CELEBRATING 40 YEARS

NJD-HCF COMMUNIQUÉ

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CHAIRMAN'S CORNER

By Darlene A. Morrison, MS, MBA, RD

I hope this newsletter finds all of you spending time with your loved ones over the holiday season.

"**Get Connected**" was FNCE 2008's theme and those of us that had the privilege to attend had many opportunities to create treasured memories. What a great city Chicago is and it certainly is true what they say about the food and shopping. They were superb! It sure was nice to travel to a new city with a group of professional comrades. I am going to continue to try and plan this yearly trip and encourage everyone to do so as well! I will briefly discuss onr of the many lectures that I attended.

"**It Takes a Team: Targeting Patient and Provider Education to Improve Anticoagulation Safety**" presented by Linda Nahlik, PharmD, CACP and Carolyn Banner, RD, LDN, CNSD

Warfarin (Coumadin®) is the most widely used anti-coagulant in the world with 20 million yearly prescriptions written in the United States alone. It has a narrow therapeutic index. Therefore, very small dose changes can result in dramatic patient responses.

The clear message throughout the lecture, was the critical importance of consistent anticoagulation, the need for frequent follow-up and monitoring, and the need for consistent and accurate information communicated by all clinicians.

Warfarin effect is commonly measured by the prothrombin time, which is standardized by conversion to the international Normalized Ratio (INR). Most common indications for warfarin administration require an INR in the therapeutic range of 2.0-3.0 or 2.5-3.5. Under-anticoagulation (INR< 2.0) results from increased dietary vitamin K and increases the risk of thromboembolism. Over-anticoagulation (INR above the target range) results from decreased dietary vitamin K or elimination of vitamin K from the diet and increases the risk of bleeding. Warfarin is typically bound to plasma protein, primarily albumin. This helps to explain why a lower dose is often required with hypoalbuminemia, due to it's decreased protein binding ability.

IF YOU CANNOT EAT THESE FOODS REGULARLY EVERY WEEK:

- Do not eat any foods containing high vitamin K. Eating even a very small amount occasionally will change the amount of warfarin you need and make it difficult to adjust your dose.
- One small serving is about ½ cup cooked or 1 and ½ cups raw.
- Do not drink grapefruit juice or cranberry juice.
- Be consistent with what you eat. Eat about the same amount of food every day.

CHAIRMAN'S CORNER (CONT.)

By Darlene A. Morrison, MS, MBA, RD

Consistent vitamin K intake plays a major role in stabilizing warfarin response. This does not equate to elimination of all vitamin K rich foods from the diet. Ater a patient interview, get the patient to agree on a plan to continue to eat a diet that includes one serving of high vitamin K food daily or every other day, week after week ***OR*** never eat foods that are considered to be high in vitamin K. It is important that the patient is aware that missing even one day (for those choosing to eat a consistent amount of high vitamin K rich foods), will cause the warfarin to work more. For those that choose to eliminate high vitamin K rich foods, they need to understand that even a small, occasional serving will stop the warfarin from working. The list used at the University of Chicago Medical Center is as follows:

Some foods are **high in vitamin K**, which can stop warfarin from working as it should. The following is a list of common vegetables with a high vitamin K content:

Broccoli, Brussel sprouts, Cabbage, Collard greens, Endive, Kale, Leafy green lettuces (bib/leaf/ baby/ spring greens), Mustard greens, Spinach, Turnip greens, Watercress

If you normally eat these foods you may choose to include them in your diet regularly and in moderation, for example, one small serving of one of these foods every other day. If you choose to eat high vitamin K foods, you must continue to eat them the same way, week after week, without change.

There are other things to keep in mind when investigating an un-explained anticoagulation response or vitamin K-induced warfarin resistance. All enteral feedings (to include meal replacements) and intravenous fat emulsion infusions provide vitamin K which is clinically significant. Again, the key is consistent intake and medication adjustment as needed. Some vegetable oils contain a significant amount of vitamin K to include soybean and canola oils. The following is a list of foods to avoid eating unusually, large quantities of:

- **Soybean Oil, Vegetable Oil, Canola Oil, Mayonnaise, Miracle Whip, Green Onions, Parsley, Pickles**

Although Green Tea is often listed as a rich source of vitamin K it is not restricted in the diet except for those using it as an herbal remedy and mixed by an herbalist. You have to eat large quantities of the tea leaves to be a concern. 100 grams of green tea leaves have 750 micrograms of vitamin K and would brew over 100 cups of tea!

Another ongoing issue is cranberry juice. Technically 100% cranberry juice negatively interacts with warfarin and moderate amounts of cranberry juice cocktail (< 240ml daily) is usually allowed.

I hope to see all of you at our Winter Seminar, January 15, 2009. Joanne Maxwell, MA, RD will present a session on LTC Assessment and Survey Update and Barbara Skinner, MS, RD, CDE will present a session on Diabetic Medications. Wishing you and your loved ones a peaceful and prosperous New Year!

Keep this Date for the Annual New Jersey Dietetics Association Meeting:

May 8th 2009 at the Hyatt Hotel in New Brunswick New Jersey

More information to follow.

Did you know that Julieta Songo MS Ed.,R.D. presented a paper on "Nutritional Health and Wellness a Twenty First Century Legacy or Paradox".in Beijing, China on November 11th 2008 as part of People to People Ambassador Programs. Julieta will provide us with her abstract in our next newsletter.

Phyllis Famularo is a member of our organization and is running to represent District 7 at the national level. ***We would like to encourage our membership to support her election.***

Phyllis Famularo MS RD works for Sodexho and isa Senior Manager of Nutrition Services. She serves the NY,NJ, Conn., New Hampshire and Rhode Island area as part of her job duties. Her nutrition expertise and her hands on experience in these states make her an ideal candidate for Area 7 representative.

Phyllis lives and works out of New Jersey and I am hoping that our NJD_HCF members will endorse and support Phyllis in her upcoming election.

Upcoming Meeting Dates:

- January 15, 2009
- April 24, 2009
- September 29, 2009

Articles in this newsletter are for your review and not necessarily the opinion of this editor or this practice group.

Mark Your Calendar!

Thursday, January 15, 2009

NJDHCF WINTER SEMINAR

PRINCETON, NJ

Deadline for the March Newsletter is February 15, 2009

Please send all articles or announcements to:

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Send Email to:
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NJD-HCF Winter Seminar
January 15, 2009

Our morning session will focus upon information essential to dietitians and managers of health care facilities regarding current and upcoming federal and state regulatory revisions, how to avoid the top dietary deficiencies, and what to look for in the future. Our speaker, Joanne Maxwell is leader of the NJ Department of Health and Senior Services survey team, will:

- Discuss recent CMS revisions of the interpretive guidance and protocol demands for survey compliance with the F325 and F371 regulatory tags, as well as the recent incorporation of the tag F326 into F325.
- Describe the most commonly cited nutritional care and dietary deficiencies
- Raise awareness on care to prevent deficient practices in these areas
- Increase readiness for the future regulatory arena

Our afternoon speaker, Barbara Skinner, will offer her experience and perspective as a certified diabetes educator and registered dietitian with an overview of the latest medications being used to treat diabetes, with emphasis on the role of the registered dietitian in the management by the health care team. The session will include a review of:

- The current science on the path physiology of diabetes.
- Guidelines for optimum control of blood glucose levels
- The names and types of diabetes medications currently being prescribed as well as their mechanisms of action
- The synergy between medical nutrition therapy and medications in the treatment of diabetes mellitus.

Getting Connected at FNCE
By Kathleen C Mahmoud, MS, RD

Attending the American Dietetic Association's annual Food and Nutrition Conference (FNCE) was a completely invigorating experience! Having the opportunity to travel to Chicago with our Chair Darlene Morrison, meet consultants and dietitians from around the country, and "feed my brain" for four days in October was such a treat!

Chicago may be known as the "Second City", but there is nothing second rate about it. The city is full of fascinating architecture, first class shopping, several fine universities, and tourist-friendly locals. McCormick Place, the main site of the convention events is a huge, light filled, convention center that comfortably housed not only FNCE but a second large convention as well. Our national practice group CD-HCF conducted a pre-conference workshop, had a booth at the exhibit hall, held several subunit meetings, hosted a reception, and presented a priority educational session over the course of the convention. In this article, I would like to present a brief summary two of the most interesting sessions I attended. (Conti.)

Getting Connected at FNCE (Conti.)
By Kathleen C Mahmoud, MS, RD

First was the CD-CHF Priority Educational Session entitled **"Nutritional Impact in Anemia Management of the Elderly" that was presented by David Thomas**. A renowned gerontologist, he noted that **anemia is not a normal finding in older persons, and expectations for hemoglobin concentration should not be adjusted downward for the elderly.** The *prevalence* of anemia, however, does increase with age.

Although iron deficiency anemia often occurs due to blood loss, failure to produce hemoglobin, or hemolysis, it also commonly occurs in elderly men due to decline in serum androgen levels (chiefly testosterone) concomitant to aging. Furthermore, men who have functional hypogonadism from pituitary adenomas and men with prostate cancer who are undergoing therapy with total androgen blockade can be expected to be anemic.

Anemia with chronic renal insufficiency is also common. Approximately 13.5 million adults have a creatinine clearance of 50 mL/min or less and about 800,000 adults have chronic *renal sufficiency-associated anemia.* Anemia of chronic kidney disease is diagnosed by recognizing renal disease in association with a low erythropoietin level. For this reason, creatinine clearance should be calculated in all nursing home residents with anemia to determine their renal status.

Anemia can be due to failure of the bone marrow to manufacture adequate blood components, gradual or rapid blood loss (hemorrhage), or rapid breakdown of blood components (hemolysis), failure of bone marrow to produce adequate blood components may be due to inadequate nutrients (vitamin B12, folate, pyridoxine, or iron) necessary for blood cell production, a primary impairment of hemoglobin synthesis (hemoglobinopathy), or altered maturation of blood cells (myelodysplastic syndromes).

Differential diagnosis of anemia is essential prior to initiating treatment, and can only be accomplished after thorough laboratory testing of blood and urine components. Dr. Thomas did conclude with a useful summary on the management of anemias in long term care, as follows:

In persons with iron deficiency, the recommended treatment is iron sulfate 325 mg three times a day, providing 195 mg of elemental iron per day. The sulfate moiety can cause gastrointestinal distress, and if this occurs, iron in the form of gluconate or fumerate may be helpful. Some experts suggest that iron sulfate once a day may have a similar effect to three-times-a day dosing if absorption is normal. The duration of iron therapy may need to be longer when iron doses are once daily. Whatever the chosen dose, a reticulocyte count should be obtained one week after starting iron, and if there is not a robust reticulocyte response, intravenous iron should be considered.

Anemia due to folate or vitamin B12 deficiency is treated by the replacement of that vitamin. Vitamin B12 can be replaced either by injections (1000 ug weekly for one month, then monthly thereafter), orally (1000 ug daily, (which should not be given with food) or intra-nasally. One mg daily of folate tablets should be used to treat folate deficiency, and should also be administered during the first few weeks of B12 therapy. In anemia of chronic kidney disease, epoetin alfa (10,000 U weekly) or darbopoetin alfa (60mcg bi-weekly) injections may be administered. Anemia of chronic disease can only be resolved by treating the underlying condition. (Conti.)

Getting Connected at FNCE (Conti.)
By Kathleen C Mahmoud, MS, RD

Dr. Thomas concluded with a reminder that iron deficiency anemia will likely result in decline in immune system function, poor healing, decreased cognition, and poor muscle function; therefore, its correct diagnosis and treatment should result in a notable increase in quality of life for our patients.

A second, and very interesting presentation I attended was titled **"Aging Boomers- Is Muscle Loss the Silent Epidemic?" by Doug Paddon Jones.** He began with the proposition that gradual progressive muscle loss may not be linear, but rather related to episodes of injury, bed rest, or prolonged inactivity. With protein intake constant, the loss of lean body mass (LBM) that occurs during those conditions is threefold in the elderly versus young study subjects. Inactivity reduces the ability to repair of rebuild protein, but supplementation of amino acids has been shown to help maintain LBM and partially preserve functional capacity and strength.

Particular amino acids can stimulate muscle anabolism effectively in all age groups. Leucine was shown to be especially effective as a prime regulator of protein synthesis. He noted that lean beef is especially high in leucine (approximately 10grams amino acids are contained in 30 grams serving of the meat). Studies indicate that protein synthesis seems to taper off when amounts of lean protein exceeds 12 ounces per day, but may be improved with resistance exercise. Benefit was maximized when the protein was consumed prior to exercise, and that consumption of about 30 grams of carbohydrate along with the protein intake appeared to promote anabolism due to the effect of post- prandial insulin release, but must accompany exercise in the elderly for maximum effect. He concluded with recommendations that 1.2-1.5 g protein per kilogram of body weight per day may be a more appropriate recommendation for aging inactive adults, with a recommendation of 1.4 g per kg for anabolism in that group.

He also noted that *protein supplements may not be necessary with an adequate dietary intake, but if a supplement is used, whey is preferable as is contains a high amount of essential amino acids,* particularly the aforementioned leucine.

Note:

If you were unable to attend FNCE, but are interested in exploring more… check out the conference web page and look for power point presentations and handouts from the educational sessions on-line at www.eatright.org.

Making the Nominating Committee Work For You

By Mary Piciocco, M.S., R.D.

To Nominate, literally to name. This is the first step in holding an office in most organizations. Perhaps you've noticed a colleague working at one of the Consultant Dietitians in Healthcare events. Perhaps you've noticed a colleague that seems to have good ideas, or stating that they like to be more involved. Perhaps that colleague is you! As the fall approaches, it's not too early to plan ahead for the following year.

How is one nominated? The process begins with the individual in the group. You have a committee that is your voice. Take the time to tell them you'd like to nominate (or name) a particular person to one of the posts in the organization. You can let the Chairperson or Chair elect know, or walk up to one of the current Nominating Committee members. These individuals can also spend a little time talking about the responsibilities of the office. You can make sure then that it's something your nominee (the person nominated) would like to do.

Sounds scary? Many times it does. I need to tell you that there are many wonderful people on the Executive Board that started in just the same way. Either someone thought that they would do a great job in an area, or they were answering their own wish to become more involved, to contribute to the operation and continuation of this organization. These same people are available as ready and willing resources to help the "new persons" adjust to their roles. Some offices are actually two years, one as an "elect" position, meaning that it is understood they are to move to the next level the following year. Usually the Chair elect and the Treasurer Elect, the time period allows the candidate to work at their own position while working along side the Chair or the Treasurer for a smooth and successful transition the following year.

Once the nominations are given, around the late fall to early winter, the Nominating Committee begins their work. All nominees are screened to make sure they meet the criterion.

1. They are members of the ADA
2. They are members of the NJ CDHCF

Each nominee is contacted to make sure they want to run for the office they were recommended. Calls are made to plug the gaps in the ballot.

Then, the fun part begins. All ballots returned within the time limit are counted. They are anonymous. (and yes, I couldn't tell you who voted for whom!). Results are presented to the Board and the group. And the cycle begins again.

As you can see, the process is pretty easy and the many hands on the board allows individuals to divide up the work among the team. The rewards? It's an opportunity to make a difference, the opportunity to help make decisions for the future, and the networking and development of friendships with talented people. Priceless.

Think about it. The Nominee might be you!

NEW JERSEY DIETITIANS IN HEALTH CARE FACILITIES

Presents Our Winter Seminar

"Regulatory Update"

By Joanne Maxwell, RD, MA

and

"Review of Current Diabetes Medications"

By Barbara Skinner, MS, RD, CDE

See Page 8 for details!

Winter Seminar

Thursday, January 15, 2009

Princeton, NJ

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