

BHN Newsletter

BHN: Fuel Your Brain, Feel Your Best!

Failure to Thrive

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Failure to thrive (FTT) is a poorly defined descriptive term generally applied to children under 3 years of age who have an abnormally low weight-for-age. Until this past decade, FTT was thought of as either organic or non-organic. *Organic* meant that there was a medical reason for the child to fail to gain appropriate weight and/or follow standard growth chart percentiles. *Non-organic* or *psychosocial* FTT meant that the child failed to gain weight with no identifiable medical condition. Often, non-organic FTT was seen as a result of environmental factors or social or economic barriers.

The definition of FTT is widely debated, and currently there is no single definition for this multifaceted condition. In developed countries, malnutrition in young children is usually described as FTT. Traditionally, growth charts have been the hallmark of determining whether a child has FTT. Common working definitions for FTT include: weight less than 75% of the median weight-for-age (Gomez Criteria), weight-for-length less than 80% of the median (Waterlow Criteria), body mass index (BMI)-for-age less than the 5th percentile, weight-for-age less than the 5th percentile, length-for-age less than the 5th percentile, or successive weights that decelerate by two or more major percentile lines (1). Some definitions include serial weight-for-age plotting below the 3rd percentile. Others focus on growth velocity or a failure to gain weight at a rate that meets established standards (2). Table 1 highlights practical definitions of FTT.

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Table 1: Suggested practical definition of failure to thrive

- Weight-for-length < 3rd percentile (CDC growth chart) or 2nd percentile (WHO growth chart)
- BMI-for-age < 5th percentile
- Poor or no weight gain over a period of time that varies according to the age of the child. In general, the younger the child, the shorter the interval in which there is little or no weight gain (children younger than 3-6 months – 1-2 weekly intervals; children >6 months – monthly intervals).
- Significant downtrend in weight percentiles
 - Additional considerations:
 - Assessment of parental size/growth
 - Correction for prematurity (where applicable)



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From the Past Chair

Sharon Lemons, MS, RDN, CSP, LD, FAND



Leadership may come naturally to some people, but in my case that was not true. I learned my leadership skills by making myself available to help with any activity my sons would have the opportunity to participate. It was important to me that those activities go well for my sons. At some point, I started participating in leadership trainings to improve my skills through the Boy Scouts of America. It really doesn't matter what organization you participate in as leader. What matters is that leadership skills only improve with use just like muscles only get stronger with use. Like most people, I learned many important aspects about leadership simply by being a leader and constantly looking for ways to improve my skills. There are a couple very important principles I want to share with you today.

First, you get out of an organization what you put into it. This year the Academy of Nutrition and Dietetics has had some moments that were nothing short of challenging. As an individual member, I felt much better about the process the Academy took to communicate with their leaders because I participated in the process. While my opinion doesn't carry any more weight than the rest of you, it is important. It is important to me that they listened and responded. As your Chair, I was glad Behavioral Health Nutrition could provide all of you an outlet to have your opinions heard. Our House of Delegates Representative, Harriet Cloud, MS, RD, FAND did an excellent job of conveying your opinions to the Academy. Behavioral Health Nutrition came out in force to participate in the process. I could not have been more proud to have been the Chair of this marvelous group at this point. I encourage all of you to keep finding ways to participate in the Academy.

Second, the best way to make sure the positive influence you have provided in an organization continues, is to make the leaders that follow you look like rock stars. This is a practice that keeps the momentum of positive programs and benefits moving forward in a positive direction. I shared my resolve to do this with the Executive Committee as we met for our transition meeting in 2014. I have never had an easier job helping the future leaders of an organization look good! In the case of your new chair, Adrien Paczosa, RD, LD, CEDRD, she already is a rock star. Adrien has an enormous passion for everything related to Behavioral Health Nutrition. I eagerly await her positive influence on this organization. Some of the activities she already has planned for the members of BHN at the Food and Nutrition Conference and Expo™ (FNCE®) will be amazing. She is a wealth of information on both eating disorders and addictions. She promotes knowledge and understanding of all behavioral health issues. The one thing I want you to know about Adrien and the incoming Executive Committee is, these are some of the best dietitians and best leaders in the dietetics community. Please do everything you can to support Adrien and the rest of the Behavioral Health Nutrition Executive Committee as we continue to be your voice with the Academy of Nutrition and Dietetics.

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Before I go, I would like to thank our wonderful sponsors for their contributions, helping BHN to continue to network, grow and learn. Thank you Trovita Health Science for sponsoring lunch and the Eating Recovery Center for sponsoring dinner for our Executive Committee during the transition meeting. Additionally, thank you Trovita Health Science and Fresnius Kabi for sponsoring our upcoming member reception at FNCE®. We hope to see you there!

Lastly, I want to thank all of you once again for the opportunity to represent you this year. It has been an enormous pleasure. I have continued to learn about our profession while serving as your Chair and I count that as one of those blessings that comes from being involved in an organization. When I learn something new I have a tendency to get quiet and just take it in. I hope all of you heard me audibly catching my breath this year as the new knowledge nearly took my breath away! While I have been listening to the dietitians from our four practice areas for many years now, listening to everyone in such a way as to ensure all their points of view are represented as Behavioral Health Nutrition goes forward has made me see how much more all four practice areas are interconnected than I realized. As the saying goes, life is not measured by the number of breaths we take, but by the number of moments that take our breath away. Serving as your Chair has taken my breath away. Thank you once again.

In Good Health!

Sharon Lemons, MS, RDN,
CSP, LD, FAND

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Failure to thrive versus other medical conditions

Malnutrition is defined as any disorder of nutrition status resulting from a deficiency of nutrient intake, impaired nutrient metabolism, or overnutrition (3). Undernutrition, or inadequate energy intake (4), is thought to be the underlying cause of the majority of cases of FTT (5).

There are many conditions that at first sight present as FTT; however, upon further assessment, these conditions are revealed as normal variants of growth. These variants can be classified into four main categories: genetic short stature, constitutional delay in growth, prematurity, and postnatal catch-down growth (6). Children of parents with short stature may be small at birth and continue to be small throughout childhood. Children with constitutional growth delay present with deceleration in length- or height-for-age and perhaps an initial fall in weight-for-age percentiles; however, these children will usually maintain weight along percentile curves. Growth parameters for premature infants should be plotted using adjusted or corrected age, and when corrected will follow percentile curves and may even show catch-up growth. Lastly, catch-down growth occurs when an infant is born larger than expected at birth and will have an initial fall in percentiles and then follow percentile curves (6).

Incidence

The incidence of FTT can be difficult to identify as children can be classified as FTT based on different definitions. The Copenhagen County Cohort 2000 monitored the growth of over 6000 children using seven of the commonly used anthropometric criteria to identify FTT (1). The seven criteria were weight <75% of median weight-for-age, weight <80% of median weight-for-length, BMI-for age <5th percentile, weight-for-age <5th percentile, length-for-age <5th percentile, weight deceleration (crossing more than two major percentile lines) from birth until present age, and a final criterion for conditional weight

gain using a method described in detail by the paper (1). FTT was identified in 0.5 to 5.0% of children depending on which criteria were used (1). The study further found that for infants aged 2-6 months the incidence was 14.7% and for older infants (6-11 months) the incidence was 20.6% percent. Interestingly, none of the children identified with FTT met all seven criteria, and the majority met only one.

Outcomes

Data from developing countries clearly show that severe, prolonged malnutrition can negatively impact a child's future growth and cognition (6,7). The data from children with FTT are less clear and have been extrapolated from the children with severe malnutrition. In individual studies, young children who had FTT followed for up to 8 years had measurable IQ deficits and learning and behavioral difficulties (8-10). However, two meta-analyses came up with differing conclusions. The first, done in 2004, suggested that FTT in infants may result in long-term problems in cognitive development with a 4.2 IQ point decrement associated with FTT (11). A 2005 meta-analysis found that FTT was associated with a three-point deficit in IQ and the authors concluded the difference was not clinically significant (12). This study did also report that early onset FTT was associated with some persistent reduction in weight and height later in childhood. However, the IQ data need to be compared with the fact that prenatal cocaine exposure is associated with an average reduction of 3.26 IQ points (13), and bottle feeding (when compared with breastfeeding) in term infants is associated with a reduction of 2.66 IQ points (14). These comparisons seem to suggest that FTT is associated with a clinically significant reduction in IQ.

Although data suggest that many children with FTT in early life eventually seem to have normal cognitive function, the trend for an individual child is worrisome. Some children with FTT will have persistent issues with cognition, and it is impossible to predict which of these children will have future problems. Despite the fact that there are no

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data that suggest that early treatment of FTT is beneficial, it seems prudent to intervene and potentially decrease growth retardation and at least marginally improve IQ.

Growth charts

Growth charts are a universally used tool to assess the growth of children, and there are many different growth charts available that are based on different populations or which are disease-specific. Understanding the source of a particular growth chart is critical to its proper use. An example can be found with the 2000 Centers for Disease Control (CDC) growth charts (15). The CDC growth charts (0-36 months) were based on a U.S. population of mainly formula-fed Caucasian infants. The CDC charts also serve as reference charts that describe how well those particular infants grew at a particular point in time. By comparison, the growth charts developed by the World Health Organization (WHO) are based on a more diverse (both racially and geographically) infant population and serve as growth standards for how infants should grow given optimal environmental and health conditions (16). The updated recommendations on the use of growth charts are shown in Table 2.

Etiology

Three basic mechanisms underlie FTT: 1) inadequate caloric intake, 2) loss of energy, and 3) increased metabolic requirements. While there are numerous specific etiologies that can lead to FTT, FTT most commonly results from insufficient caloric intake due to either lack of food or feeding and/or behavioral problems which limit a child's intake. The major diagnoses associated with FTT are delineated in Table 3.

Further exploration of inadequate energy intake is important since malabsorption and increased metabolic demand are less common causes of undernutrition. Much of the medical and nutritional treatment will need to be tailored to those specific barriers in order to treat FTT. Many of the major causes of poor oral intake in infants

Table 2: Guidelines on the appropriate use of growth charts (16)

Use WHO growth standard for all children <24 months, regardless of type of feeding
On the WHO growth charts use the 2nd and 98th percentiles to identify children with "abnormal" growth
Use CDC growth charts for children aged 24 months and older
Notes: <ul style="list-style-type: none"> • Fewer U.S. children will be identified as underweight using the WHO charts, and this is appropriate. • Slower growth among breastfed infants during ages 3-18 months is normal. • Gaining weight more rapidly than is indicated on the WHO charts might signal early signs of overweight.

Table 3: Major etiologies of failure to thrive

<p>Inadequate caloric intake</p> <ul style="list-style-type: none"> Error in formula preparation (too dilute) Poor diet (e.g., excessive juice intake) Grazing (eating or drinking in between meals/snacks) feeding behavior Behavioral problems affecting food consumption (feeding refusal) Mechanical feeding difficulties Food insecurity/poverty Poor child-parent relationship Neglect
<p>Insufficient absorption/utilization of consumed energy or excessive energy losses</p> <ul style="list-style-type: none"> Cystic fibrosis Celiac disease Liver disease Chromosomal abnormalities and genetic diseases Metabolic disorders Persistent vomiting Protein-losing enteropathy
<p>Increased metabolic requirements</p> <ul style="list-style-type: none"> Chronic lung disease or congenital heart disease Hyperthyroidism Renal disease Chronic infection Malignancy Hyperactivity

and children with FTT can be addressed through nutritional interventions. Food insecurity can play a major role in inadequate energy intake when a child does not have access to enough food and/or food quality is poor. Parental knowledge deficit related to proper infant or child feeding can also be a contributing factor. An infant will not be able to consume enough energy if s/he has difficulty with breastfeeding or bottle feeding, is being given diluted formula, or if his or her hunger and satiety cues are misinterpreted (2). Older children who are allowed to graze (eat and/or drink) between feedings, take excessive amounts of juice, or have a poor transition to high-calorie table foods may not be taking in enough calories. Maternal mental health is sometimes overlooked, but it is a critical factor to consider

when evaluating the infant with FTT. A mother experiencing post-partum depression or isolation may not be able to form a strong bond with her infant leading to inadequate energy intake in the child. Similarly, a mother who is experiencing increased amounts of anxiety and concern over her child's weight may inadvertently communicate those feelings, thus leading to overall poor intake.

Children with developmental, sensory, or motor delays may lack the necessary skills to take in a sufficient amount of calories. Infants with prolonged hospital stays (particularly in the neonatal intensive care unit) and those who required any variety of medical interventions such as intubation or

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oro-/nasogastric feeding tubes may associate feeding with pain or discomfort and may refuse oral feeds. Lack of suck swallow coordination can also interfere with intake. Decreased oral motor skills may present by a child who turns his head away at feeding time, pockets or throws food, has tantrums at feeding time, or simply refuses to eat. Lastly, infants and children can be hypersensitive to smells, textures, and tastes of foods. Collaboration with other health care providers such as speech-language pathologists, occupational therapists, social workers, and early intervention program staff is critical to assisting this sub-group of the FTT population with inadequate intake.

A small proportion of children with FTT have difficulties with energy losses, and this is commonly associated with malabsorption and other gastrointestinal disorders such as cystic fibrosis,

celiac disease, and food-protein allergy or intolerance. While most of these disorders present with either vomiting or diarrhea or both, rarely does the presentation lack either of these symptoms. In this case, a history of more-than-adequate energy intake concurrent with poor growth is seen. Increased metabolic demand is typically tied with increased cardiorespiratory workload but can also be associated with conditions such as hyperthyroidism or chronic disease.

A variety of maternal-child interaction issues can be associated with FTT (17). One common problem can be seen when a child refuses to eat. Some anxious mothers may try to forcefully feed their children. This action leads to more resistance and becomes a persistent cycle (18). In many instances this vicious cycle can be broken by stopping force feeding and placing the child on a structured meal and snack regimen and limiting any feeds or calorie-containing beverages between these times. However, in some cases the help of a behavioral psychologist may be needed to break this cycle. True neglect of a child or infant certainly can be a cause of undernutrition; however, research has shown that this constitutes a very small percentage of the FTT population (2).

Evaluation

A thorough patient history, physical examination, and review of both past and present growth data are the first steps in the evaluation of FTT (Table 4). A detailed dietary history is vital and should always include a 24-hour dietary recall (19). When possible, this should be supplemented with a 3-day food record and observation of feeding. Global assessment of parent-child interactions should also be completed. The child's anthropometric data should be plotted on the appropriate growth chart and compared to prior data obtained by the primary medical provider. A registered dietitian (RD) can assist in the physical examination by obtaining a general sense of muscle wasting and looking for presence or absence of subcutaneous fat. In general measurements of skinfold thickness and mid-arm muscle circumference are not necessary in uncomplicated FTT. These measurements may be useful in circumstances where the

weight and/or height may be unreliable, such as a situation in which a child is wearing an orthopedic cast or has had an amputation. In most children with uncomplicated FTT, laboratory tests are not typically needed.

Management

Management of FTT involves increasing energy intake, settling feeding difficulties, and strengthening positive feeding interactions between parent and child.

FTT is largely managed by nutritional intervention; the ultimate goal is to increase the energy intake of the child to enable catch-up growth. When FTT is secondary to another medical condition, management of the primary condition is required in addition to nutritional intervention. The basic principles of nutritional intervention include meals and snacks that are structured approximately three hours apart, provision of energy-dense foods (with or without a high calorie beverage), limitation of juice consumption, and promoting structured mealtime behaviors (18). These are addressed in greater detail in Table 5.

In children for whom feeding difficulties are identified by history, assessment by an occupational therapist or speech-language pathologist can lead to additional strategies to improve oral motor development and feeding skills. An interdisciplinary team (pediatric gastroenterologist, registered nurse, behavioral psychologist, RD, speech-language pathologist and/or occupational therapist) may be helpful in improving oral intake in the child with continued behavioral feeding refusal.

In general, with nutrition intervention, FTT starts resolving quickly. The length of time before follow-up is usually decided based on the severity of the FTT. In children with mild FTT, follow-up can simply be a few weight checks before discharge from the clinic. Children who continue to have FTT should be referred to either a pediatric gastroenterologist or a multidisciplinary FTT clinic. In children with severe or persistent FTT closer follow-up is essential.

It is best practice where adequate oral nutrition is not achievable despite

Table 4: Assessment of the child with failure to thrive

- Nutrition Assessment
 - Growth Charts
 - Anthropometric measurements
 - Weight- and length-for-age, weight-for-length, head circumference-for-age, and/or BMI history
 - Percentage of ideal body weight
 - Diet History
 - 24-hour recall and/or 3-day food diary
 - Feeding behavior and environment
 - Medical History:
 - Gastrointestinal symptoms including diarrhea, constipation, and vomiting
 - Other medical conditions
 - Allergies
 - Birth history including intrauterine growth retardation and prematurity
 - Small-for-gestational age is a birth weight $\leq 10^{\text{th}}$ percentile for gestational age and sex
 - Family history
 - Social history
- Common Red Flags
 - Beverage intake: excessive juice and or milk
 - Feeding environment:
 - Grazing
 - Lack of structure
 - Disruptive mealtime behaviors

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4-6 weeks of outpatient intervention, especially in children with significant developmental delays, that supplemental nasogastric tube feeding be considered. A variety of other factors may also determine whether nasogastric tube feeding should be undertaken. These include severity of malnutrition and other medical problems – both mechanical, such as significant swallowing difficulties, and comorbid conditions such as cardiorespiratory disease – all of which may hasten the decision to feed a child via nasogastric tube. Where prolonged tube feeding (>2 months) is anticipated or necessary, a more permanent enteral tube placement, such as a gastrostomy tube, may be indicated.

Conclusions

Proper nutrition is crucial to the growing child, and the evaluation of FTT requires prompt attention. Adequate nutrition is especially important during the first three years of life, as this is the period during which there is maximal brain development accompanied by exponential development of cognitive processes. FTT in this period may carry the risk of a negative impact on cognitive development. More importantly, cognitive recovery in children with FTT appears to mirror their nutritional recovery; this emphasizes the need for the effective nutritional interventions for these children.

Case study

A 15-month-old girl presents with poor weight gain. She was breastfed through 13 months of age and then transitioned to whole milk. She does not ever seem hungry. She loves her sippy cup which is filled with whole milk – “never puts it down” per caregiver report. Weight gain has been poor, and her weight-for-age and weight-for-length have fallen below the 3rd percentile over the past 3 to 4 months. Dietary history reveals that she drinks 30 oz whole milk per day and “grazes” on crackers and pretzels throughout the day. She only takes bites of solid foods at meals most

Table 5: Initial interventions in a child with failure to thrive

- Establish meal time routine
 - Consistently offer meals and snacks, approximately every 3 hours.
 - Ideally, all meals and snacks should be offered in a high chair/at the table.
 - Minimize distractions.
 - Avoid force feeding.
 - Eliminate grazing between meals and snacks; only offer water between meals and snacks.
- Curtail beverages and other low-energy-dense foods
 - Eliminate juice and sweetened beverages.
 - Recommend appropriate milk intake for age.
 - With a family who follows a low-fat diet for their child, education should be provided so that the child can be provided higher-calorie foods and foods that contain adequate fat.
- High-calorie diet
 - Use the family's regular meals but add fats only to foods presented to the child. This allows family to eat the same meal but provides the child (but not the rest of the family) with additional calories.
 - Do not add or transition to higher-calorie, less nutrient-dense foods (i.e., chips, candy).
 - High-calorie beverages
 - Explore ways to increase calorie content of breast milk. A lactation consultant may suggest ways to do this without cessation of breastfeeding or addition of powdered infant formula.
 - Consider using a 30 kcal/oz pediatric formula or adding calories to whole milk by using supplements.

likely due to feeling full from “grazing” throughout the day on snacks and milk.

This child is clearly failing to thrive given that there has been poor weight gain and her weight-for-length is now below the 3rd percentile. The RD obtained a 24-hour dietary recall and confirmed that this child is not consuming adequate energy to grow appropriately by comparing estimated intake to estimated energy needs for age. The RD estimates that she is consuming around 670 kcals per day, and of this 600 kcals are from milk. The RD estimates that this child needs at least 850 kcals per day in order to achieve catch-up weight gain. A variety of changes are recommended and put in place. The first step will be to structure meals and snacks that are approximately three hours apart and offer only water between meal and snack times. She may benefit from high calorie foods and a high-calorie beverage, either a 30 kcal/oz commercial formula or addition of a supplement to whole milk to equal 30 kcal/oz. The amount of milk that she is taking can be reduced by offering it towards the end of the meal and in limited quantities (about 4 oz, four times/day). She may be anemic due to the excessive intake of milk and related poor iron absorption. A complete blood

count should be obtained, and she should be started on supplemental iron, if indicated. Consideration should also be given to starting her on a complete multivitamin if other fortified supplements are not given.

Most children who present in this fashion respond to these interventions. If she does not increase solid food intake despite a decrease in calories from milk and structured meals and snacks, additional interventions such as a speech/feeding evaluation or referral to an interdisciplinary feeding team or gastroenterologist may need to be considered.

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CPE credit (1.0 hour) is available from BHN for the full text version of the article, Failure to Thrive.

Access the article at

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CPE Questions for Failure to Thrive

Select one correct answer for each question.

1. Management of failure to thrive
 - a. Encourages a child to graze throughout the day
 - b. Encourages the use of fruit juice as a high calorie supplement
 - c. Includes increasing energy intake and strengthening positive feeding interactions between parent and child
 - d. Is mostly medical management rather than a feeding issue
2. Nutrition assessment of a child with failure to thrive should always include
 - a. CBC
 - b. Detailed diet history
 - c. Evaluation of anthropometric data on both the CDC and WHO growth-charts
 - d. Measurement of triceps skinfold and mid arm muscle circumference
3. The underlying cause in the majority of cases of failure to thrive results from
 - a. Developmental disabilities
 - b. Inadequate energy intake
 - c. Parental knowledge deficit
 - d. Premature birth
4. Which growth chart should be used to diagnose failure to thrive?
 - a. CDC growth chart for all children regardless of age
 - b. CDC growth chart for children less than 24 months of age
 - c. WHO growth standard for all children less than 24 months regardless of type of feeding
 - d. WHO growth standard for solely breastfeed infants for the first 12 months of life
5. During initial high calorie diet interventions, which of the following would usually be recommended?
 - a. Add additional fats to food presented to the child
 - b. Discontinue breastfeeding
 - c. Low-fat milk
 - d. Using behavioral strategies such as distraction to ensure the child eats



Ruth Leyse-Wallace,
PhD, RD

The MIND diet is a combination of the DASH (Dietary Approaches to Stop Hypertension) and Mediterranean diets, which have been found to reduce the risk of cardiovascular disease: hypertension, heart attack and stroke. The MIND diet was developed from past studies of these and other diets, while paying particular attention to foods and nutrients that have supportive effects on brain function, with an emphasis on vegetables, berries, fish, healthy fats, nuts.

People with high adherence to the DASH and Mediterranean diets have reductions in Alzheimer's Disease (AD) – 39 percent with the DASH diet and 54 percent with the Mediterranean diet – but received negligible benefits from moderate adherence to either of the two diets. The MIND diet lowered the risk of AD by as much as 53 percent in participants who adhered to the diet rigorously, and by about 35 percent in those who followed it moderately well.

The study included 923 participants,

The MIND Diet Overview

Ruth Leyse-Wallace, PhD, RD

MIND = Mediterranean-DASH Intervention for Neurodegenerative Delay

MIND Diet Components

- Whole grains: ≥ 3 servings/day
- Green Leafy Vegetables: ≥ 6 servings/week
- Other vegetables: ≥ 1 serving/day
- Berries: ≥ 2 servings/week
- Red meat: ≤ 4 servings/week
- Fish ≥ 1 serving/week
- Poultry: ≥ 2 servings/week
- Beans: >3 servings/week
- Nuts: ≥ 5 servings/week
- Fast/Fried food: <1 serving/week
- Olive oil – use as primary oil
- Butter, stick margarine: <1 T/day
- Cheese: <1 serving/week
- Pastries, Sweets: <5 servings/week
- Alcohol/wine: 1 serving/day

ages 58 to 98 years, who were followed on average 4.5 years. Diets were assessed by a semi-quantitative food frequency questionnaire. The MIND diet was not an intervention, but derived from reports by participants of their eating habits for the past year. Analysis indicated no association between the diet effects and age, sex, education, physical activity, obesity, low BMI, or history of stroke, diabetes or hypertension.

The MIND diet includes 15 dietary components: 10 “brain-healthy food groups,” which includes green leafy vegetables, other vegetables; nuts, berries, beans, whole grains, fish, poultry, olive oil, wine and five unhealthy groups comprised of: red meats, butter and stick margarine,

cheese, pastries and sweets, and fried or fast food. It includes \geq three servings of whole grains per day, ≥ 6 green leafy vegetables/ week, $>$ one other vegetable every day, 1 serving wine/day. It also involves snacking most days on nuts, eating beans 3 times a week, poultry and berries at least twice a week, and eating fish at least once a week.

Participants limited intake of designated unhealthy foods, especially butter (less than 1 tablespoon a day), cheese, and fried or fast food (less than a serving a week for any of the three). In contrast to the DASH and Mediterranean diet, berries are the only fruit specifically included in the MIND diet. Dairy foods were not specified in the MIND diet as they were in the DASH diet.



BHN Member Spotlight!

Renée Hoffinger, MHSE, RD

Greetings, BHN members, from your new/old Addictions Resource Professional! My name is Renée

Hoffinger, MHSE, RD. I recently retired after 20 years as the dietitian on the Substance Abuse Treatment Team at the North Florida/South Georgia Veteran Health System in Gainesville, FL. During that time I learned as much as I could about substance abuse, substance abusers, and the importance of nutrition in recovery, and I'm sure there is still much more to learn. We incorporated hands-on nutrition education into the nutrition education program, to enhance our residents' understanding and practical application skills of diet in recovery. It was great fun and extremely rewarding. “The Recovery Diet” (Adams Media, 2012) essentially concretized in book form the core concepts of diet in recovery: eating well to replenish nutrients and reverse damage, managing moods, and diet as part of a healthy lifestyle. I'm

currently working on a manual about how to set up your own hands-on nutrition education program, hopefully to be published next year by The Academy.

An interesting twist in the business of diet and addiction is that almost all RDNs, whether they think they are or not, are indeed working in the field. An RDN may be working with diabetics, surgical patients, HIV/AIDS, weight management, other mental health disorders, etc., but with millions of Americans either actively using or in recovery, she or he is very likely to, unknowingly, be working in the field of addictions as well. This highlights the importance of the expertise of RDNs in the addictions field. Our mission is not only to help our patients navigate their way to recovery with the benefit of sound nutrition, but to help our fellow RDNs navigate their way in the world of addictions. I encourage you to reach out in your workplace, local dietetic associations, and other DPGs to share your expertise on diet and insights for effective counseling strategies in working with substance.

I would love to hear from you. What are your concerns? How would you like to get involved? Interested in writing an article for the BHN newsletter?

Questions? Ideas? Feel free to contact me at reneehoffinger@gmail.com



Carol Bradley, PhD,
RDN, LD, BCBA

Policy and Advocacy Leader (PAL) Legislative Update

Carol Bradley, PhD, RDN, LD, BCBA • BHN PAL
Past president, Texas Academy of Nutrition and Dietetics

Make Your Voice Heard!

The Academy's Public Policy Workshop (PPW) 2015, held June 6th-9th in Washington, DC, was exciting! While there, we were reminded by Academy President, Dr. Evelyn Crayton, EdD, RDN, LDN, to make our voices heard by those who represent us in office. After all, whether we voted for them or not, they work for us, their constituents. For the most part, they want to please us so they can be re-elected.

Are you an advocate of your profession? We also learned that advocacy is the act of supporting a cause or issue; lobbying is an attempt to influence public officials to secure passage of specific legislation.

What can you do to advocate for your profession, your livelihood?

You can begin by attending events you know Legislators will be at. Introduce yourself as a Registered Dietitian Nutritionist (RDN) and thank them for their service (whether you agree with them politically or not). Offer your card and let them know you are available to answer questions or provide information for any nutrition issues that arise.

Be sure to invite them to speak at a district or state meeting. If they can't come, invite them again. Legislators are real people just like you and they love to tell about themselves. (It helps to know what they are passionate about when you approach them for your request regarding a particular piece of legislation). Those who represent you need to know:

- Who we are
- What we have done
- What we will do
- What we want (The Ask)

We need to brag on ourselves and the great work we do. No one else will do it for us!

Visit them in office. Know what the important issues are. Check with your state public policy committee to be sure we have a unified voice. There is strength in numbers.

When making appointments be sure to:

- Ask for the scheduler and then the staffer assigned to healthcare issues.
- Staffers are important – it is their job to research the details.
- Be persistent! Ask for even 5 minutes.
- Know the committees of those who represent you – a good starting point for openers.
- Respect their time. Be early. Be brief and to the point.
 - Offer a solution – not just problem – let them know how they can help.
 - Bring numbers (stats) that affect your state – what impact will it have? (It's okay to use a small cheat sheet for facts/figures).
 - A story is even better! It may really touch their hearts.
- End with "Can we count on you for support?"

Take their card(s) and thank them by email that day or the next; repeat on Sunday afternoon when they are catching up on emails and remind them of your "ask."

It has been said, "Things come to those who wait, but only things left by those who hustle." Let's not get left behind when it comes to important nutrition issues that affect the health of Americans. The mantra at PPW 2014 and 2015 was "If dietetics is your profession, policy SHOULD be your passion."

The Academy's Big Three issues right now are:

- Older Americans Act
- Treat and Reduce Obesity Act
- Preventing Diabetes in Medicare Act

To find out more, visit: <http://www.eatrightpro.org/resources/advocacy/take-action/bills-and-laws>

Do you love your job or feel underpaid? What are YOU doing to advocate for your profession?

In the BHN Pipeline!

Mark your calendars and pack your bags for THE Events of the YEAR!

BHN DPG in collaboration with the Academy presents the Pre-FNCE Workshop, *Brain Data and Dogma: expanding MNT to increase fiscal reimbursement!* This fabulous workshop will be held on **October 3, 2015 in Nashville, TN from 11:30 am - 3:30 pm EST. Advance registration for the Workshop is required.**

The connection between nutritional neuroscience, behavioral modification, and your wallet have come together in this dynamic workshop by international leaders in the field of Behavioral Health Nutrition. The role of the RDN will be emphasized as an essential agent of change for brain optimization. Learn the latest research about which nutrients are most impactful for brain health and develop a personalized action plan that will teach you specific treatment codes that enhance your financial compensation for services.

Three remarkable speakers in this group-focused workshop will stimulate your neurons to begin thinking larger about your role as a RDN.

1. CAPT Joseph Hibbeln, MD, USPHS is a clinical investigator and the Acting Chief of the Laboratory of Membrane Biochemistry and Biophysics Section of Nutritional Neuroscience (LMBB/SNN) at National Institute on Alcohol Abuse and Alcoholism (NIAA). He was one of the first investigators to draw attention to the importance of omega-3 fatty acids in psychiatric disorders. Dr. Hibbeln will focus on the scientific WHY nutrition is impactful for brain health. Moreover, he will recommend a cognitive expansion of current research findings and give a call to action for RDNs to be more integrated into the area of Mental Health.
2. Ralph E Carson, PhD, RD, LD, has been involved in the clinical treatment of addictions, obesity, and eating disorders for more than thirty years using a neuropsychobiological approach. He offers a unique understanding of health, wellness, exercise, and nutrition and how they all affect

brain health. Dr. Carson will focus on WHY nutrition interventions remain ineffective, with a review of mental and environmental barriers that inhibit positive change along with techniques that accelerate cognitive reappraisal.

3. Lisa Kantor, JD, is the country's leading attorney serving the legal needs of individuals with severe eating disorders. She has been influential in enforcing mental health parity laws by advocating for her clients for proper treatment at the state supreme court. This portion of the workshop will focus on HOW to get reimbursement of MNT with individuals who present with behavioral health illness and the legal terms and tactics for proper documentation.

The 2015 BHN Member Reception will be THE CELEBRATION EVENT!

You will not want to miss this event on **October 3rd from 8:00 pm - 10:00 pm at the Omni Hotel Broadway Ballroom J.** Plans are in the works for a night of food, friends and colleagues, BHN award presentations and member recognition. Resource Professionals will be available to members with exciting news of upcoming BHN projects and events for the coming year. For those attending BHN's Pre-FNCE Workshop, you will receive VIP access to the event with an early entrance of 7:00 PM to spend more intimate time with our Pre-FNCE speakers.

Additionally, as we are gearing up for FNCE® this year, BHN leadership team wants to be your guide. For those who attend every year to first timers, it can be difficult to choose which sessions to attend due to the wealth of information available at FNCE®. BHN Leadership reviewed the FNCE® schedule and picked out topics they believe may fit each practice area and should be a strong session topic related to BHN practice areas for you to attend. Don't forget to download the FNCE® App to keep you on schedule.

Also if you want to sit by a BHN member, stay tuned for our Twitter tag for BHN members!

BHN FNCE® Cheat Sheet

The following educational sessions include the hyperlink to the FNCE® website, which you can also search by track, level, speaker, and day at www.eatright.org/fnce.

SATURDAY 10/3		
11:30-3:30 PM	Pre-FNCE Workshop- Brain Data and Dogma: Expanding MNT to Increase Fiscal Reimbursement Read Speakers: Lisa Kantor, Ralph Carson, CAPT. Joseph Hibbeln Advanced registration required	All
4:00-6:00 PM	Opening Session: An Innovative Solution to the Hunger Problem Speakers: Evelyn Crayton, Doug Rauch	All
7:00-8:00 PM	BHN DPG VIP Member Appreciation Event Open to BHN Members who attended the Pre-FNCE Workshop	All
8:00-10:00 PM	BHN DPG Member Appreciation Event	All

BHN FNCE® Cheat Sheet

Continued from page 11

SUNDAY 10/4		
8:00-9:30 AM	Women's Health, Prenatal Nutrition and Infant Outcomes: A Public Health Perspective Speakers: Helene Kent, Jamie Stang	All
	Claim the Spotlight! Beyond Traditional Media: videos, podcasts and self-publishing Speakers: Julie Beyer, Melissa Joy Dobbins	All
10:00-11:30 AM	Nutrition Focused Physical Exam: Identifying Malnutrition with Hands-On Training Speakers: Erica Raymond, Jodi Wolff	All
	Functional Nutrition: Using Food as Medicine, Connection, Information & Energy Speakers: Elizabeth Boham, Brigid Titgemeier	All
1:30-3:30 PM	Bittersweet- How Our Senses Impact Chronic Disease and Weight Speakers: Jacqueline Marcus, John Hayes, Danielle Reed	IDD
	FODMAPs: Navigating the Novel Diet in the Pediatric Populations Speakers: Kristie King, Bruno Chumpitazi	IDD
	Obesity Risk and Weight Management in Youth with Developmental Disabilities Speakers: Linda Bandini, Richard Fleming	IDD
	Type 1 Diabetes and Eating Disorder: Treatment Strategies for Dual Diagnoses Speakers: Dawn Taylor, Stephanie Critchley	ED
	Sleep and nutrition: Is getting enough Zzzzz's important to RDs? Speakers: Katherine Finn Davis, Devon Golem	All
3:30-5:00 PM	Building Blocks: Establishing Pediatric Obesity Best Practices and Standardized Care Speakers: Emily Hartline, Angie Hasemann	IDD
	The Ethics of Malnutrition Management: Must Therapy Always Follow Diagnosis? Speakers: Joseph Fanning, Louise Merriman	IDD
	Satiety Regulation and Measurement: Can Appetite Be Controlled? Speakers: Richard Mattes, John Blundell	IDD
	The Promise of Functional Foods: Translation from Crops to Community for Disease Prevention Speakers: Colleen Spees, Yael Vodovotz	All
Monday 10/5		
8:00-9:30 AM	Moving Beyond Hunger: Training and Resources for Early Care Educators Speakers: Jill Cox, Andrea Farmer	All
	From Restriction to Celebration: Deliciously Incorporating 2015 Dietary Guidelines for Americans into Kid's Meals Speakers: Joy Dubost, Gary Jones	IDD
10:00-12:00 PM	Member Showcase: The Future of Health and Human Rights Speakers: Evelyn Crayton, Regina Benjamin	All
1:30-3:00 PM	Nutrition Intervention In Autism: Gastrointestinal and Sensory Concerns for Nutritional Health Speakers: Sharon Lemons, Patricia Novak	IDD
	From Science to Sound Bites: using nutrition research to inspire behavior changes Speakers: David Katz, Britt Burton-Freeman	All
3:30-5:00 PM	Spotlight** Food for Recovery: Resolving Malnutrition and Disordered Eating Patterns in Addiction and Substance Abuse Populations Speakers: Megan Kniskern, Steven Karp	Addictions & ED
Tuesday 10 /6		
8:00-9:30 AM	Strategies for Behavior Changes and Improved Health Outcomes Among Low-Income Populations Speakers: David R. Just, Anne Murphy	All
9:45-11:15 AM	The 'Weight' is Over: The Role of the Dietitian in Behavioral Approaches to Improve Health Outcomes Speakers: Rebecca Krukowski, Catherine Champagne	All
	FODMAPs: Emerging Science and Implications for Practice Speakers: Jane Muir, Patsy Catsos	IDD
	Best-Practice Grant Writing Strategies of RDNs to Establish and Support Community Coalitions Speakers: Mary Beth Gilboy, Melissa Reed	All
12:00-1:30 PM	#Dietetic Professional: Social Media to Enrich Your Career Speakers: Faye Berger Mitchell, Christine Palumbo	All
	Team Approach to Enteral Feeding In End of Life Care Speakers: Helen Kane, Debra Way	IDD
2:00-3:00 PM	Closing Session: The Future of Food and Nutrition: The Intersection of Business, Diversity and Philanthropy Speakers: Lucille Beseler, Marcus Samuelsson	All

Delegate Update: Outcomes of the Spring 2015 HOD Meeting

Harriet Holt Cloud, MS, RD, FAND, BHN DPG Delegate 2012-2015



Harriet H. Cloud, MS, RD

The House of Delegates (HOD) met virtually on May 2-3th, 2015, for the 93rd meeting of the House. This marks the seventh annual virtual meeting. The topic for discussion was the Academy's Sponsorship Program, which was discussed on both days of the meeting.

Delegates had the opportunity to share their members' concerns and comments, discuss the impact of sponsorship at the national and local level, and brainstorm solutions to the Academy's Sponsorship Program. In addition, Delegates and invited Academy members had the opportunity to listen to two presentations on sponsorship. Neva Cochran, MS, RDN, LD, FAND discussed how decisions regarding potential sponsorships are made by both the Academy Board of Directors and Foundation Board of Directors and provided examples of positive outcomes of sponsorship. Meg Bruening, PhD, MPH, RD discussed concerns and suggestions related to sponsorship collaborations and their impact.

Prior to the virtual meeting I had contacted the members of BHN DPG for your reaction to the sponsorship issue following the Kids Eat Right logo being put on Kraft cheese. 70 members responded and there were many comments, mostly negative, with the concern that the Academy, through the Foundation, was endorsing Kraft Cheese slices. There were responses from the Academy that endorsement was not occurring for the cheese product; instead Kraft was a sponsor of the Kids Eat Right program. A second survey was sent to our members related to the sponsorship issue and there were 56 responses. The responders agreed that working with industry had many benefits for members of the Academy, but their major concern was that it not be an endorsement. When asked about the principles in place for the Academy and industry collaboration, 70% of those responding were not aware of the principles. The principles are that any sponsorship must adhere and commit to the Academy's mission, vision, positions and policies; provide scientific accuracy; demonstrate non-endorsement of products, and non-influence from the sponsors.

Discussion is sometimes difficult during a Virtual Meeting, but not this one. We met on Saturday afternoon for 3 hours and Sunday afternoon for the same time and the discussions were excellent with the Delegates emphasizing a need for greater communication about issues throughout the Academy. Two key words were communication and HOD involvement in decision making.

As a result of the dialogue, one motion was discussed and passed by the House. The following activities have been requested:

HOD Motion #1: The House of Delegates requests that the Sponsorship Advisory Task Force utilize the Spring 2015 HOD meeting discussions to develop a plan providing clear direction to the Academy, Foundation and all organizational units on how to engage in sponsorship and partnership opportunities. A report from the Sponsorship Advisory Task Force will be presented to the House of Delegates at or before the Fall 2015 HOD Meeting. The final plan will be reviewed and approved by the House of Delegates prior to being presented to the Board of Directors.

In addition, the House of Delegates approved a proposed position concept as presented by the Academy Positions Committee:

HOD Motion #2: The House of Delegates approves the proposed position concept Interprofessional Education in Nutrition as an Essential Component of Medical Education. The Academy Positions Committee will develop the position paper according to its policies and procedures.

Academy Updates

Many Academy updates were provided electronically to HOD meeting attendees two weeks in advance of the spring meeting. In recorded presentations, Sonja Connor, MS, RDN, LD, FAND (now Academy Past President), Donna Martin, EdS RDN, LD, SNS, FAND (now Academy Past Treasurer), and Terri Raymond, MA, RD, CD (now Past Academy Foundation Chair) provided updates on their respective areas. The recorded presentations can be found at www.eatrightpro.org/resources/leadership/house-of-delegates/about-hod-meetings >Spring 2015 Meeting Materials.

All materials related to Spring 2015 House of Delegates Meeting, including slides from various Academy related updates and outcome materials, are located online for members: www.eatrightpro.org/resources/leadership/house-of-delegates/about-hod-meetings >Spring 2015 Meeting Materials.

The Spring Virtual Meeting was my last meeting as your Delegate. It doesn't seem possible that this was a three year term since it passed so quickly. I will always appreciate this opportunity to have represented BHN in the HOD. Although I was an affiliate delegate in the past, I always thought the DPGs should have a representative and this experience confirmed that opinion. Cynthia Burke PhD, RDN, LD, BCBA is your new delegate and will have a great time in the HOD. I certainly did.

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BHN: Fuel Your Brain, Feel Your Best!

Mission: Empowering BHN members to excel in the areas of Addictions, Eating Disorders, Intellectual and Developmental Disabilities and Mental Health by providing resources and support.

Vision: Optimizing the physical and cognitive health of those we serve through nutrition education and behavioral health counseling.

Academy of Nutrition and Dietetics website: www.eatright.org

BHN website: bhndpg.org • BHN practice standards: www.bhndpg.org/members/practice-standards/

