Public Policy & Advocacy Home Visits Toolkit

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Introduction

"If dietetics is your profession, policy should be your passion." While this is a statement that cognitively makes sense, it can nonetheless be daunting. Contacting legislators and representatives – both at the state and federal level – can be a nerve-wracking task. However, it need not be. To help facilitate greater involvement in dietetics advocacy, we have created this toolkit to assist you as you communicate with your members of Congress about important pieces of nutrition legislation.

Don't be intimidated. Your members of Congress want to hear from you: Your passions, your work, how you help Iowans live healthier lives. Even if your conversation does not include every recommended talking point or discussion topic, simply meeting with your legislator and sharing your passion for dietetics is powerful advocacy.

We hope the materials in your toolkit assist you as you share your passion for health & wellness. Please do not hesitate to contact us with your questions!

In health,

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Types of Legislative Visits

An in-person visit to your legislator's office is not the only way to be an effective policy advocate. Here are some other ideas* that let you connect with your member of Congress and also showcase the work of registered dietitian nutritionists in the state:

- Extend an invitation to visit a diabetes education class
- Give a tour of a farm-to-school program
- Visit a community garden
- Visit a summer food service program site
- Tour a WIC or Seniors' Farmers Market
- Provide the opportunity for Congress member to help deliver a home delivered meal or visit to a congregate dining site
- Attend a Town Hall meeting hosted by the Congress member
- Attend a Tele-Town or Virtual Town Hall meeting
- Work with the affiliate media representatives to set up a radio interview with registered dietitian nutritionists and elected officials on nutrition topics of interest to consumers, including weight loss, diabetes and school meals
- Feature registered dietitian nutritionists at Farmer's Markets demonstrating how to prepare delicious dishes using the fresh produce

**Additional legislative visits ideas courtesy of the Academy of Nutrition & Dietetics*

Advocacy tip: Don't forget social media! Prior and after your visit, be sure to post any pictures, brief thank you notes, and other information, tagging your legislator. This helps promote both the dietetics profession and your member of Congress.

Tips and Outline for Contacting your Member of Congress

The following tips should help guide you through the process of setting up meetings with members of Congress in their district office. You can reach out to offices either by phone or email; however a phone contact may be more effective first step. Below are sample phone and e-mail requests. Remember to personalize your message as each Congressional office is different.

Tips on how to make the request for a meeting

- You can find your Representative and your Senators at these links. Once you find the member of Congress, click on the name of the Congress member. The link will take you to their homepage where you will be able to locate their district office phone number(s).
    - House of Representatives: http://www.house.gov/representatives/
    - Senate: http://www.senate.gov/general/contact_information/senators_cfm.cfm

- Call the office and ask for the scheduler. The scheduler may provide you an email address so that you can send the details for the requested meeting.

- State your name, your purpose and describe why you and your colleagues would like to meet with the member of Congress in his/her district office. A sample message script is provided below. If your affiliate has had any contact or working relationship with the member of Congress, be sure to mention it during the conversation or in the email. If you are a constituent, be sure to mention in the introduction.

- Make sure to request a meeting with the member of Congress as well his/her district staff member**.** The scheduler may not be able to guarantee that both will be in attendance, that's okay.

- State that you are requesting a 15 to 20 minute meeting or "brief meeting". State that you will be bringing a group of registered dietitian nutritionists and/or dietetic technicians, registered from the state/district with you to the meeting. Many offices will ask for the names of the individuals planning to attend the meeting.

- The scheduler may ask for additional information, so be prepared. You may need to follow up with the scheduler via e-mail, with any requested materials on the issues. If you need additional information from The Academy, contact the PIA staff in Washington, DC

- Ask the scheduler for the name and e-mail address of the scheduler and any key staff members who may be attending the meeting. The scheduler may ask you to follow up with each staff member in addition to setting up the meeting.

- When requesting meetings with the House of Representatives – remember to mention if you or someone you know is from the Congress member's district. A member is more likely to want to meet with someone who is a constituent.

Sample Phone Script – with scheduler

Hello my name is and I'm a (insert registered dietitian nutritionist or dietetic technician, registered) from the Senator/Representative's state. *(if you are from the Representative's district, mention that)* I would like to schedule a meeting with the Senator/Representative in August (insert dates if you have time limitations). I would also like to meet his/her district staff at that meeting. I'm a member of the Academy of Nutrition and Dietetics – and we're the largest food and nutrition professional association in the country – with over 100,000 credentialed professionals working to improve the health of Americans through food and nutrition.

During that time a number of registered dietitian nutritionists and dietetic technicians, registered, from the Senator/representative's state/district will be attending the meeting to talk about food and nutrition related policy.

I would like to schedule a meeting *(mention that you'll be bringing a group of registered dietitian nutritionists and/or dietetic technicians, registered from the state/district with you)* to discuss the Academy's positions on a number of important food and nutrition related issues. Is there a good time in August when we can meet?

Thank you.

Sample e-mail

The scheduler may ask you to put your request in writing to him/her or one of the district staff. The following is a sample e-mail message,

Dear XXX,

My name is and I am a (Insert registered dietitian registered) from the Senator/Representative's home state *(if you are from the district, mention that)*. I am a member of the Academy of Nutrition and Dietetics – the country's largest food and nutrition professional association.

I would like to schedule a brief meeting with the Senator/Representative and the district staff. Our goal will be to discuss our legislative priorities which aim to reduce healthcare costs and improve the health of Americans through food and nutrition.

I know that the Senator/Representative cares deeply about improving the health of our country while lowering costs to the system. We agree and so we would greatly appreciate the Senator/Representative's time to discuss how we as dietitians are working to accomplish these same goals every day. Please let me know when in August would work best for the Senator/Representative and staff to meet with us. If you have any additional questions, please let me know.

Thank you.

Respectfully,

Insert your name, credentials
Insert affiliate position
Insert affiliate name

Additional notes:

If the scheduler asks you to identify the issues, or transfers you to one of the district staff you can indicate that you will provide them additional information about the specific issues to be discussed prior to the meeting and restate that you would like time to talk about the importance of these issues as they pertain to improving the health of Americans through food and nutrition. You can also indicate the key issues you would like to discuss are the Preventing Diabetes in the Medicare Act, the Treat and Reduce Obesity Act, and Child Nutrition reauthorization.

You may also be asked for the names of the individuals who will be attending the meeting. You can indicate that you will provide that information prior to the meeting.

How to Engage Your Member of congress

Initial Contact

- Contacting your member is easy. Just go to their website and find the phone number to the district office that is closest to you.
- Call the office and ask for the scheduler, you can ask to schedule a meeting over the phone or ask for an e-mail address to send a written request.

Making the "Ask"

- When requesting a meeting via e-mail remember to be concise and to the point; members and staff read thousands of e-mails and receive hundreds of requests so you want to make sure and entice them with to-the-point messaging.
- Always make your messaging relevant to the district – If there's one thing members like, it's serving their constituents and fixing problems in the district.
- Strength in numbers – If at all possible try and schedule a meeting with a group of registered dietitian nutritionists or if you invite the member to your place of work try and have more than one RDN present. Having more than one RDN provides emphasis to the meeting and importance to the issues.

Time to Meet

- *What to bring to the meeting*
    - You want to bring your leave-behind material for when the meeting/visit is finished.
    - Don't hesitate to bring along your talking points so you can point out relevant statistics or data points on issues. And bring along any additional information you feel is relevant.
    - Your positive attitude and passion for what you do. That's what you want the member to see.
- *What to say in the meeting*
    - Familiarize yourself with the talking points on the various issues and always relate those issues back to you and what you do.
    - Have a personal and or professional story ready to tell, preferably one that relates to one of the specific pieces of legislation. Personal stories from the workplace always resonate more
      deeply than facts or figures. These members care about the people they represent and so by telling a story about one of their constituents (your patients/clients) you will be able to make a stronger connection from the member's understanding of the issue to the actual policy.
    - Always share your story **first** and then follow it with the relevant facts and figures.
    - Do not be afraid to say "I don't know". Nothing is worse than providing false information to a member/staffer. Remember you want to be viewed as a reliable source. Simply say "I'm not quite sure about that, but I can get you the answer later."

Follow-up contact

- Always follow-up 1 to 2 days later with a thank-you email to the scheduler; or member (if you have his/her e-mail address).
- Reiterate your messaging on the things that were discussed in the meeting/visit.
- Make sure to state that you will be reaching out the member's relevant staffer to answer any question that the member may have had or to provide any supporting materials that were requested

How to Find Your Legislators

How to find your Iowa Legislature members: https://www.legis.iowa.gov/legislators/find

How to find your United States Congress members: https://www.govtrack.us/congress/members/IA

Advocacy tip: Visit the websites of your members of Congress to sign up for their weekly e-newsletter. These newsletters include various pieces of information, including legislative topics, legislator-hosted coffees, and in-district visits. Such newsletters are a great way to stay connected with your members of Congress

United States Congress Member Contact Information

Senator Joni Ernst
Website: ernst.senator.gov/public

Des Moines Office 733 Federal Building
210 Walnut Street Des Moines, IA 50309
Phone: (515) 284-4574 Fax: (515) 284-4937

Davenport Office
201 West Second Street Suite 806 Davenport, IA 52801
Phone: (563) 322-0677 Fax: (563) 322-0854

Cedar Rapids Office
111 Seventh Avenue SE Suite 480 Cedar Rapids, IA 52401
Phone: (319) 365-4504 Fax: (319) 365-4683

Sioux City Office
194 Federal Building 320 Sixth Street Sioux City, IA 51101
Phone: (712) 252-1550 Fax: (712) 252-1638

Council Bluffs Office 221 Federal Building 8 South Sixth Street
Council Bluffs, IA 51501 Phone: (712) 352-1167 Fax: (712) 352-0087

Senator Chuck Grassley
Website: grassley.senate.gov

Cedar Rapids Office
111 7th Avenue SE, Box 13 Suite 6800 Cedar Rapids, IA 52401
Phone: (319) 363-68-32 Fax: (319) 363-7179

Council Bluffs
307 Federal Building 8 South 6th Street Council Bluffs, IA 51501
Phone: (712) 322-7103 Fax: (712) 322-7196

Davenport Office
201 West 2nd Street Suite 720 Davenport, IA 52801
Phone: (563) 322-4331 Fax: (563) 322-8552

Des Moines Office
721 Federal Building 210 Walnut Street Des Moines, IA 50309
Phone: (515) 288-1145 Fax: (515) 288-5097

Sioux City Office
120 Federal Building 320 6th Street Sioux City, IA 51101
Phone: (712) 233-1860 Fax: (712) 233-1634

Waterloo
210 Waterloo Building 531 Commercial Street Waterloo, IA 50701
Phone: (319) 232-6657 Fax: (319) 232-9965

1st District – Representative Abby Finkenauer
Website: finkenauer.house.gov

Cedar Rapids Office 308 3rd Street SE, Suite 200 Cedar Rapids, IA 52401
Phone: (319) 364-2288

Dubuque Office 1050 Main Street Dubuque, IA 52001

Waterloo Office 521A Lafayette St. Waterloo, IA 50703

2nd District – Representative Dave Loebsack
Website: loebsack.house.gov

Iowa City Office
125 South Dubuque Street Iowa City, IA 52240
Phone: (319) 351-0789 Fax: (319) 351-5789

Davenport Office
209 W. 4th Street, #104 Davenport, IA 52801
Phone: (563) 323-5988 Fax: (563) 323-5231

3rd District – Representative Cindy Axne
Website: axne.house.gov

Council Bluffs Office 501 5th Avenue Council Bluffs, IA 51503
Phone: (712) 890-3117

Creston Office
208 West Taylor Street Creston, IA 50801
Phone: (641) 782-2495
(these are currently down and in the meantime call DC at 202-225-5476)

Des Moines Office
400 East Locust Street Suite 346 Des Moines, IA 50309
Phone: (515) 400-8180

4th District – Representative Steve King
Website: steveking.house.gov

Ames Office
1421 S Bell Avenue Suite 102 Ames, IA 50010
Phone: (515) 232-2885 Fax: (515) 232-2844

Fort Dodge Office 723 Central Avenue Fort Dodge, IA 50501
Phone: (515) 573-2738 Fax: (515) 576-7141

Mason City Office 202 1st Street SE Suite 126 Mason City, IA 50401
Phone: (641) 201-1624 Fax: (641) 201-1523

Sioux City Office
320 6th Street Room 112 Sioux City, IA 51101
Phone: (712) 224-4692 Fax: (712) 224-4693

Spencer Office
306 Grand Avenue P.O. Box 650
Phone: (712) 580-7754 Fax: (712) 580-3354

Current Academy of Nutrition & Dietetics Public Policy Priority Areas

The following pages include additional information about the Academy of Nutrition & Dietetics' current legislative priorities: The Treat & Reduce Obesity Act, Preventing Diabetes in Medicare Act, and Nutrition Education in the Farm Bill. Additional current legislation is listed on the www.eatright.org website. For more information on current policy issues, log in to the site and click on the "Advocacy" tab, then "Current Legislation." The issue brief documents included here are to help educate you as a registered dietitian nutritionist on the various pieces of legislation. The talking points are helpful to guide your conversation as you meet with your legislators and their staff. The leave behind documents are for you to give to your legislators after the conclusion of your visit, to provide them with additional information and resources as they consider supporting the legislation discussed.

The issue brief, talking points, and leave behind documents are prepared by the Academy of Nutrition & Dietetics and are used in this toolkit with their permission.

At the current time, neither the Academy of Nutrition & Dietetics nor the Iowa Academy of Nutrition & Dietetics has any specific legislative priorities in the Iowa Legislature. While you may support specific pieces of legislation on a personal level, please contact Iowa Academy of Nutrition & Dietetics Public Policy Panel members prior to voicing Academy endorsement of a given piece of legislation. Our Iowa affiliate must match our actions to that of the Academy of Nutrition & Dietetics to provide a consistent message across both our state and the nation.

The Treat and Reduce Obesity Act (H.R. 2404, S. 1509) Issue Brief

Bill Summary:

The Treat and Reduce Obesity Act of 2015 is a bipartisan, bicameral bill that was recently reintroduced in the 114th Congress by Representatives Erik Paulsen (Minn.) and Ron Kind (Wis.) and Senators
Tom Carper (Del.), Dr. Bill Cassidy (La.), and Lisa Murkowski (Alaska). The bill aims to effectively treat and reduce obesity in older Americans by increasing Medicare beneficiaries' access to qualified practitioners and safe, approved pharmaceuticals for obesity.

Issue Overview:

The nation is paying the price for overlooking the importance of food and nutrition. Over the last 20 years obesity rates have doubled among adults, resulting in more than 35% of adults living with obesity and
an additional 33% being overweight.[1] Evidence suggests that without concerted action, roughly half the adult population will be obese by 2040. These numbers are particularly troubling because one out of every eight deaths in America is caused by an illness directly related to obesity; therefore, millions of Americans are at risk from a preventable and treatable disease.[2] Research studies document the harmful health effects of excess body weight, which increases the risk for conditions such as diabetes, hypertension, heart failure, dyslipidemia, sleep apnea, hip and knee arthritis, multiple cancers, renal and liver disease, musculoskeletal disease, asthma, infertility and depression. **The Treat and Reduce Obesity Act offers clinically- and cost-effective solutions to the obesity epidemic.**

The Costs of Obesity:

Obesity is an astronomically expensive problem for our nation and families. Obesity accounts for 21% of total national health care spending, equating to $210 billion annually.[3] Medicare and Medicaid patients with obesity cost $61.8 billion per year; eradicating obesity would result in an 8.5% savings in Medicare spending.[4] The indirect costs are far higher. Recent data indicates that increased health and work-related expenses associated with obesity cost an excess of $4,879 for women and $2,646 for men annually.[5] Many of these costs typically carry over into older adulthood. Obesity is a public health crisis with a widespread, devastating and costly impact.

Key Takeaways

~~Problem – Obesity~~:

- The nation is paying the price for overlooking the importance of food and nutrition.
- We are an increasingly overweight and obese nation, with 2/3 of the adult population carrying excess weight.
- Obesity is an astronomically expensive problem for our nation ($210 billion per year).

Solution – A Bipartisan Bill:

- The bipartisan bill, H.R. 2404 / S. , has promise to clinically and economically tackle the obesity epidemic.
- There are already dozens of original co-sponsors in the House and many in the Senate from both parties.

Clinically Effective:

- The bill removes unnecessary barriers to (1) allow a variety of qualifi practitioners, such as RDs, to effectively
  treat obesity through IBT and (2) authorize coverage for FDA-approved weight loss medications that complement IBT.
- esearch shows that after two years, patients who received IBT from a RD are twice as likely to achieve clinically
  significant weight loss, experience greater average weight loss, and exercise more than patients who did not receive IBT.

Effectiveness of Obesity Management:

The U.S. Preventive Services Task Force (USPSTF) concluded that intensive behavioral therapy (IBT) is an effective component in obesity management. IBT consists of measurement of Body Mass Index, dietary/nutritional assessments and intensive behavioral counseling that promotes sustained weight loss through high intensity (i.e., regular and frequent) diet and exercise interventions.

May 2015

Studies show less than six months of RD-provided nutrition therapy for people with overweight or obesity yields significant weight loss of approximately one to two pounds per week. IBT provided for six to twelve months yields significant mean weight loss of up to 10% of body weight, which is typically maintained beyond one year.[6]

The USPSTF reviewed existing evidence and found that IBT can lead to an average weight loss of 4 to 7 kg (8.8 to 15.4 lb) and improve glucose tolerance, blood pressure and other physiologic risk factors for cardiovascular disease.[7]

A USPSTF report indicates that for patients with obesity and elevated plasma glucose levels, IBT interventions decreased the development of diabetes by about 50% over two to three years. These patients also demonstrated improved blood pressure, waist circumference and glucose tolerance.[8]

Key Takeaways

Cost Effective:

- Supporting RDs to provide IBT is cost effective.
  - RDs' services cost 25% less per 2 pounds of weight loss.
  - RDs' payment fee is 85% of primary care providers' fees.
- RDs can help minimize costs for nutrition services, like IBT, while delivering the best results.
- The bill provides coordinated, interdisciplinary care that increases efficiency and efficacy, which improves health care quality and reduces costs.

Benefits of the Treat and Reduce Obesity Act:

The Treat and Reduce Obesity Act gives the Center for Medicare and Medicaid Services (CMS) the authority to enhance beneficiary access for IBT by allowing additional types of health care providers, such as registered dietitians, to offer IBT services. To be most effective, obesity management must encompass the best standards of treatments, coordination of care and clinical environment. With coordinated care, each practitioner delivers the right care at the right time utilizing their advanced skill set and allowing reimbursement for only the most efficient and effective services. This is particularly important because studies have shown that primary care practitioners are limited in time, training, and skills to conduct the most effective, high-intensity interventions.[9] **In fact, the Institute of Medicine "rate[d] dietary counseling performed by a trained educator such as a [registered] dietitian as more effective than by a primary care clinician."**[10]

Allowing registered dietitians to treat obesity is not only clinically effective, but cost-effective as well. IBT services provided by registered dietitians save 15% of the cost of services associated with primary care physicians. Moreover, studies show that the cost of losing a kilogram of weight is more expensive under a physician ($9.76) than it is under a registered dietitian ($7.30).[11] This legislation would allow for CMS to align coverage with the USPSTF recommendation that (1) IBT can produce effective, demonstrable results for patients with obesity, and (2), that these services are more effective after referral to registered dietitians or other experts and should not be limited to primary care providers in the primary care setting.

The Treat and Reduce Obesity Act also revises the Medicare Part D statute to allow safe and effective pharmacological agents as a complement to obesity management therapies. Since Medicare Part D was passed, the U.S. Food and Drug Administration approved four obesity drugs. The federal savings estimate of covering weight management drugs under Medicare Part D could be $11,400 for a female Medicare beneficiary and $113 for a male Medicare beneficiary.[12]

1 Ogden et al. *Prevalence of Obesity in the United States, 2009-2010*. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. January 2012. http://www.cdc.gov/nchs/data/ databriefs/db82.pdf

2 Carmona, Richard. *The Obesity Crisis in America*. Surgeon General's Testimony before the Subcommittee on Education Reform, Committee on Education and the Workforce, United States House of Representatives. 16 July 2003. www.surgeongeneral.gov/news/testimony/obesity07162003.htm

3 Finkelstein et al. "Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates." *Health Affairs*, 28, no. 5 (2009). 27 July. http://content.healthaffairs.org/content/28/5/w822.full.pdf+html 4 Ibid.

5 Dor et al. *A Heavy Burden: The Individual Costs of Being Overweight and Obese in the United States*. The George Washington University, School of Public Health and Health Services, Department of

Health Policy. 21 November 2010. http://sphhs.gwu.edu/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_35308C47-5056-9D20-3DB157B39AC53093.pdf
6 Grade 1 data. ADA Evidence Analysis Library, http:www.adaevidencylibrary.com/topic.cfm?cat=3949.
7 U.S. Preventive Services Task Force. *Screening for and Management of Obesity in Adults: U.S. Preventive Services Task Force Recommendation Statement*. AHRQ Publication No. 11-05159-EF-2. June 2012. http://www. uspreventiveservicestaskforce.org/uspstf11/obeseadult/obesers.htm
8 Ibid.
9 Bleich et al. "National survey of US primary care physicians' perspectives about causes of obesity and solutions to improve care." *BMJ Open* 2012:2:e001871. doi:10.1136/bmjopen-2012-001871.
10 Committee on Nutrition Services for Medicare Beneficiaries. "The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population." Washington, DC: Food and Nutrition Board, Institute of Medicine; January 1, 2000 (published) at 2, 267.
11 Pritchard et al. "Nutritional Counseling in General Practice: A Cost-Effectiveness Analysis." *Journal of Epidemiology and Community Health*, 53 (2009): 311-316.
12 Brill, Alex. *The Long-Term Returns of Obesity Prevention Policies*. A Campaign to End Obesity, Matrix Global Advisors. April 2013.

The Treat and Reduce Obesity Act (H.R. 2404, S.1509) Talking Points

Problem - Obesity: The nation is paying the price for overlooking the importance of food and nutrition. Key takeaways:

More than 35% of adults are living with obesity and an additional 33% are overweight. This represents more than 2/3 of the adult population.
One out of every eight deaths in America is caused by an illness directly related to obesity.
By 2040, it is estimated that over 50% of adults will be living with obesity and the Medicare population is the fastest growing demographic with obesity.
Obesity costs $210 billion/year and $64 billion/year to Medicare.

Solution - A Bipartisan Bill (H.R. 2404, S.1509):

This bill is a clinically and economically effective solution to tackle obesity. Numerous co-sponsors in House and Senate from both parties (see FAQs).

Clinically Effective: Removes unnecessary barriers to
allow a variety of qualified practitioners, such as RDs, to effectively treat and reduce obesity through Intensive Behavior Therapy (IBT); and
authorize coverage for FDA approved weight loss drugs to complement IBT. Research: RDs 2x as likely to help patients lose significant weight and increase exercise.
Experts agree: RDs are the most qualified food and nutrition experts, according to Institute of Medicine (IOM), MDs, and the US Preventive Services Task Force (USPSTF).

Cost Effective:
RDs bill less than other providers, leading to better results at a lower cost.
The bill allows for coordinated care by increasing efficiency & efficacy.
Improve healthcare quality & decrease costs.

Personal Story: _

The Ask: Please co-sponsor the bill **(H.R. 2404, S. 1509)** and encourage chairmen to move it to the floor for a vote.

Invite member of Congress to visit your [clinic, hospital, practice] to see an RDN in action.

Thank you for your time.

The Treat and Reduce Obesity Act H.R. 2404 S. 1509

About Us

The Academy of Nutrition and Dietetics is the world's largest organization of food and nutrition professionals, with more than 75,000 members comprised of registered dietitians (RDs), dietetic technicians, registered (DTRs) and advanced-degree nutritionists. RDs and DTRs are currently involved in a variety of successful obesity treatment initiatives at individual, local, state and federal levels.

As part of the Obesity Action Coalition, the Academy of Nutrition and Dietetics collaborated with its partners to develop this bill to tackle the obesity epidemic by expanding Medicare coverage to include additional qualified practitioners and FDA-approved medications for patients with obesity.

Please Support the Treat and Reduce Obesity Act

The Treat and Reduce Obesity Act of 2015 is a bipartisan, bicameral bill (H.R. 2404/S. 1509) introduced in the 114th Congress by Representatives Erik Paulsen (Minn.) and Ron Kind (Wis.) and Senators Tom Carper (Del.), Dr. Bill Cassidy (La.) and Lisa Murkowski (Alaska). This bill would amend the Social Security Act to enable the Center for Medicare and Medicaid Services to enhance beneficiary access to the most qualified existing Medicare providers of intensive behavioral therapy for obesity (IBT), resulting in decreased healthcare costs and lower obesity rates among older adults.

Obesity is a Public Health Crisis that Strains America's Economy
Obesity is a public health crisis with a widespread, devastating and costly impact. Over the last 20 years obesity rates have doubled among adults, resulting in more than 35% of adults living with obesity and an additional 33% being overweight.1 Evidence suggests that without concerted action, roughly half the adult population will be obese by 2040. These numbers are particularly troubling because one out of every eight deaths in America is caused by an illness directly related to obesity; therefore, every year millions of deaths could be prevented if patients had access to effective treatment and prevention programs.2 Research documents the harmful health effects of excess body weight, which increases risk for conditions such as diabetes, hypertension, heart failure, dyslipidemia, sleep apnea, hip and knee arthritis, multiple cancers, renal and liver disease, musculoskeletal disease, asthma, infertility and depression.

Our nation is paying the price for overlooking the importance of food and nutrition related diseases. Obesity accounts for 21% of total national health care spending, summing to as much as $210 billion annually.3 Obese Medicare and Medicaid patients cost $61.8 billion per year; eradicating obesity would result in an 8.5% savings in Medicare spending.4 Obesity places an enormous financial burden on American families, our economy and our nation's healthcare system.

Current Barriers to Effective Obesity Treatment

Under current law, Medicare only covers IBT when provided by a primary care provider in the primary care setting; nutrition professionals, bariatricians, endocrinologists, psychiatrists, and clinical psychologists are prevented from effectively providing IBT. However, primary care providers are limited in their time, training and skills to conduct the high-intensity interventions that are scientifically proven to be the most effective to produce the greatest results. The Institute of Medicine "rates dietary counseling performed by a trained educator such as a [registered] dietitian as more effective than by a primary care clinician,"5 and the
U.S. Preventive Services Task Force (USPSTF) has recommended that IBT should not be limited to primary care providers in the primary care setting.6

The Treat and Reduce Obesity Act is a Clinically-Effective and Cost-Effective Answer

The Treat and Reduce Obesity Act offers clinically- and cost-effective solutions to the obesity epidemic by ensuring that Medicare patients have access to the best possible care at only a fraction of the cost. The bill removes unnecessary barriers, which would allow a variety of qualified practitioners, such as registered dietitians, to effectively treat obesity through intensive

behavioral therapy (IBT). The bill also authorizes coverage for FDA-approved weight loss medications that complement IBT.

The USPSTF found that IBT helps people with obesity lose significant weight and decrease their risk for cardiovascular disease and diabetes. Results demonstrated that on average recipients lost 6% of their baseline weight over the course of a year. Additionally, they benefited from improved glucose tolerance, lower blood pressure and decreased waist circumference. Furthermore, for patients with elevated plasma glucose levels IBT decreased the development of diabetes by about 50% over two to three years.7

IBT provided by RDs for six to twelve months yields significant mean weight loss of up to 10% of body weight, which is typically maintained beyond one year. Additionally, studies show that RD-provided IBT for people with overweight or obesity yields significant weight loss at an appropriate rate of one to two pounds per week.8

Expanding Medicare coverage of IBT to RDs can decrease healthcare costs. RDs are reimbursed by Medicare at a 15% lower rate than primary care physicians. Moreover, studies show that it is less expensive to lose weight under the care of a RD than other providers.9 Modifying Medicare coverage to include RDs as another direct provider of IBT is a cost-effective alternative and will enhance access to the obesity management benefit that only 1% of eligible beneficiaries areusing.

The bill provides coordinated, interdisciplinary care that increases efficiency and efficacy, which improves health care quality and reduces costs. To be most effective, obesity management must encompass the best standards of treatments and coordination of care. With coordinated care, each practitioner delivers the right care at the right time utilizing their advanced skill set and allowing reimbursement for only the most effective services.

View of the Academy of Nutrition and Dietetics on the Treat and Reduce Obesity Act

The Academy of Nutrition and Dietetics strongly supports the Treat and Reduce Obesity Act, because it provides cost-effective and clinically-effective solutions to our obesity epidemic. The Academy is urging members of Congress to co-sponsor and pass the bill to ensure that people with obesity have access to the most effective recommended treatment, intensive behavioral therapy provided by qualified health care practitioners.

1 Ogden et al. Prevalence of Obesity in the United States, 2009-2010. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. January 2012. http://www.cdc.gov/nchs/data/databriefs/db82.pdf

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The Preventing Diabetes in Medicare Act (H.R. 1686/S.) Issue Brief

Overview

Diabetes is a tremendously costly illness, both in terms of health outcomes and of our nation's escalating healthcare costs. Today, 29.1 million people, or 1 in 10 people in the US, have diabetes; an additional 86 million people are estimated to have prediabetes.[1] The prevalence of diabetes is even more staggering among those eligible for Medicare. In 2012, over one-quarter of U.S. residents aged 65 years and older (11.2 million) had diabetes.[2]

In other words, 7 out of 10 people eligible for Medicare are affected by diabetes or prediabetes. For half of these individuals, however, diabetes could be prevented if they had access to a diet and exercise lifestyle intervention.

The Costs of Diabetes

One out of every four federal health care dollars is spent treating people with diabetes[3]. The total cost of prediabetes and diabetes to our health care system in 2012 was estimated to be $322 billion, including $244 billion in excess medical expenditures and $78 billion in reduced national productivity.[4] Combined, this amounts to an economic burden exceeding $1,000 for each American in 2012. The average yearly healthcare costs for a person with diabetes is $13,700, with $7,900 due to diabetes alone.[4]

Role of Medical Nutrition Therapy to Prevent Diabetes

Medical Nutrition Therapy (MNT) is a nutritional diagnostic, therapy and counseling service for disease management. When provided by an RDN, MNT includes: 1) lifestyle, knowledge and skills assessment, 2) negotiation of individualized nutrition goals, 3) nutrition intervention, and 4) evaluation of clinical and behavioral outcomes. To ensure an individualized therapeutic plan, MNT is conducted through one-on- one sessions between an RDN and an individual. MNT provided by an RDN is similar to the one-on- one counseling provided during national trials that were found to prevent diabetes; people receiving MNT have shown successful weight loss and improved prediabetes insulin markers.[1]

Key Takeaways:

- Over one-quarter of the Medicare- eligible population (11.2 million over age 65) has diabetes.
- The total cost of diabetes to our health care system in 2012 was estimated to be $322 billion.
- Research shows that diabetes is preventable in people exposed to diet and exercise lifestyle modification programs, particularly among people over the age of 60.
- Medical nutrition therapy provided by a registered dietitian nutritionist is an effective, evidence-based program that can result in weight loss, obesity prevention and improved prediabetes insulin markers.
- The Preventing Diabetes in Medicare Act (H.R. 1686/S.) will allow Medicare to reimburse registered dietitian nutritionists to provide medical nutrition therapy to patients at risk of prediabetes, in addition to other covered categories.

1 Centers for Disease Control and Prevention. *National Diabetes Statistics Report: Estimates of Diabetes and its Burden in the US*, 2014. Atlanta, GA: U.S. Department of Health and Human Services; 2014.
2 *Ibid.*
3 American Diabetes Association (2014). Economic cost of diabetes in the U.S. in 2012. *Diabetes Care.* Vol 37:3172-3179.
4 *Ibid.*

MNT is a part of successful diet and exercise lifestyle modification. Research shows that MNT provided by a dietitian is an effective evidence-based practice that can result in weight loss, obesity prevention and improved prediabetes insulin markers which are the same essential outcomes of other diabetes prevention programs.[5,6,7]

Cost-Effectiveness of Diabetes Prevention

Diet and exercise lifestyle modification programs have consistently been shown to be cost-effective and even cost-saving methods for preventing and treating diabetes in participants, meaning that compared to other treatment options, such as medication, diet and exercise lifestyle modification programs gives the payer (Medicare) the best return on investment.[8,9]

Bottom line: Research shows diet and exercise lifestyle interventions are cost-effective or even cost-saving treatments for people with prediabetes.

Benefits of the Preventing Diabetes in Medicare Act (H.R. 1686/S.)

The Preventing Diabetes in Medicare Act will help to prevent cases of diabetes in the Medicare population by allowing medical nutrition therapy to be provided by a registered dietitian nutritionist for individuals with prediabetes or with risk factors for diabetes. Currently, Medicare covers screening for type 2 diabetes, and medical nutrition therapy for diabetes, but not for prediabetes.

H.R. 1686 is a bi-partisan bill that was introduced in the 114th Congress by Congresswoman DeGette (D-CO) and Congressman Ed Whitfield (R-KY).

5 Redmon JB, et al. (2005). Two-year outcome of a combination of weight-loss therapies for type 2 diabetes. *Diabetes Care.* Vol. 28(6):1311-1315.
6 Corpeleign E. et al. (2006). Improvements in glucose tolerance and insulin sensitivity after lifestyle intervention are related to changes in serum fatty acid profile and desaturase activites: the SLM study. *Diabetologia*. 49(10):2392-2401.
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8 Anderson JM. Achievable cost saving and cost-effective thresholds for diabetes prevention lifestyle interventions in people aged 65 years and older: a single-payer perspective. *J Acad Nutr Diet.* 2012;112(11):1747-54.

9 Chatterjee R, et al. (2010). Screening adults for prediabetes and diabetes may be cost-saving. *Diabetes Care*. Vol 33(7):1484-1490.

Problem-Increasing diabetes rates in Medicare population.

Today, 29.1 million people have diabetes, while 86 million are estimated to have prediabetes. Three out of four individuals eligible for Medicare are affected by diabetes or prediabetes.
Total cost of prediabetes and diabetes to the U.S. healthcare system in 2012 was estimated to be $322 billion. One out of every three federal health care dollars is spent treating people with diabetes.
Medicare covers screening for type 2 diabetes, and covers medical nutrition therapy for patients with diagnosed diabetes, but not for prediabetes.
In 2014, there were 46.2 million adults aged 65 and older in the United States; by 2060, this number will double to 98 million, putting a greater burden on Medicare.

Solution- the Preventing Diabetes in Medicare Act (H.R. 1686/S.)
This bill is a clinically and cost effective solution to prevent diabetes in the Medicare population.

Clinically effective:
Allows Medicare coverage of medical nutrition therapy for patients with prediabetes, or with risk factors for diabetes.
Medical nutrition therapy, provided by registered dietitian nutritionists, is an evidence- based intervention that prevents or delays the progression from prediabetes to diabetes.
Cost effective:
Medical nutrition therapy used as a lifestyle intervention for individuals with prediabetes is cost-effective for Medicare.

Personal story:

The Ask: Please co-sponsor the Preventing Diabetes in Medicare Act (H.R. 1686/S.), and encourage committee chairman to move the bill to the floor for a vote.

Invite Member of Congress to visit your (clinic, hospital, practice) to see an RDN in action. Thank you for your time!

The Preventing Diabetes in Medicare Act (H.R. 1686/S.

About Us

Registered dietitian nutritionists work to improve the health of all Americans through access to healthy food and nutrition services. The Academy of Nutrition and Dietetics is a nonpartisan organization representing more than 100,000 registered dietitian nutritionists (RDNs) and dietetic technicians, registered (DTRs) nationwide. Weare the world's largest organization of food and nutrition professionals (www.eatright.org).

Support the Preventing Diabetes in Medicare Act

The Preventing Diabetes in Medicare Act (H.R. 1686/S._) would amend the Social
Security Act to extend Medicare coverage for Medical Nutrition Therapy (MNT) services for persons with prediabetes and risk factors for developing Type 2 diabetes. Under current law, Medicare covers MNT provided by a registered dietitian nutritionist (RDN) only for beneficiaries with diabetes and renal disease. The Preventing Diabetes in Medicare Act would allow people with prediabetes to access MNT services from an RDN, giving them the necessary tools to help prevent the development of Type-2 diabetes – a very costly disease.

- Over one-quarter of the Medicare- eligible population (11.2 million over the age of 65) has diabetes.
- The total cost of diabetes to our healthcare system in 2012 was estimated to be $322 billion.
- The Preventing Diabetes in Medicare Act will allow Medicare to reimburse RDNs to provide MNT to patients at risk of diabetes or with prediabetes.

Medical Nutrition Therapy

Medical Nutrition Therapy (MNT) is a nutritional diagnostic, therapy and counseling service for disease management. When provided by an RDN, MNT includes: 1) lifestyle, knowledge and skills assessment, 2) negotiation of individualized nutrition goals, 3) nutrition intervention, and 4) evaluation of clinical and behavioral outcomes. To ensure an individualized therapeutic plan, MNT is conducted through one-on-one sessions between an RDN and an individual. MNT provided by an RDN is similar to the one-on- one counseling provided during national trials that were found to prevent diabetes; people receiving MNT have shown successful weight loss and improved prediabetes insulin markers.[1]

Diabetes in the United States

Almost 1 in 10 people in the U.S. (or 29.1 million people) have diabetes, and approximately 86 million have prediabetes.[2] The diabetes burden among people over age 65 is staggering: over ¼ of the Medicare-eligible population (11.2 million) has diabetes.[3] In the U.S., diabetes is the leading cause of death of kidney failure, amputation and blindness and results in higher risk of premature death, cardiovascular disease and nerve disease.[4]

1 Corpeleign E. et al. (2006). Improvements in glucose tolerance and insulin sensitivity after lifestyle intervention are related to changes in serum fatty acid profile and desaturase activites: the SLM study. *Diabetologia*.49(10):2392-2401.
2 Centers for Disease Control and Prevention. *National Diabetes Statistics Report: Estimatesof Diabetesand its Burden in the US, 2014*. Atlanta, GA: U.S. Department of Health and Human Services; 2014.
3 *Ibid.*
4 *Ibid.*

May 2016

Diet and Exercise Lifestyle Modification Programs Can Prevent Diabetes

Several recent studies have shown the effectiveness of MNT in preventing diabetes. A 2014 study from the Journal of the Academy of Nutrition and Dietetics (JAND) shows that individualized MNT is effective at decreasing hemoglobin A1c (the gold standard diabetes diagnosis marker) in prediabetic patients after 12 weeks.5 Additionally, numerous studies have found that lifestyle interventions that result in weight loss are effective at delaying type 2 diabetes in pre-diabetic individuals.6-8 A 2015 JAND study found that participants enrolled in a 16-week group lifestyle intervention had significant long-term weight loss (beyond the program) if they were able to achieve that weight loss by week 5.9 Furthermore, MNT is not only beneficial for the patient, but is also cost-effective and cost-saving according to a 2012 JAND study because it is cheaper and more individualized than other intensive
lifestyle intervention programs.10

The Cost of Diabetes

The total cost of diabetes to our healthcare system in 2012 was estimated to be $322 billion, including $244 billion in excess medical expenditures and 9 $78 billion in reduced national productivity. Combined, this amounts to an economic burden exceeding $1,000 for each American in 2012. The average
yearly health care costs for a person with diabetes is $13,700, with $7,900 due to diabetes alone.11 One out of every four federal health care dollars is spent treating people with diabetes.12

Diet and exercise lifestyle modification programs have consistently been shown to be cost-effective and even cost-saving methods for preventing and treating diabetes in participants, meaning that compared to other treatment options, such as medication, diet and exercise lifestyle modification programs gives the payer (Medicare) the best return on investment.13,14,15,16,17

View of the Academy of Nutrition and Dietetics on the Preventing Diabetes in Medicare Act

The Academy of Nutrition and Dietetics supports the Preventing Diabetes in Medicare Act (H.R. 1686/S.), and is urging members of Congress to co-sponsor and support passage of the bill. By co-sponsoring and voting for the bill, members of Congress would ensure that patients with prediabetes and those with risk factors for diabetes would have access to evidence-based preventive services to prevent diabetes.

The Preventing Diabetes in Medicare Act (H.R. 1686) is a bipartisan bill that was introduced in the 114th Congress by Rep. Diana DeGette(D-Colo.) and Rep. Ed Whitfield(R-Ky.).

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5 Parker AR, Byham-Gray L, Denmark R, Winkle PJ. The effect of medical nutrition therapy by a registered dietitian nutritionist in patients with prediabetes participating in a randomized controlled clinical research trial. J Acad Nutr Diet. 2014 Nov;114(11):1739-48.

6 Diabetes Prevention Program Research Group (2002). Diabetes Prevention Program Research Group. Reduction in the incidence of Type 2 diabetes with lifestyle intervention or metformin. *New England Journal of Medicine*. Vol. 346:393-403.

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10 Anderson, JM (2012). Achievable cost saving and cost-effective thresholds for diabetes prevention lifestyle interventions in people aged 65 and older. *J. Academy of Nutrition and Dietetics* Vol 112(11):1747- 54.

11 American Diabetes Association (2014). Economic cost of diabetes in the U.S. in 2012.
Diabetes Care. Vol 37:3172-3179. 10 *Ibid.*

11 *Ibid.*

12 Saha, S, et. al.(2010). Economic evaluation of lifestyle interventions for preventing diabetes and cardiovascular disease. *Int. J. Environ. Res. Public Health.* Vol. 7:3150-3195.

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adults. *Diabetes Care*. Vol. 30(11):2874-2879. 16 Wylie-Rosett J.,et al. (2006). Lifestyle intervention to prevent diabetes:
intensive and cost-effective. *Curr. Opin. Lipidol.* Vol. 17:37-44.

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Academy of Nutrition and Dietetics

Nutrition Education Programs and the Farm Bill

These are photos of the Iowa SNAP-Ed program

Background

Most American diets fall short of recommendations for good health and contribute to excess rates of preventable chronic diseases. About three-fourths of the population has an eating pattern that is low in vegetables, fruits, dairy and oils.[1] Food insecure-populations have unique challenges, like transportation to/from the store, access to and variety of nutritious foods and affordability of nutritious food when resources are constrained.[2]

Food insecurity is defined as "household-level economic and social condition of limited or uncertain access to adequate food." The United States Department of Agriculture (USDA) further breaks this down into low food security, or insecurity without indications of reduced food intake, and very low food security, or insecurity with reduced food intake and irregular eating patterns.[3]

Food insecurity is declining, but is still above pre-recession level. In 2015, 12.7 percent (15.8 million) households were food insecure compared to 11.1 percent in 2007 and the recession peak of 14.9 percent in 2011. Of these households, 5 percent experienced very low food security, meaning some members ate less. 7.8 percent of households with children experienced food insecurity in 2015.[4] **Our nation's nutrition safety net, the largest and wide reaching program SNAP, is critical to addressing basic nutritional needs for families.**

About Us:

The Academy of Nutrition and Dietetics is committed to:

- Improving the health of Americans by assuring access to a healthy, safe, affordable and adequate food supply.
- Ensuring that quality nutrition services and appropriate nutrition education are integral components included in nutrition assistance programs.

The Academy strongly supports reauthorization of nutrition education programs in the Farm Bill, paired with nutrition assistance programs. This will help improve the demand and marketplace for a diversity of foods that contribute to health and food security.

May 2017

Nutrition Education's Role to Improve Diet Quality and Reduce Food Insecurity

Nutrition education and promotion can be a tool to empower people to make healthy, safe affordable food choices. Nutrition education and promotion is designed to be innovative, engaging and tailored to the unique needs of the community served in order to support behavior change. These changes result in healthier lifestyles and help decrease costly chronic disease and can improve food security status.

The Farm Bill reauthorizes two effective nutrition education programs: SNAP Nutrition Education and Obesity Prevention grants (SNAP-Ed) and the Expanded Food and Nutrition Education Program (EFNEP). These education programs coordinate and create synergies to maximize reach and attempt with limited funding to meet the need for nutrition education messages to empower families to make healthy choices.

SNAP-Ed and EFNEP are innovative nutrition education program that meets the unique needs of low-income communities nationwide. **These programs provide targeted effective nutrition education that empowers families to make lasting behavior change and builds skills to manage limited resources towards economic self-sufficiency beyond the short time that a typical SNAP recipient utilizes that benefit.**

SNAP-ED AND EFNEP FAST FACTS

SNAP-Ed:

SNAP Ed completed 562,894,054 contacts in 2015. These contacts consist of the following three categories:

- Direct education: 41,489,783 contacts
- Indirect education: 146,515,970 contacts
- Social marketing: 374,888,292 contacts

Federal investment: approximately $400 million/year or 0.5 percent of the total SNAP budget.

SNAP-Ed is offered in all 50 states, Guam, the Virgin Islands and the District of Columbia.

USDA's Food, Nutrition and Consumer Service (FNS) manages SNAP-Ed grants awarded to the state agency that administers SNAP. That state agency contracts with organizations like land-grants universities, state health departments and other nonprofits to deliver the nutrition education programming.

SNAP-Ed programming is carefully designed to meet the needs of the community and the audience. As a result, the delivery can be different in every state. Each state and community can decide whether a direct education, multi-level interventions and community and public health approaches to improve nutrition works best to have successful outcomes.

Find your State's SNAP-Ed Program: https://snaped.fns.usda.gov/state-contacts

SNAP-ED AND EFNEP FAST FACTS (CONTINUED)

EFNEP:

EFNEP reaches more than 119,000 adults and 378,000 children.

Federal investment: approximately$68 million/year.

USDA's National Institute of Food and Agriculture (NIFA) manages EFNEP and provided funding to 75 land-grant universities, which in turn send EFNEP peer educators into communities to provide hands-on, evidence-based learning opportunities.

EFNEP is available in more than 800 counties in all 50 states, six U.S. territories and the District of Columbia.

Find your state's EFNEP program: https://nifa.usda.gov/sites/default/files/resource/EFNEP%20Coordinator%20Directory%20-%2009Feb2017B.pdf

Effectiveness of SNAP-Ed and EFNEP

Every state has a different name for its SNAP-Ed program, which might make it difficult to identify the one in your state. However, a snapshot of SNAP-Ed and EFNEP successes show:

- Purdue Extension Nutrition Education Program improved Household food security by 25 percent in households with at least one person participating in the SNAP-Ed curriculum when compared to a control group. Participants saw lasting effects one year post-intervention.[5]
- A California SNAP-Ed program found a significant increase in the number of participants meeting the recommended 5+ servings of fruit and vegetables daily. The greatest improvements were seen in those populations that have the greatest need. (91 percent improvement in the poorest segment of the population, 77 percent improvement in the African American population, 43 percent improvement in the Latino population).[6]
- A Pennsylvania SNAP-Ed program, through the Food Trust, as part of a multifaceted approach, has shown a 50 percent reduction in the incidence of overweight among elementary school students.[7]
    - Nationally, EFNEP shows that 94 percent of adults improved their diet, including consuming an additional ½ cup of fruits and vegetables.[8]
    - According to an analysis by the Agricultural and Applied Economics Association, $1 spent on the adult EFNEP program produced a public health benefit equivalent to $10.96. Other results differed, ranging from Oregon's $3.62 benefit per $1, to Iowa's $12.50 benefit per $1, but all point to significant programmatic value.[9]

Just a Few of the Names of SNAP-Ed Programs in Your State

SNAP-Ed has a name that is unique to your state or community. Below are just a few names of these SNAP-Ed programs.

Recent Changes to SNAP-Ed

Nutrition education is changing and SNAP-Ed has kept up with these changes. The Healthy, Hunger-Free Kids Act of 2010, USDA Guidance, regulations and federal/state cooperation that followed all strengthened the mission of SNAP-Ed and its effectiveness.

Some of these changes include:

- Adding physical activity and obesity prevention to the mission
- Reaching more low-income people, by using a blend of education, marketing, public health and community approaches
- Coordinating with other federal agencies, including CDC and NIH
- Using evidence-based interventions to increase accountability, through the SNAP-Ed Evaluation Framework.

Conclusion

The Academy of Nutrition and Dietetics strongly supports the necessity of pairing nutrition assistance programs with strong and comprehensive nutrition education programs. SNAP-Ed and EFNEP continue to provide innovative and effective nutrition education that empower families to make lasting healthy choices.

More on the SNAP-Ed Evaluation Framework:

In June 2016, building on the **30-year history of innovative state evaluations**, a team with representation from the USDA, CDC and the National Collaborative on Child Obesity Research released the SNAP-Ed Evaluation Framework and Interpretative Guide. This evaluation **framework is designed as a science-driven roadmap to show how collective efforts across the country could lead to population results**. It is designed to help SNAP-Ed implementing agencies capture the more far-reaching and permanent benefits to society that experts say are needed and that this kind of work can generate.

Frequently Asked Questions (FAQs)

Q: How are EFNEP and SNAP-Ed different?

A: EFNEP and SNAP-Ed are both nutrition education programs that work together to maximize investment in nutrition assistance programs. They are different, but complimentary. SNAP-Ed is the larger of the two federal investments and is delivered in a variety of ways, including indirect and direct education, social marketing and policy system and environmental strategies. EFNEP is a para-professional model utilizing direct education in a series.

Q: How are these programs evaluated?

A: SNAP-Ed utilizes an evaluation framework that measures how collective efforts across the country can lead to population change. Each state has an impact report that is sent to USDA annually. EFNEP also collects data on health impact and reach of the program which is reported annually to USDA.

Footnotes

1. Dietary Guidelines for Americans 2015–2020. United State Department of Agriculture and Health and Human Services. Chapter 2 Shifts Needed to Align with Healthy Eating Patterns. Accessed at https://health.gov/dietaryguidelines/2015/guidelines/chapter-2/current-eating-patterns-in-the-united-states/#current-eating-patterns-in-the-united-states on May 11, 2017
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8. USDA, National Institutes of Food and Nutrition Expanded Food and Nutrition Education Program. Accessed May 4, 2017 at https://nifa.usda.gov/program/expanded-food-and-nutrition-education-program-efnep
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TALKING POINTS FOR ACADEMY MEMBERS

Academy of Nutrition and Dietetics

Nutrition Education Programs and the Farm Bill

Problem:

Most American diets fall short of recommendations for good health and contribute to excess rates of preventable chronic diseases.

- About three-fourths of the population has an eating pattern that is low in vegetables, fruits, dairy and oils.
- Poor diet quality leads to costly chronic disease like, diabetes, heart disease, obesity and cancer.

Food-insecure populations have unique challenges when resources are constrained to feed their families in a healthy way.

- The USDA published a Household Food Security Report in 2015 showing 14.1 percent of individuals living in principal metropolitan areas and 15.4 percent of individuals in rural areas experience food insecurity.
- Issues such as transportation to/from the store, access to and variety available of nutrition foods and affordability of nutritious food impact the food security of individuals and families.

Consequences of food insecurity include higher incidences of chronic diseases like type two diabetes and hypertension, behavioral problems seen in children in school and at home, hunger and many others.

Solution:

Nutrition education paired with nutrition assistance programs is critical tool that can improve health and food security.

The Farm Bill reauthorizes two effective nutrition education programs:

- SNAP Nutrition Education and Obesity Prevention grants (SNAP-Ed)
- Expanded Food and Nutrition Education Program (EFNEP)

These effective nutrition education programs coordinate and create synergies to:

- Maximize limited funding to meet the need for nutrition education programming
- Empower families to make healthy choices.

SNAP-Ed and EFNEP programming continue to be improved and meet the SNAP populations where they live, shop, worship and go to school.

Many programs are led by highly qualified staff like registered dietitian nutritionists who track outcomes and strive to improve the programs to be most effective.

Share Your Personal or State Story (share the impact on your community; each state has a SNAP-Ed and EFNEP program):

The Ask

Since the inception of nutrition assistance programs, Congress and the USDA have recognized the critical role of federal investment in nutrition education and promotion that help the most nutritionally vulnerable populations make healthy food choices.

"Please reauthorize and fully fund SNAP-Ed and EFNEP in the Farm Bill."

Invite your member of Congress to see a RDN, DTR in action.

Thank them for their time.

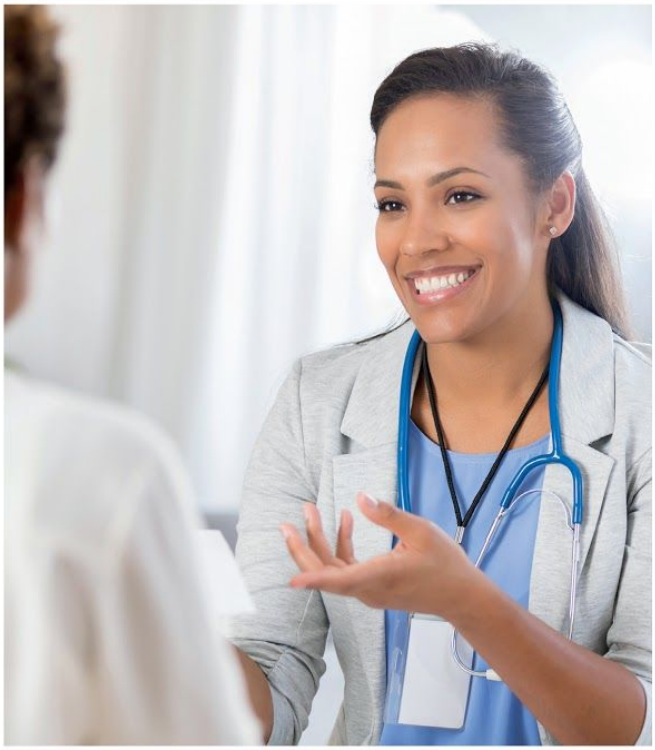
May 2017

The Role of RDNs and NDTRs in Malnutrition Prevention and Treatment

Issue Brief for Academy Members

About the Academy

The Academy of Nutrition and Dietetics is committed to improving the nation's health and advancing the profession of dietetics through research, education and advocacy. Our members include registered dietitian nutritionists, nutrition and dietetics technicians, registered and advanced-degree nutritionists. The Academy works with leaders to find nonpartisan public policy solutions that promote health and reduce the burden of chronic disease, including malnutrition, through nutrition services and interventions.



What Is Malnutrition?

Malnutrition is the inadequate intake of nutrients over time and may contribute to chronic and acute illness.[1] Malnutrition is a leading cause of morbidity and mortality, especially among older adults.[1] Up to half of adults 65 and older and as many as 39 percent of older adult patients may be malnourished or at risk.[2] Additionally, up to 31 percent of malnourished patients and 38 percent of well-nourished patients experience nutritional decline during hospital stays.[3] Despite the high prevalence of malnutrition in hospitals, a review of nationally representative data indicated that, in 2013, only 7 percent of patients had a diagnosis of malnutrition,[4] potentially leaving millions of patients undiagnosed and untreated.

People can be either underweight or overweight and still be malnourished when they lack sufficient nutrients needed to promote healing, rehabilitation and reduce their risk of medical complications.[1] Changes commonly associated with aging such as loss of appetite, limited ability to chew or swallow and use of multiple medications place older adults at a higher risk for developing malnutrition.[5] Patients experiencing malnutrition are at an increased risk for complications; they are five times as likely to die in the hospital[4] and have a 54 percent increase in readmissions compared to non-malnourished patients.[6]

The Cost of Malnutrition

According to estimates by the Centers for Disease Control and Prevention, one in five Americans will be 65 or older by 2050.[8] With an increasingly older population that is at risk for malnutrition, the cost of malnutrition is expected to increase. Hospital costs may be up to 100 percent higher for malnourished patients compared to non-malnourished patients ($25,000 vs. $12,500).[4] The estimated economic burden of disease-associated malnutrition in the U.S. is $157 billion and nearly one third of this cost ($51.3 billion) can be attributed to older adults.[7]

September 2018

Role of the MQii to Prevent and Treat Malnutrition

Preliminary data collected from the MQii Learning Collaborative suggests a significantly reduced likelihood of 30-day readmission for malnourished patients who receive a nutrition care plan from a Registered Dietitian Nutritionist compared to those without a nutrition care plan.

Despite evidence that demonstrates the benefits of nutrition for healing and recovery and a clinical consensus model for implementing optimal nutrition care, significant variation and gaps remain with respect to nutrition screening, assessment, intervention, monitoring and overall care for malnourished and at-risk hospitalized older adults.[1] In addition, no national benchmarking of malnutrition in acute care hospitals exists in the United States.[1] To address these issues, Avalere Health and the Academy of Nutrition and Dietetics have collaborated to develop the Malnutrition Quality Improvement Initiative. This is a dual-pronged approach to advancing malnutrition care for hospitalized older adults that includes the implementation of an evidence-based toolkit as well as the adoption of four electronic quality measures.[9] The eCQMs help hospitals demonstrate successes and identify remaining gaps in care and the toolkit provides guidelines for hospitals to achieve best practices for nutrition care.[10]

The eCQMs are:

- Completion of a malnutrition screening within 24 hours of admission
- Completion of a nutrition assessment for patients identified as at risk for malnutrition within 24 hours of a malnutrition screening
- Creation of a nutrition care plan for patients identified as malnourished after a completed nutrition assessment
- Appropriate documentation of a malnutrition diagnosis[10]

Etiology-based Malnutrition Definition

Adult malnutrition may be described in the context of acute illness or injury, chronic diseases or conditions and starvation-related malnutrition.[11]

Criteria for Diagnosis

Since no single parameter is definitive for adult malnutrition, identification of two or more of the following six characteristics is recommended for diagnosis:

- Insufficient energy intake
- Weight loss
- Loss of muscle mass
- Loss of subcutaneous fat
- Localized or generalized fluid accumulation that may sometimes mask weight loss
- Diminished functional status as measured by hand grip strength[11]

A composite measure that encompasses these eCQMs has been submitted to the Centers for Medicare and Medicaid Services to be considered for adoption into CMS' programs.[10] Hospitals that participate in the MQii also receive substantial support via participation in the Learning Collaborative, which is a network of hospitals that collaborate to successfully implement the MQii and generate reports on successes and challenges. In 2017, Learning Collaborative members reported meaningful improvements in the delivery of malnutrition care.[9]

Screening for Malnutrition

Nutrition screening is a critical step for identifying malnutrition risk and, consequently, for determining if a patient or client should continue on to the Nutrition Care Process with a full nutrition assessment. However, numerous adult nutrition screening tools exist for use in various populations, though many institutions use different screening methods without valid or reliable evidence.

To address this gap in knowledge, the Academy's Evidence Analysis Center research staff and experts are conducting systematic reviews. The adult nutrition screening workgroup reviewed validity and reliability of adult nutrition screening tools that were quick and easy to use and could be used for a variety of age groups, settings, diseases and treatments. Of the six nutrition screening tools, the most frequently examined were the Malnutrition Screening Tool, Malnutrition Universal Screening Tool, Mini Nutrition Assessment-Short Form. MST received Grade I (Good/Strong) evidence, while the other five nutrition screening tools (Short Nutritional Assessment Questionnaire, Mini Nutrition Assessment-Short Form-Body Mass Index and Nutrition Risk Screen-2002) received Grade II (Fair) evidence. The workgroup ranked the nutrition screening tools from highest to lowest: MST, MUST, MNA-SF, SNAQ, MNA-SF-BMI and NRS-2002. The findings of the systematic review are expected to be published on the EAL in September.

While changes in acute-phase proteins (e.g. albumin and prealbumin) have been used in health care settings to diagnose malnutrition, analyses conducted by the Academy's Evidence Analysis Library indicated these parameters appear to better reflect the severity of inflammatory response rather than poor nutritional status.[12–14] Therefore, the Academy and the American Society for Parenteral and Enteral Nutrition do not propose any specific inflammatory markers for diagnostic purposes at this time.[11]

Cost-Effectiveness of the MQii

Nutrition interventions have repeatedly been shown to be cost-effective in improving health outcomes among malnourished patients.[15,16] For example, a 2017 *American Health and Drug Benefits* study found implementation of a nutrition-focused quality improvement program reduced costs by $4.9 million and saved hospitals an average of $3,900 per patient.[17] The MQii Toolkit was tested over a three-month implementation period in 2016 through a multisite demonstration and learning collaborative. Findings suggest the toolkit helped hospitals achieve performance goals in nutrition care.[10] A 2017 *Journal of Parenteral and Enteral Nutrition* study found optimizing nutrition care in hospitals could result in a 27 percent decrease in 30-day readmission rates and a two-day reduction in average length of stay for malnourished patients.[18]

Next Steps

The MQii is continually looking for ways to track and improve malnutrition care. A patient's condition and needs may change during the course of a chronic or acute illness, which could necessitate a change in care setting.[10] Therefore, in March, the MQii convened multi-stakeholder dialogue proceedings on malnutrition care transitions.[10] A pilot program will be established to implement and test a number of the recommendations outlined at the proceedings with the goal of advancing identification and treatment of patients as they transition across care settings.[19]

Malnutrition Prevalence Across Care Settings

Acute Care 20-50% | **Post-Acute Care 14-51%** | **Community Care 6-30%**

More than 40% of patients age 50+ are not getting the right amount of protein each day.

70% of adults are overweight or have obesity.

NHANES data from 2007-2008.[22]

Addressing malnutrition directly aligns with the U.S. Department of Health and Human Services' National Quality Strategy priorities related to patient safety, care coordination, patient- and family-centered care, population health and affordability.[1] In the 2017 Inpatient Prospective Payment System rule, CMS recognized the prevalence and negative consequences of malnutrition as well as the need for improved screening, assessment and diagnosis.[20] The MQii Learning Collaborative grew from three hospitals in 2015 to 50 hospitals in 2017.[21] The goal in 2018 and beyond is to further expand participation in the Learning Collaborative and to generate additional evidence to support adoption of the eCQMs by CMS for the advancement of malnutrition care across our nation.[10]

Recommended Policy Proposals

The Academy asks Congress to support the role of RDNs and NDTRs in the prevention and treatment of malnutrition and encourages Congress to support policies to better align with the goals of treatment and prevention. Malnutrition prevention and treatment should be included in future health care discussions, including in chronic disease legislation and quality measures.

The Academy recommends[9]:

- A multi-stakeholder group of health and community leaders and advocates came together in a national dialogue to identify real-world solutions to integrate nutrition risk identification and care into existing care transition pathways and accountable care models. The results of their discussion are the basis for these policy-related recommendations to better integrate optimal nutrition care into national quality programs.

- Adopt clinically meaningful malnutrition-related quality measures and improvement activities into accountable care models and population health initiatives to improve prevention, identification and management for patients across care settings.
- Incorporate nutrition status into transfer of health information upon admission to and discharge from acute and postacute care settings (IMPACT Act implementation).
- Include nutrition risk identification and malnutrition care in the Welcome to Medicare Exam and Annual Medicare Wellness Exam.
- Include nutrition risk identification and malnutrition care in CMS Quality Programs and Advanced Alternative Payment Models (Comprehensive Primary Care Plus Program, Bundled Payment for Care Initiative, Oncology Care Model Quality Payment Program, Hospital Inpatient Quality Reporting, Home Health and Skilled Nursing Facility Quality Reporting Programs).
- Adopt standardized malnutrition terminology and clinical standards in EHRs to improve malnutrition risk identification and data transfer across care settings.
- Establish state commissions to develop targeted local plans to improve nutrition risk identification and malnutrition care.
- Collect data and publish results from CMS national and state care transition pilots that incorporate nutrition-related activities.

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The Role of RDNs and NDTRs in Malnutrition Prevention and Treatment

Leave Behind for Members of Congress

About Us

The Academy of Nutrition and Dietetics is the world's largest organization of food and nutrition professionals, representing more than 100,000 registered dietitian nutritionists, nutrition and dietetics technicians, registered and advanced-degree nutritionists. The Academy is committed to a world where all people thrive through the transformative power of food and nutrition. RDNs and DTRs are involved in many successful malnutrition treatments.

Malnutrition in the United States

Malnutrition is a leading cause of morbidity and mortality, especially among older adults.[1] Up to half of adults age 65 and older and as many as 39 percent of older adult patients may be malnourished or at risk.[2] Additionally, up to 31 percent of malnourished patients and 38 percent of well-nourished patients experience nutritional decline during hospital stays.[3] Despite the high prevalence of malnutrition in hospitals, a review of nationally representative data indicated that, in 2013, only 7 percent of patients had a diagnosis of malnutrition,[4] potentially leaving millions of patients undiagnosed and untreated.

Malnutrition is the inadequate intake of nutrients over time and may contribute to chronic and acute illness.[1] People can be either underweight or overweight and still be malnourished when they lack sufficient nutrients needed to promote healing, rehabilitation and reduce the risk of medical complications.[1] Changes commonly associated with aging such as loss of appetite, limited ability to chew or swallow and use of multiple medications place older adults at a higher risk for developing malnutrition.[5] Patients experiencing malnutrition are at an increased risk for complications; they are five times as likely to die in the hospital[4] and have a 54 percent increase in readmissions compared to non-malnourished patients.[6]

September 2018

The Cost of Malnutrition

With an increasingly older population that is at risk for malnutrition, the cost of malnutrition is expected to increase. Hospital costs may be up to 100 percent higher for malnourished patients compared to non-malnourished patients ($25,000 vs. $12,500).[4] The estimated economic burden of disease-associated malnutrition in the U.S. is $157 billion and nearly one third of this cost ($51.3 billion) can be attributed to older adults.[7] According to estimates by the Centers for Disease Control and Prevention, one in five Americans will be 65 or older by 2050.[8]

Role of RDN and NDTRs to Prevent and Treat Malnutrition

RDNs and NDTRs have the knowledge and expertise to identify malnutrition across the life cycle and around the globe. Despite evidence that demonstrates the benefits of nutrition for healing and recovery and a clinical consensus model for implementing optimal nutrition care, significant variation and gaps remain with respect to nutrition screening, assessment, intervention, monitoring and overall care for malnourished and at-risk hospitalized older adults.[1] Malnutrition treatment and prevention require an interdisciplinary team approach. RDNs and NDTRs are an important key component of the team and have the opportunity and responsibility to be at the forefront. Using evidence-based tools, RDNs can help diagnose malnutrition; both RDNs and NDTRs can help assess, document and treat malnutrition in a variety of practice settings. Preliminary data collected from the MQii Learning Collaborative suggests a significantly reduced likelihood of 30-day readmission for malnourished patients who receive a nutrition care plan from a Registered Dietitian Nutritionist compared to those without a nutrition care plan.

RDNs and NDTRs play important roles in the identification of, and intervention for, malnourished individuals. The Academy and Avalere Health have developed quality measures aimed at performance gaps in malnutrition care with the goal to place malnutrition front and center in health care settings.

Addressing malnutrition directly aligns with the U.S. Department of Health and Human Services National Quality Strategy priorities related to patient safety, care coordination, patient- and family-centered care, population health and affordability.[1] Additionally, in the 2017 Inpatient Prospective Payment System rule, the Centers for Medicare & Medicaid Services recognized the prevalence and negative consequences of malnutrition as well as the need for improved screening, assessment and diagnosis.[9]

Estimated Malnutrition Costs in the United States

- Estimated economic burden of disease-associated malnutrition in the U.S. $157 billion
- Nearly one-third of this cost can be attributed to older adults.[6]

Key Takeaways

- Malnutrition treatment and prevention requires an interdisciplinary team approach. Registered dietitian nutritionists and nutrition and dietetics technicians, registered are an important key component of the team.
- Malnutrition is a leading cause of morbidity and mortality, especially among older adults.[1]
- Millions of patients are undiagnosed and untreated.
- RDNs can help diagnose malnutrition.
- RDNs and NDTRs can help assess, document and treat malnutrition in a variety of practice settings.
- Preliminary data collected from the MQii Learning Collaborative suggests a significantly reduced likelihood of 30-day readmission for malnourished patients who receive a nutrition care plan from a Registered Dietitian Nutritionist compared to those without a nutrition care plan.

Recommended Policy Proposals

The Academy asks Congress to support the role of RDNs and NDTRs in the prevention and treatment of malnutrition and encourages Congress to support policies to better align with the goals of treatment and prevention. Malnutrition prevention and treatment should be included in future health care discussions, including in chronic disease legislation and quality measures.

The Academy recommends[10]:

- Adopt clinically meaningful malnutrition-related quality measures and improvement activities into accountable care models and population health initiatives to improve prevention, identification and management for patients across care settings.
- Incorporate nutrition status into transfer of health information upon admission to and discharge from acute and postacute care settings (IMPACT Act implementation).
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- Collect data and publish results from CMS national and state care transition pilots that incorporate nutrition-related activities.

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Helpful Data*

Number of registered dietitians in Iowa (as of May 2016): 1046

Number of registered dietitians in nation (as of May 2016): 94,084

Obesity prevalence in Iowa (Centers for Disease Control & Prevention, 2014): 30.9%

Attributable health care cost due to obesity (National Conference of State Legislatures, in millions, 2009): $1,435 (http://www.ncsl.org/research/health/obesity-statistics-in-the-united-states.aspx#6)

Adults diagnosed with diabetes (Iowa, 2014): 225,365 (http://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html#)

Percentage of adults with diagnosed diabetes (Iowa, 2014): 9.5%

Projected cases of adults with diagnosed diabetes in 2030 (Iowa): 367,691 (http://stateofobesity.org/states/)

Adults with prediabetes (Iowa, 2014): 167,000 (http://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html#)

Percentage of adults with prediabetes (Iowa, 2014): 6.6% (http://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html#)

*Helpful Data compiled from various Academy of Nutrition & Dietetics resources