitan Statistical Area. a. However, entities that participate in a Federal telemedicine demonstration project approved by (or receiving funding from) the Secretary of the Department of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location. 3) The originating sites authorized by law are: a. Offices of physicians or qualified non-physician practitioners b. Hospitals c. Critical Access Hospitals (CAHs) d. Rural Health Clinics e. Federally Qualified Health Centers f. Hospital-based or CAH-based Renal Dialysis Centers (including satellites) g. Skilled Nursing Facilities h. Community Mental Health Centers 4) The provider is at a "distant site" at the time the service is being furnished. 5) An interactive audio and video telecommunications system must be used that permits real-time communication between the provider at the distant site and the beneficiary at the originating site. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system. a. Asynchronous "store and forward" technology is permitted only in Federal telehealth demonstration programs conducted in Alaska or Hawaii. 6) Claims for telehealth services are submitted using the appropriate CPT or HCPCS code along with the telehealth modifier GT "via interactive audio and video telecommunications system" (e.g., 97802 GT). By using the GT modifier, the distant site provider certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished. a. In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, providers use the telehealth modifier GQ "via asynchronous telecommunications system" (e.g., 97802 GQ). 7) For DSMT telehealth services, a minimum of 1 hour of in-person instruction in the self-administration of injectable drugs training must be furnished in-person during the year following the initial DSMT service, if the beneficiary is prescribed this type of drug therapy. The injection training may be furnished through either individual or group DSMT services. 8) Providers at the distant site can bill either the Medicare Carrier or the Part A/Part B Medicare Administrative Contractor (MAC) for telehealth MNT and DSMT. Reimbursement rates are the same as when MNT and DSMT services are delivered face to face. 9) In addition, the originating site that owns the specialized audiovisual equipment can bill the Medicare Carrier or A/B MAC a facility fee, as described by HCPCS code Q3014 (telehealth originating site facility fee). Facility fee is a separately billable Part B payment. Providers paid according to applicable payment methodology for facility or location; usual Medicare deductible and coinsurance policies apply to this code. In 2010 to 2011, the average facility fee was $24.00.

RD's usual and customary fee: $60 for one 30-minute unit of group MNT (CPT code 97804). Medicare's geographically adjusted reimbursement rate: $15 per 1 unit. RD must accept $15 as payment in full; cannot bill beneficiary directly or beneficiary's supplemental insurance for difference between $60 fee and Medicare's payment rate of $15. Does not mean, however, that RD should make usual and customary fee the same as Medicare reimbursement rate. Fees determined by compiling and analyzing several factors, including Medicare reimbursement rate, but not solely on that rate. *Legend: HCPCS: Healthcare Common Procedure Coding System; CPT: Current Procedural Terminology, copyright American Medical Association; AADE: American Association of Diabetes Educators; ICD-9-CM: International Classification of Diseases, 9th Ed, Clinical Modifications; DSMT: Diabetes Self- Management Education/Training; EMR: Electronic Medical Record; the Academy: Academy of Nutrition and Dietetics; ADA: American Diabetes Association; NPI: National Provider Identification number.

Table 2. Procedure Codes Required by Medicare for Billing MNT and DSMT

HCPCS or CPT® Code	Description	Utilization Limits in Initial Episode of Care and Provision of Hours	Utilization Limits in Follow-Up Episode of Care and Provision of Hours
G0108	Diabetes outpatient self-management training services (DSMT): individual visit, face-to-face with the patient, each 30 minutes of training. DSMT program must be accredited as meeting 10 National Standards of DSME by either the ADA or AADE.	10 hours in first consecutive 12 months upon written referral by physician (MD or DO) or qualified non-physician practitioner; 9 hours to be in group, unless: • Barriers that hinder group learning documented by referring provider. • No DSMT program scheduled within 2 months of referral date. • Referring provider orders additional insulin training.	2 hours in subsequent calendar years, starting with calendar year following year in which beneficiary completed initial 10 hours of DSMT, upon another written referral by physician (MD or DO) or qualified non-physician practitioner. 2 hours may be individual or group; documentation of learning barriers not required in order to provide individual follow-up DSMT.
G0109	DSMT: group session (2 to 20 individuals*), face-to-face with patients, each 30 minutes. *Note: 2 to 20 individuals must be patients; not all patients need be Medicare beneficiaries.		
97802	MNT: individual, initial assessment and intervention, face-to-face, each 15 minutes. ***See Table 3: CMS' Guide for Fifteen-minute Time-based CPT Codes***	3 hours in initial episode of care (initial assessment and intervention) in first calendar year upon referral from treating physician (MD or DO).	2 hours in follow-up episode of care (reassessment and intervention) in subsequent calendar years upon another written referral by treating physician.
97803	MNT: individual reassessment and intervention, face-to-face, each 15 minutes.		
97804	MNT: group initial assessment and intervention, and reassessment and intervention, face-to-face, group (≥2 individuals), each 30 minutes.		
G0270	MNT: reassessment and subsequent intervention(s) following 2nd referral in same year for change in diagnosis, medical condition, or treatment regimen, individual, face-to-face, each 15 minutes.	No limit* for additional hours >3 initial hours and >2 follow-up hours if RD obtains: • Documentation of medical necessity for specific number of additional hours. • Another physician's referral for specific number of additional hours plus documentation of medical necessity. *To date, no limit specified by Medicare for additional hours.	
G0271	MNT: reassessment and subsequent intervention(s) following 2nd referral in same year for change in diagnosis, medical condition, or treatment regimen, group (≥2 individuals), each 30 minutes.		

AADE =American Association of Diabetes Educators; ADA = American Diabetes Association; CPT® = Current Procedural Terminology, copyright American Medical Association; DSME = diabetes self-management education; DSMT = diabetes self-management training; HCPCS = Healthcare Common Procedure Coding System; MNT = medical nutrition therapy; Adapted from: 1) Indian Health Service. Step-by-step guide to Medicare medical nutrition therapy (MNT) reimbursement 2nd ed. http://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Training/WebBased/CKDNutrition/MNT_Reimburse_Guide_508c.pdf.; 2) American Association of Diabetes Educators. Diabetes education services, reimbursement tips for primary care practice. http://www.diabeteseducator. org/export/sites/aade/_resources/pdf/research/Diabetes_Education_Services6-10.pdf. Accessed November 15, 2011.

Table 3. CMS' Guide for Fifteen-minute Time-based CPT® Codes*

1 unit =	> 8 minutes to <23 minutes	5 units =	>68 minutes to <83 minutes
2 units =	>23 minutes to <38 minutes	6 units =	>83 minutes to <98 minutes
3 units =	>38 minutes to <53 minutes	7 units =	>98 minutes to <113 minutes
4 units =	>53 minutes to <68 minutes	8 units =	>113 minutes to <128 minutes

*Includes medical nutrition therapy codes 97802, 97803, and G0270.
From: Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual, Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services, Rev. 2160.

Table 4. Diagnosis Codes for Billing Predialysis Renal Medical Nurtrition Therapy to Medicare

ICD-9-CM Diagnosis Code	Classification of Renal Disease	Glomerular Filtration Rate Value
585.1	I	90
585.2	II (mild)	60 to 89
585.3	III (moderate)	30 to 59
585.4	IV (severe)	15 to 29
585.5	V (dialysis)	15
585.9	CKD, unspecified	

Adapted from: International Classification of Diseases, 2009 Revision, Clinical modifications, World Health Organization. http://www.cdc.gov/nchs/icd/icd9cm.htm

Table 5. Patient Education and Self-Management CPT® Codes*

98960	Education and training for patient self-management by a qualified, non-physician healthcare professional using a standardized curriculum, face-to-face with a patient (could include caregiver/family) each 30 minutes, individual patient.
98961	Group education and training, 2 – 4 patients
98962	Group education and training, 5 – 8 patients
Follow-up education and training: education and training related to subsequent reinforcement or due to changes in patient's condition or treatment plan reported in same manner as original education and training.	

*Not for Medicare use.
Note: CPT codes, descriptions and material only are copyright © 2006 of the American Medical Association. All Rights Reserved.

Table 6. Potential Billing Codes for Medical Nutrition Therapy and Diabetes Self-management Education/Training (14)

S9140	Diabetes management program, follow-up visit to non-MD provider
S9145	Insulin pump initiation, instruction in initial use of pump (pump not included)
S9455	Diabetic management program, group session
S9465	Diabetic management program, dietitian visit
S9470	Nutritional counseling, dietitian visit

From: American Association of Diabetes Educators. Diabetes Education Services – Reimbursement Tips for Primary Care Practice. http://www.diabeteseducator.org/export/sites/aade/_resources/pdf/research/Diabetes_Education_Services6-10.pdf

Summary

Reimbursement can be confusing and challenging. However, in today's changing health care environment of shrinking dollars, compressing organizational charts, and the trend of paying non-nutrition clinicians for nutrition and diabetes education services, it is vital for RDs to become experts in this area.

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Resource List

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Online Interactive Tool

The Academy's Reimbursement Community of Interest (COI) is an interactive online tool that offers a private and secure area for the Academy's members to connect. The COI is available to Academy members who desire to learn more about coverage for medical nutrition therapy (MNT) and exchange best practices to help advance coverage of nutrition services with health plans, employers and third party payers.

More information about the COI: ***http://www.eatright.org/Members/content.aspx?id=7490***

Pica: An Important and Unrecognized Problem in Pediatric Dialysis Patients

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Reprinted from Journal of Renal Nutrition, online publication ahead of print, Chryso Pefkaros Katsoufis, et al. Pica: An Important and Unrecognized Problem in Pediatric Dialysis Patients, Pages, Copyright (2012), with permission from Elsevier/National Kidney Foundation.

This article has been approved for 1.0 CPEU unit. 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. This CPEU offering is available to current RPG members only and the expiration date is July 15, 2013.

Objective: Pica is the compulsive consumption of non-nutritive substances, and this disorder may occur more frequently in dialysis patients. The purpose of our study was to determine the prevalence of pica and the associated demographic and metabolic characteristics.

Design: Retrospective, cross-sectional analysis.

Setting: Hospital-based, outpatient, pediatric hemodialysis unit.

Subjects: Eighty-seven pediatric patients on chronic dialysis therapy were interviewed. Sixty-seven patients were receiving hemodialysis, whereas the remaining 20 were maintained on peritoneal dialysis. The predominantly nonwhite (93%) patient population had a mean age of 17.2 ± 7.2 years. Dialysis efficiency, estimated by urea clearance per patient volume (Kt/V), averaged 1.5 ± 0.5.

Intervention: Standard patient interview and documentation of laboratory and dialytic parameters.

Main outcome measure: Prevalence of pica and associated comorbid conditions.

Results: The survey indicated that 46% of patients experienced pica, further divided into simple ''ice'' pica (34.5%) versus ''hard'' pica (12.6%). Hard pica included the consumption of chalk, starch, sugar, soap, sand, clay, Ajax cleanser, sponge, wood, and potting soil. Patients on hemodialysis were 8.3 times more likely to have hard pica compared with those on peritoneal dialysis. Greater than 5 years on dialysis was associated with a 3.2 odds ratio of having pica (P = .02). Anemia was the most significant morbid association, occurring at an odds ratio of 4.4 (P = .001) for all pica and 10.6 (P = .004) for hard pica.

Conclusion: Pica, therefore, is prevalent and potentially harmful, requiring further attention in the nutritional management of pediatric dialysis patients.

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Introduction

The compulsive consumption of non-nutritive substances, pica, is a phenomenon that has been explored in children, pregnant women, and the mentally handicapped, with more recent study of the dialysis-dependent population.[1] There are well-described associations of geophagy, most notably with religious or medicinal attributions, often occurring in ethnic African American communities in the Southeast United States.[2]

In healthy children, the prevalence of pica has been reported over a wide range, depending on the definition used and age-group studied, with higher rates observed in younger children.[3,4] However, more precise estimates place the prevalence at 25% to 33% of children aged <6 years.[3] Invariably, the rate is higher among African American children, as compared with Caucasians.[3,5] Among adult dialysis patients, pica has been observed particularly in the Southeastern United States.[6,7] In Atlanta, GA, incident dialysis patients were noted to have a rate of 16%,[8] whereas established patients exhibited a higher rate of 22%.[9]

A number of comorbid conditions have been associated with pica, the most common of which is anemia, specifically iron-deficiency anemia. Whether pica has been spurred by iron deficiency, or whether the consumption of non-nutritive substances prevents gastrointestinal iron absorption,[10] has been greatly debated. Proposed mechanisms for adverse effects mediated by pica behavior include excess calories, displacement or reduced absorption of essential nutrients, toxicity, and relative excess essential nutrients in compromised individuals.[11] Consequently, case reports of various pica behaviors in adult dialysis patients have identified several other metabolic derangements, including hyper-/hypokalemia,[12-14] hyper-/hypophosphatemia,[6,8,14] hypercalcemia,[14] alkalosis,[6] hypoalbuminemia,[2,8] ascorbic acid deficiency,[2] and zinc deficiency.[6,13] However, data are particularly lacking with respect to the pediatric dialysis population, whose combination of young age and high prevalence of anemia may yield prime candidates for the behavior of pica. The purpose of this study was to explore the prevalence of pica and associated comorbidities in an established group of children undergoing chronic dialysis therapy.

Patients and Methods

The study was a retrospective, cross-sectional analysis of dietary history assessments required under standard of care. All subjects were assured anonymity in compliance with the Health Insurance Portability and Accountability Act. The study included 87 patients on chronic dialysis therapy who were followed at the pediatric dialysis center of the University of Miami/Holtz Children's Hospital from January 2006 through January 2010. These patients were surveyed for the compulsive ingestion of non-nutritive substances, reported for at least 1 month. These dietary histories were obtained monthly as a standard component of nutritional health assessment in our multidisciplinary outpatient center. Ice pica is defined as the nonnutritive and compulsive ingestion

of ice alone, whereas hard pica reflects the similar consumption of any other substance. The patients were also assessed for demographic, nutritional, and metabolic characteristics. The patients received either hemodialysis (HD) or continuous cycling peritoneal dialysis (PD). Those undergoing HD received three to four weekly sessions, using hollow fiber dialyzers. Those undergoing PD received nightly cycling. Dialysis efficiency was estimated by calculating urea clearance per patient volume, Kt/V. Variables were compared using Fisher exact test, calculating odds ratios (OR) with 95% confidence intervals (CI) for effect size. Multiple regression analysis was performed using pica as the dependent variable compared with age, gender, race, dialysis modality, dialysis vintage, dialysis efficiency, and hematocrit. Results are reported as mean ± standard deviation. Statistical significance was set at $P < .05$. Software package GraphPad InStat 3.0 was used for these analyses.

Results

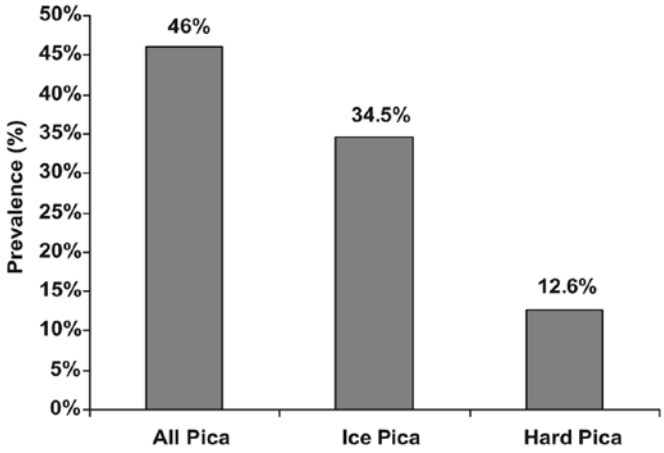
Of the 87 patients surveyed, 38 (44%) were male and 49 (56%) were female. The mean age of the patients was 17.2 ± 7.2 years. The racial composition of the group was predominantly African American (56%) and Hispanic (37%), with only 7% Caucasian participants. All patients were established on chronic dialysis therapy for 3 months. Sixty-seven patients (77%) received HD, whereas the remaining 20 (23%) received PD. Patient demographic information is summarized in Table 1. The survey identified some form of pica to be present in 40 patients, indicating a prevalence of 46%. Of these 40 patients, 30 exhibited ice pica and 11 exhibited hard pica, including 1 patient who reported both types of behavior. These data reflect overall prevalence rates of 34.5% and 12.6% for ice pica and hard pica, respectively, as depicted in Figure 1. Beyond ice, the objects consumed included starch, clay, sand, chalk, potting soil, sponge, sugar, soap, Ajax cleanser, and wood. Type of dialysis therapy and dialysis-specific variables were studied for their association with pica. Table 2 shows that, with respect to dialysis modality, in this population, patients exhibiting hard pica were more likely to be receiving HD than PD (OR: 8.3; 95% CI: 0.5 to 148.2; P = .06). There was no statistically significant difference identified when ice pica alone was examined. There was also no difference when comparing hard pica and ice pica. Dialysis adequacy, as estimated by Kt/V urea, averaged 1.5 ± 0.5, which was above the recommended minimum of 1.2. There was no difference in Kt/V values between those patients with and without pica, or between the pica subgroups.

Table 1. Demographics of the Subjects

Total Patients	n = 87
Age (years)	**17.2 ± 7.2**
Gender	**n (%)**
Male	38 (44)
Female	49 (56)
Race	**n (%)**
Caucasian	6 (7)
African American	49 (56)
Hispanics	32 (37)
Dialysis modality	**n (%)**
HD	67 (77)
PD	20 (23)
Kt/V	**Mean: 1.5 ± 0.5**
Kt/V <1.2	n = 55
Kt/V >1.2	n = 26
TOD (years)	**Mean: 4.0 ± 3.6**
TOD >5 years	n = 59
TOD <5 years	n = 28
Hematocrit (%)	**Mean: 33.0 ± 4.0**
Hematocrit >34%	n = 47
Hematocrit <34%	n = 40

HD, hemodialysis; PD, peritoneal dialysis; TOD, time on dialysis.

Figure 1. Prevalence of pica



Duration of time receiving dialysis therapy was a significant variable. This time reflects the most recent initiation of chronic dialysis therapy, but it does not include interruptions, due to transplantation, for example. The mean time on dialysis was 4.0 ± 3.6 years, among all of the patients surveyed. Greater than 5 years on dialysis was associated with an OR of 3.2 (95% CI: 1.3 to 8.3; P = .02) for any form of pica, more specifically, hard pica (OR: 9.8; 95% CI: 2.2 to 44.2; P = .002). Multiple regression analysis further elucidated the significant (P = .005) relationship of time on dialysis to hard pica. When comparing the two types of pica, for patients on dialysis for greater than 5 years, the odds of hard pica versus ice pica was 5.3:1.

Anemia, a long-studied comorbidity of renal failure, was evident in this patient population, with a mean hematocrit of 33 ± 4%. Patients with any form of pica displayed an OR of 4.3 (95% CI: 1.8 to 10.8; P = .001) for hematocrit < 34%. Multiple regression analysis revealed significant relationships between this variable

and all forms of pica, as well as hard pica (P = .0061 and .02, respectively). Further breakdown of the data revealed that for patients with a hematocrit of < 34%, when comparing pica subgroups with non-pica patients, there were ORs of 3.0 (95% CI: 1.2 to 8.0; P =.03) and 10.6 (95% CI: 2.0 to 55.5; P = .004) for ice pica and hard pica, respectively. The concurrent use of either iron or erythropoietin derivative was not taken into account in these analyses.

Additional complications were observed in some children who exhibited hard pica. Hypophosphatemia was seen in association with chalk pica, whereas poor weight gain, abdominal pain, and fever resulted in multiple hospitalizations for one patient with sponge pica.

Discussion

In this South Floridian, multiethnic, pediatric dialysis population, we identified a high prevalence of pica. This predominantly African American and Hispanic group exhibited a prevalence of 46% of patients endorsing any form of compulsive consumption. Of the 87 patients surveyed, 34.5% acknowledged ice pica and 12.6% acknowledged hard pica. This overall prevalence is greater than the range reported in the adult literature, even greater than that noted by Stillman and Gonzalez,[7] whose adult study population was otherwise analogous to the one described here. More interesting, however, is that the prevalence in this adolescent aged group is higher than that previously noted in healthy children aged 6 years, who are known to have a higher rate owing to their developmental immaturity. Dialysis patients with pica are likely to have learned it from other family members.[8] In fact, the end-stage renal disease state, per se, may constitute a potent stress and stimulus for pica in those patients with an underlying cultural predisposition.[9] Therefore, the high prevalence may be anticipated to some degree by the high proportion of African American patients in the study population, as the increased prevalence of pica in otherwise healthy African Americans is already known.

Prolonged time on dialysis was significantly associated with pica. Those patients with the behavior were 3.2 times more likely to have received dialysis for greater than 5 years. Moreover, a dialysis vintage of greater than 5 years conferred an increased risk of exhibiting hard pica, specifically. Further, there was an increased proportion of pica-endorsing patients on HD, although without statistical significance. This could not be explained by inefficient dialysis, as Kt/V values were not only adequate but also equal between patients with and without pica. However, it may be explained by the fact that in this cross-sectional group, on average, there was a greater dialysis vintage among HD patients as compared with PD patients.

Unlike the adult-based study, also from Miami, FL,[7] our pediatric patients with pica exhibited a significant risk for anemia. While patients with ice pica alone were more likely to be anemic, which is consistent with previous findings,[8] those with hard pica were 10 times at risk for anemia. Multiple regression analysis confirmed the association between anemia and pica. However, the debate remains regarding the causal relationship between anemia and pica, and whether either spurs the other. Coltman[15] and Crosby[16] have argued that iron deficiency is the primary insult, through iron repletion studies and anecdotal reports, respectively. In contrast, Gutelius, as cited by Reid,[17] found that iron therapy had no effect on pica behavior, as compared with placebo. Although this work supports the association of anemia and pica in pediatric HD patients, further research of iron deficiency in this context is warranted.

In this study, an increased prevalence of pica was unveiled, despite study limitations, including small sample size and retrospective analysis. As a potentially harmful problem, pica deserves further nutritional and psychological management in dialysis-dependent children.

Practical Application

This study extends the discussion of pica, as the first published report of prevalence and associated factors in pediatric dialysis patients. Forty-six percent of study patients endorsed either ice pica or hard pica, with potential causal associations to prolonged time on dialysis and anemia. It is appropriate to inquire about these behaviors to prevent further morbidity in an already vulnerable population.

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Using DISC to Understand the Learning Style of Your Clients

Eileen Stellefson Myers, MPH, RD, LDN, FADA

Article originally appeared in the Winter 2012 Weight Management Matters Newsletter, reprinted with permission.

Nutrition professionals, especially those working in the area of weight management, understand the benefit of incorporating various counseling techniques into medical nutrition therapy. However we may not think about a recipient's "learning style" as we try to inform their lifestyle changes to support weight management. This article discusses a behavior style classification called "DISC" that can help you understand the learning style of your clients.

Learning is a product of coaching and counseling patients, or it should be. Counseling techniques such as open-ended questioning, reflective listening and motivational interviewing are part of the repertoire we use to understand patient's strengths and what areas they are willing and ready to improve.

Beyond counseling techniques, understanding a patient's learning style is also critical. Adults, like children, learn best by different methods based on their "learning styles." For more effective results with patients, assessing their learning style upfront can lead to quicker understanding and possible changes on their part. Some patients prefer watching and thinking while others might prefer doing and feeling. By taking the time to learn your patients preferred learning and behavioral style you can select the best teaching strategy to further customize your counseling to be patient-centric and more effective.

"DISC" is an acronym that describes a person's behavioral patterns and emotions useful in understanding learning styles. Your own learning preferences may come to mind as you read the styles below.

Thank you…

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for providing our test questions

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D or Directness is a behavioral style that is motivated to solve problems and questions the status quo. He/she likes challenges. This person is a very independent thinker. When working with a "D" style, provide direct answers and allow the patient to problem solve on his/her own.

I or Influence is a behavioral style that likes to persuade others. This person is good at verbalizing thoughts and feelings and likes to work with others and tell stories and can easily get off track. He/she doesn't like much detail. An "I" style wants to participate in the discussions and role-playing helps this style become more engaged.

S or Steadiness is a behavioral style that likes things organized. This person is patient to sit back and hear you talk. This person participates in groups but doesn't direct the group. This person gets the job done. The "S" style appears very cooperative. He/she likes a step-by-step approach with the chance to observe and then do.

C or Conscientiousness is a behavioral style that likes to achieve and has high standards. This person weighs the pros and cons before deciding to take action. He/she likes to know the expectations and works well with others who have high standards. The "C" style wants to know as much as possible about the topic. This style likes logic over emotion and will ask lots of questions.

Along with using your listening and asking skills to understand the nutritional needs and behavioral barriers of your patient, use these same skills to understand the learning and behavioral style of your patient. This can be accomplished by asking direct questions such as, "What way do you enjoy learning new skills or information?" Other clues can be learned from further discussion. Listen for attributes related to indicators of directness, influence, steadiness, and conscientiousness as you conduct a session.

Just as we have different styles of learning, remember patients do too. Motivational interviewing and attention to client-centered learning are powerful tools for us to use in helping individuals to transform their eating and activity lifestyles.

Author bio

Eileen Stellefson Myers, MPH, RD, LDN, FADA, is the director of prevention and health management for The Little Clinic, a retail health clinic and subsidiary of the Kroger Company. Eileen received her undergraduate degree in nutrition from the Pennsylvania State University and her graduate degree in public health from the University of North Carolina. She is a Fellow of the American Dietetic Association and Director-Elect of the WM DPG Nominating Committee.

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Is Change Affecting You or Are You Effecting Change?

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"Your time is limited, so don't waste it living someone else's life. Don't be trapped by dogma — which is living the results of other people's thinking. Don't let the noise of others' opinions drown out your own inner voice. Have the courage to follow your heart and intuition. They somehow already know what you truly want to become. Everything else is second."

– Steve Jobs, Stanford's 2005 Commencement

Introduction

Is the health care environment really changing? Will registered dietitians (RDs) need to learn to function differently? Should RDs be proactive in addressing anticipated changes? If you haven't watched the news, don't own a smart phone, haven't heard of Twitter, Linkedln, or Facebook, you may be unaware that our society is in a state of rapidly changing flux and health care is a vital part of that change. Everyone in health care has been interested with the Patient Protection and Affordable Care Act scheduled to take effect in 2014, which is bringing about changes that include the creation of entities such as accountable care organizations, a mandate for use of electronic health records, and more emphasis on managed care organizations and patient-centered medical homes.

The 2011 Future Connections Summit on Dietetics Practice, Credentialing, and Education, held March 23-24, 2011, looked at the future of the dietetics profession and was summarized in the October 2011 issue of the Journal of the American Dietetic Association (JADA). The ten change drivers cited in that article affect the practice, education, and future credentialing of dietetics. These change drivers were based on the Commission on Dietetics Registration's Workforce Demand Task Force-sponsored "Future Changes Driving Workforce Supply and Demand, Future Scan 2011-2021." Change drivers cited in the article included:

1. Education within the workforce
2. The need for interdisciplinary teaming
3. The question of whether RDs should be generalists or specialists
4. The population's health risk factors and ongoing nutrition initiatives
5. Personalized nutrition plans
6. Changes within the food industry
7. The aging population base
8. Increased diversity in the population and workplace
9. Increased technology
10. Health care reform legislation

The meeting also included topics such as RD opportunities based on industry need, alternative education, and models offered by other professions, such as physical therapy.

Workforce Changes

The American Association of Diabetes Educators (AADE) Guidelines for the Practice of Diabetes Self-Management Education and Training (DSME/T) state, "Approximately 90% of diabetes care is delivered by primary care providers (PCPs), often without the involvement of a qualified diabetes educator. Although DSME/T is recognized as a crucial component in diabetes care, and is both cost-effective and efficacious, many patients never receive formal training. On average, only 14.3% of all diabetes-related primary care visits include diet or nutrition counseling, 10% include exercise counseling, and 3.6% include weight reduction counseling. PCPs may only provide advice on risk reduction rather than training in diabetes self-management; therefore, patients may only receive information about diabetes care without receiving the education and skills training they need to effectively manage their diabetes" (2). This situation needs to change and RDs should position themselves to address this opportunity.

The executive summary of the Future Changes Driving Dietetic Workforce Supply and Demand Future Scan 2011-2021 clearly indicates that the dietetics profession faces many workforce challenges and opportunities and must prepare for new public priorities and changes in population. One opportunity for RDs is becoming involved in an accredited diabetes education program. The AADE's DEAP (Diabetes Education Accreditation Program) and the American Diabetes Association's ERP (Education Recognition Program) offer enhanced flexibility and employment opportunities for all diabetes educators, including RDs. In 2008, AADE sought to become a Centers for Medicare & Medicaid Services approved accrediting body, in large part to open up new opportunities that allow multidisciplinary teams of diabetes educators (e.g., an RD and registered nurse) to take on more entrepreneurial roles by setting up their own accredited programs and encourage physicians to contract with these new programs. Per a workforce analysis commissioned by AADE in 2011, "In order for the supply of diabetes educators (DE) to be commensurate with that level of demand (approximately 1.5 percent growth per year), DEs would have to grow at 4 percent per year between now and 2025 " (3).

In terms of the employment market for DEs, the scope of work settings would be broader, ranging from traditional hospital outpatient and physician office positions to such roles in industry sales (both pharmaceutical and medical device), medical weight management clinics, community health centers, and workplace wellness programs for large self-insured companies. In terms of job responsibilities, it is anticipated that more DEs will be called upon to serve as program managers and coordinators. Given the

results of Medicare claims analyses, which showed declining reimbursement for group sessions versus individual sessions, many health care delivery systems will bring in lower-level DEs such as community health workers to deliver the group sessions, with higher-level DEs (CDEs and BC-ADMs) supervising them, meeting with patients individually, and creating curricula. Higher-level DEs will also help design technology interfaces, such as patient Web portals, that will allow remote delivery of more services. DEs will also likely be asked to expand their scope into the realm of performance measurement and quality achievement. Currently, quality measures for diabetes care focus on glycemic control, blood pressure control, lipid control, tobacco non-use, and aspirin use. In upcoming years, quality measures should be developed specifically for diabetes education.

Sylvia A. Escott-Stump, MA, RD, LDN, president of the Academy of Nutrition and Dietetics (the Academy), had this message for dietitians in the JADA October 2011 issue: "An ongoing, cyclical approach to planning, with regular reassessment and adjustment as necessary, is as useful to individual practitioners as it is to an organization, and I encourage all Academy members to develop and follow your own strategic plan. An annual self-review prior to an evaluation with your supervisor could well be a practitioner's strategic plan. Think hard about your strengths, your needs, and your goals and write them down. Putting your plan on paper (including setting deadlines for completing tasks or attaining objectives) is shown to increase the likelihood you will work toward achieving your plan"(4).

Public Health Arena

As an RD in the public health arena, I have become involved in examining the future of public health in a continually changing environment. As public health agencies move toward accreditation, the sector is learning to plan and measure for success before the change. The 10 Essential Public Health Services (EPHS) (5) provide the basis for the National Public Health Performance Standards; A Guide for Accreditation (6).

The public health sector is very serious about making sure its workforce is ready to meet future health care challenges. The 8th EPHS is "Assure a Competent Workforce." Meeting this EPHS requires an assessment of the workforce (including volunteers and other lay community health workers). The Academy and AADE have each conducted studies examining the future of their respective professions and workforce. In addition, both organizations have maintained public health workforce standards, including efficient processes for licensure/credentialing of professionals, and have incorporated core public health competencies to include the EPHS into personnel systems. Both the Academy and AADE have defined competencies for the RD and the DE as well as professional continuous quality improvement and lifelong learning programs for all members of the public health workforce, including opportunities for formal and informal public health leadership development. Both organizations offer numerous lifelong learning opportunities for their members, but it is up to the individual to become involved in such lifelong learning. Visit their websites (the Academy at eatright.org or AADE at diabeteseducator.org) to find information on a variety of topics to keep professionals educated and moving toward the future.

Mobilizing for Action Through Planning and Partnerships

One tool to help move the public health sector toward accreditation and ultimately success in improving the health of the communities served is the Mobilizing for Action through Planning and Partnerships (MAPP) tool (7). The community drives the process for this tool, creating and implementing a community health improvement plan by using resources efficiently and effectively. It provides a long-term strategy that leads communities to: 1) define measurable improvements; 2) increase their visibility; 3) identify community advocates; 4) develop the ability to anticipate and manage change effectively; and 5) build a stronger public health infrastructure, partnerships, and leadership. The MAPP framework could be used by many RDs as they move toward positioning themselves for a changing environment through:

Step 1: Organizing for success
Step 2: Developing partnerships
Step 3: Becoming visionary
Step 4: Assessing the situation
  a) What are your strengths?
  b) What is happening in the system that surrounds you?
  c) What is the status, such as health indicators (access to care, disease statistics, etc.)?
  d) What are the positive and negative external forces that affect your profession?
Step 5: Identifying strategic issues based on the information gathered from the four assessments to reach an individual vision
Step 6: Formulating goals and strategies
Step 7: Taking action by planning, implementing, and evaluating your plan

This is only one example of a planning tool to help the RD prepare for the future. Many other tool sets are available. The key is to begin the process!

Conclusion

So, what does the future hold for you and your profession? Are your skill sets and competencies ready for the challenges you will face in a changing workforce? Will you apply to start a DEAP or ERP? Are you prepared to become part of a multi/interdisciplinary team? Will you be part of or lead an accountable care organization? What does health care reform hold for you? Are you depending on the professional association to lead the way or can the professional association depend on you to set the path forward?

Is Change Affecting You or Are You Effecting Change?

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Many member inquiries are received regarding whether the CPE quizzes and credits recorded online are forwarded to CDR. Please note that RPG has provided the online recording as a personal tool and benefit for members. This will allow members to have access to a compiled summary of the credits completed online over time. Thus it is the responsibility of each member to transfer the CPE credit information into their respective CDR Portfolio to record credits with the CDR.

If you have built castles in the air, your work need not be lost; that is where they should be. Now put foundations under them.
– HENRY DAVID THOREAU

TRY THESE LINKS……..
RPG Professional Resource Center
http://www.renalnutrition.org/store/store_results.asp?Brand=4&estore_filter=1

RNF Searchable Archives
http://www.renalnutrition.org/members_only/forum_new.php

Researching a topic for a presentation? Check out the New Renal Research ToolKit
https://www.adaevidencelibrary.com/store.cfm?category=13&auth=1

Can't find a resource or have a suggestion for a great link?

WE WANT TO HEAR FROM YOU!
Cathy M. Goeddeke-Merickel, MS, RD, LD
RPG Electronic Media Manager
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Visit RPG's web site: www.renalnutrition.org for CPEU offerings and valuable professional and patient resources

App Review

App: Kidney Diet

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The Kidney Diet app by Pain Free Living, Inc. claims to help people with Chronic Kidney Disease "watch the 3 P's". Although a fair first attempt at helping CKD patients monitor their potassium, phosphorus, and protein intake via mobile technology, the Kidney Diet app version 2.3 has a limited database that may leave patients stumped when trying to find their favorite foods.

The app has clear instructions that lead the user to input a dietary prescription, which the instructions state should be obtained from their physician. The user enters phosphorus, potassium, protein, fluids, sodium, calories, and carbohydrates. Users are able to leave fields blank for any nutrients they do not wish to track.

Once the diet prescription is entered, a simple blank screen allows the user to add foods one by one via an "add new item" button. Alternatively, one can choose from a scrolling alphabetized list of foods. Once selected, each food has a drop-down menu from which portion size can be selected, and a second drop-down to choose the number of portions. Portions for some foods are easily measured by the user, for example, the choices for Rice Krispies include 1.25 cups (the NLEA serving size) or 1 cup. However, other foods follow the USDA database portions and are less easily measured by the average layperson: red sweet peppers (sautéed) only have a 100 gram portion listed. The screen then lists the nutrient content of the food chosen, with undesirable amounts of a nutrient highlighted in red. It should be noted that 361 mg of potassium in a small banana was not highlighted in red, despite the 2000 mg potassium diet restriction entered. Additionally, certain foods only have one preparation listed; for the red sweet peppers, raw red sweet pepper was not an option, only sautéed. At any time, the user can consult a comparison of their daily total nutrient intake to the physician prescription they entered. If the user has consumed more than the prescribed amount of a nutrient, the total will appear in red.

Another feature of the app is a tab with basic ESRD guidelines and a note stating that a CKD patient not on dialysis may have different nutrient needs. There are also portion size tips and unit conversions, but these are very limited.

The primary limitation of the Kidney Diet app is the small size of the database. Although some fast food options are available (McDonald's, Taco Bell), others had no listings. Although it may not be desirable for CKD patients to consume some of these items on a regular basis, the reality is that patients will partake of these from time to time, and therefore should have access to the nutrient information for such choices.

Future updates of this app should bring an expanded database. The website does have a "contact us" section for users to send comments and database food addition suggestions. Overall, the price of $4.99 may be more than the app is worth. Food diary app prices range from free to $9.99. Some with more comprehensive databases and additional features, such as Calorie Counter by MyFitnessPal.com, are offered for no charge. However, the Kidney Diet app has potential to become a very useful tool for people with CKD.

Link: *http://kidneydiet.com/*

Calendar of Events

August 2012

American Association of Diabetes Educators (AADE) Annual Meeting
Indianapolis, IN
August 1-4, 2012
https://www2.cmrreg.com/aade_1s/AADE2012/index.html

AAKP Annual Patient Meeting
Atlanta, Georgia
August 9-11, 2012
www.aakp.org/events/convention

NATCO 37th Annual Meeting
Washington D.C.
August 12-15, 2012
http://www.natco1.org

October 2012

Academy Food & Nutrition Conference & Expo
Philadelphia, PA
October 6-9, 2012
www.eatright.org/fnce/

ASN Kidney Week 2012
San Diego Convention Center, San Diego, CA
October 30–November 4, 2012
http://www.asn-online.org

December 2012

International Conference and Exhibition on Obesity & Weight Management
Philadelphia, PA
December 3-5, 2012
www.omicsonline.org/obesity2012

February 2013

Clinical Nutrition Week 2013
Phoenix Convention Center, Phoenix, AZ
February 9-12, 2013
http://www.nutritioncare.org/ClinicalNutritionWeek/index.aspx?id=502

CRRT 2013 Conference
Hilton Bay Front, San Diego, CA
February 12-15, 2013
http://www.crrtonline.com/conference/

March 2013

33rd Annual Dialysis Conference
Seattle, WA
March 10-12, 2013
www.som.missouri.edu/Dialysis/

2013 Canadian Society of Transplantation Annual Scientific Conference
Lake Louise, AB; Canada
March 14-16, 2013
http://www.cst-transplant.ca/AnnualConference.cfm

April 2013

National Kidney Foundation Spring Clinical Meetings
Walt Disney World Swan and Dolphin, Orlando, FL
April 2-6, 2013
http://www.kidney.org/news/meetings/clinical/general/future_dates.cfm

May 2013

American Society of Pediatric Nephrology Annual Meeting
Washington D.C.
May 4-7, 2013
http://aspneph.com/educationmeetings.asp

June 2013

International Society of Nephrology World Congress of Nephrology
Hong Kong
May 31-June 4, 2013
http://www.wcn2013.org/

New Name, New Prizes
for Academy Promoters!

eat right. Academy of Nutrition and Dietetics

Our name may have changed, but our commitment to rewarding individual Academy champions remains the same. That's why those who participate in the 2012-2013 Promoter Program are eligible to win some fantastic prizes this year.

All you have to do is encourage your friends and colleagues to join the Academy. The more you recruit between April 1 and September 1, 2012 the better your chances of winning.

To get Promoter credit, make sure your recruit enters your name in the "Did someone recommend Academy membership to you?" section of the 2012-2013 Academy Membership Application.

Prizes for our top promoters include:

- Apple iPad2
- Kindle Fire
- 12-month Netflix subscriptions
- Free Academy membership
- And special recognition for your efforts!

Remember, nobody can recruit Academy members better than you can!

Applications can be downloaded at www.eatright.org/joinacademy.

For questions, please e-mail promoter@eatright.org and thank you for supporting the Academy of Nutrition and Dietetics.

NKF Update

Rachael R. Majorowicz, RD, LD
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Philip Gregory, PharmD, FACN of Creighton University and editor of the Natural Medicines Comprehensive Database, reviewed their most recent findings in his presentation, "Drug-Supplement Interactions." He shared that roughly 20% to 60% of prescription medication users in the U.S. are taking their medication in combination with a natural supplement. As we are aware, most patients do not tell their health care providers about their use of these natural supplements, even when directly asked. As a result, the potential for drug-supplement interactions is considerable. In fact, the database has identified over "1900 potential interactions between herbs or dietary supplements and prescription and over-the-counter medications."

The majority of the current literature investigates the "metabolism" of medications. Most notable is the cytochrome P450 34A enzyme, which is involved in the metabolism of over 50% of the drugs on the market. Any supplements that "induce" 34A would reduce the effectiveness of medications (e.g. St. John's wort and AIDS medications). Supplements that inhibit 34A would have the opposite effect.

The potential severity of drug-supplement interactions can be rated as follows:

"Major - Do not use the combination together. These combinations can result in serious consequences and should be avoided."

"Moderate - Use with caution or avoid the combination. Some combinations can result in interactions that do not cause serious harm, but are still bothersome. In these cases, the combination should be avoided or used cautiously." 75% of reactions potentially fall into this category.

"Minor - Be watchful with the combination. In some cases, certain combinations of drugs and supplements may cause an interaction, but the outcome is not severe or bothersome. Nonetheless, in certain people the interaction could be more problematic."

Sadly for renal patients, it seems that concerns for warfarin users extend beyond cranberry juice. Evidence shows that orange, apple, and cranberry juices cause a similar effect. Since the drug-nutrient effect can last up to 4 hours, recommendations should be to either avoid intake of these juices, use consistently each day, use small amounts (smaller dose = less effect), or ensure the medication and juice are not used within four hours of each other. The exception is grapefruit juice, which at any dose, has an effect for 24 hours and should be avoided entirely with contraindicated medications.

Also notable for renal practice, Dr. Gregory recommends never combining nutritional supplement drinks and medications unless you are sure there are no interactions as medication absorption issues may occur.

Unfortunately, there is no research on the "excretion" aspect of drug-supplement interactions and therefore, it is not well known what the effects of renal failure may have. However, Dr. Gregory did reinforce current logic/advice that renal patients should avoid natural supplements since it is likely that limited renal excretion will cause a build-up and potential for toxicity (unless approved by the healthcare team). However, his greater concern would not be the toxicity of the natural supplement, rather the resulting accumulation of the medication.

Another consideration for your practice… not all drug-supplement interactions will be found using an interaction checker. In many cases, health care providers have to "think it through." For example, natural supplements that work in the same way as a medication can be predicted to cause a summative effect (e.g. supplements to "help depression" would likely affect serotonin levels like an antidepressant medication). Therefore, it seems increasingly apparent that the renal healthcare team needs to regularly include the services of a pharmacist.

Exciting Changes for the November CSR Exam

The November 2012 exam will be administered in a new format. The current patient management problems/simulations will be replaced with 150 multiple choice scenario-based questions. Register by August 13, 2012 for the CSR exam administered November 1-21, 2012. For more information on the new exam format, visit www. Renalnutrition.org or www.cdrnet.org

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Shari Neul, Ph.D. is a renal psychologist for Texas Children's Hospital. After attending her presentation "Effective Approaches for Dealing with Challenging Patient Behaviors," I wish every dialysis clinic could have a licensed professional such as her to help with difficult patients. One of the models she discussed was the "Systems Perspective" based on Bronfenbrenner's social ecological models of development.

In this model, there are four levels of what the patient "brings to the table." The four levels are the macrosystem, the exosystem, the microsystem, and the mesosystem. Each level has its own potential sources of difficulty. The macrosystem relates to society's perspective of the patient including economic conditions and cultural beliefs. The exosystem gets closer to the patient's individual life including workplace and extended family. The microsystem encompasses the daily parts of a patient's life, but not necessarily controllable factors such as the dialysis unit/clinic, CKD disease process, spouses, friends, family, and coworkers. Lastly, the mesosytem incorporates things directly dealing with patient interactions such as patient-medical staff, spouse-medical staff, family-medical staff, and patient-spouse/family.

Dr. Neul offered some recommendations for prevention. On the microsystem level, she recommended medical team education and professional development training for effective communication using "role plays" as a teaching method. She also said checklists and/or report cards for staff to use with patients and families can be helpful for the training. Another suggestion she had was a new patient manual which would include what to expect from the dialysis unit and what the unit would expect from the patient and/or family. The manual also should address grievances. One thing Dr. Neul noted about grievances was that if there is a "trouble" patient looking for attention, it is important to remind that patient of the grievance process and to not continue listening to the problem. She said oftentimes it helps to keep the problem less personal and to focus efforts on the resolution.

One thing that was very interesting but still needs to be researched in the renal community is the concept of "medical traumatic stress." It has been mostly researched in cancer patients. Patients are asked to retrospectively think back to their diagnosis and when they did, the patients' symptoms were described as traumatic, upsetting, and anxiety driven. I think this is a fascinating concept that our renal patients may have had a medical traumatic stress and we should help them adjust, adapt, and cope with their new life.

Her recommendations for the mesosystem efforts include early intervention. She mentioned that if there is a medical team issue, a meeting with the medical team to identify the problem and another meeting with the patient/family is a good strategy. At the family meeting, it is important to share concern and seek feedback and ask what the team can do to make the situation better, but most importantly, to end with "What can you (the patient) do?" It is very important to have the patient's steps be specific, concrete strategies. Some of the other early intervention strategies include remembering safety first, consistency, set limits but maintain empathy, and set expectations and keep them. She mentioned that if we set limits, it helps our patients pull through and be successful. Lastly, she reminded us a crisis is a state of a person, not the event but triggered by a previous event.

I believe patients can be difficult for many different reasons. Dr. Neul's presentation reminded me to be compassionate to our patients because CKD is such a multifaceted disease. Not only does it flip their lives around; it completely encompasses it.

HOD Update

Outcomes of the Spring 2012 HOD Meeting

Pam Kent, MS, RD, CSR, LD
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The House of Delegates met virtually on April 26-27, for the 87th meeting of the House. This marks the fourth annual HOD virtual meeting.

The focus of the meeting was the continuum of Professional Progression and Growth. The dialogue session centered around the Dietetics Career Development Guide and how to build a stronger understanding of the guide amongst the meeting participants in order to disseminate the Guide to all members for use and implementation. The dialogue session began with video vignettes, where three Academy members shared personal stories of their career development which demonstrated the unique ways in which a dietetics career can evolve. The meeting participants identified ways to create new opportunities at each level of the development guide. The dialogue concluded with meeting participants determining other tools and resources that may be developed to help support the Dietetics Career Development Guide in order for members to realize the ranges of possibilities at each level of practice.

The second part of the mega issue focused on advanced practice. A visioning worksheet was provided for meeting participants to envision the most compelling elements for what exists currently and how it will be different in 2020. Also, the worksheet helped to identify what the visions and opportunities for RDs/DTRs will be for 2020 and the obstacles that may need to be overcome. Meeting participants worked together to establish an understanding of the importance of advanced practice to the future of the profession.

Based on the dialogue, a series of guiding principles were identified (the list provided is not all inclusive):

- Professional development and personal responsibility are required to achieve diverse career opportunities and aspirations.
- The Dietetics Career Development Guide is a tool that can assist current practitioners to identify career opportunities and to achieve career aspirations.
- The Dietetics Career Development Guides is a valuable tool to incorporate into all levels of dietetics education to assist current and future students.
- Academy organizational units and individual members can mentor practitioners to utilize the Dietetics Career Development Guide.
- A variety of communication vehicles will be needed to share information on how practitioners and students can use the Dietetics Career Development Guide.
- The Academy and individual members should share stories with practitioners and students about the multiple paths, personal initiatives and passion that lead to career growth and achievement.
- Advanced practice enables practitioners to achieve tangible and intangible rewards for furthering career opportunities.
- Advanced practice positions practitioners for leadership opportunities within practice settings, communities, public policy advocacy efforts and various organizations, including the Academy.
- Advanced practice is a profitable investment that impacts the bottom line for health care organizations, businesses, institutions and practitioners. The Academy and individual members will work collaboratively to promote the value of advanced practice and specialist credentials.

Since the dialogue, the resulting motion was passed by the House. The following activities have been requested by the House of Delegates:

1. The Academy of Nutrition and Dietetics and its affiliates adopt the Dietetics Career Development Guide as a blueprint for future education, professional development and practice for the profession; and encourage all dietetics practitioners to understand and implement the Dietetics Career Development Guide as a tool to assist them in achieving the highest potential level of practice.
2. CDR incorporates the Dietetics Career Development Guide into the Professional Development Portfolio process and encourages its utilization by all credentialed practitioners.
3. All Academy organizational units support the utilization of the Dietetics Career Development Guide in appropriate projects, initiatives, policies, tools and resources designed for students and practitioners.
4. The HOD dialogue summaries will be forwarded to the Council on Future Practice for use in developing new Dietetics Career Development Guide tools and resources specific for students and practitioners to utilize.
5. Individual members are encouraged to perform outcomes research that measures the financial impact and the career growth opportunities of advanced practice.

All materials related to Spring 2012 House of Delegates Meeting, including slides from various Academy related updates and outcome materials, are located online for members: www.eatright.org/hod > Spring 2012 Meeting > LearnMore.

We would love to hear from you! How do you see the Dietetics Career Development guide being implemented in the nephrology setting? Please send your comments/thoughts to pamkentrd@yahoo.com.

Public Policy Workshop Update

Sarah Mott, MS, RD, LDN
RPG Public Policy Chair
mott_sa@yahoo.com

As the new Public Policy Chair for the Renal Practice Group, I had the opportunity to attend the Academy of Nutrition and Dietetics' Public Policy Workshop this past April in Washington DC. This workshop included two days of informational sessions on current issues in nutrition policy as well as on how to be an effective advocate. There were many exceptional sessions, including a session with United States Secretary of Agriculture Tom Vilsack and a session highlighting the many aspects of First Lady Michelle Obama's "Let's Move" initiative. Workshop sessions presented us with background information on four key issues facing our legislators in the upcoming months; including the Preventing Diabetes in Medicare Act, the Preserving Access to Life-Saving Medication Act, the Older Americans Act, and the Farm Bill. The highlight was the final day of the workshop which culminated in meetings on Capitol Hill with state congressmen and representatives (or more often their legislative assistants). We had the opportunity to personally represent the Academy of Nutrition and Dietetics and advocate for bills that are important to our profession.

Armed with information on the state of these bills as they work their way into law, as well as with our own personal experiences and expertise as registered dietitians, we were able to advocate for the following bills. First, the Preventing Diabetes in Medicare Act would amend the Social Security Act to extend Medicare coverage for Medical Nutrition Therapy (MNT) to individuals with pre-diabetes. As renal dietitians are well aware, providing MNT to patients with pre-diabetes could prevent the development of diabetes, and in turn prevent the consequences of diabetes such as advancing stages of chronic kidney disease.

Second, the Preserving Access to Life-Saving Medication Act of 2011 would require prescription drug manufacturers to notify the Secretary of Health and Human Services in the case of an event which could lead to a shortage of a drug (including IV vitamins and minerals for TPN), and would also penalize manufacturers in violation of the guidelines. The Drug Shortage Prevention Act of 2012 also addresses this issue and would establish a National Critical Drug list which would list essential drugs. Information about shortages of these drugs would be publicized, providing essential information for prescribers who could then make alternative plans for dealing with these shortages.

Third, the re-authorization of the Older Americans Act, which provides for congregate and home-delivered meals for seniors, has stalled. The Academy focus is to get the process moving again and include language in the bill that would require inclusion of registered dietitians at all levels of the aging network, with a focus on nutrition screening, assessment, counseling, and education.

Finally, the Food, Farm, and Jobs Bill encompasses five areas. The first of these is the Supplemental Nutrition Assistance Program (SNAP) and SNAP-Ed (the educational component of SNAP). The second, the Commodity Supplemental Food Program, provides commodity foods to agencies such as food banks. The Fresh Fruit and Vegetable program provides fruits and vegetables to elementary schools. Finally, the bill also provides for nutrition research. This information and more on these bills is available in briefing papers at www.eatright.org.

In addition to the four issues of focus for our meetings on Capitol Hill, the National Coverage Determination for intensive behavioral counseling for obesity was discussed. The Academy is exploring additional avenues to allow registered dietitians to bill directly for providing these services.

My brief experience in our nation's capitol as a representative of the Academy of Nutrition and Dietetics and an advocate for our profession taught me a number of lessons, but I believe the most important is this: every voice counts! In order for our agenda to be heard, we need voices. A congressman or senator may need to hear from just one of their constituents that an issue is important for that legislator to back a bill. Or they may need to hear from ten. But if we registered dietitian members of RPG don't speak out for bills that would support and protect nutrition care for our nation and the value of our profession, who can we expect to do it? So write a letter, make a phone call, send an e-mail, visit your legislators in your home state or join hundreds of your fellow registered dietitians and attend the Academy's Public Policy Work shop next year. If you would like more information on the current issues that are impacting our profession, visit www.eatright.org and also be sure to follow Eat Right Weekly, the Academy's weekly e-mail.

WANT TO GET INVOLVED?
Let us know!

Contact Membership Outreach Chair:
Nilima Desai
rpgmember.outreachchair@gmail.com

Renal Dietitians Chair Message

Sarah Kruger, MS, RD, CSR
RPG Chair
kruger_sarah@yahoo.com

Welcome to the 2012-2013 fiscal year for the Renal Dietitians Dietetic Practice Group! The Academy of Nutrition and Dietetic's fiscal year is from June 1-May 31, so we have just started a new year. In preparing for this year as chair, I spent a lot of time brainstorming what I would like to see accomplished. I came up with an overall theme for my term as chair:

"Innovation, Technology, and Change."

Innovation

In order to keep up with the changing demographics, needs of society, and the needs of our patients, we had to start thinking bigger. RPG was in desperate need of a revision and the executive committee (EC) kick-started those changes last year with a complete overhaul of our organizational structure. We didn't completely throw out our old model, but we got rid of positions not being utilized and expanded in areas where we thought our membership needed our help the most. Some of the new positions we added include Social Media Chair, Mentor Chair, and Webinar Chair. For some of the other positions, we gave them a facelift and changed their title. For instance, the title of the Lending Library was changed to Professional Resource Center and the Legislative Chair was split into two positions: Public Policy Chair and Reimbursement Chair. Lastly, we used to have only one person who managed all of our educational needs. In this day and age, we feel what our membership needs most are educational resources. Therefore, we expanded the position from one person to five. The Education Chair is now Projects Chair and will oversee the Handouts Subcommittee Chair, iPad Subcommittee chair, Website Reviewer, and the Kidney Friendly Food Initiative Chair. Hopefully with so many new EC members, we will be able to create innovative products that will help you become a better practitioner.

Technology

The world is changing and it is moving toward technology. It is time for RPG to catch up with the pack! The first step for RPG: redesign our website. We want to improve the functionality and make it your premier site for renal nutrition. With the redesign, we hope to make it easier for you to access the new material we will be creating for you. Some of the materials you will be able to find are webinars, handouts, and eventually some interactive patient education modules on renal nutrition related topics such as phosphorus, potassium, and protein. At a time when many places are cutting back their resources, RPG wants to improve ours to be your source for everything renal nutrition related!

Change

"If you do what you've always done, you'll get what you've always gotten." – Tony Robbins

I like this quote because it not only applies to RPG, but also to the practitioners RPG is trying to help. RPG is changing. We want to grow and be the largest group and premier resource for dietitians working with renal patients. To do that, we are providing new resources, innovative information to educate you, and creative tools for you to use with your patients. RPG is changing so we hope you might consider changing, too. I often hear of dietitians who are sick of working in renal disease because the patients are so frustrating, unmotivated, or unresponsive to their educational methods. I think it is time to take a look at how we are counseling and make a change. Earlier this year we presented a webinar series "Directing Patient Conversations toward Meaningful Behavior Change." If you missed it, check it out. It will be a great start toward looking at your own counseling methods.

In conclusion, I hope you see value in your membership through RPG. At the end of the year, if you don't see a change from us or don't know what we have done for you, email me your suggestions. RPG will try and make it happen. FNCE is October 6-9, 2012 in Philadelphia, PA. I hope to see you all there!

REGISTER NOW!

RPG and DHCC Member Networking Reception
Sunday October 7, 2012
6pm – 9pm

This unique reception includes a fabulous cruise along the Delaware River on the Spirit of Philadelphia.
www.spiritofphiladelphia.com
Register Now!
www.renalnutrition.org

*www.renalnutrition.org will take you to the registration on DHCC's website. Please log-in as a member on their site to receive the discounted rate at $25.
Non-members (family and friends) can attend for $75. If you have any questions or difficulty registering please contact Marla at dhccdpg@mchsi.com.

Recently Published

December 2011

Gutierrez OM, Katz R, Peralta CA, et al. Associations of socioeconomic status and processed food intake with serum phosphorus concentration in community-living adults: the Multi-Ethnic Study of Atherosclerosis (MESA). *J Ren Nutr.* 2012 Jan 2. doi: 10.1053/j.jrn.2011.08.008. [Epub ahead of print]

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January 2012

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February 2012

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March 2012

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April 2012

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Martin KJ, Gonzalez EA. Long-term management of CKD-Mineral and Bone Disorder. *Am J Kidney Dis.* 2012 Apr 19. doi: 10.1053/j.ajkd.2012.01.027. [Epub ahead of print]

Memmer D. Implementation and practical application of the nutrition care process in the dialysis unit. *J Ren Nutr.* 2012 April 21. doi: 10.1053/j.jrn.2012.01.025. [Epub ahead of print]

May 2012

Juraschek SP, Guallar E, Appel LJ, et al. Effects of vitamin C supplementation on blood pressure: a meta-analysis of randomized controlled trials. *Am J Clin Nutr.* 2012;95(5):1079-1088.

The Executive Committee in Nashville for the transition meeting April 21, 2012. The meeting was a great opportunity for the EC Members to meet each other, work together and have some fun too!

Left to right: Rachael Majorowicz, Sara Erickson, Stacey Phillips, Nilima Desai, Pam Kent, JoAnn Randazzo, Sarah Kruger, Cathy M. Goeddeke-Merickel, Aimee Zajc. And of course- Elvis in the middle.

2012-2013 RPG Executive Committee

Mission: Renal dietitians 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.

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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 Academy of Nutrition and Dietetics.

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.: Torry Pines Press; 2003.

Web site:
Medscape drug info. Available at www.medscape.com/druginfo. Accessed August 15, 2011.

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 and 2-3 key words along with feature article submissions.