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WHRN report

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CHAMPION NUTRITION: ADA Public Policy Workshop, April 23-25, 2007

By Dee Sandquist, MS, RD

Over 400 registered dietitians attended the Public Policy Workshop (PPW). I learned that in order to maximize the success of the future of our profession every dietitian needs to participate in grassroots efforts. Why? Look at the HIV/AIDS outcome of getting the Ryan White Act passed. Our membership should be proud because this was used as an example of a recent grassroots effort that truly made a difference and will result in better treatment for the patient provided by a qualified professional (the RD).

The workshop included education about the political process and the history of ADA's efforts. ADA members visited Senate and House offices to ask for support for expanding Medical Nutrition Therapy coverage and to support certain nutrition-related amendments to the Farm Bill.

Medical Nutrition Therapy

Senate bill S.1161, introduced by Sen. Jeff Bingaman (D-NM), Larry Craig (R-ID), Kent Conrad (D-ND), Charles Schumer (D-NY) and Maria Cantwell (D-WA), would give Medicare the authority to expand the MNT benefit based on a "necessary and reasonable" standard of review. This would help simplify the legislative process so that a separate law would not need to be passed for each disease (i.e. diabetes and end stage renal). In addition, Senate bill S. 755, introduced by Sen. Charles Schumer and Pete Domenici (R-NM) would require state Medicaid programs to cover screening and treatment (including MNT) of diabetes. In the House we asked our Representative to co-sponsor and support Rep. Xavier Becerra's bill to give Medicare the authority to expand Medicare's MNT benefit. Also, in the House we asked for support of Rep. Diana DeGette's bill to add pre-diabetes to the MNT coverage under Medicare.

Farm Bill

In the Senate we asked for co-sponsorship and support for S.971, (known as the National Institute of Food and Agriculture Act) introduced by Sen. Kit Bond (R-MO), Tom Harkin (D-IA) Richard Lugar (R-IN), Ben Nelson (R-NE). This bill would build upon the foundation laid by the six Human Nutrition Research Centers in the U.S. to provide additional research to support evidence based decisions. We also sought support for an amendment to the Farm Bill to change the timeline from 5 to 10 years for the release of updated Dietary Guidelines for Americans. In this way, more research could be completed and included in the updates.

Another amendment to the Farm Bill we have asked legislators to support would provide improvements to USDA's food assistance programs. It would help people who use food stamps purchase foods that are consistent with the Dietary Guide lines for Americans through the use of incentives to purchase those foods and through nutrition education. The House version of the National Institute for Food and Agriculture Act is sponsored by Rep. Colin Peterson (D-MN), Charles Boustany (R-LA) and Sam Graves (R-MO).

Older Americans Act

A new opportunity for registered dietitians may be changes to Title IIIC of the Older Americans Act which will include nutrition services. An opportunity to practice your advocacy skills would be to contact your local Agency for Aging. Also the Medicare Senior Risk Reduction Program will be piloting wellness models. Write a business plan and submit a request to be part of this with your area's Medicare supplemental health plan. A new concept is on the horizon called "money follows the person." The idea is to provide some services outside of institutions that currently are only available in institutions. The goal is to promote independent living.

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WHRNreport

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We're on the web!
www.whrndpg.org

from the chair **Cathy Fagen,** MA,RD

I'm back! Seven years ago I served as Chair of WHRN and here I am again. I may be seven years older but I'm also seven years wiser.

This is truly an exciting year for the WHRN DPG! I have been an active member since its inception in 1994. We have come a long way with development and improvements in our newsletter, the membership listserv and the WHRN website. I am so proud of our Committee Chairs and Coordinators and the strides they have made over the years. You will notice a new look to the WHRN Report with the service of a layout contractor this year. If you are not signed up on our membership listserv you will want to do that right away and get connected with our members. And **YOU HAVE GOT TO CHECK OUT** our new web site this summer!

The most exciting news is that we have developed a strategic plan for the WHRN DPG. Last fall we received a grant through ADA to support a facilitator to assist us in the development of a 3-5 year strategic plan. In April our Executive Officers and two Past Chairs met in Chicago to begin the strategic planning process under the direction of Marianne Smith-Edge, RD, LD, FADA. We could not have done this without the membership responses to the survey Jeanne Blankenship conducted last summer. Thank you Jeanne and the members who took the time to complete the online survey. The strategic plan is almost completed and we plan to have a roll out of the WHRN DPG strategic plan at our annual membership reception at FNCE in September. Stay tuned!

One of the things we learned from the input we have received this past year is that many ADA members still think of WHRN as the DPG for women's reproductive health. Our DPG's scope has expanded into lactation and women's health issues non-related to reproduction. We tried to reflect that with the name change 5 years ago from Women and Reproductive Nutrition (WRN) to Women's Health and Reproductive Nutrition (WHRN). But we have learned that we are still viewed as the DPG specializing in women's reproduction. A suggestion from the Strategic Planning Retreat in April was that we should change our name to Women's Health DPG. This name would make it obvious that we are advocates of women's health throughout the life cycle and not just in the reproductive stages. **In order to make a DPG name change, we need the vote of our membership.** The DPG name change survey was conducted by Jeanne Blankenship in June through Survey Monkey. We'll know the results soon! You are the future of our DPG!

from the editor **Krista Neal,** MS,RD,LD

Greetings! If you're new to WHRN, welcome. If you are a returning member, I'm happy to have you back. I think we will have a very exciting year. I'd like to thank everyone who contributed their leadership and talents in the last year. This issue of the WHRN Report brings us topics to broaden our horizons. As I was working on this newsletter, I realized how focused I've become on my professional area. I have tunnel vision. In the report of the results of last summer's membership survey, I am reminded that not all of us do the same type of work. The results were discussed last year at FNCE, and some of your responses and suggestions have already been put to work. You all had outstanding suggestions for future newsletter topics. We also have a report from the Public Policy Workshop held in April. If, like me, legislative issues are relatively unfamiliar to you, this article is an excellent introduction. It helped me to know where to focus my efforts. Also included is an interesting article on the economic impact of becoming a Baby Friendly Hospital. As part of my tunnel vision, I had never even considered the cost of becoming Baby Friendly. I was so busy thinking about the benefits for moms and babies that I forgot to think of the economic benefits. Last, but by no means least, this issue features member spotlights from two of our 50 year members. Hearing about the career paths others have taken always reminds me just how broad our world of dietetics is. Hopefully, when you've finished reading you will be reminded of how varied our careers and lives can be.

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What's new with ADA?

The Board of Directors has approved "Grassroots Affiliate Structure" which was recommended by the LPPC. Intended outcomes are to streamline processes, improve communication, empower members, increase the impact of grassroot efforts, reach key legislators, and increase visibility for the profession.

Recommendations are as follows:

– Establish an ADA Public Policy Coordinator (PPC) position to work in each state.

– Establish Public Policy Panels (PPP) to strategize and manage advocacy. This includes establishing State Policy Representatives (SPR) who track state legislative and regulatory issues. A Public Policy Panel would include the PPC and SPR plus 2-4 members.

– Affiliates would have a structure with the PPP that gathers a strong combination of knowledge, skills and access to decision makers in the affiliates.

– Invest in an ongoing culture of communication and leadership training.

– Create Education Opportunities for members to learn about the need to get involved in public policy and advocacy.

Six Rules for Effective Advocacy:

Rule 1: Make a plan and know the "Who, What, When, Where and How." Who needs to be influenced? Who will advocate for change? What are the key messages? What is the best way to communicate those messages? When are the best opportunities to advocate for change? Where are the best places to influence and promote changes? How will you bring about change and gain support?

Rule 2: Determine "Who" the target audiences are and "Who" will help (key decision makers, other key players, and partners).

Rule 3: Know "What" you are after. What is your goal?

Rule 4: Know "When" to advocate for change. Are there meetings key decision makers will attend?

Rule 5: Know "Where" to advocate for change. This will depend upon your goal.

Rule 6: Know "How" to advocate for change and develop concise tools that have a clear and direct message. Pictures or short stories are helpful. Keep your speech short, less than 2 minutes. Use the media to promote your message.

ADAPAC is the only Political Action Committee that exists to focus only on food, nutrition, and health.

If you haven't made a contribution, I encourage you to participate. Visit www.adapac.org for more information.

CALL FOR NOMINATIONS

WHRN Needs YOU!

Each year members of our DPG Nominating Committee spend time lost in deep thought about the future of the WHRN and who will be entrusted with leadership positions. As you can imagine, without knowing who is interested in serving, we tend to think of our friends and acquaintance, former officers and committee members. There should be a better way, and this may be it. Let us know if you are interested in joining the group of fun, interesting, and dedicated WHRN members who are the driving force behind our DPG. If you do join in, chances are you'll be rewarded with wonderful, new friendships. Involvement won't take a ton of your time, but it will require your best thoughts and a willingness to contribute to WHRN activities. We are looking for nominations for the following officer and committee positions: Chair-elect: This Executive Committee (EC) member performs the functions of the Chair in her/his absence, appoints committee chairs, prepares the program of work for the next year's term as Chair; and plans, organizes, and coordinates the next year's educational programs for the ADA Food & Nutrition Conference and Expo. This person takes over the Chair position after a one-year term as Chair-elect, and then assumes the role of past-chair for a year. Secretary: As a member of the EC, is responsible for ensuring that the minutes of meetings of the EC and the DPG are recorded, reviewed, and filed at ADA Headquarters. She/he directs distribution of the official ballot to members, notifies candidates of election results, and maintains official documents of the WHRN DPG. (2 year term) Nominating Committee: Three elected committee members identify qualified candidates for WHRN's elected offices (1 year term). The Executive Committee meets once a year, in person and several times a year by conference call. There is a membership reception held annually at FNCE. Our DPG provides financial support for attending FNCE for the chair, chair-elect, past-chair, treasurer, secretary and the newsletter coordinator. Additional appointed and elected positions are supported as the program of work requires and the budget allows. If you are a WHRN practice group member and would like to nominate yourself or someone else you think would do a great job, or find out more information about roles and responsibilities of the positions (such as full position descriptions), please email Judy Brown, PhD, RD at brown002@earthlink.net.

THE BABY FRIENDLY HOSPITAL INITIATIVE: Economic Considerations

Debra A. Waldoks, MPH, RD *Director of Breastfeeding Programs, Lincoln Medical and Mental Health Center, Bronx, NY*

Background

Suboptimal global breastfeeding rates inspired the creation of the Baby Friendly Hospital Initiative (BFHI), with the goal of improving hospital practices known to influence breastfeeding initiation and continuation. The World Health Organization (WHO) and the United Nations Children's Fund launched the international initiative in 1991. Currently, there are 56 United States hospitals and more than 15,000 facilities worldwide that bear the Baby-Friendly designation. Designated facilities adhere to the "Ten Steps to Successful Breastfeeding" (see Figure 1).

The BFHI has been successful at improving breastfeeding rates in the United States. One study showed that breastfeeding initiation rates increased from 58% to 87% and exclusive initiation rates increased from 6% to 34% after a Boston hospital received the Baby-Friendly designation (2). Results from a national survey of US Baby-Friendly hospitals in 2001 confirmed these increased rates by showing an average initiation rate of 84% and an exclusive initiation rate of 78%, compared with the national rates of 70% and 47%, respectively (3).

The BFHI has also improved breastfeeding rates worldwide (1). In six years, Cuba saw their exclusive four month breastfeeding rate increase from 25% to 72% as the majority of their hospitals became Baby-Friendly. In China, where there are over 6,000 Baby-Friendly facilities, urban areas more than quadrupled their exclusive initiation breastfeeding rate. In Chile, where one of the first Baby-Friendly hospitals was initiated, six months exclusive breastfeeding rates rose from 20% to over 60%.

Despite the great success that the BFHI can foster, most US hospitals are not part of the initiative. In other countries, the government may work in conjunction with the BFHI to develop a hospital accreditation program. However, in the US, where there is no universal health care and the majority of hospitals are privately operated, individual hospitals decide whether or not to be part of the initiative. There are three factors that hospital administrators can consider when deciding to become a Baby-Friendly hospital: philosophy, organization, and economy. This article will focus on the economic aspects of becoming part of the BFHI.

Ten Steps to Successful Breastfeeding

1. Maintain a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give infants no food or drink other than breast milk, unless medically indicated.
7. Practice "rooming in"– allow mothers and infants to remain together 24 hours a day.
8. Encourage unrestricted breastfeeding.
9. Give no pacifiers or artificial nipples to breast feeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Figure 1 (1)

Many hospital administrators are hesitant to become Baby-Friendly due to the financial cost of enacting the steps on an already constrained hospital budget. It is not enough to know that an intervention will be effective; it must also be cost-effective. This article will broadly examine the costs and benefits of the BFHI, outlining the factors that hospitals should consider when deciding whether to become baby-friendly. This article is not a true cost benefit analysis since it does not assess effectiveness. Rather, it is designed to serve as a rough guide to hospital administrators considering the BFHI initiative.

Costs

Initially, it is quite likely that Steps 2 and 6 will cost hospitals additional money. The other 8 steps will most definitely cost the hospital additional time, and quite possibly money as well. However, time spent doing something is time not spent doing something else, and is therefore costly. In a true cost-effectiveness analysis, hourly rates are considered even when the professionals involved are not "paid" for doing the specific tasks in order to transform all values into dollars to make equal comparisons.

Step 2: Training all health care staff is lengthy and possibly costly. Besides the cost of training and the hours of paid training time, the cost of staff coverage for training hours should also be considered (4). According to Baby-Friendly USA, the WHO-designated organization in the US, "all staff with primary responsibility for the care of breastfeeding mothers and babies will have a minimum of 18 hours of training inclusive of 3 or more hours of competency verification. Training for other staff members may be tailored to their job description and degree of exposure to breastfeeding." Even with low-cost training modalities, such as web-based courses and hospital journal clubs, it could be difficult to find the time to conduct the training. Furthermore, high staff turnover rates translate into a continuous need to accrue training hours. Having an in-house breastfeeding instructor can defray some of these costs. Depending on the training method, each hospital will experience varying costs for this step.

Step 6: Imbedded in step 6 is a clause that states that hospitals must not accept free or discounted infant formula. This is in alignment with the WHO Code of Marketing Breast Milk Substitutes, which stipulates that health care facilities and professionals neither accept nor offer free or low-cost substitutes for human milk (5). The BFHI requires that hospitals purchase infant formula in the same manner that it purchases other medical supplies. It also stipulates that hospitals not give free samples, literature or other items bearing the name of a formula company to breastfeeding mothers (6). While paying for formula may seem steep, the amount of formula a hospital receives for free before implementing the

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BFHI is much greater than the amount of formula that will actually be consumed after implementation of the BFHI. The reason for this is two-fold. First, consumption of formula will be reduced due to increased breastfeeding rates. Second, since formula is no longer free, greater caution will be taken to guard against frivolous use of formula and pilferage (7).

Other Steps:

Step 1: If the hospital does not already have a written breastfeeding policy, it must create one. This policy also must be routinely communicated to all health care staff. This involves many hours of senior administration staff, ideally working together as part of an interdisciplinary team, to create the policy in addition to staff meeting-hours to communicate the policy. Depending on how long it takes to create the policy, and how often the policy is communicated, the total cost will vary.

Steps 3, 5, 8, and 9: Informing pregnant women about the benefits and management of breastfeeding is not inherently costly (step 3). However, creating the venues by which this information will be relayed can cost money. Prenatal classes are usually taught at night, possibly requiring the hire of an additional staff member. Additionally, distributing information pamphlets, posting posters, and buying educational videos may also incur a cost. Ensuring that health care providers in community clinics discuss breastfeeding during each prenatal care visit is a low cost method to ensure that patients learn about breastfeeding. Showing mothers how to breastfeed and maintain lactation, as well as encouraging unrestricted breastfeeding require the health care staff to spend more time with patients (steps 5 & 8). Although this extra care should be standard, in hospitals where this is not currently the routine practice, it may require additional staff time. Similarly, without the use of pacifiers, nurses may need to spend extra time with patients and babies to teach soothing techniques (step 9).

Steps 4 and 7: There is likely no economic cost of helping mothers initiate early skin-to-skin contact and allowing rooming-in, but there are likely many organizational barriers to changing long-standing practices. Delaying non-urgent care such as bathing and warming may be met with resistance since it makes organizational sense to do these practices immediately after the baby is born, when all the doctors and nurses are still on shift and are present. Similarly, since babies are no longer in one convenient nursery, rooming in may mean more work for the baby nurses. In such a case where the hospital rooms are not large enough to provide room for both baby and the mother, then rooming-in would indeed necessitate hefty construction costs.

Step 10: Establishing support groups may or may not cost additional money. If the support group can be scheduled during the day and lactation consultants have time to facilitate it, the cost will be low. However, if the support group is at night, or the lactation consultant(s) already have a full schedule, the hospital will likely have to pay someone to come in and teach it. Where community based support groups exist, i.e. in WIC programs, La Leche League, and Nursing Mother's Counsel, there will be no cost to the hospital to refer mothers to the support groups.

Other Costs:

After the hospital has implemented all of the Ten Steps, two assessors will come to the site to confirm eligibility. The one-time assessment fee is $3,000, plus travel, lodging and per diem for two assessors. Annual fees range from $550 – $900, depending on the size of the hospital and number of births.

In addition to the cost to the hospital, decision-makers may also want to consider the costs to their patients. Breastfeeding women need an additional 500 calories per day, requiring more food than they would normally consume. Additionally, many women will also purchase nursing bras, bra pads, and possibly a few items of nursing-wear clothes. If a nursing mother returns to the workforce fulltime, she will need to buy a good quality daily-use pump. A fee for a counseling session with a lactation consultant may also be considered.

Benefits

Breastfeeding provides nutritional, immunological and psychological benefits for both the infant and the mother, which also result in economic benefits to society (8, 9). Infant mortality in the United States is reduced by 21% in breastfed infants (10). Research has provided evidence that breast milk reduces diseases such as otitis media, gastroenteritis, bacterial meningitis, bacteremia, diarrhea, respiratory tract infection, necrotizing enterocolitis, and urinary tract infections (9). Psychological benefits include decreased abandonment rates (11) and possibly higher scores for cognitive development (12). Other benefits that have been studied but need more clarification include: reductions in asthma, obesity, diabetes and certain childhood cancers. Health benefits to the mother include: reduced hip fractures, reduced rates of ovarian and breast cancer, and faster return to pre-pregnancy weight (9). The economic benefits of these reduced diseases can be seen in the short term, as in otitis media, and the long term, as in obesity. Savings secondary to reduced diseases can be realized through reductions in medical expenditures such as reduced health insurance premiums and fewer Medicaid reimbursements.

Studies have proven that promoting breastfeeding is cost-effective for federal programs such as Women, Infants and Children (WIC) and Medicaid because it reduces the cost of formula purchases and health care expenditures (13-15). Riordan estimates that $225 million extra dollars is spent treating 50% of all respiratory syncytial virus cases that could have been avoided by breastfeeding (16). Additionally, Ball and Wright estimate that $331-$475 is spent on each non-breastfed infant in the first year of life for excess office visits, hospitalization, and prescriptions (17). An analysis conducted by the Economic Research Service estimated that $3.6 billion would be saved due to decreased costs for three diseases if breastfeeding rates increased to the Healthy People 2010 goal of 75% at initiation and 50% at six months (18).

In addition to savings from health benefits, not having to purchase formula will save each family about $830 per infant for the first 6 months. Breastfeeding will also save society money on infant formula production, advertisement, and disposal.

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Employers improve their bottom line because breastfeeding mothers are more productive at work than non-breastfeeding mothers since they require fewer days off to tend to their sick children (19). The economic benefits of emotional security and cognitive development have not been studied, but are likely also important.

Measuring the direct savings to the hospital as a result of an increased breastfeeding rate is difficult. Many of the benefits will not provide a direct cost savings to the hospital, but rather society at large. While hospitals and hospital clinics will see fewer incidences of diseases such as otitis media, lower respiratory infection and necrotizing enterocolitis, insurance reimbursement may prompt perverse incentives not to decrease incidence of disease. However, inadequate reimbursement, lack of health insurance, and excessive emergency room usage all make a higher breastfeeding rate seem appealing to hospitals. The BFHI will also bring quality improvement, good public relations, and prestige to the hospital (4).

Conclusions

Interdisciplinary breastfeeding teams will become more prevalent in hospitals as prenatal care policies are amended. Dietitians can be integral members of a breastfeeding team and can use the information presented here to consider the economic costs and benefits of the BFHI. Since there are no published cost-effectiveness analyses of the BFHI, it is difficult to know whether it is cost-effective to individual hospitals. However, it is quite likely that this type of intervention is cost effective from a societal perspective (20). The societal perspective examines everyone's costs and everyone's benefits: every hospital's cost to be Baby-Friendly and all of the resulting reduced disease rates nationwide. The societal perspective allows for a larger view of the BFHI and how it fits into the health care system. Hopefully, when administrators are deciding whether to invest in becoming "Baby-Friendly," they will also consider the societal effects that can result, and not simply the individual effects to the hospital.

While hospitals may not be willing to invest in such an intervention, the government should consider grants, subsidies, or instituting a national Baby-Friendly plan. Considering that the costs will likely decrease as breastfeeding becomes the standard feeding method, the nation can save precious health care dollars. Alternatively, policy makers may consider piloting the program in high-risk communities with low breastfeeding rates. This will likely be very cost-effective as these communities often have high rates of diseases that can be affected by breastfeeding, coupled with lack of health insurance and excess emergency room usage.

The decision to breastfeed is multi-faceted and includes influences from society, family and social support, and maternal employment. Medical and hospital practices also have a large effect on breastfeeding rates. Insufficient lactation education and encouragement, disruptive hospital policies and provision of free infant formula in the hospital undermine the decision to breastfeed (8). The BFHI is one way to positively affect women's decisions to breastfeed.

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our mission

"To be an expert resource for accurate and timely nutrition women's health, along with advocating for the improvement of nutrition across the lifespan."

MEMBERSHIP SURVEY REPORT

Jeanne Blankenship, MS RD *Chair, WHRN 2006-2007*

Section 1: WHRN Membership Survey

In the summer of 2006, members of the WHRN DPG were asked to complete an electronic member survey. At the time of the survey, there were approximately 700 members. The response rate of 257 members was therefore representative of over 30% of the membership. For purposes of this report, it was assumed that those who responded reflected the general characteristics of the membership. The demographics of the membership are shown in the following chart. The large percentage of new members (those who are members three years or less) challenges the DPG to meet the needs of newcomers while simultaneously supporting those members with longer membership histories.

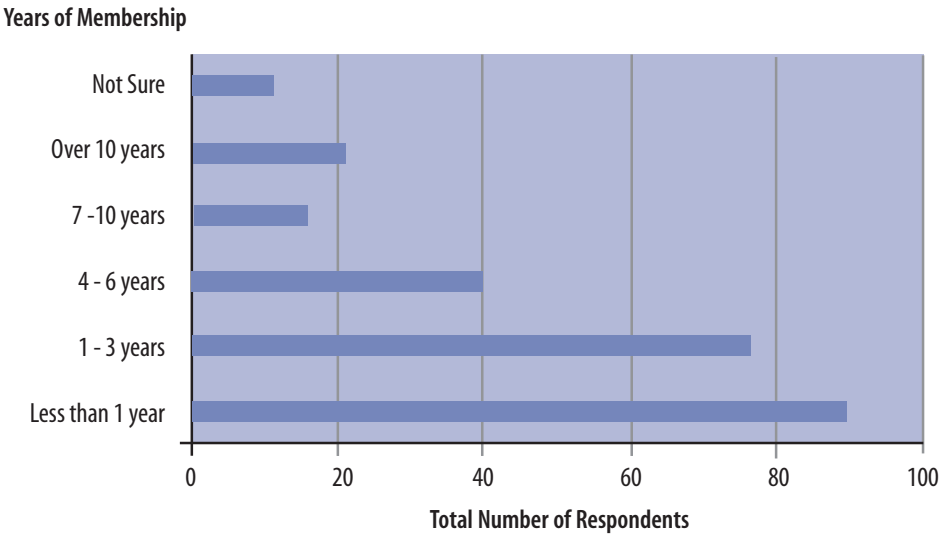
The majority of WHRN members are active members (92%) and 8% of members are students. Retired members make up a small percentage of the membership. Approximately 15% of those members who were new to this area of practice indicated an interest in being mentored. Another 9% were unsure. Interestingly, 20% of veteran members were willing to mentor those new to the field.

Members of WHRN are also active in other DPGs. The most common joint memberships included Diabetes Care and Education (26%), Pediatric Nutrition DPG (35%) and Weight Management DPG (19%). Many members noted that WHRN is the only DPG to which they belong. These individuals likely turn to WHRN for general information from ADA in addition to the specialty and practice-specific information provided by the DPG. For many, WHRN is their link to ADA and this should not be overlooked.

WHRN members work in a variety of settings, but 50% of the respondents work in clinical dietetics and community/public health practice areas.

Members of the DPG are likely to have advanced degrees and specialty certifications. Over 65% of members have a master's degree and almost 10% have doctoral degrees. Common specialty certifications include the Certified Lactation Educator (CLE) or Counselor (CLC). In addition, members also have certifications in diabetes education (CDE) and nutrition support (CNSD).

DEMOGRAPHICS OF DPG MEMBERSHIP



Benefits of Membership

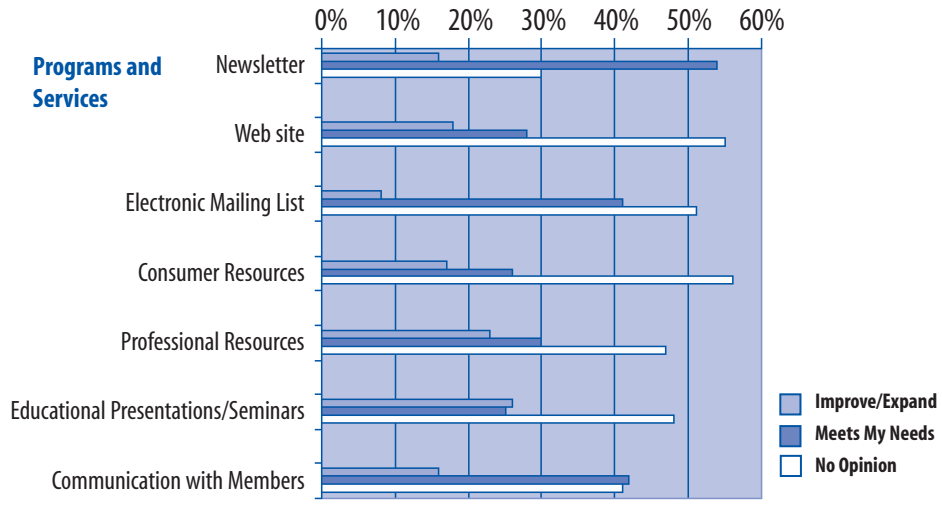
Members noted that the newsletter, networking and up-to-date research information were benefits of membership. Others noted that the DPG provides personal as well as professional enrichment.

Areas in Which Improvements are Needed

Members were asked to rate several services and programs offered by WHRN. The results are summarized below.

Is there a service or program that you think the WHRN DPG needs to improve or expand?

The fact that many of the respondents were new members likely influenced the results of the question.



Continued on page 8

MEMBERSHIP SURVEY REPORT Continued from page 7

Newsletter Preferences

One idea that has been suggested as a cost-savings measure is to offer one or more newsletters electronically. Since the newsletter is rated highly as a benefit of membership, changes to the distribution could potentially influence customer satisfaction and retention. Nearly 32% of respondents preferred an electronic copy or had no preference. This percentage is similar to those for hard copy and both hard and electronic copies.

Newsletter Sections

Members were asked which areas of practice are the most important to them professionally. The overwhelming majority of respondents stated that all three areas (breastfeeding/lactation, reproductive nutrition and women's health) were equally important.

Suggestions for Newsletter Topics

Members suggested many potential topics for the newsletter. These included specific areas in each category. It is clear that respondents want a variety of articles from each of the three topic areas. A broadened scope of articles including information on chronic diseases and nutrigenomics was requested.

What Members Want to Know

The following table summarizes the areas about which members would like more information. This section provides important information for DPG leaders regarding what to include in strategic planning objectives and goals.

What Members Want to Know

What is the mission and/or purpose statement?	32.1%	53
What are the strategic goals for the upcoming year?	53.3%	88
What are the volunteer opportunities within ADA?	29.1%	48
What are the benefits of membership?	59.4%	98

Other information respondents would like more information about include educational events and continuing education as well as the history of the DPG. Many members requested more information on the web site and many were not aware that a website existed.

Focus of the DPG for the Next Three to Five Years

Members expressed the need for the DPG to continue to lead dietitians in the area of women's health. Many expressed a growing need for research-based practice guidelines while others encouraged the DPG to provide cutting edge information

Section II: WHRN Exit Survey

Approximately 215 members dropped their membership from WHRN at the conclusion of the 2005-2006 fiscal year. These individuals were queried to determine why they discontinued their membership. Fifty-seven members responded for a response rate of nearly 27%. The top two reasons listed for discontinuing were a change in career or professional course (28.1% of respondents) and the cost (24.6% of respondents). Other reasons for discontinuation included unmet expectations, lack of professional value and lack of communication. Several comments were that the focus of the group was limited only to reproductive health, not to women's health. Cost was reiterated in the written comments, and a link to the total costs of ADA membership was noted.

Summary of WHRN Membership Report

The 2006 Membership Survey provided important information about the demographics and needs of the WHRN membership. The exit survey gives important information about why members leave the DPG. The information contained in this report will be useful in developing a strategic plan for the next few years. In addition, the ideas and suggestions of members regarding DPG activities can be used to improve the content of the newsletter and website. Finally, a list of members interested in volunteer positions was created from the survey providing an opportunity to expand the volunteer and leadership roles offered by the DPG.

have you received your newsletter?

If you are aware of any WHRN member who has not received their newsletter, please tell them to contact WHRN Secretary Egondu Onuoha, (see leadership contact information). They should provide their name, mailing address, ADA membership number, phone number and issue missing. We want all members to receive their newsletters!

To join the WHRN listserv send an email to:

WHRN_list-subscribe@yahoogroups.com

Join the WHRN Breastfeeding Taskforce! Send an email to:

WHRN_BF_Taskforce-subscribe@yahoogroups.com

BABY BOOMERS: Looking for ways to stop the clock

By: Heather Baden, MS, RD, CDN

Look younger, live longer. Aren't we all looking for ways to slow the aging process, and improve brain function? There are two web sites that profess to do just that. www.realage.com states they provide readers with information that will help them live longer, healthier lives. www.brainready.com intends to fight the natural decline aging has on brain function.

www.realage.com is best known for "The Real Age Test". The Real Age Test, a patented test, calculates your RealAge, the biological age of your body based on lifestyle, genetics, and medical history. Your RealAge is dependent on how well you take care of your body and may be higher or lower than your calendar age.

My RealAge Test: RealAge is calculated by assessing over 100 different health factors. These include facets of lifestyle, genetics, and medical history. The factors which trigger aging are counteracted by the things you are doing correctly, RealAge Benefits. The Benefits and Costs Chart provides a breakdown of what makes your RealAge younger or older. For example, a younger RealAge will be an effect of good quality cardiovascular level; appropriate intakes of fruits, vegetables, and grains; having a positive attitude; having a happy marriage; healthy resting heart rate; good omega-3 intake; ideal BMI; safety belt/ air bag usage; daily breakfast; etc. Costs, which will make the RealAge older, include low calcium intake; inappropriate workout schedule; low strength training level; too much sleep; lack of flexibility exercise; and poor flossing habits.

The RealAge Plan is an individualized plan based on the outcome of your RealAge test. It explains how to improve your RealAge. You are encouraged to select 1-3 action steps to carry out each week for the subsequent 12 weeks or 90 days. Following the time period changes should be updated on the RealAge test to receive a new calculation and plan.

The in-depth nutrition analysis is a detailed nutrition analysis with your current intake of a variety of components such as fiber, flavonoids, and cholesterol. It discusses which vitamins and minerals you are missing, what to eat to make your RealAge younger and provides a recommended calorie allowance for your height and weight. An action plan provides some ways to increase your intake of certain nutrients which may be lacking. A Nutrition Summary page provides a chart of your goals including vitamins and minerals, fats, fiber, flavonoids recommended intakes, and food sources.

Other tools include:

1. Tip of the Day - recent tips include "3 Tips for Better Plane Food"; and "Is a Migraine in Your Forecast?"

2. Wellness Centers - covers information on everything from Abrasions to Women's Health.

3. The Health Library - provides a medical encyclopedia of information.

4. Health Tests and Tools – there are 65 available including a skin damage predictor.

a. The RealAge® Skin Damage Projector is used to discover what happens to your skin when you smoke or do not use sunscreen. A photograph can be imported and morphed giving you the ability to visualize the damaging effects of smoking and the sun.

b. Other areas of testing include menopause, sleep, anxiety, and first aid.

The scientific advisory panel includes Dr. Michael Roizen and Dr. Mehmet C. Oz, co-authors of the New York Times #1 best-sellers YOU: The Smart Patient (2006) and YOU: The Owner's Manual (2005).

RealAge was awarded the Best Wellness Book of 1999 by the Books for a Better Life Awards

www.brainready.com claims to fight the effects that aging has on your brain and body. Since mental and physical decline begins in the twenties and affects work, abilities, skills, and overall quality of life it is important to start training the brain. BrainCasts, BrainFlex, Health Features, and the BrainReady store are a few of the available links.

BrainCasts offer visitors of the website downloadable audio brain training tools, as well as health articles which can be saved to an iPod, MP3 player, or CD.

BrainFlex provides quick workouts which are used to cross-train the brain. The BrainFlex workbook includes daily brain training worksheets which consist of visualization exercises, simple math and logic problems, creative projects, and memory challenges.

The Health Features section provides articles on topics such as "Avoid the Dreaded D"; and "The Top 5 Brain Health Foods". BrainReady has classified 5 specific health foods as top for the brain. The top 5 were determined based on "a variety of factors" ranging from overall proven health benefits (through multiple peer-reviewed, valid scientific studies from around the world over many years); experience of BrainReady staff; reports from consumers, proven safety, lack of contraindications; and general availability/ease of incorporation of foods. The top 5 foods mentioned include wild salmon, cacao beans, mencha (tencha-grade green tea powder), acai berries, blueberries, and coffee beans.

The BrainReady store offers consumers the ability to buy the brain exercise workbooks, along with several other products which are promoted throughout the web site. Some of these items include organic acai, dark chocolate, and anti-aging supplements. A few of the supplements include cinnamon caps, fish oil caps, green tea extract, and memory support capsules.

Columnist Commentary: Overall, the two web sites do contain some valid information. Realage.com does provide legitimate health advice, however, it should not be a substitute for seeing a healthcare professional such as a dietitian for proper nutrition guidance! Brainready.com did have interesting activities for brain stimulation; however, it would have been better to see a few links providing documented clinical research.

WHRN FNCE NEWS

WHRN Membership Reception, Honolulu, HI. Back row: Barbara Dubois, Krista Neal, Cathy Fagen, Laura Couillard, Jamillah Hoy-Rosas, Susan DuPraw (ADA Staff), Alyce Thomas (ADA PID). Front row: Ginger Carney (Breastfeeding Taskforce Member), Egondu Onuoha, Margarette Williamson, Jeanne Blankenship.

– It's seems like yesterday that we were in Philly. That was 2002 and my first FNCE experience. Here we are in 2007 once again infiltrating the city of cheese steaks. Can we make that low fat? It is always a pleasure to see those we meet throughout the years and the new faces in our group.

– Our Executive Committee and Committee Coordinators meeting will be held on Saturday, September 29, 2007 from 7am – 3pm.

– On Sunday September 30, 2007, 8:30am – 10:00am WHRN is pleased to announce we will be co-hosting with the Research DPG a Priority Session titled **Reproductive Obesity: Effects on Maternal and Child Outcome.** This session will be a level 3, 1.5 credits; Learning Needs Codes 4130 and possibly 4050, 4180. Speakers for this session are Janet C. King, PhD, RD, Senior Scientist and Professor at Children's Hospital Oakland Research Institute and Kathleen Rasmussen, ScD, RD, Professor in the Division of Nutritional Sciences at Cornell University.

– For our membership meeting, we have a change in our usual venue this year, instead of doing a reception on Sunday evening, we will have a Breakfast Membership Meeting on Monday, October 1, 2007 6:00 am till 7:45am. The meeting will be held in M591 at the Philadelphia Marriot. Start your day with WHRN!

– We would love to see you twice so also venture over to our booth at the DPG Showcase between 10:30 am – 1:00 pm.

– If you are interested in becoming involved in the Breast Feeding Task Force they will be meeting at FNCE 2007. It will be Sunday from 5:00 pm - 6:00 pm in M590 at the Philadelphia Marriot. An E-Vite of events will be sent to all members registered for FNCE closer to the conference dates.

Once again we will be involved with the Mother's Room at FNCE. This is a great place for breastfeeding mom's to nurse, pump and socialize in a relaxing atmosphere while still attending conference. Anyone interested in volunteering an hour or so of their time please contact Krista Neal: Krista.Neal@dshs.state.tx.us

Looking forward to seeing you all in Philly,
Laura Couillard, FNCE Coordinator 2007

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MEMBER SPOTLIGHT Interviews by Allison Starr

This year we have several members who have been a part of ADA for 50 years or more. We asked them questions about their professional lives. Here we feature two of those members (please note: due to their extensive experience and space constraints, we were only able to able to include part of their responses).

Pat Hennessey, MS, CLC, RD - Montana

What was your first job?
I started out immediately at St. Vincent's Hospital, Billings, MT, after completing my internship at Ancker Hospital, St. Paul in August, 1947. The job included teaching the student nurses, writing menus, instructing and counseling patients. When the cook didn't show up Sunday mornings, I would of necessity prepare the breakfast while frantically rounding up another cook. Breakfast I could handle, but no way was I doing the other meals.

What are your favorite tools and resources on women's health?
Without a doubt, Ellyn Satter's material. I continue to advocate, educate, promote, and push for her philosophy of feeding and nutrition in all our Montana health programs.

How have things changed since you started practicing? For example, how has your life as a dietitian and professional woman evolved through the years?
I have learned we have many, many public health problems in our community. I met and worked with the wonderful and dedicated professionals who were determined to solve those problems such as prematurity, anemia, bottle baby tooth decay, and domestic violence. Then there was the promotion of breastfeeding, improvement in the school lunch programs, and home visiting. We did improve the health of our community and it's interesting that even today, people stop us and tell us they remember bringing their kids to clinic and thank us for what we did for them.

During this time, I started the local WIC program. With a board across the drinking fountain that was attached to the wall, and a chair on either side, I signed up our first client, we agreed on her nutrition plan, issued our first WIC check and she immediately started to cry so loudly the whole office came to see what I'd done. She was crying because she'd be able to give her 7 children orange juice and seconds on milk, a first for them.

I worked with Mary Bates, MS,RD (deceased) to organize the Consultants in Long Term Care group.

We started Healthy Mothers, Healthy Babies, (HMHB) the Montana Coalition in the early 80s. When I retired, I proposed to HMHB that I have a project in the coalition called the Nutrition Resource Project. We had been on the verge of getting a bill passed in the legislature that would protect the rights of the mom to breastfeed and the baby's right to be breastfed when it got put on hold. Rounding up supporters statewide, we worked during the next two years and on October 1, 1999, SB #398 became law. For the last two years I've been part of another great team of individuals who've been working on SB89, a Breastfeeding in the Workplace bill. It was signed into law April 26, 2007.

What do your consider a highlight of your career?
The highlights of my career have to be the people I've met during these years. They are exceptional professionals who have taught and inspired me and have been my friends.

It's a great profession - the best. Do you know, I've never had to look for or apply for a job? Not in all these 60 years. And it's still fun.

Judith Roepke, RD, PhD - Indiana

Where have you worked?
I started at Northwestern Hospital in Minneapolis, and then worked in Alexandria, Virginia for a couple of years before moving to Texas and doing Public Health work at the Austin Travis County Health department. That experience has carried throughout the rest of my career in one form or another. Then we moved to Indiana where I have remained and started teaching at Ball State University. I held some administrative positions and eventually was Dean of Continuing Education and faculty member at Ball State University, prior to retirement in 2000. I am now Dean Emerita, School of Continuing Education and Public Service, and Professor of Family and Consumer Sciences, Ball State University.

What are your favorite tools and resources on women's health?
I use professional journals such as American Journal of Clinical Nutrition, Journal of the American Dietetic Association, Journal of the American Medical Association, Journal of Pediatrics and Pediatrics extensively in addition to other journals as needed.

How have things changed since you started practicing? For example, how has your life as a dietitian and professional woman evolved through the years?
I have seen our profession become more professional as we have used evidence based practice to a great extent. In addition I have seen dietitians/nutritionists making more decisions about course of treatment. For a number of years I have been concerned about the conflict of interest I see in ADA and impressed by the effort physicians are making to address this professionally. Dietitians in WHRN are very careful about this but we need to expect ADA to do much more monitoring in this area- in the Journal, in conferences and exhibits and in day to day operations.

What do your consider a highlight of your career?
My years as a teaching professor working with Dietetic Students and work in Public Health.

What are your recommendations for WHRN DPG?
Continue to try to stem the tide of conflict of interest especially the pressure from food manufacturers that have much to gain from our work. And Bravo for all that has been accomplished.

GOALS OF THE WHRN PRACTICE GROUP

WHRN DPG promotes the development of dietetics professionals in the specialty area of nutritional care in women's health which includes preconception through pregnancy and lactation and expanded to late menopause.

The objectives of the Women's Health and Reproductive Nutrition DPG are:

- **To promote nutrition and dietetics as an area of practice in the field of women's health .**
- **To provide technical input to ADA concerning the role of nutrition throughout a woman's lifespan.**
- **To promote increased understanding of perinatal nutrition issues, both normal nutrition, and high-risk management, within the dietetics profession.**
- **To encourage and stimulate research in the area of women's health and perinatal nutrition.**
- **To provide leadership in the specialty area of maternal nutrition needs during pregnancy and lactation. To serve as a resource to the public and professionals providing health care for women.**
- **To provide the ADA membership with a forum and network for exchange of information, issues, and concerns in women's health. The Food & Nutrition Conference & Expo sessions and a quarterly publica tion are current methods for communication.**
- **To produce educational materials and standards of care to address both normal nutrition and high-risk conditions requiring medical nutrition therapy dur ing preconception, pregnancy, lactation, and through menopause.**
- **To develop networks with allied health professionals and organizations concerned with the care of women in their reproductive, perimenopausal and menopausal years.**

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Women's Health and Reproductive Nutrition

A Dietetic Practice Group of
The American Dietetic Association
Your Link to Nutrition and Health℠