Message from the ADA CEO
by Patricia M. Babjak, MLS - ADA Chief Executive Officer

In this year of healthcare reform, I am proud of the role members of the American Dietetic Association played in advocating for our profession and for dietetics practitioners. We achieved new and expanded nutrition services and inclusion of the Registered Dietitian and Dietetic Technician, Registered as preferred providers of these services that reach across the lifespan. But passage of comprehensive health reform legislation does not mean our public policy advocacy work is finished: In fact, just the opposite is true!

As the members of ADA’s Dietetics in Health Care Communities DPG know better than anyone, achieving long-term success with your clients and patients, helping them enjoy healthier lives as they age, means rolling up your sleeves, getting involved, working hard. That is how you make a difference. ADA is proud and committed to support all RDs and DTRs who practice in long-term care settings, and we want the great work you do to continue.

In 2011, Congress will consider reauthorization to the Older Americans Act, effective in Fiscal Year 2012. I don’t need to tell you how important the OAA is to the aging population in our country, or that you have a stake in the outcome of this legislation and other policy issues in Washington, DC and in every state. The Association relies strongly upon DHCC to help develop our key messages in this area, and we look forward to building and strengthening this relationship in order to collectively work toward our vision of optimizing the nation’s health through food and nutrition.

We have already begun advocacy efforts to ensure our priorities are included in the OAA reauthorization. Immediate past president Jessie Pavlinac appointed an impressive Task Force which is already working hard to prepare ADA for the reauthorization. Conversations have begun with the Administration on Aging (AoA) and with various other stakeholders, and the Association has submitted recommendations to the AoA for their report to Congress. Assistant Secretary on Aging, Kathy Greenlee, JD, will be on the agenda at FNCE in November in Boston.

These are exciting times for ADA and I know that there are many important issues vital to the dietetics profession today. In the states, it is critical that we are prepared to be in the forefront of healthcare reform as many new initiatives and grants are implemented. ADA will be continuing with the all important state and local advocacy efforts. Advocating for nutrition and dietetics is something every ADA member has the ability – and should have the confidence – to do. We ask that you as individual members take personal responsibility in getting involved to make a real difference.

ADA members need to make our case to Congress as well as to state legislators, federal agencies and all the policy makers who are in a position to help.

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I encourage all DHCC members to advocate for aging and long-term care policies that improve the health of Americans using the services of RDs and DTRs.

Ms. Babjak joined ADA in 1975 and became ADA's Chief Executive Officer in 2009. In 2004, in recognition of her service to ADA and to the dietetics profession, she was awarded honorary Association membership. She is a graduate of the University of Illinois-Chicago and earned a master's degree in library science from Dominican University.

Health Care Reform Legislation

by Thomas P. Bruderle

The most far-reaching health care reform legislation coming out of Washington, DC, in a generation, tracing its roots to Medicare and Medicaid more than 45 years (and eight presidents) ago, has moved from the center stage of debate and politics to the more restrained precincts of the regulatory process.

The historic health care reform measure actually consists of two separate but closely related pieces of legislation. First, on March 21, 2010, the House agreed to the Senate's Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), and President Obama signed it into law the following day. At the same time, the House also approved a second bill, the Health Care Education and Reconciliation Act of 2010 (P.L. 111-152), amending certain portions of the legislation the Senate approved last Christmas Eve. When the Senate shortly thereafter agreed to these changes, the President added his signature to the second half of health care reform on March 23.

First outlined in the early days of the 2008 presidential campaign, and later characterized by events that were at times dramatic and chaotic, the new legislation, for better or worse, defines the nation's new health care policy for the overwhelming majority of its citizens. Its impact will be felt for years to come.

But it is the less exciting and more complex regulatory process that will determine how that policy will be implemented. For the uninitiated, the relationship between the politically-charged legislative process and its complement, agency rule-making (which can be equally contentious when competing interests perceived they could be harmed by a statute), can be confusing.

Years ago, attempting to distinguish between making law and making regulations, a Capitol Hill observer said that the former is equivalent to sketching the outlines of a box, while the latter, the task of the appropriate federal agency, is to make, shape and define that box to assure that it does what Congress designed it to do.

No fewer than 13 agencies within the Department of Health and Human Services share responsibility and jurisdiction for health care reform rulemaking. They include: the Office of the Secretary (OS), the Administration for Families and Children (ACF), the Administration for Children and Families (ACF), the Centers for Medicare and Medicaid Services (CMS), and the Office of Inspector General (OIG).

Connections

The quarterly publication of Dietetics in Health Care Communities (DHCC), a dietetic practice group of the American Dietetic Association.

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For CPEU Quizzes, go to www.dhccdpg.org and sign in as a member.

Viewpoints and statements in this publication do not necessarily reflect policies and/or official positions of DHCC/American Dietetic Association.

If you have moved recently, or had a change of name, please notify ADA Membership Team as soon as possible by emailing membrshp@eatright.org or at ADA's Web site at www.eatright.org Edit Profile.

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Greetings to DHCC Members,

Welcome to an exciting year with DHCC. As your new Chair, I am committed to preserving the rich history of this DPG while embracing our vision and mission and moving ahead to meet the challenges that are before us. DHCC will continue to empower our members to be the nation’s food and nutrition leaders and optimize the nation’s health through food and nutrition.

Your DHCC Executive Committee (EC) includes visionary leaders that are committed to the industry and profession. They have a passion for leading the DPG and proven success in producing positive outcomes. While our members practice in many diverse settings, the DHCC EC will proactively provide valuable resources and support to promote success.

DHCC has listened to the members and has been working several years to develop an internal organizational framework to meet member needs. Many thanks to Linda Roberts, MS, RD, LDN, DHCC Chair 2008-09 and Carol Elliott, RD, LD/N, DHCC, Chair 2009-10 and the Executive Committee for their dedicated efforts to develop a framework that will promote sustainability of the many programs needed by our members.

The DHCC Program of Work for 2010-11 includes many exciting programs and projects. Let me share a few with you:

- **The Connections** quarterly newsletter that will continue to keep you informed on the latest in what is going on across the nation regarding regulations, best practices, and evidence-based research and how to apply this information to your work situation. Each newsletter will have a theme with this newsletter having the theme of “Public Policy.” Themes for future newsletters include Clinical Best Practice, Technology, and Food Service Management and Operations.

- The new DHCC website was introduced in 2009, and in 2010-11 you will see continued improvement in information to include EC information, award winner information, updates on regulatory issues, links to ADA initiatives that impact our membership, best practices and any other information that the EC feels will advance the practice group, the Association and the profession.

- Exciting new additions will include DHCC social media as a method of communicating current information and to promoting networking opportunities.

- DHCC is committed to continued support of our valued Sub-Units, and in providing scholarships to our members through the American Dietetic Association Foundation, and other approved sources.

- DHCC Network Projects will continue to build and maintain networking relationships with allied health care organizations according to the structure specified by ADA. DHCC will network and maintain representation with those promoting nutrition and the role of the long-term care dietitian and dietetic technician, registered within our practice areas.

- Public Policy is a focus area for DHCC and we will continue to work closely with the ADA Policy, Initiatives and Advocacy Group in dealing with legislative issues affecting long-term care dietitians and dietetic technicians, registered.

- DHCC will continue to be a leader in Professional Development/Quality Improvement for our members. We are committed to supporting development and implementation of publications, workshops/webinars, and tools/resources to enhance and enable the practice of members in healthcare communities.

- DHCC will sponsor a workshop prior to the ADA Food & Nutrition Conference & Expo (FNCE) “Redefining Nutrition with Aging,” and will sponsor member events at the ADA FNCE. DHCC will have a booth on the exhibit floor and participate in the DPG Showcase and Product Marketplace. This year we are excited to offer a co-reception with the Healthy Aging (HA) DPG for a wonderful cruise on the Spirit of Boston. (check out the details in this newsletter)

- The DHCC Chair’s Project for 2010-11 is supporting nutritionDay in the US, a global non-profit initiative that addresses improved resident quality of care by raising awareness and increasing knowledge about disease related malnutrition. This initiative promotes optimal nutritional care in the US healthcare facilities by increasing knowledge, awareness, nutrition monitoring and benchmarking.

The DHCC DPG is large and diverse. Members work in long term care, corrections, home care, hospitals, and work as consultants, employees and entrepreneurs serving a wide range of client ages. DHCC will continue to be here for you. Be sure to tell others about DHCC and invite them to become a member. All of us working together will continue to lead the profession and industry with innovative cost-effective outcomes. Thank you for allowing me to serve you as DHCC Chair for 2010-11.

Brenda Richardson, MA, RD, LD, CD
Aging (AoA), the Agency for Healthcare Research and Quality (AHRQ), the Agency for Toxic Substances and Disease Registry (ATSDR), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS), the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), the Indian Health Service (HIS), the Office of the Inspector General (OIG), and the substance Abuse and Mental Health Services Administration (SAMHSA).

Each agency may have a set of rule-making responsibilities involving several of a statute’s provisions. For example, the new health reform statute gives CMS a broad portfolio directing it to write regulations pertaining to Medicare, Medicaid, and the State Children’s Health Insurance Program (CHIP). It will also develop requests for proposals or applications for pilot studies, demonstration projects and other state and local efforts initiated by the statute.

Regulations may be of three types: proposed, interim final and final. Usually an agency faces a statutory deadline (ranging from 45 days to a year following enactment) for drafting a regulation, a process taking into account the complexity of the issue, the competing interests the rule-makers must consider, the urgency to get regulations in place, and other variables.

If the cost of regulatory compliance could be considered expensive, the agency may refer the proposed rule to the Office of Management and Budget (OMB), located in the Executive of the President, for review and a cost analysis. In addition to helping the president in the development and administration of the annual federal budget among executive agencies, OMB also oversees and coordinates the government’s White House’s regulatory processes. This includes, in the words of OMB’s mission statement found at its website, reducing “any unnecessary burdens on the public.”

At this point, the proposed rule, and any attendant cost data, is published as a Notice of Proposed Rule-Making (NPRM) in the Federal Register, the government’s daily record of executive branch proposed and final regulations, documents, meeting notices and other events and information. The Federal Register is available online at www.federalregister.gov.

A unique feature of the rulemaking process is the open period for public comments on an agency’s proposed regulation. Like other member-based associations, the American Dietetic Association (ADA) provides comments on relevant proposed regulations. These are based on position papers, evidence analysis and insight from appropriate Dietetic Practice Groups. Individual comments are also welcome. ADA’s comments are posted at www.eatright.com in the Public Policy section under “rules and regulations”.

It is at this point that the comment process could become animated, especially if groups perceive that their interests are threatened, or could be advanced, by the proposed regulation. What can follow are often dueling analyses, sometimes prepared by private research firms or academics, under contract to the organizations with a deep interest in the proposed rule, detailing why the proposed rule is or is not in the public or their members’ interest. Although the rule-making process can excite intense association or industry advocacy (comment letters and other communications numbering in the thousands to an agency on a proposed regulation are not uncommon), the effort is often driven by data.

At the conclusion of the comment period, the agency then reviews the data and information collected in issuing its final rule. Although it is not obligated to include in the final regulation the comments it has received, the agency is required to explain why it has chosen to reject (or accept) the arguments presented for change in its proposed rule.

A variation agencies occasionally employ is the “interim final” regulation. Under this device a final rule is issued, and takes effect immediately, but the public is provided with a brief period for comments, generally two weeks. Agencies have been known to operate under interim rules for years.

Final agency rules are included as part of an agency’s administrative law in the U.S. Code of Federal Regulations (CFR). For example, earlier FDA regulations governing nutrition labels for packaged food products, and CMS requirements for facilities to receive Medicare and Medicaid payments for services, among scores of other regulations, are part of the CFR.

In sum, rules are a constant in the lives of all Americans, regardless of age, residence, income, or education. They range from drinking water and energy sources, to food labels and public program reimbursement. Some examples of how federal regulations will affect dietitians under health care reform include:

• the determination of funding and grants for nutrition programs;
• setting parameters for various health care demonstration and pilot programs often by CMS (including the Patient Centered Medical Home Project scheduled for implementation later this year);
• identifying which practitioners will provide services in health care programs, which is especially important since federal regulations often list registered dietitians as providers while federal statutes usually contain “recommendations” for who the providers should be; and
• setting Medicare standards for both a referral process and reimbursement rates.

There are 10 provisions in P.L. 111-148 and P.L. 111-152 that could pertain to registered dietitians and dietetic technicians, registered, in long-term care, corrections and homecare.

HEALTH AGING, PREVENTIVE SERVICES FOR ADULTS 55-64

The statute establishes a grant program for state and local health departments and Indian tribes for public health intervention, community preventive screenings, and referral and treatment for chronic diseases in people between 55 and 64 years old. Intervention activities include improving nutrition and increasing physical activity.

WORKFORCE

The statute calls for an analysis of the current health care workforce, including registered dietitians, to determine gaps in the delivery of care in underserved communities. (The effective dates vary based on the program).

SCHOOL-BASED HEALTH CLINICS

Grants are established to provide school-based clinics with nutrition counseling as an optional service, although providers are not listed. (The sum of $50 million is authorized to be appropriated for the current 2010 fiscal year).

PREVENTION TASK FORCES

The statute created a Preventive Services Task Force and a Community Preventive Services Task Force upon enactment. A $2.4 billion Prevention and Public Health Investment Fund is created for 2010 with a funding ceiling of $4.6 billion by 2019.

MEDICARE PREVENTIVE SERVICES

CMS is provided with authority to expand existing preventive services and establish others. Medical nutrition therapy (MNT) is on the list of services which CMS could expand, beyond renal and diabetes, but it is not required to take this step. ADA will ask CMS to support a broader role for MNT. The statute also eliminates co-payments and deductibles (cost-sharing) for both preventive services and an annual wellness visit effective January 1, 2011. Along with physicians and nurses, registered dietitians are listed as screening and counseling providers, and CMS must establish appropriate reimbursement policies and rules for referral. Specifically, CMS must determine when a referral is warranted and how many counseling sessions a patient can receive. CMS has 18 months from the March 23, 2010, enactment date to finalize regulations.

MEDICAID

A five-year grant program is established to encourage healthy lifestyles among Medicaid beneficiaries, and directed toward weight and cholesterol reduction, preventing the onset of diabetes, and diabetes self-management. CMS will set the parameters for awarding grants.

Currently the United States Preventive Services Task Force (USPSTF) recommends “intensive nutrition behavioral counseling” for adults with hyperlipidemia and “other diet-related chronic diseases.” The new statute includes preventive services recommended by USPSTF, but CMS must determine what constitutes “diet-related chronic diseases” and who will provide the counseling. USPSTF recommends referral to an RD after physician treatment. Cost-sharing for these services is also eliminated effective January 1, 2011.

HOME HEALTH

The statute provides for a demonstration program for direct, home-based patient care, effective January 1, 2012. CMS will set the parameters, and although RDs are listed as possible providers, this is a recommendation, not a requirement. Those working in home health who want to show the benefits of having an RD provide nutrition services should follow carefully the rules for the program and application procedures when they are proposed in the coming months.
settings and schools through educational, counseling and training activities.

HOW CAN YOU GET INVOLVED

Not only will health care reform affect nearly all Americans, especially those covered by Medicare and Medicaid, its impact will also be profound on health care providers. This is especially true in those instances where federal and state statutes and regulations may pit RDs in competition for reimbursements and eligibility standards with other providers.

As professionals, RDs know that their body of knowledge, training and skills are unique in the delivery of health care. And furthermore, as professionals they also know the importance of sharing this expertise with agency officials whose regulations will shape the care given the patients they treat.

The regulatory process is of paramount importance to RDs. It is the nexus of policy contained in law and its implementation through the rule-making. It is where the details of the statute are set, including such important considerations as which providers may participate in health care delivery and the circumstances of that participation.

RDs are welcome to comment on an agency’s proposed rule. Your comments, however, will be more meaningful and far-reaching by working with ADA staff in the development of the association’s views. By working with ADA and your colleagues from around the country, you bring to bear the force of your experience, fact-based research and professional judgment in shaping health care for all Americans well into the future.

With more than 25 years experience lobbying health care issues on behalf of member-based health care organizations before Congress, the White House and federal agencies, Thomas P. Bruderle first came to Washington, DC, through a competitive internship in the Executive Office of the President of the United States. During his extensive career he has represented the interests of the radiology, pharmacy and pharmaceutical, health insurance and, most recently, the multispecialty medical group communities.
October 1, 2010, will bring major changes to the resident/patient assessment process for nursing homes and swing bed facilities. On this date, after eight years of testing and revision, the Minimum Date Set 3.0 (MDS 3.0) will finally be implemented. Dietitians working with these facilities, whether full-time, part-time or as consultants must be aware of the differences between the current assessment tool, MDS 2.0 and the new tool, MDS 3.0.

When deciding to revise MDS 2.0, the Centers for Medicare & Medicaid Services (CMS) set several goals:

- To improve the clinical relevance and accuracy of MDS assessments
- To increase the voice of residents in assessments
- To improve user satisfaction
- To improve the efficiency of the reporting process

MDS 3.0 was tested in 71 nursing homes in eight states. The national trial showed improvement in the following areas:

- Accuracy and reliability of the assessment instrument
- Increased involvement of residents in the assessment process
- Improved clinical relevance of assessment items
- Decreased time for completion of the tool (reduction of completion time by approximately 45%)

Although there are many differences between MDS 3.0 and MDS 2.0, this article is reviewing Section K - Swallowing/Nutritional Status, Section L - Oral/Dental Status, and Section M - Skin Conditions.

**Section K: Swallowing/Nutritional Status**

Revisions in this section seek to improve the detection of swallowing problems and to help identify when weight loss is a result of an intentional weight loss program.

- Changes from 2.0
  K1. Oral Problems
  This was replaced with K1 a-e Swallowing Disorder. It includes a list of observable signs and symptoms of a possible swallowing problem. The chewing problem and mouth pain items are now part of Section L - Oral/Dental Status.

  K3. Weight change
  This was expanded to include: 1) Yes, on physician prescribed weight loss regimen; and 2) Yes, not on physician prescribed weight-loss regimen. K3bWeight gain was removed.

K5. Nutritional Approaches
Syringe, dietary supplements, plate guard and planned weight change items were eliminated. Other changes include the addition of descriptive terms that relate to information currently in the instruction manual

K6. Parenteral or Enteral Intake
Categories for calories received through parenteral or tube feeding and for average fluid intake were reduced. Only those categories required for payment for these services remain.

**Section L: Oral/Dental Status**

The rationale for revision of this section included the need for a thorough examination of the oral cavity.

- Changes from 2.0
  This section was revised to include six checklist items that can be completed by staff after examination of the resident’s oral cavity. It also allows a response for “none of the above” and a response that indicates inability to examine the oral cavity.

**Section M: Skin Conditions**

This section was revised to eliminate reverse staging, to indicate the degree of healing, to appropriately identify stasis ulcers and diabetic foot ulcers, to document pressure ulcers that are present on admission, and to allow identification of “unstageable” pressure ulcers. CMS’s goal for the revisions was to align the items included in this section with best practice guidelines.

- Changes from 2.0
  This section was completely changed and greatly expanded. These changes include but are not limited to the following:
  - Skin conditions are now coded as “Present on admission” from stages 2 through unstageable. NPUAP staging definitions are used to enhance reliability.
  - New items were added to facilitate assessment of each stage so that ulcers that are healed or worsened are identified.
  - Venous/arterial ulcers are separated from diabetic foot ulcers. Stasis ulcers are no longer staged.

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CMS has provided extensive resources for providers to use when implementing MDS 3.0. All of the items listed below are available for download at this link:


- **MDS 3.0 Training Slides V1.00 June 3, 2010.** These are excellent PowerPoint training slides to facilitate MDS 3.0 training. Both sections K and L are included.
- **MDS 3.0 Instructor Guides V1.00 June 3, 2010.** These are instructor guides to accompany the training slides, that explain the recommended training procedures.
- **MDS 3.0 Item Subsets V1.00.2 April 8, 2010** - This zip file contains printable versions of each MDS 3.0 assessment form (e.g. admission, quarterly, annual, significant change, discharge, entry, etc).
- **MDS 3.0 Q&A V1.00.2 April 12, 2010** - Question and Answer Document addressing questions received during the March 2010 RAI Training in Baltimore. In addition to the revisions outlined above, the new MDS 3.0 assessment tool calls for increased resident participation in the process by introducing more items that require resident interviews. These are included in sections on Cognitive Patterns, Mood, Behavior and Preferences for Customary Routine and Activities. Explanation of the development and validation of these new sections can be found in the document, “Development & Validation of a Revised Nursing Home Assessment Tool: MDS 3.0” by Rand Health Corporation. This document can also be downloaded from the above website.

Every practitioner responsible for residents/patients in extended care settings is encouraged to take advantage of the resources provided by CMS. Becoming fully informed on MDS 3.0 enhances the provider’s knowledge in implementing this new process and positions the RD and DTR as invaluable members of the health care team.

In looking forward to the future, one of the next legislative activities that will be facing us as a profession will be in 2012 when Congress is scheduled to consider the reauthorization to the Older Americans Act. During reauthorization, Congress can make amendments to the standing law.

In 1965 Congress passed the Older Americans Act (OAA) in response to concerns by policymakers about a lack of community social services for older persons. The original legislation established authority for grants to states for community planning and social services, research and development projects, and personnel training in the field of aging. The law included the creation of the Administration on Aging (AoA) to administer the newly created grant programs and to serve as the Federal focal point on matters concerning older persons. Grants are allocated to the states and territories by a formula based on their share of the population aged 60 and over. Since then many other services through federal programs have been created for older individuals. However, the OAA remains the primary provider and vehicle for delivery of social and nutrition services for this population and their caregivers.

The OAA is broken into sections and authorizes three different nutrition programs under Title III C1, C2, and NSIP.

- Title III C1 - Congregate Nutrition Services
- Title III C2 - Home-Delivered Nutrition Services
- NSIP - Nutrition Services Incentive Program which is a funding program to encourage efficient service provision through the provision of cash or commodities to States and Tribes based on the number of meals served in the previous year.

Title VI provides grants to Tribes, Tribal Organizations and public and nonprofit private organizations representing Native Hawaiians for the provision of nutrition services, supportive services and family caregiver services that meet the unique cultural needs of this population.

Total Title III Funding for Nutrition Services during the past five years is as follows:

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<thead>
<tr>
<th>Year</th>
<th>Amount</th>
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<tr>
<td>FY 2005</td>
<td>$718,696,000</td>
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<tr>
<td>FY 2006</td>
<td>$714,578,000</td>
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<tr>
<td>FY 2007</td>
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<td>FY 2008</td>
<td>$758,003,000</td>
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<tr>
<td>FY 2009</td>
<td>$809,743,000</td>
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In review of possible revisions for the program the American Dietetic Association has provided the following recommendations:

The Title III C Nutrition Program and its goals meet those of the Older Americans Act and the Administration on Aging, helping older Americans stay in their homes and communities and avoid unnecessary nursing home placement. However, Title III C can be improved to achieve the full potential of nutrition services to prepare for the burgeoning numbers of boomer clients while balancing the current needs of today’s very frail population. Title IIIC can be transformed to better address the nutrition-related health and well-being of older persons, increase agency accountability and reporting, build program capacity, and achieve positive program and client outcomes cost effectively.

ADA recommends the AoA:

- Develop and fund a Nutrition Resource Center. The function of this center would be to help the aging network improve programmatic operations including implementation of best practices, capacity building, broadening coordinated care linkages, resource and information sharing, problem solving, cost containment and multidisciplinary collaboration interactions;

- Develop and promote a strong evidence-based nutrition and health component; through programs that include targeted nutrition screening, assessment, nutrition counseling and education. Build a model evidence-based chronic disease self-management program around a structured nutrition program, e.g. DASH diet, a randomized control trial for successful management of hypertension in older persons;

- Consolidate Titles III C1 and III C2 into a single Title III C that will fund both congregate and home-delivered nutrition services and allow greater flexibility at the state and local levels to target funds to best meet the needs of older adults at the community level;

- Fully fund Title IIIC and invest in the opportunity to use funds not only to serve the current population in need but also to transform congregate nutrition sites and home delivered nutrition services into desired models to meet the needs of the growing numbers of older

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individuals seeking to remain healthy in their communities.

- Eliminate dollars allowed to be transferred out of Title IIIIC.
- Increase funding for Title III B and Title III C in order to ensure adequate funds to provide services for older individuals who need them;
- Increase the numbers of RDs and/or persons with comparable expertise at the local, regional, state and federal levels to increase availability and to support provision of cost-effective nutrition services, especially as programs try to balance the needs and expectations of the aging population with those of the currently very frail older adult;
- Maintain nutritional health and reduce food insecurity through provision of Title III C and VI meals that meet established nutritional standards;
- Improve state and local area plans by including nutrition-related community needs assessment addressing functionality, food security and depression;
- Conduct individual client assessments to reduce potential for nutrition risk and provide appropriate solutions;
- Collect strong and relevant outcomes data that relate to nutrition program measures;
- Fully fund Title VI, to promote the delivery of supportive services, including nutrition services to American Indians, Alaskan Natives, and Native Hawaiians that are comparable to services provided under Title III.

As we continue to move to a more home based focus with long term care intended as the last step in care rather than the first it is important that we are an asset to our clients through understanding the services that are available and the growing opportunities for us to be of continued value to our communities in which we serve. Below you will find resources to help you in this endeavor.

http://www.tcsg.org/law/oaa/reauth.htm
http://www.aoa.gov/

Why Public Policy is Important.....?

“All politics is local.” This quote is attributed to the late Thomas P. (Tip) O'Neill, Jr., former Speaker of the House. We have all heard this quote, but what does it mean for us? It means that we can all have a say, and we can all make a difference.

Members of the American Dietetic Association have many resources available to them in the political arena. Attendees at the first Advocacy Training Workshop in Washington, D.C., on May 17 and 18 learned that ADA is continually working to ensure that nutrition and preventive services are included in health legislation. We must work together to educate our community, state and federal leaders of the value of nutrition and preventive services in local, state and federal public policy.

“Members of the American Dietetic Association, experts in food, nutrition and health, work on a broad range of issues to advance the nutritional status of people here and around the world.” (www.eatright.org, Public Policy Priority Areas.)

ADA Member Resources for Public Policy
What resources are available to ADA members to become active in public policy areas or to expand their horizons? There are MANY on the ADA Web site! Go to www.eatright.org/advocacy, and sign in as a member. Please take the time to explore for yourself the materials and resources available. The following areas are found under the Public Policy section of the Web site:

- Priority Areas
- Legislative and Public Policy Committee (LPPC)
- State Affairs
- Testimony and Statements
- Rules and Regulations
- Public Policy Workshop (PPW)
Why Public Policy is Important…..?
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• Eatright Weekly and Policy Initiatives and Advocacy Report
• Take Action
• Legislation

Where is an easy place to start?
Have you explored the Grassroots Manager? You can find the Grassroots Manager under the Take Action section of the Web site. Go to: http://www.eatright.org/members/actioncenter.aspx.

Through the Grassroots Manager, you can:
• Write your U.S. Representative and U.S. Senators a letter
• Send your U.S. Representative and U.S. Senators a fax
• Send your U.S. Representative and U.S. Senators a direct e-mail
• Call your U.S. Representative and U.S. Senators
• Educate others by spreading the word about important issues
• Contact your State Senators and Representatives

The Grassroots Manager makes this quick and easy for YOU. Click on “Find My Legislators” and you will automatically get information on your federal and state lawmakers. There is no need to enter ANY information; you just need to click on the link! Names, pictures, political affiliation, birth date, etc., appear! Now THAT is easy – you don’t even have to remember your own address!

Click on “Action Alerts” and you can email, write or call your Senators or Representative – just follow the steps provided. Again, this is EASY!

“Sending letters or calling your members of Congress is important because if they don’t hear from dietitians, they don’t know what issues are important to you. Members of Congress work on many different issues every day. If they know their constituent is concerned about a particular matter, they will pay attention to it,” explains Angela Sader, MBA, RD, LD, of the DHCC Executive Committee.

Contacting your member of Congress is important, and ADA makes it easy when you use the Grassroots Manager.

Taking Action
Under Public Policy, click on Take Action. Here you will find a wealth of information on ways to be involved. The following sections are found there:
• Advocacy Tutorials
• Recorded Webinars
• Grassroots Advocacy: How ADA’s Affiliate Structure Works
• Congressional Materials
• Congressional Visits FAQs
• ADA Stance on Scope of Practice
• ADA Grassroots Report

These resources allow you to explore information and learn how to be an advocate at your pace. It also includes materials to take to your member of Congress if you visit him or her in person. If you plan to visit a member of Congress, contact your state affiliate Public Policy Coordinator (PPC) to let them know. The PPC coordinates all congressional appointments, and it’s important to stay in touch with your affiliate public policy leaders.

Rules and Regulations
Regulations are a fact of life, and you can get up to date information starting at http://www.eatright.org/Members/content.aspx?id=884. There are links to the Centers for Medicare & Medicaid Services (CMS) as well as downloadable information for state regulations for Assisted Living and Nursing Facilities, which are of particular interest for DHCC members. Knowing the facility requirements for your state is essential for seeking new opportunities and increased responsibilities in your facility, as well as helping your facility maintain high standards of care.

Why DHCC Members Should Be Involved
The ADA Web site states it perfectly:

“You can help shape better food and agriculture policies by talking to lawmakers about nutrition. You make a difference when you speak up for increased investments in food and nutrition research. You’re the experts who can explain how the Dietary Guidelines for Americans can be made more valuable. And you can have an impact in overall public health by urging a better integration of the Dietary Guidelines in public programs and individual decisions.

Lawmakers need to hear from experts in food, nutrition and health. Becoming a champion for nutrition is just one of many ways to effectively advance nutrition care and services. Being an advocate is just one of the most important:”

Get involved – write, call, email! As a DHCC member, you are an expert in a specific practice area, which makes you invaluable to your affiliate and to your members of Congress. Working together, the members of ADA and DHCC CAN make a difference!
DHCC Needs YOU!

Are you interested in Public Policy and moving the RD/DTR forward through knowledge and representation? DHCC has volunteer opportunities available with various levels of responsibility. We need YOU to help us all to move forward in critical initiatives impacting long term care. This is a GREAT way to make a difference in the profession, build your resume, and enhance your skill sets.

Please review the opportunities below and check those you are willing to help with.

☐ Legislative Committee members
  o This group is for members interested in what Congress is doing in regards to nutrition and the role of the RD/DTR in the life of the older American. Members will review proposed bills and provide comment to ADA as well as supporting ADA action alerts when grassroots efforts are needed. These committee members will partner with the ADA affiliate State Policy Representatives (SPCs) and State Regulatory Specialists (SRSs) to communicate long term care initiatives.

☐ Reimbursement Committee members
  o This committee will collaborate with ADA and other sources on reimbursement resources in long term care. Committee members will obtain information from members who are currently practicing and are actively receiving reimbursement for services provided by the RD/DTR. This committee will offer updates and resources to DHCC membership for reimbursement of nutrition services.

☐ Regulatory Committee members
  o The members of this team will review proposed regulations, seek member input and provide feedback to ADA for submission to CMS and other government organizations impacting long term care. The committee will assist in providing timely updates to the DHCC regarding CMS revisions and updates to keep members informed. This committee will partner with the ADA state affiliate State Policy Representative (SPC) and State Regulatory Specialists (SRS).

Please check mark the area(s) above you are interested in. Complete the information below and send to Marla Carlson, DHCC Executive Director at carlsonmom@mchsi.com:

Name __________________________________________
E-mail Address __________________________________
Phone__________________________________________

Thank you so much!
Angela Sader MBA, RD, LD
DHCC Public Policy Coordinator
Quality is about providing safe, effective, patient/resident/client-centered, timely, efficient, and equitable dietetics care. These six dimensions of quality are outlined in a report by the committee on the Quality of Health Care in America (1). Overall, the report makes an urgent call for fundamental change to close the quality gap, recommends a redesign of the American health care system, and provides overarching principles for specific direction for policymakers, health care leaders, clinicians, regulators, purchasers, and others. The report urges these health care constituencies to commit to a national statement of purpose for the health care system as a whole. In making this commitment, the parties would accept as their explicit purpose “to continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States (1).

What steps must be taken to provide quality dietetics care?

RDs in all practice settings must review and understand federal and state regulations, accreditation standards (if applicable to their facility or service), their facility policies and procedures, and their individual scope of practice. RDs must read the regulations and interpretive guidelines of the Centers for Medicare & Medicaid Services (CMS) - Conditions of Participation for their respective practice setting.

RDs must know the federal and state licensure requirements for food and dietetics service personnel, the food and dietetics service standards, laws and regulations, and their state practice acts to locate what, if any, legal scope of practice is defined within the state where they are employed.

RDs must also note their accreditation standards (if applicable) that their facility or practice setting utilizes to ensure they are providing quality care. These accreditation standards are aligned with the CMS Services - Conditions of Participation and its regulations for food and dietetic services. Accreditation organizations are: The Joint Commission, Healthcare Facilities Accreditation Program of the American Osteopathic Association, DNV-National Integrated Accreditation for Healthcare Organizations, and Public Health Accreditation Board.

Next, RDs must know their facility policies and procedures in order to perform effectively within medical executive approved disease and condition specific protocols that outline standing nutrition orders. RDs must determine and approve, along with the Medical Executive Director or Board, their formulary of therapeutic diet orders for the patients/residents/clients under their nutrition care. RDs who demonstrate competency at the advanced practice level may then apply to obtain clinical privileging in their facilities to perform medical level tasks.

How do RDs know that they are able to apply for privileges within their facility?

According to CMS, clinical privileging “is a process by which the governance of the hospital specifically the governing body and the medical staff- develop and implement a process to ensure safe and quality patient care” (2). Practitioners, including RDs, must demonstrate competence of medical level tasks (e.g., ordering therapeutic diets, ordering parenteral nutrition) to obtain and maintain clinical privileges. Obtaining clinical privileges for RDs depends on the RD’s legal scope of practice, medical staff bylaws in the facility, culture of the facility, and the RD’s competency level (2).

How is scope of practice defined?

Scope of practice is defined by The University of California at San Francisco’s Center for the Health Professions as: “legal scopes of practice for the health care professions establish which professionals may provide which health care services, in which settings, and under which guidelines or parameters. With a few exceptions, determining scopes of practice is a state-based activity. State legislatures consider and pass practice acts, which are referred to as statute, law, or code. State regulatory agencies, such as medical or other health professions’ boards, implement laws by writing and enforcing rules and regulations detailing the acts” (3).

Each RD must know his/her individual scope of practice and should be performing at his/her highest level to provide best quality care. How does an RD determine this level? By using the ADA Scope of Dietetics Practice Framework to determine his/her own individual scope of practice and verify if he/she is qualified to do what he/she has been hired to do. What competencies has the RD obtained? Does the RD accept responsibility and accountability for his/her own nutrition care actions?

Bottom-line --- Quality begins with Competency. The ADA Scope of Dietetics Practice Framework is designed to assist the RD with determining whether a service is within his/her own scope of practice. RDs will not find a laundry list of services and skills a dietetics practitioner can do. Lists tend to limit practice. Scope of practice is a fluid concept. It changes as knowledge, the...
What is Quality Dietetics? Do RDs Practice It? How Do Dietetics Practitioners Know the Activities They Are Authorized to Perform? continued from page 13

healthcare environment, and technology expand. Dietetics practitioners must possess the knowledge, skills, and competencies to perform their duties; therefore, scope of practice comes down to the competency of the individual dietetics practitioner and his/her particular practice setting (4).

The Framework is divided into three blocks: foundation knowledge, evaluation resources, and decision aids.

Block Two – Evaluation Resources – comprises the Standards of Practice (SOP) in Nutrition Care and Standards of Professional Performance (SOPP) for RDs and DTRs which are a guide for self-evaluation (5). The SOP in Nutrition Care and SOPP for RDs and DTRs are minimum competent levels for RDs and DTRs in all practice settings. Practice specific SOP and SOPP identify generalist, specialty, and advanced levels of practice within a particular practice area (e.g., education, pediatrics, management, sports dietetics, etc). RDs and DTRs can use the SOP and SOPP to determine their individual competency level, determine areas where skills need to be developed, and devise a professional development plan to advance their level of practice.

RDs must provide evidence-based, quality dietetics practice. An RD’s practice must be measured, documented, and reported as part of their performance improvement program to verify quality services and demonstrate value through outcome, process, and structural measures. How involved are RDs in their quality team or quality and safety committee at their facility or practice setting? Quality is not going away – it is being taken to the next level as demonstrated in our future federal and state health care reform (6). Be prepared to measure your performance, be patient/resident/client-centered driven! RDs must decide on how to be included in measurement, as measurement will predict quality and quality will receive compensation for nutrition care services. Do It Right the First Time: Quality Dietetics Practice is the RD and DTR.


This article was written by Sharon M. McCauley, MS, MBA, RD, LDN, FADA, manager of Quality Management at ADA in Chicago, IL, and Cecily Byrne, MS, RD, LDN, manager of Quality Management at ADA in Chicago, IL.

Correction

In the Spring, 2010 CONNECTIONS, the article “Survey Report Card . . . Are you going to make the grade” was written by Ellen Butler, RD, SCG, LDN. We sincerely regret the error.
DHCC is fortunate to have many member mentors with demonstrated success in the profession. We will be featuring a mentor section in CONNECTIONS to share their “guidance and advice” for our members. One of the most valuable assets your career can have is a good mentor.

Our Featured Mentor and author for this issue is Pam Womack, RD, owner of Challenge Enterprises, Inc a consulting firm that specialized in administrative and survey troubleshooting for long term care and assisted living. She has authored three books on dysphagia and texture modified diets which you can see at her website: www.dysphagiabooks.com. She is a past Area I coordinator and Secretary of DHCC.

I have been a Registered Dietitian (RD) for 40 years. My path was a year internship at The Seattle Internship for Hospital Dietitians that incorporated both clinical and administrative experience in three different hospitals in the Seattle area. During six months of administration training we rotated through production, tray line and cafeteria services as an employee and as a supervisor in training. We did food and supply ordering, worked on inventory systems and learned to supervise employees. We learned that to supervise you first must know job tasks in order to evaluate skills and competency. The clinical training was intense; it included research, out-patient, surgical, and all clinical skills you would expect.

I felt that my internship was the best part of the five years of training. It gave me the practical skills to become a well rounded RD and later a consultant. My first job was supervising tray line and cafeteria services for Harborview Medical Center in Seattle where I had just completed my internship. Then later as corporate RD for a large nursing home chain, consultant self employed in LTC and a Washington State Surveyor for Centers for Medicare & Medicaid Services (CMS).

I have always included administrative, clinical and educational hours in my proposal for employment and never been turned down for additional hours when I needed to increase my time in the facility. Please review the “Adequacy of Consultant Hours in LTC” article written for spring 1999 CD-HCF Newsletter at the DHCC Web site professional resource section for members.

I set up a system that only took an additional eight hours/month to cover the administration/food service parts of my consulting. I did a little each week working with the dietetic technician, registered (DTR), or dietary manager or foodservice manager as a team. My facilities had few or no deficiencies in dietary or related F-Tags.

Here are some thoughts on incorporating the administrative piece into your practice:

- You cannot know if the dietary department is compliant with the federal tags unless a monthly inspection of the department is completed.
- You need to observe meal time not only in the dining rooms but also in the kitchen for production and to check food safety protocols.
- There are forms available at the DHCC Web site under member’s only, professional resources.
- Can you answer the following administrative questions?
  - The DTR, or dietary manager or foodservice manager should be monitoring all food safety guidelines on a daily basis, do they? What are the results?
  - Are the dishwasher temps accurate and done twice a day? Are they using test strips to make sure the gauges are working and/or chemicals are correct? Is it a high temp or low temp machine? What are the differences? I have noted dietary managers and RDs that can’t answer those questions.
  - What is the pH of sanitized water? Are they using bleach or Quatenary? What’s the difference? Are they routinely checking the level with test strips?
  - Are the cooks following the menu? Breakdowns? Who checks for accuracy?
  - Are fortified foods being prepared to your recommendations? Do you provide recipes?
  - Who determines the supplements given for weight loss? When are they giving the supplement? How is the acceptance monitored?
  - Do you monitor the quality assurance for dietary monthly?

How did you do in answering the questions? These are a few of the important points you need to know to determine if the regulations for Dietary Services 483.35 are in compliance.

I feel we need to improve marketing our RD skills, proving efficiency of time and educating staff about nutrition/ food service issues. We must be efficient in the hours we bill

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and not waste time talking to staff about personal issues unless you are off the billing for those conversations.

As a consultant there is a fine line between being on the facility team and working with them and being efficient with the hours we have to complete the documentation needed. In their eyes we are expensive so we need to be mindful of the costs. On every visit I gave the dietary manager and the Director of Nursing (DON) a list of who I had charted on including the recommendations for the resident. Once a month I would compile my report. Each report included information on clinical, administrative, inservices given and facility observations made that month. I presented the report to the Administrator, dietary manager and Director of Nursing. Early in my career, I discovered that everyone involved should hear the words out of my mouth and receive a copy of the report. Then there was no misunderstanding of what I said and it gave the team a chance to discuss the issues. It was important that I always identified the specific F-tag that was not in compliance and we discussed how to fix the problem and set a timeline for repair if needed. This was the time for all team members to discuss important operations, recommendations and compliance issues.

Administrators are appreciative of this report because they can follow up with department heads to assure compliance. Reporting in this manner makes the RD credible and an important person in their quality assurance program. In the Administrator in Training program, soon to be administrators learn about dietary but are not usually competent in the area for evaluation. They need our expertise with observations and recommendations with follow through.

My observations over the years are that administrators and corporations often work on the premise that you only have to follow good protocols when you are in the survey window. I heard this in all areas of my practice. But it is my belief if you establish good protocols and use them daily you never have to worry about survey because your bases are covered. I have to admit before I became a surveyor I was not as knowledgeable about the State Operations Manual (SOM) as I should have been. It tells you exactly what you need to do to be in compliance and what the survey team will be using to evaluate your systems. It is easy to access at the DHCC website under members only, legislative.

As a surveyor I saw RDs who took a job in LTC without understanding the full ramifications of the job. They had good clinical skills but lacked administrative oversight, didn’t make themselves part of the facility team and didn’t make recommendations to the administrator.

The following are some of the common observations I made as a surveyor for RDs in facilities determined not to be in compliance with regulations involving nutrition.

- Did not understand the survey process or how they fit into the team other than clinical documentation. 
- Prescribed 2 gm Na and strict diabetic diets not understanding the need to liberalize the diets for the elderly. One RD thought she was “compromising” the resident by liberalizing the diet. 
- Charting was done without observation of the resident at meal time. 
- Inconclusive recommendations made for a resident because the dietitian had not consulted with the DTR, dietary manager or nursing team to glean insight into problems the resident was experiencing related to weight loss or inability to consume 50% or more of a meal. 
- RD did not leave nursing, the DTR, or dietary manager a list of assessment recommendations for follow-up. 
- RD’s worked nights and weekends when department heads were not in the building to communicate important issues. 
- Regular visit days were not set up so staff would have weights and admit data available. 
- RD did not understand the need for oversight of dietary department regarding sanitation and safety issues. 
- These RDs worked in a “bubble” assessing with good skills but not communicating with the team by sharing their ideas and taking feedback from staff.

These are all important components of the consultant’s responsibility and must be considered.

It doesn’t matter whether you are full time or only consult a few hours a week - the facility relies on your expertise. But you have to be open to suggestions for the well being of the resident. The DTR, dietary manager and nursing personnel are the eyes and ears of the dietitian. You need to be the educator and work with them to bring about positive outcomes and then these disciplines will value your expertise and share their observations about the
Meet the New DHCC Executive Committee Members

Lisa Eckstein, MS, RD, LD, DHCC Secretary
Lisa Eckstein, MS, RD, LD, graduated from the University of Georgia (UGA) with Bachelor of Science degrees in Biology and Psychology. She has worked in long term care for over 20 years, beginning in the Activity Department, then Social Services & Admissions and ultimately finding a place in Food Service as a Certified Dietary Manager. Realizing her passion for the nutrition health of the residents, Lisa returned to UGA to obtain a Master’s Degree in Food and Nutrition and a Certificate of Gerontology. She returned to long term care as a Food Service Director, Consultant, and is currently Director of Nutrition Services for SavaConsulting. She has been ServSafe® certified since 1998 and is a Certified Instructor. Lisa is a member of the Georgia Dietetic Association and has served as Secretary and CPI. She has also supported DHCC as Area Coordinator, Treasurer and now looks forward to serving as Secretary.

Carolyn Breeding, MS, RD, LD, FADA, DPG HOD Delegate
Carolyn Breeding, MS, RD, LD, FADA earned her Master’s Degree from the University of Kentucky and has been a practicing dietitian for over 35 years. As president and owner of Dietary Consultants, Inc., she provides consultation to health care facilities in Kentucky and surrounding states. Through her other companies, Carolyn is also involved in medical billing, group purchasing, and providing review courses for dietetic students preparing to take the registration exam.

She is a past president of the Kentucky Dietetic Association, as well as past chair of the DHCC. Carolyn currently serves as chair of the Kentucky Licensure Board for Dietitians and Certified Nutritionists and is a past recipient of the ADA award for excellence in Business and Consultation, as well as the prestigious Medallion award.

Carolyn believes that her diversity of experience in practice will result in a unique perspective as a member of the House of Delegates.

Maggie Gilligan, RD, LDN, Communications Coordinator
Maggie Gilligan, RD, LDN, received her BS in Dietetics/Nutrition from Miami University in Oxford, Ohio, in 1981; completed her Dietetic Internship at Shadyside Hospital in Pittsburgh, PA in 1982. Her master’s work was in the area of Bio-Medical Computer and Information Processing at Ohio State University. Maggie has worked as a dietitian for over 28 years with long term care experience ranging from a food service director to a consultant dietitian in the states of Ohio, Pennsylvania and North Carolina. Additionally, her acute care experience ranges from Patient Food Service Manager for Ohio State University Hospitals, to a clinical dietitian on the Modification of Diet and Renal Disease Study (MDRD Study) funded by the National Institute of Health to Operations Dietitian for Shadyside Hospital. In 2003, she began the development of NutraManager, a clinical software system to support the management of a clinical case load for the long term care dietitian. Professionally, she spearheaded the start up of the North Carolina DHCC group after a period of inactivity. Currently, she has been appointed to the Nutrition Care Process / Standardized Language Committee, from 2010 - 2013, serving as the Member At Large for Informatics additionally, she is looking forward to serving the DHCC Executive Committee as Communications Coordinator.

Bonnie Gunckel, RD, CD, Newsletter Editor
As incoming Newsletter Editor, I would like to introduce myself. In 1961 I received my BA degree in Foods and Nutrition form Avila College in Kansas City, Missouri, completed my Dietetic Internship in 1962 at Eastman Kodak in Rochester, New York, and graduate work at University of Missouri. I have been an ADA member for 48 years and worked in Hospitals, Nursing Homes, Assisted Living Facilities, Group Homes, Senior Centers, Hospice, Home Health Agencies, Schools, Food Manufacturers and Jails; taught in Colleges and Universities, with my first opportunity to work in long term care in 1966 and have had a consulting practice since then. It has been a privilege to volunteer at the district and state level over the years including president of Missouri and Indiana Dietetic Associations as well as chair for the Indiana Dietitians in Health Care Communities.

The Connections Newsletter will focus on various issues this year. This summer issue is devoted to Public Policy: Legislation and Regulations. The themes for this year’s Connection are fall: Best Practice - Clinical Advancements; winter: Advancements in Technology; spring: Food Service Operations and Management. Please contact me if you are interested in contributing an article and/or information you would like to see included in your newsletter.
Award for Grassroots Excellence

Brenda Richardson, MA, RD, RD, LD, CD, 2010-2011 Chair of Dietetics in Health Care Communities (DHCC) was awarded ADA's 2010 Award for Grassroots Excellence, the highest award an ADA member can receive for Public Policy.

The award was presented May 17 at ADA's First Advocacy Training Workshop in Washington, D.C. In presenting the award, President Jessie M. Pavlinac, MS, RD, CSR, LD, mentioned Brenda's efforts to involve RDs in state programs and policies as well as her strong connections throughout the state of Indiana.

where she arranged for volunteers to work the governor’s booth and increase awareness of the registered dietitian. These activities are just a small sample of all that Brenda has done to promote nutrition and dietetics in Indiana.

Brenda’s own words best describe the award and its meaning to her:

“It represents so many people and such great teamwork. I thank Bonnie Gunckel, RD, CD, and the Indiana Dietetic Association who submitted the nomination.

“I was presented with a beautiful award from ADA. I was then given a U.S. flag that my Congressman (Rep. Baron Hill) had flown over the United States Capitol Building on May 4th honoring my selection for the 2010 Award for Grassroots Excellence given by the American Dietetic Association. Honestly when the flag was presented, there were not many dry eyes throughout the room. What a wonderful day. I felt like I had received an Emmy and the Nobel peace prize all at one time!!”

“After the celebration then we had some great meetings about public policy and then went to Capitol Hill to meet with our Senators and Representatives. There was also a meeting with White House staff!!

Please join with DHCC in congratulating Brenda Richardson in receiving the ADA Award for Grassroots Excellence.
“Great minds discuss ideas, average minds discuss events, and small minds discuss people.”

If Eleanor Roosevelt was seated at the table with long term care professionals attending Creating Home in the Nursing Home II: A National Symposium on Culture Change and the Food and Dining Requirements Invitational Stakeholder Workshop she would have been in awe of the great minds discussing the advancement and vision for individualized care of our elders in healthcare communities.

Just imagine 60 plus representatives from the majority of long term care professional organizations seated at one table brought together by co-sponsors Centers for Medicare & Medicaid Services (CMS) and Pioneer Network. In addition, individuals working in government agencies (CMS, CDC, FDA), facilities, and academia were in attendance. But perhaps the most important person in there was Betty, an elder from Lincoln, NE.

Those gathered were assigned to participate in workgroups with the task of identifying current barriers to individualized care and brainstorm ideas that would enable us to break down those barriers. Workgroup topics included:

1. Individualized Care Regulatory Recommendations
2. Individualized Care Professional/Clinical Recommendations
3. Infection Control & Prevention Regulatory Recommendations
4. Infection Control & Prevention Professional/Clinical Recommendations

Much of what was discussed centered on quality of life and the resident’s right to self-determination by knowing the risk/benefits of the decision, ensuring the resident makes a true-choice, not one that staff manipulated and following-up on the decision with the resident. The choice may lead to a negative outcome, but it is the resident’s right to folly.

As providers are we willing to take the risk? CMS support is vital and exists. Educating health care professionals, surveyors, families, and residents will be essential in the successful transition from a hospital model to a home model. Documentation in the medical record will become even more important as we tell the true story of our resident’s journey toward self-determination.

Note: Creating Home in the Nursing Home II: A National Symposium on Culture Change and the Food and Dining Requirements scheduled for February 11, 2010, was cancelled due to snow. Instead of rescheduling, CMS and Pioneer Network elected to offer the program to everyone via webinar. DHCC members Linda Bump, MPH, RD, LD, LNHA and Linda Handy, MS, RD, through the guidance of Carmen Bowman, MHS, recorded brilliant webinars as did the other presenters. You may access all the presentations at http://www.pioneernetwork.net/Events/Creati ngHomeOnline/Symposium/

American Medical Directors Association (AMDA) Network Update
Suzanne Cryst, RD, CSG, LD
DHCC AMDA Liaison

The March 2010, AMDA Annual Conference, “Golden Opportunities,” was very aptly titled. The Conference was multidisciplinary in nature with a wide variety of topics that focused on the frail older adult, but at times spun off on the challenges of the younger, short term stay resident. From interdisciplinary team (IDT) topics, including palliative care, ethics, dementia, diabetes, culture change, wound care, quality, exercise and physical activity in LTC to very specific, Medical Director sessions, the program committee succeeded in meeting the challenges of their theme.

During this past year, as the DHCC Network representative to AMDA, I have participated in a variety of capacities, with the focus of keeping the RD/DTR in the conversation as the Nutrition Expert, by being visible and contributing to their missions and sessions as listed below.

1. Appointed as a committee member to identify task statements on the role of the medical director in person-directed care and then reviewed the final draft of the white paper that was presented to the AMDA House of Delegates and approved.
2. Approved for a poster session on Dining and Culture Change. Many of the attendees stopped to chat and listen and asked a variety of questions. From, “Why should I care about dining and environment,” to specifics on how our facility is embracing change, what is the IDT role, how to liberalize diets in their facilities. Linda Handy, MS, RD, was there with her poster, as well as Suzanne Gillespie, MD, RD. Ann Gallagher, RD, LD, past ADA President and past DHCC Chair, was also in attendance. So nice to have fellow

continued on page 20
RD’s there to share their perspectives in the various sessions.

3. Appointed to serve on the AMDA Foundation Awards Committee to review the applications for the AMDA/Evercare Quality Improvement Awards and select three winning submissions. I was then honored to serve as the session moderator when the winners presented a summary of their projects.

4. Submitted a proposal for the new session on Model Programs and Policies and was one of five topics selected. This was a first time offering, creating a forum for members of the interdisciplinary team (IDT) to share innovative programs and policies. The topic I shared was Identifying Patterns during Incident Investigations: Diabetes Management and Incident of Falls.

5. Answered the call for submissions for the Caring Canine Calendar. Monique, our facility pet therapy dog, was so very proud to pose in her pink scarf and be part of this wonderful AMDA Foundation scholarship initiative.

6. During the conference, attended one very memorable session, “In The Trenches Table Topics” during Saturday lunch. There were 34 sessions to choose from and I spent the 90 minutes with 12 others at Dr. John Morley’s Nutrition session, where he shared his research and lead the group discussion on whatever subject was brought forth.

To round out the conference, Dan Buettner, was the keynote speaker on Friday morning as he shared his “Blue Zones: Secrets of a Long Life”, and Sunday closed with Dr. Jeffrey M. Levine, sharing “Humanistic Medicine, Geriatrics and Art” and David Solie, MS, PA , presenting, “I Can Hear You Now: Practical Communication Strategies for Long Term Care Professionals.”

As we start a new year, I look forward to continuing to represent our DPG to this association. If I can answer any questions, please contact me at scryst@maria-joseph.net

Association of Correctional Food Service Affiliates (ACFSA)

Joseph W. Montgomery, MS, RD, LDN, CCFP

ACFSA will be meeting August 22-26 in San Diego, CA. To learn more about ACFSA and the forthcoming correctional food service conference go to their Web site (www.ACFSA.org). We have not had much communication so far this year, though Michigan ACFSA held a Spring training conference this past May. I look forward to meeting with all the correctional dietitians (ACFSA, ADA, and DMA members) and the many other correctional professionals in August.

For more information, contact Joe Montgomery at joe.montgomery@wolfe creek.net

MENTOR CORNER “Enhancing our Practice”

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resident at meal times, dining experience, and acceptance of food and supplements. Always include their observations about resident behaviors at meal time in your documentation, if applicable. If you miss this step then your recommendations are not always followed and your assessment is not complete. Negative outcomes will surface for the resident and on the survey. It is also important to be in the facility during the week when the main team players are at work. Working weekends or evenings is not recommended.

In conclusion, the RD is the nutrition expert hired to oversee the nutrition aspects of resident care, and compliance with federal regulations that have dietary components, both clinically and administratively. It is important to keep in mind that the federal regulations are for minimum competency of care set by CMS. Your consistent communication to the facility of your observations helps facilities exceed the expectations of the federal government in the care of our elderly.

References

CD-HCF Strategy Paper “Adequacy of Consultant Hours in Long Term Care” by Jody L. Vogelzang, MS, RD, LD, FADA and Pam Womack RD. Located at DHCC website under professional resources newsletter spring 1999.

**Member Reception**
(Registration required; fee charged, space is limited)
Join Dietetics in Health Care Communities (DHCC) and Healthy Aging (HA), dietetic practice groups of the American Dietetic Association for a joint **Member Networking Reception**.

**When:** Sunday, November 7, 2010  
**Where:** Aboard the *Spirit of Boston*  
**Time:** 6:30-9:30pm

**Space is Limited**  
**Registration begins June 15, 2010**

**Sponsored by**
- US FoodService  
- Nestle Nutrition USA  
- Lemon-X  
- GA Food Service, Inc.  
- Advance Food Co.

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**DHCC PreFNCE Workshop: REDEFINING NUTRITION SERVICES FOR THE AGING**
(Registration required; fee charged, space is limited)

**Saturday, November 6, 2010**  
7:30 am – 3:00 pm  
**World Trade Center, at The Seaport Hotel Amphitheater**  
Boston, Massachusetts

**Session Topics Include:**

**The Aging Population and Provision of Nutrition Services**  
Mary Hager, PhD, RD, FADA, ADA Policy Initiatives & Advocacy Group

**Reimbursement Opportunities for Nutrition Services with the Aging**  
Jane White, PhD, RD, LDN, FADA; Dian Weddle, PhD, RD, FADA

**Sarcopenia: Best Practice Updates - Identification, Evaluation and Management of Sarcopenia in Aging**  
George Blackburn, MD, PhD

**Until Further Notice, Celebrate Everything: Using the Menu to Enhance Food Selections in Extended Care Communities**  
Valencia Browning Keen, PhD, RD; Carol Elliott, RD, LD/N

**Culture Change and Redefining the Dining Experience**  
Linda Roberts, MS, RD, LDN, Candace Johnson, RD
Memories of 13 years on the Executive Committee!
by Marilyn Ferguson-Wolf, MA, RD, CSG, CD

Dear Executive Committee and past EC Members,

As I open a “Word” document to start this letter, I see file after file in my “CD-HCF” folder on my desk top. The folders within are stuffed full of EC minutes, policy and procedures, newsletter articles and just general items related to serving on the EC for the past 13 years. I’m sure Marla could give me many tips on how to eliminate and re-organize all of these folders, but as you know, life on the executive committee is fast paced and getting the work done is a bigger priority than organizing your computer! And there is always tomorrow to re-organize!

This is an anniversary of sorts for me. After starting on the board 13 years ago, I will no longer be officially part of the DHCC Executive Committee structure. Thirteen years is a long time—when I started my children were 10 and 7 years of age, now, one has graduated from college and the other ready to start his junior year in college. I know many past and current EC members can report similar disbelief of how the time has passed. And how much this organization means to them.

When I started, some of us didn’t have email addresses or even computers with internet hookups that would allow for the necessary communication between members. When I started, our publications were in a member’s garage and were shipped out by that member and those publications were revised with pen and paper, mailed to the person in charge of editing. When I started, minutes were recorded on a tape recorder, later to be transcribed and faxed out to the members for approval; newsletter articles were mailed to the editor for review; and almost all committee and EC activities were conducted face to face! Wow, how we have changed during my short time on the EC and the history of our DPG.

When any of us are in the booth at FNCE we hear how much we mean to our members: “This is the best DPG. You are always there to answer my questions and to give me help with resources to answer my questions and to expand my practice. I love your books. You guys are the best.” Yes, I do believe we have the best DPG. The reason being, we have a long history of a fabulous EC, starting at the very beginning of the DPG and continuing into the future. Our EC members, past and current, are the movers and shakers of ADA, CDR, in the community and in the practice of dietetics, everywhere you look. Our members reach out beyond Long Term Care, Corrections and Home Health, they can be found in hospitals, research, education, private practice, food production and manufacturing, plus many more areas. We are the field of dietetics.

I want to thank the current executive committee and all the past members I have served with. As life changed, my involvement would ebb and flow, always someone else was there to pick up for me when needed and to keep our group on course. This experience has moved me forward professionally and personally. I’ve had the opportunity to work with an amazing ever changing EC; to learn how to organize projects and people via email and conference calling; to give presentations; to work on the development of our Gerontological Specialty Certification; to meet our members and to learn how to best serve our membership based on their needs rather than our own personal needs. What an experience! Thank you for this opportunity.

My belief is that once you have served with DHCC, you are always called up when your expertise can be put to the best use—another wonderful trait of our DPG. So who knows when I might pop up again, until then, keep up the good work! As you know, not only do our members depend on you, so do all the clients we serve. Every day you have the opportunity to make life better for someone through your own work and through the work you do on this board. Thank you!

Marilyn Ferguson-Wolf, MA, RD, CSG, CD
Appreciative Business Consulting and Coaching
Certified Specialist in Gerontological Nutrition
Certified Wellness Coach

DHCC 50 Year Members 2010-2011

Please join DHCC in congratulating our 50 year members.

Thelma W. Anderson, Mishawaka IN
Della H. Creach, Bixby OK
Ruth P. Cross, Lake View Terrace CA
Kathleen K. Donohoe, Braintree MA
Louise M. Genovese, Farmington Hills MI
Patricia R. Henderson, Seattle WA
Josefina C. Johnson, Bronx NY
Freddie L. Johnson, Baton Rouge LA
Eleanor C. Martin, Willis TX
Jeanne C. Meyer, Oklahoma City OK
Carol A. Nealon, Belmont MA
Sylvia Maria Rodriguez, San Antonio TX
Anne S. Smith, Charlottesville VA
M. Arline Smith, Coralville IA
Anna P. Stecker, Pinckney MI
Delma D. Wilburn, Pineville LA
Nanette F. Yaroscak, Armonk NY
   
   #5003   $20.00
   
   Filled with suggestions for the health care team to address eating problems. Utilizes the multi-discipline team approach; RD, RN, OT, and SLP. Updated information on dysphagia, finger foods, checklist for compliance with dining skills, staff competency and more.

2. **DINING SKILLS: Restoring Pleasure to Mealtime; Techniques for Helping the Older Adult VHS (1995)**
   
   #5001   $12.00
   
   DVD # 5035
   
   Excellent cross-training tool for all health care providers who strive to host independent dining skills.

3. **POCKET RESOURCE NUTRITION ASSESSMENT**
   
   (7th Edition, 2009)
   
   $66.00 ADA Members $50.50
   
   Now in its 7th Edition! Spiral-bound; sized to fit in a pocket. Expanded to meet your changing needs. Guidelines are included for: developmentally disabled, anthropometric assessments, medications and labs, basic nutrition requirements, enteral and parenteral feeding assessments and more.

   
   $5009
   
   Covering everything the health-care provider needs to know when working with the older adult either at home or in an extended care facility. Covers factors affecting nutrition, nutrition and disease, nutritional assessment, dining challenges and regulatory compliance. Scientifically sound and practical resource for new and experienced professionals includes new forms, resources, the food guide pyramid for older adults and an index of tables.

5. **NUTRITION CARE OF THE OLDER ADULT, 2E, CPE Questions**
   
   $5031
   
   $20.00 ADA Members $15.50
   
   This companion piece to Nutrition Care of the Older Adult, 2e includes questions, an answer key, a form for reporting CE hours and a certification of participation. Approved for 21 hours of CPE credit.

6. **NUTRITION RISK ASSESSMENT FORM, GUIDES, STRATEGIES & INTERVENTIONS (1999)**
   
   $5014
   
   Material developed by the ADA Long Term Care Task Force and CMS.

7. **POCKET RESOURCE FOR MANAGEMENT (2006)**
   
   $5016   $15.00
   
   A quick reference for food service management. Essential information for all areas including personnel, education, kitchen design, quality, cost control, survey information, emergency management, etc. Newly updated and revised. Buy with the POCKET RESOURCE FOR NUTRITION ASSESSMENT and get both for $35.00 5090

8. **NUTRITION AND FOODSERVICE MANAGEMENT IN CORRECTIONAL FACILITIES 3rd edition (2008)**
   
   $5023
   
   $20.00
   
   Designed for the dietetic professional working in the correctional area. Pertinent to both the newcomer and those familiar with corrections.

   
   $5025
   
   $10.00
   
   Overview of what a consultant needs to know: developing a business, & marketing plan, setting fees, IRS information, etc. Includes contracts, forms, etc.

10. **STEPS TO SUCCESS: FOOD SERVICE SYSTEMS (2004)**
   
   $5030
   
   $10.00
   
   A well-run, financially sound operation serving attractive, appetizing food can mean success. Features up-to-date information, classic guidelines, & sample forms to complement your knowledge of equipment, food preparation techniques, budgeting, kitchen design, and quality improvement. Buy BOTH STEPS TO SUCCESS for $16.00 5091

11. **INSERVICE MODULE 1 SANITATION (2002)**
   
   $5026   $10.00
   
   Revised & expanded! Concentrates on basic sanitation: Standard Precautions, Personal Hygiene, Dump Mopping, etc. Pre-tests, post-tests, and handouts. Great addition to your educational library.

12. **INSERVICE MODULE 2 FOOD SAFETY (2002)**
   
   $5027   $10.00
   
   Concentrates on safe food handling: HACCP, food temperatures, storage, leftovers, foodborne illness, etc. Pre-tests, post-tests and handouts.

   
   $5032
   
   $10.00
   
   Concentrates on essential, basic information for dietary staff including department orientation, HIPAA, resident rights and much more!

14. **INSERVICE MODULE 4 MEDICAL NUTRITION THERAPY (2006)**
   
   $5033
   
   $10.00
   
   The 4th module in the series of Inservice sessions for the nutrition services department. This module focuses on medical conditions that may be impacted by nutrition interventions, special diet needs, etc. Buy ALL 4 INSERVICE MODULES for $12.00 5092

   
   $5028
   
   $18.00
   
   A comprehensive guide for the professional who is training feeding assistants for those residents who need help during mealtimes. Developed in response to CMS regulations.

16. **MANUAL FOR FEEDING ASSISTANTS (2003)**
   
   $5029
   
   $7.00
   
   Designed for each feeding assistant to use during training and afterwards as a reference. Includes learning activities and important information taught in 5028.

17. **SURVIVAL SKILLS FOR NUTRITION SERVICES (2006)**
   
   $5034
   
   $20.00
   
   Are you new to the nutrition services department or do you need to increase your overall knowledge? Is the dietary manager new? This manual is just what you are looking for to help! Gives a broad overview of Systems Management, Clinical, Management, Compliance and Evaluation.

18. **NUTRITION ESSENTIALS FOR THE HOME CARE DIETITIAN**
   
   $5036
   
   $20.00
   
   Do you work in Home Care? Are you considering this growing field? This manual is beneficial for both the dietitian new to Home Care and those already working in the field.

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