Cardiovascular Health and Well-being
a dietetic practice group of the
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Pathways

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Publication of Cardiovascular Health and Well-being Dietetic Practice Group

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Publication of Cardiovascular Health and Well-being (CV-Well), a dietetic practice group of the Academy of Nutrition and Dietetics

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In This Issue

CPE Opportunities in This Issue

After reading this issue of *Pathways*, current CV-Well DPG members (and nonmembers who purchase this publication) can earn 1 hour of continuing education units (CEUs), level 2 approved by the Commission on Dietetic Registration (CDR). Users must complete the post-test and Critical Thinking Tool in the Academy's Learning Management System (LMS) by March 28, 2025. You can begin this activity by logging in here. The certificate of completion is valid when the CPE self-assessment questionnaire is successfully completed, submitted, and recorded by CV-Well DPG/Academy of Nutrition and Dietetics.

Call for Authors

Pathways, the flagship quarterly publication of CV-Well DPG, welcomes the submission of manuscripts to be considered for research-based or practice-based articles. Research articles summarize and discuss recent scientific evidence related to cardiovascular health (prevention and treatment) and well-being. Practice articles translate evidence into application for dietitians working in various settings, providing tools and recommendations on topics related to cardiovascular health (prevention and treatment) and well-being. Authors may be DPG members or nonmembers.

CV-Well Said

A Message from the Chair

Support and Challenge

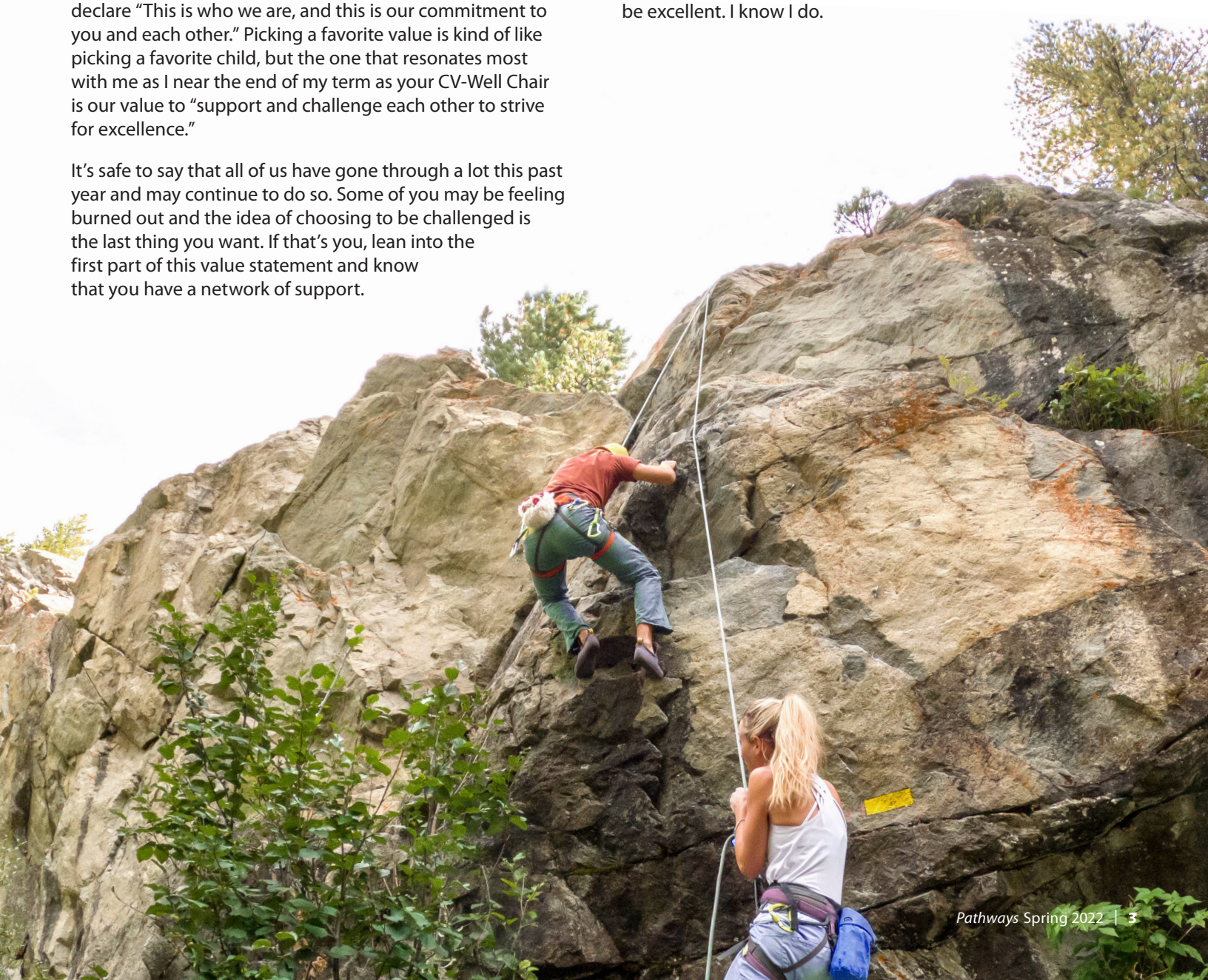
by Elizabeth Abbey, PhD, RDN, CDN, CV-Well Chair

About this time last year, the CV-Well transition team was working to articulate our mission, vision, and values. Value statements are less common than a mission and vision, but I think they are crucial to the grounding of an organization and add a layer of accountability. Value statements essentially declare "This is who we are, and this is our commitment to you and each other." Picking a favorite value is kind of like picking a favorite child, but the one that resonates most with me as I near the end of my term as your CV-Well Chair is our value to "support and challenge each other to strive for excellence."

It's safe to say that all of us have gone through a lot this past year and may continue to do so. Some of you may be feeling burned out and the idea of choosing to be challenged is the last thing you want. If that's you, lean into the first part of this value statement and know that you have a network of support.

If, however, you're ready to be stretched, know that you have a professional home of colleagues and resources to take your practice to the next level. This edition of *Pathways* embraces that challenge as we consider the controversies surrounding saturated fats and the way we talk about dietary fats with our patients and clients. Our profession is constantly evolving, and CV-Well is here to help you stay ahead of the curve.

As we prepare to launch a new CV-Well year, we look forward to connecting with you *in person* at FNCE in October and at our inaugural CV-Well Symposium in spring 2023. I hope you find CV-Well to be a trusted resource that supports and challenges you to be excellent. I know I do.



CPE Research Article

Saturated Fatty Acids: Controversies and Future Research Needs

by Lisa M. Sanders, PhD, RDN; Kevin C. Maki, PhD, CLS; and Carol F. Kirkpatrick, PhD, RDN, CLS

CPE Objectives

- Summarize the evidence supporting current dietary recommendations regarding intake of saturated fatty acids (SFAs).
- Discuss the debate surrounding the impact of SFA intake on cardiovascular health.
- Identify areas in need of additional research on dietary SFAs and atherosclerotic cardiovascular disease.

For years, dietary guidance from national and international health authorities has included limiting saturated fatty acid (SFA) intake to manage hypercholesterolemia and reduce the risk of atherosclerotic cardiovascular disease (ASCVD).[1-8] It is recommended that generally healthy individuals consume <10% total daily energy (TDE) from SFAs,[1,3,4] whereas individuals with dyslipidemia limit their SFA intake to even lower levels.[2,4,7] These recommendations are based on evidence that dietary SFAs raise plasma concentrations of low-density lipoprotein cholesterol (LDL-C) compared with carbohydrates or unsaturated fatty acids, and elevations in LDL-C contribute to the development and progression of ASCVD.[1-8] However, debate over these recommendations continues due to criticisms of the quality of scientific evidence for the relationship between SFA intake and ASCVD.[9] This review summarizes the evidence for, and controversies surrounding, recommendations to limit SFA intake to promote cardiovascular health, as well as identifies areas for additional research.

Impact of SFA Intake on LDL-C

Evidence from observational studies and randomized controlled trials (RCTs) supports a reduced risk of major cardiovascular events with lower circulating LDL-C, a surrogate for circulating concentrations of atherogenic lipoprotein particles.[10-12] There is also near-universal agreement that a lower LDL-C concentration for a longer duration is better.[13] A meta-analysis of individuals on statin therapy for ~5 years showed a 22% reduction in risk of major vascular events (e.g., myocardial infarction, stroke) for every 38.7 mg/dL reduction in LDL-C.[10] A similar meta-analysis revealed a 32% reduction in risk of coronary heart disease (CHD) events for every 38.7 mg/dL reduction in LDL-C over a period of ~12 years and a 52% lower risk over multiple decades (>50 y).[11,12]

Considering this clear benefit of LDL-C reduction on ASCVD risk, numerous controlled feeding trials have evaluated the effect of reduced SFA intake on LDL-C levels. Because reduction of SFAs in the diet results in a reduction of calories, the calories may be replaced with other macronutrients (i.e., monounsaturated fatty acids [MUFAs], polyunsaturated fatty acids [PUFAs], or carbohydrates). A meta-regression analysis demonstrated that replacing 1% of calories from SFAs with calories from MUFAs, PUFAs, or carbohydrates lowered LDL-C by 1.6, 2.1, and 1.3 mg/dL, respectively.[14] Therefore, with replacement of 5% of calories, LDL-C could be lowered by 8 mg/dL with MUFAs, 10.5 mg/dL with PUFAs, and 6.5 mg/dL with carbohydrates.

Some experts argue this is a small effect that may not be clinically relevant,[15] but others suggest that, if maintained over many years, it could significantly reduce ASCVD risk.[11,12] Based on calculations from Maki et al.,[12] replacement of 5% of calories from SFAs with PUFAs could lower the risk of a major vascular event by 6.6% over 5 years and reduce the risk of CHD by 18.3% over several decades.

Taken together, the evidence supporting reduced risk of ASCVD with lower levels of LDL-C and the reduction in LDL-C achieved through limiting SFA intake supports current dietary guidance suggesting SFA intake <10% TDE, which is lower

than the current average of ~11% TDE in the United States.[3] However, some have questioned these conclusions.[15,16]

It has been suggested that LDL-C reduction by limiting SFA intake will have less impact on ASCVD risk because the reduction is primarily in large LDL particles, and small LDL particles are more strongly associated with ASCVD risk.[16,17] However, when LDL particle concentration is controlled in statistical analyses, the association of LDL particle size with ASCVD risk is typically lost.[12,18] Furthermore, statin therapy preferentially lowers large LDL particles and reduces ASCVD risk; also, individuals with familial hypercholesterolemia have primarily large LDL particles and are at increased risk of ASCVD.[12,19] Thus, it is likely that all LDL particles, regardless of size, are atherogenic, and reduction of LDL-C by limiting SFA would be expected to lower ASCVD risk.

Impact of Macronutrient Replacement for SFA and ASCVD Risk

Many observational studies report a lower risk of CHD and cardiovascular events with low SFA intake. However, risk reduction differs depending on the macronutrient replacing SFA. One study that pooled data from multiple large U.S. cohorts demonstrated that higher intake of PUFAs and carbohydrates from whole grains was significantly associated with a lower risk of CHD.[20] A substitution analysis showed a 25%, 15%, and 9% lower CHD risk when 5% energy from SFA was replaced with PUFA, MUFA, and whole grain carbohydrates, respectively. However, when 5% energy from SFA was replaced with refined starches and sugars, there was no associated reduction in CHD risk.[20] This has contributed to the SFAs controversy, given it is difficult to determine whether benefits on CHD risk are due to the reduction of SFA or to the addition of MUFA and/or PUFA to the diet.[15] In addition, the quality of carbohydrates in the diet may also impact CHD risk.

There are relatively few RCTs evaluating the effect of SFA reduction on cardiovascular outcomes. Results from a recent meta-analysis suggest a benefit of lower SFA consumption on cardiovascular outcomes, but the risk reduction is small and often nonsignificant.[21] However, this meta-analysis did not analyze the effect on outcomes based on the macronutrient source used to replace energy from SFA, in addition to other limitations (i.e., sample size, study duration, definition of cardiovascular events) of the included RCTs.[12] In evaluating the RCT evidence, the Science Advisory Committee of the American Heart Association concluded that trials replacing SFA with PUFA demonstrate a reduction in ASCVD event risk, but the same effect was not seen when carbohydrates replaced SFA.[6]

Overall, observational and RCT evidence are concordant, suggesting reduction of SFA intake is beneficial for ASCVD risk when replaced with unsaturated fatty acids. However, additional RCTs examining replacement of SFA with different macronutrients are needed. Several RCTs in meta-analyses are decades old and do not meet current standards for RCT quality. Moreover, they were conducted when the prevalence of ASCVD risk factors, such as obesity, hypercholesterolemia, smoking, and uncontrolled hypertension, differed from current prevalence rates.[6,12]

Impact of Different SFAs and the Food Matrix

Another topic of debate around SFA and ASCVD risk is the differential effects of specific SFAs. Stearic acid (18:0) intake does not raise LDL-C levels compared with carbohydrate, whereas lauric (12:0), myristic (14:0), and palmitic (16:0) acid do raise LDL-C concentrations.[14] In addition, palmitic acid (16:0) contained in plasma phospholipids is positively associated with the incidence of cardiovascular disease (CVD), whereas stearic acid (18:0) is inversely associated.[12,22] However, these findings should be considered with caution given dietary SFAs are not the only determinant of phospholipid fatty acid content, and palmitic acid is the primary product of de novo lipogenesis (conversion of carbohydrate to fatty acids).[12,23] Some odd-chain fatty acids, such as heptadecanoic acid (17:0) found primarily in dairy foods, have been shown in observational studies to be inversely related to CVD risk,[12,24,25] but well-controlled trials are necessary to further clarify the relationship of specific SFAs to ASCVD risk.

The impact of SFA on LDL-C and ASCVD risk may also be influenced by the presence of other potentially beneficial components (e.g., calcium, potassium, fermentation products) in the food matrix. Results from observational studies indicate that SFA intake from dairy foods is associated with a neutral effect or lower risk of ASCVD, whereas SFA intake from meat products is associated with increased risk.[26] Even among dairy foods, studies have found that high-fat milk intake is associated with increased CHD risk, while cheese intake is inversely associated with CHD risk.[27] However, these results should be interpreted with caution because observational studies are subject to various sources of bias and confounding and they cannot directly demonstrate causality. RCTs have shown that whole-fat fermented dairy products, such as yogurt and cheese, have less impact on LDL-C than would be expected considering the SFA content.[28]

These differences based on the food matrix have created debate about food-based dietary guidelines that typically advocate for low- or reduced-fat dairy to minimize SFA consumption. Additional research is needed to understand how the food matrix impacts the effect of SFA on LDL-C and risk of ASCVD among Americans.

Impact of SFA Intake on Other Biomarkers of ASCVD Risk

In addition to their effects on LDL-C, SFAs may influence other biological determinants of ASCVD risk, such as inflammation, coagulation, and HDL function, although much less evidence exists for these variables. Controlled feeding trials are needed to further explore the potential impacts of different fatty acids on these risk factors.

Conclusion

Despite the debate surrounding SFA, the evidence presented supports current dietary recommendations to limit SFA intake to <10% TDE for the general, healthy population[1,3,4] and to even lower levels for individuals with hypercholesterolemia or other ASCVD risk factors.[2,4,7] The evidence also supports an emphasis on dietary patterns that promote foods rich in high-quality carbohydrates, MUFAs, and PUFAs, including whole grains, fruits, vegetables, nuts, seeds, legumes, and non-tropical oils (e.g., canola, olive, safflower, sunflower). Additional research is needed to further understand the role of specific SFAs and food matrix influences, as well as nonlipid effects of SFAs on ASCVD risk.

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CPE Practice Article

Dietary Fat: Shifting Away From the Good Versus Bad

by Kerry Clifford Hackworth, MS, RD

Learning Objectives

- Explain the concept of the food matrix and discuss its relevance when making dietary recommendations.
- Describe key messages for educating clients on following a fat-flexible approach.

Scrambled eggs with avocado and pepper jack cheese. Cheesy roasted cauliflower. Pan-seared steak with asparagus and peas. Ricotta toast with fresh strawberries. Dietary fat is more than just 9 calories per gram—it also adds flavor and creaminess to recipes, helps with absorption of vitamins A, D, E, and K, and can create a sense of fullness after a meal.[1] Despite these beneficial effects, registered dietitian nutritionists can find it challenging to balance the emerging science while staying in line with recommendations from the 2020-2025 Dietary Guidelines for Americans (DGAs), the American Heart Association, American College of Cardiology, and several other national and international organizations.[2]

A History of Dietary Fat Recommendations

While the science on dietary fat has evolved, the recommendation to avoid saturated fat has essentially remained the same. The recommendations go back to 1958, when early hypotheses began based on the famous Seven Countries' Study (Finland, Greece, United States, Italy, Yugoslavia, the Netherlands, and Japan) conceived and directed by Ancel Keys, PhD. The findings suggested a relationship between mortality from coronary heart disease (CHD) and several lifestyle factors, including saturated fat intake in the diet.[3] Following publication of this study and in the face of the rising prevalence of cardiovascular disease (CVD), the 1977 Dietary Goals for Americans (DGA) and the 1980 DGA focused their recommendations on avoiding excess total fat, saturated fat, and dietary cholesterol because of their association with CVD.[4]

Unfortunately, CVD continues to be the leading cause of death for men and women and across most racial groups in the U.S. and globally.[5] Concurrently, obesity prevalence in the U.S. has also increased from 30.5% (1999-2000) to 42.4% (2017-2018).[5]

Consumption Trends Among Americans

The 2020-2025 DGAs recommend limiting saturated fat to less than 10% of calories per day starting at age 2. Even though American adults are not far off from this recommendation and their intake levels have been relatively stable (consuming ~11% of their calories from saturated fat), CVD prevalence rates remain the same. The main sources of saturated fats in the American diet are sandwiches, burgers, tacos, burritos, desserts and sweet snacks, rice, pasta, and grain-based mixed dishes.[6]

Americans are inundated with headlines, messages, and recommendations regarding saturated fat. According to the International Food Information Council (IFIC) 2021 Food and Health Survey, 14% of survey respondents (n=1,014) believed that fat is the cause of weight gain (21% of parents with children under age 18 thought that fats are most likely to cause weight gain). Approximately 40% of respondents reported trying to limit or avoid saturated fats.[7]

In another IFIC report on fats and oils, 34% of respondents considered coconut oil to be the healthiest fat for cooking.[8] Given that 1 tablespoon of coconut oil contains 12 g of saturated fat, this response suggests that about one third of Americans have a misunderstanding of the effects of different saturated fats on health and/or which food sources contain saturated fats. The survey also revealed that 21% of consumers are adding or increasing full-fat dairy, which is primarily composed of saturated fatty acids and some unsaturated fats.[9] These survey findings demonstrate that the general American population is confused about recommendations regarding saturated fat intake.

Introducing the Food Matrix

Perhaps we need to shift our emphasis from what is on the food label (calories and grams of macronutrients) to thinking more about the food matrix effect. The U.S. Department of Agriculture defines the food matrix as: "the nutrient and non-nutrient components of foods and their molecular relationships, i.e., chemical bonds, to each other."[10]

For years, nutrition research as we know it has concentrated on macro- and micronutrients, and thus dietary recommendations have focused on macronutrients. More recently, the past two DGAs have shifted toward a dietary pattern approach and have noted: *"researchers, public health experts, and registered dietitians have acknowledged that nutrients and foods are not consumed in isolation. Rather, people consume them in various combinations over time—a dietary pattern—and these foods and beverages act synergistically to affect health."*[6]

The food matrix concept recognizes that foods have complex microstructures made up of a physical form (liquid, solid, or gel) and a chemical form, which can be impacted by processing techniques, individual digestibility, and even food pairings that go beyond basic nutritional value. From simple carbohydrates to complex carbohydrates, to the different amino acids, to the nearly 400 different types of fatty acids, vitamins, minerals, and now to bioactives, nutrition science is truly evolving. The food matrix is emerging as an important topic in nutrition science, as we often cannot explain the health effects of a particular food by the individual nutrients they contain.[11]

As discussed in the research article by Sanders et al in this issue of *Pathways* (pages 4-6),[12] there remains ongoing scientific debate around saturated fat and perhaps we need to look closer at the particular foods instead of categorizing them as "good" or "bad" based on their nutrient content in isolation.

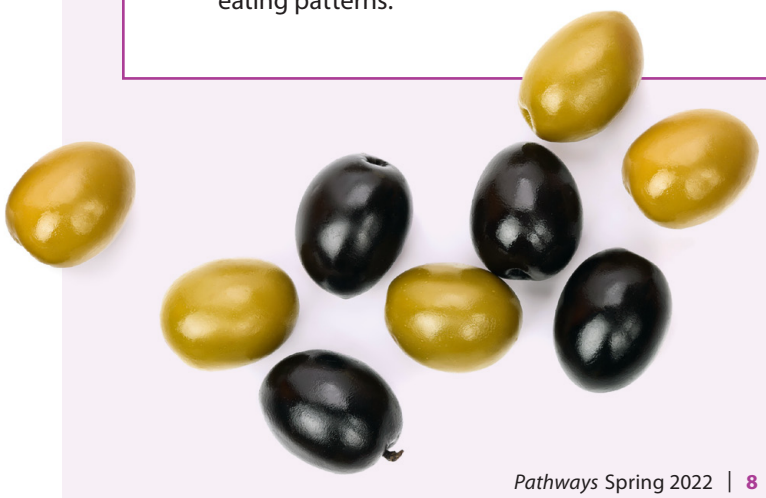
A Focus on Food Around the World

Some of the healthiest people from countries around the world incorporate various types of fats into their cuisines. For example, the French paradox is the notion that, despite the French population's higher saturated fat and dietary cholesterol intakes, they have a low prevalence of CHD.[13] Researchers still have not pinpointed the exact reason, but perhaps it is the totality of the diet, smaller portion sizes, physical activity levels, or overall lifestyle.

In addition to higher amounts of total fat in French cuisine, dietary fat is a staple for many traditional cultures around the world where CVD rates may be lower, for example:[14] ghee or clarified butter (Indian cuisine); schmaltz or chicken/goose fat (Eastern European, Polish cuisines); duck fat (French cuisine); pork fat or lard (Southern European, Mexican, South America cuisines); and peanut oil or palm oil (African cuisine).

Tips on Teaching a Fat-Flexible Approach

- **Avoid "all or none" thinking.** Teach patients/clients to enjoy their favorite foods and recipes, while skipping the ones they don't.
- **Don't call fats "good" or "bad."** All fats have a place in the diet.
- **Focus on food pairings.** Consider produce and protein (e.g. carrots and hummus, apples and cheese). It tastes good and allows room for fat flexibility.
- **Enjoy foods closest to their natural form.** For example, freshly ground peanut butter—nothing added, nothing taken away.
- **Consider various dairy options.** One of the 3 recommended servings of dairy could be whole milk, whole-fat yogurt, or whole-fat cheese.
- **Make lower-fat versions using other fats.** If opting for a lower fat version of a food, swap in other sources of monounsaturated fats or polyunsaturated fats, and don't add in processed carbohydrates (e.g., make a dip with 2% Greek yogurt and avocado).
- **Focus on cultural traditions.** Inclusion of family recipes is a crucial part of a healthy lifestyle.
- **Be mindful of portion size.** When selecting whole-fat versions, portion control is important.
- **Keep it positive and realistic.** These are important keys to adopting healthy eating patterns.



The Fat Flexibility Approach

Multiple organizations have demonstrated that heart-healthy eating patterns are primarily made up of fruits, vegetables, whole grains, low-fat dairy foods, seafood, and lean cuts of meat or poultry.[15] While the science behind the mechanisms of CHD development continues to unfold, recent studies have shown that certain foods higher in saturated fat (e.g., whole and reduced-fat dairy foods) can be included in the diet while staying within the DGA recommendations of limiting saturated fat to <10% calories.[16] Nutrition science will always continue to evolve, and as RDNs we can individualize our recommendations to our patients and clients and include whole, real foods and recipes in a positive and realistic way.

Kerry Clifford Hackworth, MS, RD, *is director of sustainable nutrition affairs at National Dairy Council. Her experience studying the sustainable food systems in Italy and working in corporate wellness and retail marketing have shaped her food philosophy to include whole, real foods that taste great and eating healthy shouldn't have to be boring or tasteless.*

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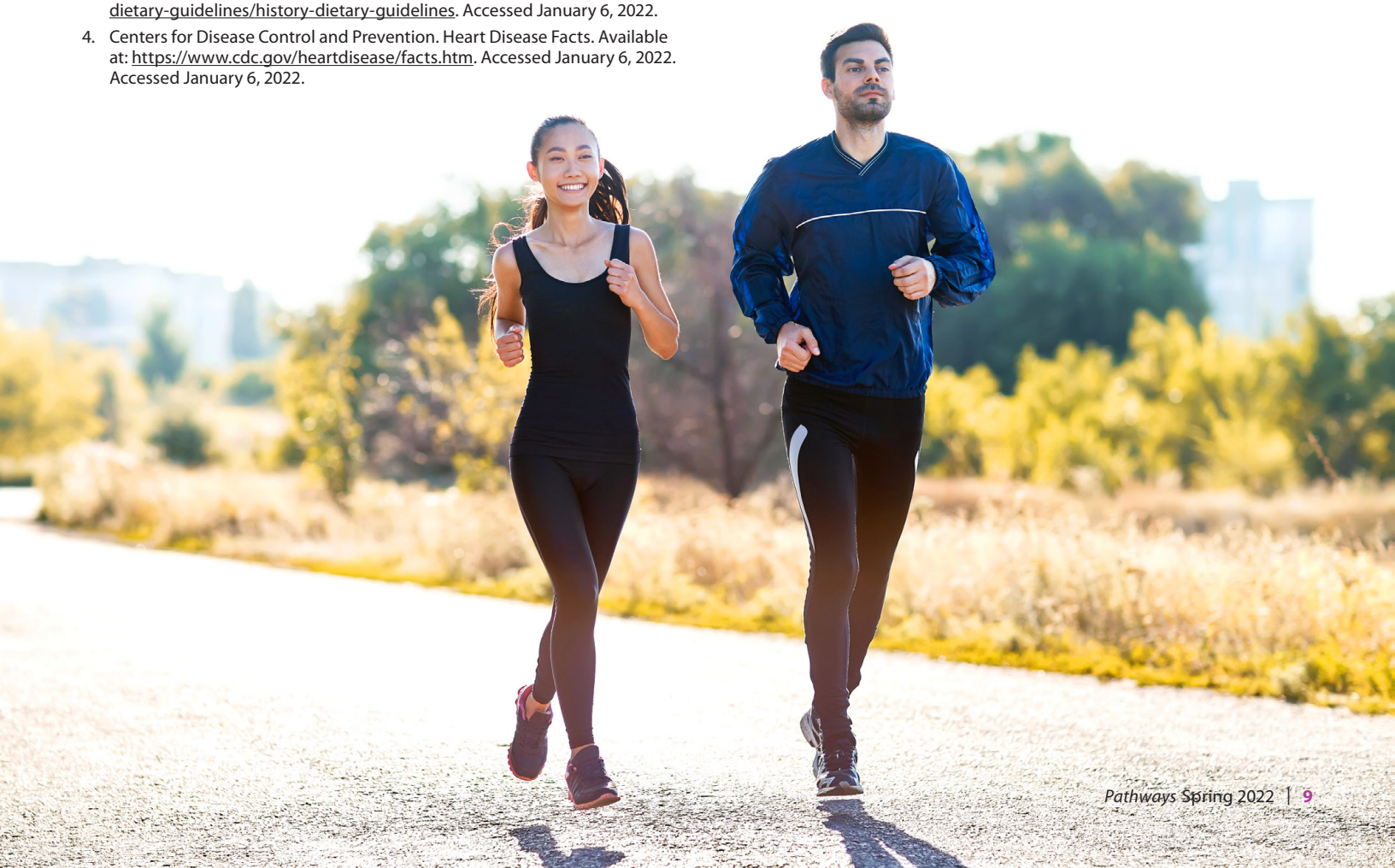

CV-Well Informed

Policy & Advocacy Update

by Geeta Sikand, MA, RDN, FAND, CDE, CLS, FNLA, CV-Well Policy and Advocacy Leader, and Carol Bradley, PhD, RDN, BCBA, FAND, CV-Well Payment Specialist Representative

RDNs can help reshape the health care landscape by getting involved in advocacy as well as becoming reimbursement savvy. Here are some ways to do that:

Nutrition and Dietetics Advocacy Summit a Success

Nearly 600 food and nutrition professionals participated virtually in the Nutrition and Dietetics Advocacy Summit held in January to advocate for two of the Academy's top policy and advocacy priorities: medical nutrition therapy expansion and child nutrition. A total of 77 meetings were held with the Senators and their staffers.

ACT Now for MNT Campaign

Passage of the Medical Nutrition Therapy Act (H.R. 3108/S. 1536) would be a win-win for our profession and our communities—practitioners would receive more reimbursement opportunities while also addressing the gap in care for seniors who only have access to MNT for diabetes and renal disease, a crucial step needed to achieve health equity. Please join the ACT now for MNT campaign, and once you've taken action, use the campaign's social media toolkit to spread the word.

Licensure Questions? Attend "Wednesday Office Hours"

Whether you have a quick question, want some updates, or have more in-depth concerns about consumer protection and licensure issues, the Academy's staff for Consumer Protection and Licensure can help. Use this link to join every Wednesday from 2 to 3 p.m. (EST) to ask any questions you may have on licensure, however big or small.

What's New in 2022 for Medicare Payment Rates?

For Medicare providers wondering about RDN payment rates for 2022, the Academy has taken the worry out of calculating the 85% of physician payment rate. Download Medicare payment rates for MNT CPT codes by geographic area, specific to RDNs. Rates are effective for service dates between January 1 and December 31. While payment rates are slightly lower than last year, advocacy efforts by the Academy and a large coalition of Medicare provider groups helped to avert deeper cuts in payment rates.

NSPS Speakers Bureau

Those working on a planning committee for a seminar/webinar can tap into the expertise of the Nutrition Services Payment Committee for speakers and presentations on several topics related to payment for services, such as *The Virtual RDN: Providing Nutrition Services via Telehealth*. The presentations provide continually updated cutting-edge information. To inquire about speakers and presentations, email reimburse@eatright.org.

Join the Payment & Reimbursement Discussion Board

Through the revamped online discussion board, Academy members can network and share tips relating to coverage and reimbursement for MNT services. The venue also lets you exchange ideas and best practices to help advance coverage with health plans, employers, and third-party payers. Click here to join.

CV-Well Done

Members in the Spotlight

Interviewed by Jean Storlie, MS, RD, CV-Well Leadership Cultivation Director

Featured in this issue's "CV-Well Done" is Georgia Kostas, MPH, RDN. As a pioneer in cardiovascular nutrition and wellness, Georgia founded one of the nation's first preventive cardiology programs at the renowned Cooper Clinic.

With a career spanning more than four decades as a registered dietitian, Georgia Kostas is now semi-retired. In describing her life these days, she says she continues to do some nutrition counseling while also being a "forever student." Georgia's work through the years has focused on preventive and cardiovascular nutrition, wellness, weight control, and media communications. An active volunteer, Georgia was appointed and elected to various leadership roles in SCAN, and most recently served on CV-Well's Visioning Team.

When did you decide to pursue a career in nutrition and dietetics?

Growing up in Houston where cardiovascular surgical advances made the news every day, I felt *preventing* heart disease must be better than requiring surgery. And while I was in grad school, Dr. Kenneth Cooper's book, *Aerobics*, inspired me. My job search, however, was deflating—one dietitian even tore up my resume in front of me! Then I wrote a proposal to Dr. Cooper to start a nutrition program for his preventive cardiology clinic—and I landed my dream job.

What are you most proud of in your career?

I'm most proud of establishing the Nutrition Program at the Cooper Clinic in Dallas, which in 1979 was one of the first preventive cardiology nutrition programs in the nation.

What do you enjoy most about your work?

It's always gratifying to see patients experience "aha" moments that turn around their thinking and eating patterns.

What has helped you in your career?

Sometimes Dr. Cooper's grand visions exhausted me, but he challenged me to constantly do more. Also, becoming involved in SCAN was pivotal. We were all navigating unchartered waters, and everyone supported each other's growth. Many of my early SCAN nutrition heroes became my lifelong friends.

What advice do you have for newcomers to our field?

Dream big. Don't quit when you hit bumpy roads. Get involved in CV-Well and other DPGs that inspire and stretch you. Always keep growing.

Where do you see the CV health and wellness profession heading?

Our expertise and honesty are needed by the public more than ever. People are confused by all the "nutrition noise" and need guidance they can trust. It's up to us to "package" nutrition in ways consumers understand.

What's your favorite quote or saying?

"Be your best." —My Dad

What are your keys to well-being?

COVID brought me the gift of Zoom yoga, which I do three times a week. I also started growing veggies and cooking more of my mom's and grandmother's recipes. Through a group scripture study, I continue to grow spiritually. And I'm starting pickleball!

Why did you decide to get involved in CV-Well?

Last winter, I participated in a visioning session for the new CV-Well DPG. The commitment and energy of the leaders taking the helm reignited a spark in me—the same way SCAN moved me all those decades ago.

CV-Well Rounded

News, Notices, and More

Join the CV-Well Ambassador Team

If you're looking for a volunteer position that requires minimal time and involves participating in fun CV-Well events, become a CV-Well Ambassador—it's a great way to gain valuable experience for potential future leadership opportunities! Your role will be to grow and foster the CV-Well community by raising awareness of our efforts, member benefits, and activities. You'll support our efforts to encourage a diverse and active membership and promote involvement of all CV-Well members at virtual networking and educational events. Those interested should email Tracy Bonoffski.

New Member Program: CV-Well Mentoring Circles

Has someone made a difference in your career—a teacher, boss, colleague, or mentor? Mentoring connections—whether formal or informal—often turn into impactful, lasting relationships. This inspired us to create the Mentoring Circle Program, which will launch as a pilot program in June 2022. Each Mentoring Circle will be led by a seasoned leader and include 6 to 8 members spanning all professional levels, from entry to advanced. Circle membership will be matched for interest areas (e.g., wellness coaching, preventive cardiology, media communications, entrepreneurship). To learn more, click here for an overview and application. Applications are due on April 17, 2022. Contact Jean Storlie with any questions.

Become a CV-Well Volunteer

Click here to view open volunteer opportunities, such as External Relationships Director and FNCE Events Committee members.

Free CEUs Available to You

Check out our previous webinars focused on cardiovascular health and well-being and archived SCAN webinars under the Educational Resources tab at www.cvwell.org/home. Recent additions include: **(1)** "A Healthy Dietary Pattern Benefits Major Risk Factors for CVD by Multiple Mechanisms," by Penny Kris-Etherton, PhD, RD; **(2)** "Unlocking the Cardiovascular Benefits of Tea," sponsored by Lipton (a proud ekaterra brand); and **(3)** "Controlling Yourself in Uncontrollable Times," by Phillip Snider, DO, MS, RD.

We Welcome Your Input

Do you have an idea for a CV-Well webinar or *Pathways* article? If so, please complete this form.

Don't Forget These Great Member Benefits!

CV-Well members have access to all past issues of *Pathways* here. Members also receive free access to the Natural Medicines Database for unbiased, scientific, clinical information on complementary, alternative, and integrative therapies and access to EBSCO Databases, which contains over 10,000 journals and magazines in a wide array of content on nutrition, well-being, etc.

CV Reimbursement Trends and Efforts

If you're interested in becoming involved in our efforts to increase awareness of reimbursement issues and topics, contact Carol Bradley at carol.bradleyrd@yahoo.com.

Upcoming CV-Well Events and Webinars

April 6

Join us for our Spring CV-Well Workshop on *"The Power of Conversation: Motivational Interviewing and Self-Determination Theory to Support Behavior Change."* This interactive event (worth 2.5 CEUs) will focus on how to improve patient/client outcomes through behavior change strategies. Register here.

April 21

Webinar on activity as medicine, sponsored by the Hass Avocado Board. Register here!

CV-Well Seasoned

Recipes from Your Colleagues

Hearty Spring Salad

Recipe by Claire Tibboles, Dietetic Intern and Graduate Assistant, Bowling Green State University

Kale is hailed as a great source of vitamins and minerals, but it's often criticized for being too tough to eat, especially raw. Why not try massaging your kale? Ingredients in this recipe such as salt and lemon juice can help break down the fibrous material in kale leaves, making it much easier to chew and digest. Plus, the acidity of the lemon will keep your apples from browning while the salad is being served!

Total time: 20 minutes
Serves: about 5

Ingredients

For the salad:

- 1 bundle kale (about 5 cups, packed)
- 1 teaspoon kosher salt or sea salt
- ½ lemon, squeezed
- 1 teaspoon olive oil
- 1 large Honeycrisp or Pink Lady apple
- 1 cup fresh strawberries (about 5)
- ½ red onion
- ¼ cup feta cheese
- 1/3 cup roasted nuts of choice
- Optional: grilled chicken breast (or other lean, high-protein food)

For the dressing:

- 2 tablespoons olive oil
- 2 tablespoon white or red wine vinegar
- ½ teaspoon dried oregano
- ¼ teaspoon garlic powder
- 1/8 teaspoon onion powder
- ½ teaspoon honey or agave

Directions

1. Preheat oven to 425^{0} F.
2. Wash and dry all produce. Remove tough stems from kale and roughly chop.
3. Massage kale with a generous sprinkle of salt, lemon juice, and oil until greens feel more tender.
4. Core apples and dice into ½-inch pieces. Halve and slice strawberries. Dice red onion into ¼-inch pieces.
5. Place nuts on baking sheet and roast for 5-7 minutes or until lightly browned. Watch nuts closely.
6. Combine all dressing ingredients in a closed jar and shake until mixed well. Toss desired amount into kale; the recipe should yield just the right amount.
7. Top salad with apples, strawberries, onion, feta cheese, and roasted nuts. Enjoy!

Nutrition Facts

Per serving (1.5 cups): 164 calories, 10g total fat, 12g carbohydrate, 3g protein, 334mg sodium, 3g fiber