Multivitamin and mineral supplements for older adults: how do they compare?

by Melissa Ventura Marra, PhD, RD, LD

Although taking a daily multivitamin/mineral (MVM) pill may not prevent cancer, heart disease or other chronic diseases in healthy adults, they can help some older adults prevent vitamin and mineral inadequacies by filling dietary gaps. Vitamins and minerals most often low in the diets of older Americans include vitamins A, B6, C, D, E and K in addition to calcium, magnesium, potassium, and zinc. The effectiveness of a MVM in filling these nutrient gaps depends partly on the types and amounts of nutrients the supplement provides. Many commercially available MVMs designed for older adults have recently been reformulated. This article compares the ingredients of a few one-daily over-the-counter MVMs formulated to meet the needs of older adults.

Table 1 compares the types and amounts of ingredients each MVM provides. For each essential nutrient, the table also shows the percentage of Recommended Daily Allowance (RDA) or Adequate Intake (AI) for women and men over 50 years of age the MVM provides. This percentage is used instead of the % Daily Value (DV) typically shown on supplement labels because the % DVs are calculated using outdated reference values based on 1968 RDAs.

- **Vitamin A.** The amounts range from 2500 to 4000 IU/d. They provide between 107% and 171% of the RDA for women and between 83% and 133% for men. Because vitamin A intakes equivalent to about 214% of the RDA from retinol (but not from beta carotene) have been associated with increased risk of hip fracture in older women, most MVMs for this segment of the population now supply a portion of their vitamin A from beta carotene.

- **Vitamin B6.** The amounts range from 3 to 7 mg/d which is between 200% and 467% of the RDA for women and between 176% and 412% for men.

- **Vitamin C.** The amounts range from 60 to 180 mg/d which is between 83% and 200% of the RDA for women and between 100% and 240% for men.

- **Vitamin E.** The amounts range from 33 to 70 IU/d or 147% and 311% of the RDA for older adults.

- **Vitamin D.** The amounts range from 400 to 1000 IU/d.

- **Zinc.** The amounts range from 11 to 22.5 mg/d. They provided between 138% and 281% of the RDA for women and between 100% and 205% for men.
What can we learn from Michelle Obama’s inaugural dress? To me, this was not a traditional ensemble of a well-educated, professional, female attorney. Instead, the dress she wore to her husband’s inauguration reflected change and sparked debate.

Health care reform is a priority for the Obama administration. Keeping health care costs in check by emphasizing prevention is part of the strategy. Where do dietitians fit? Martin M. Yadrick, MS, MBA, RD, FADA, ADA President, released a memo stating, “...the next hundred days may determine the future of the dietetics profession.” Based on Obama’s remarks in a January 2008 debate, “...paying for a dietitian for people to lose weight, as opposed to paying the $30,000 foot amputation. That will save us money.” - I’m feeling pretty optimistic.

Health care reform is also a priority of CD-HCF and ADA. Last summer, the Pioneer Network invited ADA to send a representative to their annual meeting. Pioneer Network, as you may know, is dedicated to making fundamental changes in values and practices to create a culture of aging that is life affirming, satisfying, humane, and meaningful. I was fortunate to be the member attending the meetings representing both ADA and CD-HCF. To my dismay, there were no programs last year on dining or nutrition. Not to worry, I spoke to Bonnie Kantor, Executive Director, and offered our full support identifying potential speakers for the 2009 program. I am optimistic dining and food service will be represented in this year’s program.

Also of interest, last year the Centers for Medicare & Medicaid Services (CMS) and Pioneer Network hosted a symposium on Culture Change and Environmental Requirements. The symposium was a huge success. This year Bonnie Kantor submitted a proposal for a grant to fund a continuation of the CMS/Pioneer Network symposiums with this one on Culture Change and Dining! Of course I offered CD-HCF support on this exciting project.

After the Pioneer Network meeting, an invitation arrived to the Brookings’ Engelberg Center for Health Care Reform. This meeting was to introduce the Long-Term Care Quality Alliance (LTCQA) to various stakeholders within the long-term care community. Agencies represented ranged from American Association of Retired Persons (AARP), Administration on Aging (AoA), American Health Care Association (AHCA), American Medical Directors Association (AMDA), Pioneer Network to Visiting Nurse Associations of America (VNAA). The primary objective of the LTCQA will be to support improvements in quality care centered on individuals who need long-term and post-acute care and supportive services regardless of setting. Mary H. Hager, PhD, RD, FADA, Director, Regulatory Affairs from ADA in Washington, DC, attended the meeting with me, and we both agreed this is a great opportunity for CD-HCF and ADA to be involved in a reform organization with significant representation from all professions within the long-term care and post-acute care industry.

With all things in life, one thing leads to another and so is the case with the next organization we have been invited to become a part of. The Long Term Care Professional Leadership Council represents nursing home administrators, medical directors, directors of nursing and pharmacists. This Council was formed to foster collaboration defining and addressing issues related to standards for quality care in long-term care facilities. Advising the Council is a Professional and Technical Group (PTAG). Members of PTAG include professional organizations, ancillary service professionals, governmental and regulatory agencies whose members service long-term care. Members of PTAG serve as an expert review panel for professional and technical issues being considered by the Council.

What all these groups have in common is long-term care reform. ADA & CD-HCF will represent each of you, but like Michelle Obama you must don yourself in the fabric of change. Question the traditional and lead those around you to reforms that will spark debate and ultimately lead to an improved quality of life for those we serve.

The times, they are a changing. Let’s make sure our voices are heard!

In Washington, DC integrity is respected, but money talks. I urge each of you to go to your wallet, take out a $5 bill, place it in an envelope, address it to: ADAPAC, 1120 Connecticut Ave. NW, #480, Washington, DC 20036. Include in the envelope your name, address, employer, and occupation. Do it now!! I just did. Together we can get things done.

Linda
Now. Your donation, no matter how big or small, will support ADA’s work on Capitol Hill by supporting pro-nutrition candidates.

Go to the ADAPAC Web site at: http://www.adapac.org and click on the donate button. Donations of $10 or $25 - or of much greater amounts - will make a huge difference in what ADAPAC is able to do.

With Congress poised to debate your future in health care, there isn’t a better investment you could make.

Change is happening. Be a part of the change!

Sincerely,

Martin M. Yadrick, MS, MBA, RD, FADA
President, American Dietetic Association

Susan H. Laramee, MS, RD, FADA
Chair, ADA PAC Board of Directors

AMERICAN DIETETIC ASSOCIATION NAMES PATRICIA BABJAK CHIEF EXECUTIVE OFFICER

CHICAGO – Patricia Babjak, previously the executive vice president of the American Dietetic Association, has been named the Association’s Chief Executive Officer by ADA’s Board of Directors, effective immediately.

“Pat Babjak is well-known to ADA members and is exceptionally well-qualified to serve as Chief Executive Officer,” said registered dietitian and American Dietetic Association President Martin M. Yadrick. “Pat will fill this position with the same professionalism, ability and distinction she has brought to every position she has held at ADA since joining our Association in 1975.”

Babjak joined ADA as assistant coordinator of ADA’s Commission on Dietetic Registration. She became director of CDR in 1978, serving until 1998 when she became executive vice president for strategic management. Babjak also served as ADA’s interim chief executive officer in 1997.

In her previous position, Babjak supervised research and scientific affairs and development of ADA position statements, among other areas. She was also responsible for overseeing development and implementation of ADA’s strategic plan and for developing mechanisms to measure...
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the Association’s progress toward goals and objectives.

Babjak facilitated the reorganization of ADA’s governance structure, including new roles for the Board and House of Delegates and the transformation of ADA’s Nominating Committee into a force for leadership development and diversity within the Association.

In 2004, in recognition of her service to ADA and to the dietetics profession, Babjak became just the fourth ADA staff member to be awarded honorary Association membership.

Babjak has served on the Advisory Committee of the Harvard University Leadership Institute as well as on the Pew Health Professions Commission on Educating Health Care Workforce Task Force. She has chaired the National Commission for Certifying Agencies and served on the Leadership Council for the National Organization for Competency Assurance. Babjak is a graduate of the University of Illinois - Chicago and earned a master’s degree in library science from Dominican University.

The American Dietetic Association is the world’s largest organization of food and nutrition professionals. ADA is committed to improving the nation’s health and advancing the profession of dietetics through research, education and advocacy. Visit the American Dietetic Association at www.eatright.org.

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**Vitamin K.** Amounts of the nutrient ranged from 0% to 89% for women and 0% to 67% for men. Most of the supplements provided 25% or less of the vitamin. These low amounts of vitamin K are likely related to the vitamins interaction with blood-thinning medications. For those taking blood thinning medications, consistent intake of a supplement is particularly important.

**Calcium.** Most MVMs only provide around 200 mg or 17% of the AI. The highest amount provided among these supplements was 405 mg or 34% of the AI. Because calcium compounds are large by nature providing higher amounts in a MVM would result in a pill too large to swallow.

**Magnesium.** The MVMs provided either 50 or 100 mg of magnesium which equate to 16% and 32% of the RDA for women and 12% and 24% for men respectively.

**Potassium.** At most the MVMs provided only 2% of the AI for potassium.

**Other Nutrients.** Iron and vitamin B₁₂, are not generally dietary shortfall nutrients but their amounts in MVMs for older adults are different from those found in MVMs for adults in general. Most MVMs for older adults (and those for men), including those reviewed here do not contain iron. Should a person need iron supplementation, a separate pill or a MVM formulated for adult women can be taken. As for vitamin B₁₂, most MVMs targeted for older adults supply higher amounts of this nutrient than do MVMs for adults in general. The supplements reviewed provide a minimum of 1042% of the RDA for this nutrient. Amounts of selenium ranged from providing 36% to 364% with the largest amount being in a MVMs formulated for older men.

With the exception of Centrum® Silver® chewable (which provides less than 100% of the RDA/AI for iodine, niacin, molybdenum), the other MVMs provide at least 100% of the RDA/AI of thiamin, riboflavin, niacin, folic acid, biotin, pantothenic acid, iodine, molybdenum, copper, manganese and chromium.

**Extras.** To set the supplements apart, additional ingredients are often added usually in relatively small amounts. These “extras” include: minerals without established RDAs/AIs (e.g. boron, nickel, silicon, tin, and vanadium), phytonutrients (e.g., lutein and lycopene), herbs (e.g.ginko biloba), and coenzyme Q10.

Overall, MVMs can be effective in filling intake gaps of older adults for vitamins A, B₆, C and E and zinc but not for vitamin K, calcium, magnesium, and potassium. All the brands reviewed provide at least 100% of the RDA/AI for vitamins A, B₆, C and E and zinc except for three that provide 83% of the
“How many calories does she really need?” “Why does he keep gaining weight on the tube feeding? —- I am providing him what I calculated.” “She is only eating 45% of what we give her, and she does just fine – her weight and lab values are stable.”

Do you ever ask yourself these questions? Do you wish there was another way to determine caloric needs in your long term care residents, without relying on predictive equations? Well, today, there is another way – and is being tested in long term care facilities.

Indirect calorimetry (IC) has been around a long time. You might remember the big, cumbersome metabolic carts in the hospitals. Yes, you can measure someone’s metabolic rate with one of those, but now, the technology has advanced and it is possible to measure using a much smaller, portable, and less expensive machine. Almost anybody can be measured; the only contraindication is residents receiving continuous oxygen. The resident simply needs to sit back, relax, and breathe. Accurate results can be obtained in 10 to 20 minutes. In addition, the procedure is reimbursable under Medicare. So, this is a “win-win” situation; you get the information you need for your assessment and it is reimbursable.

History
We have all heard the story of how back in 1919 Dr. J. Arthur Harris and Francis G. Benedict measured indirect calorimetry in 239 subjects and derived 2 predictive equations (one for each gender) from these measurements. What did people look like back then? Would you believe for most of us). And, think about the obvious changes in overall life expectancy between these eras.

Interestingly, Harris and Benedict explicitly cautioned against using their equations inappropriately. And, what did we do? We adopted these formulas as the preferred method of caloric assessment for decades.

Our Evidence Analysis Library (EAL) states, “Measuring resting metabolic rate with indirect calorimetry is a way to improve the accuracy of the RMR value as compared to the common prediction equations. However, IC is not free from error…” Our EAL adds, “Clinical judgment is needed to determine when the RMR will be a critical element of the nutrition care plan and likely to impact significantly important patient/client outcomes. Regardless of the method to determine Resting Metabolic Rate (RMR), estimated or measured, careful clinical judgment is essential to evaluate the RMR value and its application in an individual’s nutrition care and outcome.” We agree that measuring RMR in long term care residents is imperative to the development of the individual’s nutrition care plan to affect the most beneficial outcomes.

Our EAL admits that there have been few studies on RMR in long term care residents and a review of published research in this area yields very little. In “Nutrition, energy metabolism, and body composition in the frail elderly,” a compilation of 4 studies published in 2007 by Eva Lammes, Karolinska Institutet, Stockholm, Sweden, Dr. Lammes states, “…recent reviews conclude precision is poor when using equations to estimate Basal Metabolic Rates (BMR), especially on the individual level.” In her studies, energy intakes were low, with mean intakes below 1600 kilocalories per day and nutrient intake and nutrient density were low for vitamins D and E, folic acid and selenium. She concludes that “the nutritional treatment ought to be targeted according to the needs of each individual.”

The Implementation of Revised F-Tag 325, September 1, 2008:
Dr. Lammes’ observations and conclusions coincided with the implementation of F-Tag 325 revisions in the fall of 2008. The emphasis of this F-Tag is the individual, specifically focusing on maintaining acceptable parameters of nutritional status; providing nutritional care and services to each resident; recognizing, evaluating, and addressing the needs of every resident; and taking into account each resident’s clinical condition and preferences.

What an opportunity for registered dietitians! Indirect calorimetry provides a proactive approach, assisting staff to identify residents with unusually high or low needs quickly. Indirect calorimetry provides science-based rationale for the plan of care and supplies the necessary documentation to justify interventions and evaluate the effectiveness of interventions.

Case Studies:
Indirect calorimetry was performed on a 27-year old severely mentally retarded, tube-fed only female who had gained 20 pounds in a few months. She appeared to be...
very uncomfortable in her bed and was now on intermittent oxygen with very little activity of daily living (ADL). Her tidal volume was only 319 mL and her RMR was measured at 907 kcal/day, 36% less than Harris-Benedict predicted (1423 kcal/day). When compared to Mifflin-St. Jeor (1321 kcal/day), there was a discrepancy of 31%.

The dietitian had come to the conclusion that Harris-Benedict and Mifflin-St. Jeor were over-estimating the patient’s needs and had gradually reduced her tube feeding to only provide 1056 calories/day. The KORR ReeVue™ arrived at the resident’s RMR in only 10 minutes. Indirect calorimetry quickly and accurately identified this resident’s resting metabolic needs.

Another example involved a 70 year old female with involuntary tremors (history of cerebrovascular accident [CVA]) and increased breathing issues (smoker). Her measured RMR was 2146 kcal/day, 35% higher than predicted with Harris-Benedict (1592) and 38% higher than Mifflin-St. Jeor (1559). She had stashes of snacks and regular soft drinks by her bed and she admitted she was hungry most of the time. Not only was a high RMR identified, but also an opportunity for the facility to provide her with more nutritious food.

Comments from RDs in the Field:
Dietitians who are using IC are positive on the procedure. “I am so less stressed because now I know that the resident’s needs are being met. I have an actual measurement from which to work.”

“I now understand why the resident is maintaining weight and is satisfied with their food, even though they are only eating 40% of most meals (resident provided 2400 kilocalories per day).”

Conclusion: Challenge- nutrient density in smaller caloric amount:
One concern that has arisen during this work-in-progress is that within the smaller caloric levels, we need to meet the nutrient needs of our residents. This can be a challenge, especially with increased protein needs common among elderly residents with multiple chronic conditions. We can achieve this, keeping in mind that our overall goal is to provide the most individualized care for each one of our residents and focusing on the content, i.e., nutrient-density, of calories served, rather than calories per se. Think about this: the starting point for individualized care is measuring rather than estimating each resident’s RMR using indirect calorimetry.

References:
Evidence Analysis Library, American Dietetic Association, 2008.
Fran Bevins Williams, RD, LD, CPT, has an avid interest in helping individuals of all ages improve their nutritional statuses. She is Clinical Director for Nutri-Style, LLC, a division of Dietary Consultants, Inc., in Richmond, Kentucky, and has spearheaded the indirect calorimetry investigations in LTC. Nutri-Style is an authorized distributor for the KORR ReeVue™ indirect calorimeter. All inquiries regarding indirect calorimetry should be directed to Nutri-Style.

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Men’s RDA for vitamin A and one that provides 80% of the RDA for women. All the MVMs provide 100% of the current AI for vitamin D for adults 51-70 years of age, but those providing only 400-500 IU fell short for adults over 70 years. Some of the newer formulations of MVMs provide up to 1000 IU of vitamin D; an amount that required a separate supplement in the past. In some cases, the percentage over 100% of the RDA or AI vary significantly between MVMs. However, health benefits derived from intakes beyond RDA/AI levels are not evident for most nutrients.

Taking a MVM should not take the place of a healthful diet. MVMs do not ensure adequate intakes of all key micronutrients. Even those formulated for older adults do not supply

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There has been widespread debate over the care and treatment of offenders and the amount of resources that should be allocated to their care. The increases in mandatory and longer sentences have resulted in an increase of cost of correctional health care.

The impact on the corrections budget is significant. While per capita medical costs for younger offenders typically range from $400 to $600 per year, older offenders’ per capita costs range between $2,000 and $12,000. On average, offenders 55 and older cost 16 times more for medical care. The prison infirmary, where offenders used to stay for a few days while they recovered from surgeries, now houses the terminally ill. Whereas before it operated as a clinic, it now serves as a round-the-clock nursing care facility for the sick (1). In 1997, it cost about $22,000 a year to keep the typical adult offender incarcerated and about $70,000 a year to keep an offender over the age of 60 incarcerated (2).

The growing demand for medical services within correctional facilities has become an important issue in prison health care. As offenders age, we see increased disability, the need for accommodation and more chronic conditions. Arthritis and hypertension are the two leading chronic conditions, followed by stomach ulcers, cardiac disease, diabetes, stroke, cancer, renal failure and obesity. As medical risks increase, aging offenders have a greater need for lab work, EKGs, costly dental care and multiple medications due to multiple chronic illnesses. Typically correctional facilities have offered a variety of therapeutic diets for chronic conditions. Diets can either be prepared on site or purchased; however, the choice becomes adding to food service staff responsibilities or adding expense to the food service budget.

In an effort to reduce the cost of correctional health care, dietitians in corrections play a vital role to develop and implement effective clinical strategies that lead to sustained dietary changes among aging offenders, as well as the general population of our facilities. It starts with educating offenders and providing a heart-healthy menu, recommended by the American Diabetes Association and with the 2005 Dietary Guidelines (increased fiber, controlled fat, reduced sodium). Ultimately, we can improve the overall health of offenders, resulting in lower costs in health care.

References
(1) Aging offenders pinch prison’s health budget, Lisa Rosetta, The Salt Lake Tribune, 1/23/06

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substantial amounts of vitamin K, calcium, magnesium, and potassium. Compared to MVMs targeted women, those for older men contain lower amounts of calcium in exchange for higher amounts of selenium and lycopene (for prostate health). Thus, intake from food sources of these nutrients (i.e. fruits, vegetables, whole grains and dairy products or substitutes) remain particularly important. Additional calcium can also be obtained from fortified foods and/or a separate supplement.

One particular MVM may not be appropriate for all older adults. In deciding which MVM supplement best meets a person’s needs, we must consider information on the individual’s total intake (intake from conventional and fortified foods, liquid nutrition supplements and other dietary supplements) to be sure that intake does not exceed Tolerable Upper Intake Levels (ULs); medication regimen to minimize the potential for nutrient drug interactions; and medical issues to determine if supplementation of a particular nutrient is contraindicated.

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It was WONDERFUL to see members of the home care group again and some new faces too! There were the usual introductions of who was seated around the table and the role they play in home care. We also had a few guests from the CD-HCF Executive Board, who were very interested in what was going on in home care.

In a quick hour, we proceeded to discuss the action plans of this group. The new home care manual was introduced at FNCE 2008. It is entitled Nutrition Essentials for the Home Care Dietitian. It is available through ADA and will be available through CD-HCF website as well. It sold very well in the exhibit hall and the product marketplace. Some members around the table already had purchased theirs, and found it to be a great resource. The Area Coordinators for CD-HCF will have a sample copy available at state meetings, so you can check it out before you purchase.

Time was spent discussing topics for The Consultant Dietitian newsletter and decided that the next submission will be an article on tube feeding; everything from ordering, storage, donating, educating, etc. Other areas of interest were collecting data and billing.

The Home Care sub-unit’s mission and vision statements will be changed to coincide with the new mission and vision statements of ADA and CD-HCF.

The electronic mailing list (EML) for Sub-Unit Home Care will soon be discontinued to be more cost-effective for the membership. The home care subunit can certainly sign up on and use the forum EML. It is requested that the subject line state: “Home Care.” This way, anyone that reviews the listings for the day can easily identify this group. Being on the forum EML may actually elicit more responses and conversation about home care.

Another action plan that was discussed was the possibility of CD-HCF hosting a webinar in the spring about home care and hospice. The Executive Committee will continue to look into this option, and we already have some potential leaders of the session.

As usual, the hour went by so quickly, with everyone benefiting and learning from each other – that is what this group is known for. I thank those that attended and look forward to meeting more home care dietitians at future meetings.

The CD-HCF Corrections Sub-Unit met during the ADA Food & Nutrition Conference & Expo (FNCE), with 24 registered dietitians in attendance. We listened to a presentation by Beth Mills, RD with Strativa Pharmaceuticals on Megace ES, followed by discussions on several issues in our unique environment:

Meeting DRIs - need research in meeting the DRIs for Corrections. Also, caloric provisions may need revision due to rising food costs.

Fortified foods, i.e., calcium added to bread and fruit beverage mix replacing milk.

Growing popularity of religious diets and litigation involved.

Removing fruit from menus, due to pruno (alcohol made by offenders).

Prepackaged meals for therapeutic diets.

Members were encouraged to purchase the 3rd edition of the CD-HCF Nutrition and Foodservice Management in Correctional Facilities manual from ADA and to submit articles for the CD-HCF quarterly newsletter. I would also encourage all who have not already joined the Corrections Sub-Unit, to go to www.cdhcf.org, click on Corrections and go to page 2 to join. Benefits of membership include the electronic mailing list (EML), employment opportunities, network building, CD-HCF recognition and RD support for up-to-date information.
In 2007, CD-HCF established a network relationship with the Home Health Specialty Practice Group of The American Association of Diabetes Educators (AADE). This relationship is unique because it connects the home care units of two major health care organizations and provides an opportunity for sharing information for those practitioners in the home care arena.

Registered dietitians (RDs) who work in home care are well aware of the large percentage of home care patients who have a diagnosis of diabetes; one of the top three admitting diagnoses in most home care agencies. At least 42% of the diabetic population is 65 or older, and this is the population most often served in home care. Even when diabetes is not the primary admission problem, it is often a contributing factor in delaying healing, which then extends the episode of care. At the AADE, Home Health business meeting in August, it was decided to develop a plan to assist home care practitioners of both organizations develop tools for diabetic teaching. Home care has some restrictions on teaching that require different teaching methods; for example, there is only a limited amount of materials, supplies, etc that can be carried into a home. Computer facilities are not always possible; Internet teaching is often not an option.

An ongoing initiative of the network between these two groups is to find a way to identify practices, suggestions and ideas for creative teaching in the home. In order to identify unique teaching methods, we are asking members to send us any ideas which they have found to be particularly successful. We are including an example here; please feel free to send us any ideas that you have found useful in reaching your clients with diabetes and we will share with the readership of both organizations in the future. No idea is too small; we can all learn from each other and many RD’s, who are new to this field, are anxious for your help!

**CARBOHYDRATE COUNTERS**

I have been teaching carbohydrate counting by use of carbohydrate counters - small slips of paper (made on the computer) which are labeled CARBOHYDRATE SERVING. I also make slips labeled DAIRY, FRUIT, STARCH, MEAT, FAT, VEGETABLE. After planning with the client how many servings a day are appropriate, I give out the correct number of slips. Some patients do well with giving, for example, 14 slips that say CARBOHYDRATE. Other clients need more specific meal planning, so I give the correct number of each of the food groups mentioned above.

I instruct the client to use two small bowls; every morning all slips are in 1 bowl. As the client eats, he/she evaluates the food eaten and moves the appropriate number of slips to the other bowl. The client can then visually see how many servings have been eaten and how many servings are remaining.

There are a few rules to this method:

- If you don’t use all your servings (slips) for one day, don’t force yourself to eat it all at night!
- If you have “extra” servings from one day, you can’t carry them over to the next day
- If you run out of servings every day, we may need to adjust your meal plan
- If you run out of carbohydrate servings, you may eat free foods

Clients need to be instructed to divide food appropriately throughout the day. It may take one or two follow-up sessions to be sure that clients understand the carbohydrate counters. These follow-up sessions allow the RD to adjust the servings, according to the blood glucose readings.

WE ARE ANXIOUS TO HEAR YOUR IDEAS!

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**CPE Questions and Certificate**

CD-HCF is going electronic and GREEN

Find the CPE questions, take the exam and get the certificate at www.cdhcf.org

Not connected to the Web? Call 319.235.0991
The RD’s role in enteral nutrition has traditionally been in the acute setting and/or long term care. When patients go home with enteral nutrition therapy, there is often little to no clinical nutrition monitoring—this is where RDs can be instrumental in the home setting. By educating ourselves beyond the conventional dietitian role, we can raise the standard of care for the home enteral patient.

Across the country, RDs have begun working with home enteral providers in order to extend the continuum of care from the hospital to the home. This continuity of care is accomplished by RDs following three significant steps of care:

The RD is involved from the beginning by providing nutritional evaluation prior to transitioning the patient home. The dietitian then educates patients and caregivers upon discharge from hospital pertaining to care of feeding tube, feeding technique, and pump operation.

The RD conducts patient follow-ups and communicates with the physician to ensure the continuum of care. In this role, the dietitian acts as a liaison between patient and physician and provides feedback to the doctor if signs of intolerance appear.

The RD monitors disease progression, wound healing and other clinical disorders. Patients should be followed until the tube feeding has been discontinued, which allows the dietitian to help with decreasing the patient’s enteral nutrition as PO intake increases.

RDs can further be beneficial in the home care setting by working to obtain coverage for formula and enteral supplies. For example, Medicare will cover formula and supplies but the appropriate documentation and justification is required. The RD and physician work together to submit this information to Medicare on the patient’s behalf. By being involved in this process, dietitians can help prevent unnecessary financial hardship for the patient.

In summary, RDs are raising the standard of care for the home enteral patient by receiving specialized training in home enteral nutrition therapy, tube identification, family problem solving, enteral case management and more to provide better care for patients on tube feeding in the home. A higher standard of care for home enteral patients is long overdue. These patients not only need our help, they deserve it.

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The National Association for Home Care and Hospice Meeting (NAHC) 2008 was held in Ft. Lauderdale, Florida October 11-15 at the Broward County Convention Center. This year's meeting was entitled "Charting New Frontiers in Health Care." Home Care is a rapidly growing business to help take care of the homebound citizens of the United States. In approximately 800 days, the first Baby Boomers will be collecting benefits through Medicare and Medicaid based on their age. There are about 78 million getting ready to move into their retirement years. There will be many more people requiring skilled nursing and therapy services than hospitals and nursing homes can provide. Not to mention that many of these Baby Boomers are very intelligent, affluent and not wanting to stay in a nursing home or a rehabilitation facility. There is no doubt that that the Baby Boomers will change traditional attitudes toward aging and retirement. It will be a challenge for all of us to meet their needs while observing rules, regulations and reimbursement options.

This meeting focused on the 2008 election, healthcare options, promises and known truths about healthcare and the options we have as healthcare providers. In the state of Florida, the population has been predominantly older Americans and the struggles that this state has in providing for the needs can help many of the other states to put programs into place to help maximize funds and professional staff available. One of the disheartening facts of this meeting for me was the lack of desire to acquire a registered dietitian's (RD) expertise in the areas of wound healing, weight management, improving outcomes for known diet related diseases such as cardiac disease and diabetes. I attended quite a few of the clinical classes offered and an RD's contribution was mentioned very briefly for diabetes management. I know that I am very lucky to work for a company that has seen the benefits of having an RD on staff and our teams works together nicely to help many of our clients with tube feeding issues, wound healing issues, heart disease, lung disease and diabetes.

One of my focal points for attending seminars was to see how others addressed the problems with staffing and retention. Many of the nursing homes and home care agencies I have worked in over the years have always had problems with finding the "right" people, training, developing and empowering those employees that allow you to go home at night at a decent hour and have days off. A major focus was identifying the needs of the multigenerational workforce that we see applying for jobs today. We have four different generations working in many of our facilities and are about to see the next generation enter the ranks. Each generation has their own special qualities and needs they feel are important from their employers. Three of the seminars at the convention showed strategies that these companies used to engage employees and retain employees. One of the speakers stated that when we lose an employee it costs the company 150% of that employee's annual salary to replace that employee. We spend thousands of dollars annually trying to recognize employees, provide continuing education and retaining employees. We are finding that the hourly wage is not always the main reason an employees stays with a company. We have much to learn about employee development and retention. As a Baby Boomer from the tail-end (born in 1964), I see the differences between the way my father treated his job and the way my daughter (who is 15 years old) sees maintaining employment. As employers, we need to have benefits packages that are flexible to meet the needs of the single mother versus the soon-to-be retired person. We should also create incentives for tenure with the company, client satisfaction, attendance and productivity. For many employees, it is the money or the paycheck that will increase productivity and retention.

I was very fortunate to hear Bill Clinton speak during the conference. He was slated as one of the guest keynote speakers. He is an engaging speaker and was very politically correct as he wove his way through audience questions, his presentation and questions from the President of NAHC, Val Halamanardis. He mentioned the need for all of us to be politically aware of what will happen on November 4th and what it will mean to us as health care providers. Both presidential candidates focused a portion of their campaign promises on healthcare, benefits and who will receive them in their speeches, commercials and media releases. He challenged all those in the room to be more knowledgeable of the presidential programs, to vote on November 4th and to be aware of the many changes that we will see in healthcare in the next four years.

I am very thankful for the opportunity I was given to attend the NAHC Conference. There were 180 hours of seminars, exhibitions and information areas. It was challenging to pick the seminars each class period and to not worry about what I was missing in another session. As I completed my evaluation for the meeting, one of the areas I felt was lacking again was the impact that nutrition has on healthcare and I mentioned this as I was writing my suggestions for the future. I know that one of the problems with this is that there is no direct reimbursement for nutrition education, medical nutrition therapy and this keeps many companies from utilizing the expertise of the dietitian. Working in a healthcare agency in a management position, I am constantly trying to improve the nutrition education, medical nutrition therapy, and the direct reimbursement.
We want to learn more about our members and all the wonderful things they do! One of the ways we do this is by reminding members about CD-HCF’s scholarship and awards. By recognizing members with these awards and scholarships, we can share their accomplishments with the entire group. You can participate by nominating someone today or by applying for one of the scholarships.

The following is a brief discussion of the awards and scholarships available. Members may nominate other members or apply for themselves. The application forms and deadline dates can be found on the web site at www.cdhcf.org under the member section subcategory “awards”. You will have to sign in with your ADA number and will then see the following table:

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**CD-HCF Chair’s Scholarship - Sponsored by Medical Nutrition USA, Inc**

**Purpose:** To provide funding for one CD-HCF member to attend either the ADA Public Policy Workshop or the ADA Leadership Institute annually. The focus will be to provide a new educational experience and promote leadership within the organization.

**Award:** Up to $1500.00* will be awarded to provide transportation, lodging, and per diem, to either the Public Policy Workshop or the ADA Leadership Institute.

**CD-HCF Best Practice Award**

**Purpose:** The purpose of the “Best Practice Award” is to recognize innovations in practice, communicate practices to the CD-HCF membership, and encourage ongoing efforts that improve practice. Do you have something that “works” to help improve your professional performance that you would like to share?

**Award:** “Best Practice Awards” will be selected quarterly. The winners will be announced and their submission published in The Consultant Dietitian and will also receive $100.

**CD-HCF Distinguished Member Award**

**Purpose:** The Distinguished member award is given to recognize a CD-HCF Member who has made significant contributions to the profession and organization. Many past recipients have been invaluable within the state CD-HCF groups. Do you know someone to nominate today?

**Award:** New this year, there will be up to 3 awards annually regardless of geographic area. Awards are presented during the Food & Nutrition Conference & Expo (FNCE).

**F. Ann Gallagher Award**

**Purpose:** This $1,000* award is designed to provide financial support to a Registered Dietitian who is a member of the Consultant Dietitians in Health Care Facilities DPG. Applicants should have a demonstrated interest in state or federal legislative issues.

**Award:** Awarded money goes to support the promotion of state or federal legislation to advance the profession of dietetics; it may be used to foster participation by dietitians in legislative issues related to dietetics and may include, seminar and symposium fees, travel, lodging and educational materials.

**Gaynold Jensen Educational Stipend**

**Purpose:** The purpose of the Gaynold Jensen educational stipend is to award scholarships for educational programs that enhance the contributions of the consultant dietitian to health care. Is there a seminar or conference that you want to attend? Are you willing to share what you have learned with the other members? Then please apply today!

**Award:** The stipend is limited to 75% of the cost for each educational program attended as long as it does not exceed $500.00 and may be applied toward travel expenses but may not be used for lodging or meal expenses. In return, the recipient writes a short summary of the event for possible publication in the CD-HCF Newsletter.

**Abbott Leadership Award**

**Purpose:** This is one of the highest honors the practice group can grant to members never having served on the CD-HCF Executive Committee. The honor is awarded for outstanding contributions to their profession and the clients the serve.

**Award:** One award of $1,000 may be made annually and is continued on page 13
Delaware – Mary Williams, RD, CD-N continues to volunteer as the State Chair.

Maryland – The Fall Workshop that MD CD-HCF presented on November 13, 2008 drew a large crowd, who continued their education on topics such as “F325 and F371: New Regulations and Solutions for Compliance” (Becky Dorner, RD, LD), “But We’ve Always Done It That Way: Changing the Culture of Caregiving” (Kelly Poole, MS, RD), “Network to Stay A Step Ahead – ADA Public Policy Update” (Dana Whitley) and “Update from the Office of Health Care Quality” (Beth Bremner, RD, LND). Not to rest on their laurels, Sharon Goldstraw, MA, RD, LDN, and her Board soon began planning more events for their group, including a networking event in February – “The History of Chocolate” as well as their Spring Workshop in May.

North Carolina – Congrats to Maggie Gilligan, RD, and her new Board for re-activating the North Carolina CD-HCF group! Maggie mobilized a small group of motivated CD-HCF members to create the state sub-unit with NCDA, and plan a very successful Fall Educational Seminar and Annual Meeting, held on October 14, 2008. Attendees heard Sue Bell, RN, Medical Nutrition USA, Inc. (MNI)speak on the topic of “Protein: Critical in Pressure Ulcer Healing” and participated in a hands-on workshop on “The Nutrition Care Process for LTC,” led by Sylvia Escott-Stump, MA, RD, LDN. Well done!

Pennsylvania – The PA CD-HCF group’s hard work also paid off at their Fall Symposium on November 6, 2008. Over 40 members turned out for a day packed with timely topics, such as “Helping Home Health care patients with Diabetes help themselves” (Gretchen Cararie, MS, RD/CDE, LDN), “Nutrition Informatics: The Time Has Come” (Amy Buehrle Light, RD, LDN), “Surveying for Food Safety Systems and Nutrition Care: Becoming Deficiency Free” (Linda Handy, MS, RD) and “Nutrition and the Bariatric Patient” (Anna Ardine, MBA, RD, LDN). Renee Stasko, RD, LD, LDN, and her Board are now busy planning their spring workshop in conjunction with the PADA Annual Meeting in April.

Virginia – Tonya Price, RD, and her Board are also busy, with a Fall Workshop in October under their belt with topics such as “UTI prevention” sponsored by MNI, “Cutting Costs in the Foodservice Department” sponsored by SYSCO, an update on the investigative protocols for F325 and F371, and a state health regulation update from the Virginia Department of Health. An upcoming workshop on “Dietitians and Healthcare Litigation” will be held during the VDA Annual Meeting in March hosting Randy Krantz, RN, JD (Commonwealth Attorney), Dr. Michael Gillette, PhD (Bioethicist), and Renee Brenneman, MS, RD (from the University of Virginia). VA CDHCF will be offering their first scholarships to qualifying members for continuing education and a website is also under construction to better network with their members! Planning is now underway for VA CDHCF’s Fall 2009 Conference to be held in Williamsburg, VA.

CD-HCF Scholarships and Awards

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presented during FNCE. Please look on the web site for more details on qualifications and the application process.

**CD-HCF “Up and Coming” Member Award**

**Purpose:** The CD-HCF Up & Coming Member of the Year award recognizes the competence and activities of members who have been in practice for 10 years or less and who have been members of Consultant Dietitians in Health Care Facilities (CD-HCF) DPG #31 of the American Dietetic Association for at least three (3) years. The purpose of this recognition is to encourage their continued participation in CD-HCF and identify potential leadership for CD-HCF at the district, state, and national levels.

**Award:** Up to 3 awards may be given annually and presented during FNCE. Do you know someone you can nominate for this award that CD-HCF would love to recognize? If so, please see the web site for details or email one of the board members.

**US Foodservice Outstanding CD-HCF Member Award**

In addition to these CD-HCF awards, the awards committee works with US Foodservice to promote their annual US Foodservice Outstanding CD-HCF Member Awards. Award winners receive airfare, conference registration and lodging for FNCE. Applications and details can be found at the web site, [www.cdhcf.org](http://www.cdhcf.org).
Abbott Leadership Award - Elise Smith, MA, RD, LD
Elise has worked as a dietitian for over 30 years; in LTC for over 20 years. She has continued to stay on the forefront of ways to enhance the resident’s dining experience and has developed processes to aid healthcare facilities in the implementation of alternate dining methods including family style, buffet style, and restaurant style of dining. She has designed several computerized tools to aid consultants in resident care responsibilities. Elise is a personal and professional mentor to many dietetic students/interns throughout the school year. As a preceptor for several dietetic programs in the state, she strives to teach up and coming professionals to be the best they can be. At any given time during the working day, Elise’s consultants are able call with question, issues or concerns. One could say that she has an “open-door” policy. She assists them in trouble-shooting while allowing her staff to use their own clinical/professional judgment. Elise also serves on the Nutrition Care Process/Standardized Language Committee. This committee serves to develop and advance the Nutrition Care Process as the standard method of documentation for medical nutrition therapy.

Circle Award - Medical Nutrition USA, Inc.
It is a great honor to announce Medical Nutrition USA is the CD-HCF’s Circle Award winner for 2008! This award is for a non-member individual or organization that has contributed time and expertise to the members of CD-HCF. MNI has supported our members not only with clinically proven products developed specifically to remedy nutrition related health issues of the long-term care elderly, but have shared considerable resources for the education of our members at the national and state level. CD-HCF thanks you.

Up & Coming Member of the Year - Sharon Clark, MS, RD
Sharon has been active as the state chair for the Virginia Consultants group. She has been instrumental in the groups’ organization by establishing an e-mail distribution list, writing the newsletter, and coordinating the conference. She has provided leadership in the creation of a state-wide taskforce to develop a guide for dietitians working in assisted living in the state. Sharon has provided numerous presentations. She is also actively involved with diabetes programs and studies through her consulting company.

Distinguished Member Award Area 1 - Pat Dahlstrom, RD
Pat has been involved in leadership roles in the Oregon and Washington consultants groups. She has served as Area 1 Coordinator for CD-HCF. Pat has done numerous presentations for the DMA and served as a speaker for Direct Supply, Knoll Pharmaceuticals and other organizations. She has served as author for many newsletter articles and has been involved in various research and review projects, including an analysis of F371 causative factors and the prevalence of thickened liquids. She was a member of CD-HCF’s national menu task force. As the Director of Food and Nutrition Services for Evergreen Healthcare, a large multi-facility company in the northwest, has promoted participation in ADA and CD-HCF by reimbursing company dietitians for association and practice group membership. She has served as a mentor for many new dietitians – new to the practice and new to her geographic area.

Distinguished Member Award Area 2 - Ruth Rauscher, MA, RD, CSG, LMNT
Ruth has been involved in numerous activities with CD-HCF. She served as Area 2 Coordinator and has been involved in numerous positions with the Nebraska state consultant group. Ruth authored and co-authored several chapters in CD-HCF products, as well as articles in other publications and newsletters. In addition to her work with CD-HCF and the Nebraska state consulting group, she has served on the board of the Nebraska Dietetic Association and the Central Nebraska District Dietetic Association. Ruth has presented numerous presentations about nutrition topics related to long-term care. She has served as an advocate for the profession with her involvement in the development of rules and writing for the Nebraska Certified Nutritionist law. Ruth is a Board Certified Specialist in Gerontological Nutrition.

CD-HCF 2008 Awards & Scholarships Winners
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Distinguished Member Award Area 3 - Janet McKee, MS, RD, CSG, LD/N
Janet has been an active member of the Florida consultants group for many years. She has been involved with the board, provided innovative continuing education programs and authored numerous publications. She developed a membership drive that increased Florida’s state consultant group membership to approximately 75 members last year. She was a member of the CD-HCF nominating committee for 2007-2008. Janet has contributed many articles for the Consultant Dietitian newsletter. In addition to her work with CD-HCF and the state consultants group, she has been involved in leadership positions with the East Central Dietetic Association and the Florida Dietetic Association.

Distinguished Member Award Area 4 - Nikita G. Wray, RD (Niki)
Niki has been involved in several leadership roles with the Arizona consultants group. She has authored several newsletter articles and has given numerous presentations on a variety of topics to dietitians and dietary managers working in long-term care. Niki has encouraged and supported continuous active research in individual accounts for the purpose of monitoring and improving the quality of nutritional health care. She has committed to staying abreast with current trends/research and then transferring that information to her associates/clients. Niki is an active supporter of ADA since 1981 along with its mission/vision.

Distinguished Member Award Area 5 - Sharon Zwick-Hamilton, MS, RD, CSG, LD, CDE
Every-day life in Long-Term Care creates challenges and requires decision making regarding resident rights, care and services, employee direction and management, family communication, collaboration with other caregivers, and regulatory compliance for clinical care and fiduciary conduct. In every case, Sharon has demonstrated her commitment to the highest ethical standards. She demands the best care for the residents in her care, treats every person with kindness and respect, and holds her staff accountable for full compliance with all regulatory guidelines and statutes. Sharon has been active throughout the Association including the Ohio CDHCF; the Ohio Dietetic Association as President and in other positions; and has served as President of the Cleveland Dietetic Association as well as in other capacities.

Distinguished Member Award Area 6 - Marcy Ethererson, MBA, RD, LDN
Marcy has been involved in all aspects of the operation of the Maryland consultants group. She has been involved with the board, planning and running the workshops. Since moving to the western part of Maryland, she has become involved in the local Dietetic Caucus through the Western Maryland Area Health Education Center. Marcy promotes the RD, fosters networking through the group and also encourages young dietitians and other professionals to work in rural areas. She is a continuous supporter of membership in CD-HCF and encourages all dietitians with whom she works and interacts to get involved at the state and national level.

Distinguished Member Award Area 7 - Helen Long, RD, LDN
Helen has served as the Massachusetts consulting group chair and has been instrumental in leadership and organization. She has worked for Sun Healthcare Group in various capacities over the last six years and has supported dietitians working in long-term care facilities. Helen also supports food and nutrition education by serving as an instructor for the food service supervisors in health care facilities course at local community colleges. Of an interesting note, Helen is conversational in French, German and Hungarian!

Chair's Scholarship (Sponsored by Medical Nutrition USA, Inc.) – Carol Jean Hill, RD, LD
The CD-HCF Chair’s Scholarship provides funding for one CD-HCF member to attend either the ADA Public Policy Workshop or the ADA Leadership Institute annually. The focus will be to provide a new educational experience and promote leadership within the organization. Carol, from Ankeny, Iowa, has chosen to attend the Public Policy Workshop in Washington, DC, next February. She is the Director of Nutrition Services at Fountain West Health Center, West Des Moines, Iowa and is an Adjunct Faculty Member at the Des Moines Area Community College (DMACC).
A great debate rages about what makes performance appraisal programs work, or whether they work at all. Whatever the organization’s position on performance appraisal, some means of measuring progress toward achievement of corporate goals is necessary. This writer used a literature review to examine why companies conduct performance appraisals and how they use the information to enhance quality, customer satisfaction, regulatory compliance, ethics, and organizational commitment. Discussed are the theoretical bases that underlie measurement of job performance, program features that positively impact job performance, and the kinds of outcomes that constitute appraisal effectiveness.

Review of the literature identified desirable performance appraisal outcomes and many program features that users believe contribute to program success.

The Joint Commission/Joint Commission on Accreditation of Health Care Organizations (TJC/JCAHO) is one of the primary drivers of the revolution in industry practices. The language built into its standards strongly influences performance appraisal system design:

Employee competence must be objectively measured and provable, and must be subjected to tracking/trending and to improvement efforts. The organization demanded in its Agenda for Change that health care organizations “identify the important governance, managerial, clinical, and support functions that, when performed well, enhance quality of care.”

In a study of workers in long-term care, researchers looked at how tenure, performance, and organizational commitment are maximized. Most workers leave because of poor communication and feelings of powerlessness in job relationships. The investigation suggested that where workers feel integral to the care process, feel free to express a different opinion and to criticize existing policies and procedures, and feel needed by the resident, they remain on the job longer. Likewise, when they work for a manager who is neither “too bossy” nor “too easy-going,” job tenure is greater. Attention to the performance appraisal system is one way to give voice and authority to subordinates and to monitor the manager-subordinate relationship. Resident care workers who feel they are valuable to the organization will commit to it and will treat clients as assets. Nursing home employees are able to do their jobs better when roles are clear and tasks are well-articulated. Organizational commitment is significantly and positively correlated with skill variety, task identity, and autonomy; it is significantly and inversely associated with role conflict and role ambiguity.

Below are some features of successful performance appraisal systems:

Educating organization members about both the formal and informal aspects of the process is essential. In a study on performance appraisal in municipal government, 96% of respondents stated that communication is absolutely essential or very important to performance appraisal outcome. Perhaps most important, rater training helps to assure validity of the job evaluation process.

A clearly-stated organizational intent yields less confusion and ambiguity. Educating workers about performance appraisal gives an articulate answer to the “why are we doing this” question. Longenecker and Goff (1992) surveyed 400 members of large organizations having formal performance appraisal systems, and found that unclear performance standards and subjective ratings are the second most often reported cause of performance appraisal failure, according to subordinates.

The practices found to contribute to effectiveness all suggested multi-party cooperation in system development: senior management and employee involvement, uniform performance measures, and emphasis on coaching and feedback. In the literature, collaboration appears frequently as a developmental predictor of performance appraisal success. This practice, which helps assure that the system meets users’ needs, entails having supervisor and worker together identify job responsibilities, write objective performance standards, create evaluation instruments, participate equally in the inter-

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Giving workers the opportunity to rate their supervisor, improves morale and satisfaction, and keeps the performance appraisal process meaningful. **Alignment of performance appraisal with the organization’s culture and practices** is a logical step toward fostering individual and organizational development, and accomplishing “best fit” between employer and employee.

**Behavior-focused, task-centered feedback**, based on job analysis or descriptions and reflecting specific, written performance standards, is supported widely in recent literature.

Hitchcock’s survey (1996) of characteristics of effective peer review systems showed that 85% of **companies using a customized form were more satisfied than those with standard forms**.

Several publications support shortening the review period. **Planning appraisals at intervals during the year** helps to measure progress toward goals and also to reveal systemic obstacles to satisfactory performance. Ongoing appraisals are an extension of the formal, planned performance evaluation and may occur in day-to-day encounters or may be scheduled to occur semi-annually or quarterly. The informal phases assure that surprises will be fewer in the formal phase.

A performance appraisal should be a **dialogue between supervisor and worker**, perhaps going so far as to allow for the worker to receive a blank copy of the appraisal form before the meeting if he/she was not provided with one at hiring.

Effective performance appraisal requires **employee participation at all phases** (rating interview, self-appraisal, and system development), in a setting where the worker believes that the supervisor is genuinely interested in his/her input.

Anecdotal supervisory notes, examples, notes from management rounds, or diaries are all **data-gathering techniques** that make the interview more objective. The observability factor is supported in that it yields behavioral rather than personal information. **Critical incident, or diary-keeping**, is consistent with studies which show that the way raters process information rather than the rating instrument itself determines performance appraisal effectiveness and undergirds performance measurements.

The consensus is that **personality assessments should be avoided** because they are subjective and qualitative, and that appraisals should concentrate on specific goals and on factors over which the worker has control.

Using **multiple sources for feedback information** has been reported to yield increased participation, improved accuracy and perception of fairness, better information for personnel decisions, more satisfactory Equal Employment Opportunity compliance, more quantitative/objective feedback for participants, time-savings for managers, and cost-savings for the organization.

Also effective are **one-on-one, face-to-face meetings** and **sessions that are scheduled regularly and prepared in advance**.

No writers advocated linking pay to performance. Only 20-25% of managers stated that lack of resources to reward performance could be blamed for performance appraisal failure. Wanguri’s review of performance appraisal literature supported **tying performance to non-monetary incentives**.

**Efforts to make the system fair** yield better acceptance which in turn predicts effectiveness: that is, a performance appraisal process that motivates employees, improves productivity, reduces absenteeism, and weeds out non-performers.

Maroney and Buckley (1992) suggested that improved rater/ratee relations may be an outcome yielded by an effective performance appraisal program. Other system outcomes suggested in the literature are: perception of fairness, support of upper management, improvement in the number of performance evaluations completed, better time-management for raters, and a positive impact on customers.

The health care industry is trickier than the manufacturing sector where human resource management is con-
The cost of living in fear is great. Fear is the source of stress, anxiety, and procrastination. There is no joy when living in fear. It feels heavy and burdensome to be worried and concerned, to be unable to relax, paralyzed, to hold back from doing what you want to do, what you know you can do...

There are many fears that keep us living small, shallow lives: fear of happiness, success, failure, making mistakes, being insignificant, not being good enough or not having enough. You may fear not being liked, being controlled or losing control, not being loved or lovable, being alone or being abandoned. Whatever your fear, it permeates every fiber of your being and impacts your life in a myriad of ways.

Fear is based on a thought, a perception of your mind from your life's experiences and from your expectations which are also based on thought. When you allow your mind to wander in thought through the fear, you are taken on a ride through fantasy land of the worst possible scenarios of what could happen if you act. This only serves to intensify the fear causing anxiety, worry, and feelings of impending doom. By learning to unearth your fears and challenge them, you can choose new, supportive thoughts and take different actions. You can choose to act in spite of feeling fear and learn to control the thoughts that have you fantasize worst-case scenarios; you don't have to go there. That way, YOU are in charge of your thoughts, of the experience you have even in the privacy of your own mind. You don't have to experience that heightened level of anxiety and all the drama that leads to inertia. You can choose a different inner experience that leads you to success and happiness.

Fear as Motivator and as Suppressor
Fear is one of the greatest motivators and one of the greatest suppressors. As a motivator, fear forces you to act — or to not act. Either way, you are not at choice but rather, you act to avoid what you perceive to be painful. Many people use fear as a tool to motivate or control others; it is a leadership style. This leadership style reduces productivity by stifling creativity and innovation of the person being controlled. Fearful of speaking up and sharing ideas, the employee keeps his ideas to himself. This leader often is disliked and although he may be effective at producing results, morale is usually poor. Unfortunately, this leader does not understand the impact his behavior is having on others and is completely unaware that he is operating from fear himself.

At home, parents can wield fear as well, creating uncomfortable environments which not only stifle the growth of our youth but can lead to depression, anxiety, addiction or suicidal thoughts. As spouses, fear creates hostile environments. You don’t feel safe to be yourself. You’re always worried about what you do or say. Living on eggshells all the time takes a tremendous amount of energy. This might be why you stay late at work and spend your days wishing life were different.

Living in fear, self- or other-imposed, you shrink and suppress your brilliance, live beneath your capability, avoid taking risks, and live an unhappy life. Fear robs you of your greatness as your talent lies hidden beneath its cloak. The fear you feel seems real. It seems like it would be the worst thing in the world if you were to walk through the fear and act. But that is how the brave do it. Courageous people experience as much fear as anyone else. They have just learned to focus on the goal and their purpose for achieving it. They act in spite of the fear. It’s the difference between letting fear be in charge or YOU being in charge.

Fear is sneaky. It can force you to behave in ways that produce certain positive results. For instance, if you fear being alone, then perhaps you build a strong community through networking and that has enabled you to be very successful in your field because you are well-liked and well-known. This is good, right?

Yes, it is good. However, being driven by fear has its limitations. You are driven to behave a certain way in order to avoid your fear rather than face it. Constantly trying to live up to some ideal, you stress over avoiding unpleasant outcomes. And no matter what you do or how many people you meet, you continue to feel alone, it's not enough, and your feelings of dissatisfaction continue. Perhaps that community of people is more social or collegial; they are acquaintances not deep friendships, and during a rough time, you wonder who you can lean on for support. It is impossible to experience true intimacy when you fear being alone because you are coming from a place of neediness and that shows up energetically. Oftentimes, fear of being alone shows up as a fear of intimacy and you avoid having people get to know you because if they knew the real you, my goodness, what would they think!? If you are not a very

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Beyond Your Fear

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social being, fear of being alone can show up in other ways such as carrying debt or chronic borrowing. You might do this so that you build long term, albeit superficial, relationships with institutions or people who will never leave you.

Fear as a Message
Fear is normal. It helps us to know that we are on the right path. When you experience fear, it signals that you are moving toward the edge of your comfort zone, meaning you are expanding your horizons and stretching yourself to become more of what you are capable of becoming. The fear feels real, as if we are experiencing the fight, flight, or freeze mechanism, our body’s natural reaction to danger. When we are in danger, the body responds with hormones making us stronger and more alert. This physiological response can occur to something real or something perceived in the mind, making it difficult to discern whether you are really in danger or if a belief or thought pattern is being threatened by what you are about to do. Either way, your body reacts as if danger is imminent, causing you to question your actions. It is in this moment where you can find your power. You can choose to act and push through the fear or you can succumb to the fear and hold yourself back.

Uncover Your Greatest Fear
Look at the places in your life where you feel stuck. Look at the patterns in your life. If you fear success, then you will act in ways that have you avoid being successful or you may be successful but no matter what you achieve, you feel as though it will never be enough. If you fear being good enough, then you might act in ways to prove yourself and you may be unwilling to see your own goodness which, again, perpetuates the cycle. If you fear making mistakes or being wrong, then you will constantly look for ways to prove you are right. You may get into fights or debates, or only spend time with people who are not as smart as you so they don’t question or challenge your perspective. If you fear being alone, then you will be alone, fearing that anyone you might get close to will leave or hurt you so why bother? OR you have so many friends that your time is taken up completely by others and you feel resentful that you have no time for yourself. You keep looking for love in all the wrong places.

Fear has been said to be false evidence appearing real. In recovery programs, FEAR is an acronym for Face Everything And Recover. If you want to improve your circumstances and move beyond your stuck points, then become aware of your fears and how they control you and limit you. It’s one thing to be afraid, it’s quite another to let that fear run your life. YOU can decide for yourself how you want fear to impact your life. Be in charge of your fear by creating awareness around it and give yourself the freedom to choose.

Julie Fuimano, MBA, BSN, RN, CSAC is named one of the TOP 100 THOUGHT LEADERS in personal leadership development. Your happiness and success is her business! Julie utilizes the system and services of 6 Advisors to transform lives and organizations. Every action, feeling, belief, and mood begins with a thought and you have thousands of thoughts all day long. Who’s leading your thoughts? Are your thoughts serving you or sabotaging you? At Nurturing Your Success, we focus on identifying and re-training your thought processes - for individuals and for transforming cultures in organizations. Visit www.NurturingYourSuccess.com to take the assessment and uncover your greatest strength and most challenging weakness. The 6 Advisors Assessment is the diagnosis; our coaching is the prescription for unleashing your brilliance. Contact Julie@NurturingYourSuccess.com to have her speak at your next meeting or conference.

Charting New Frontiers in Health Care

continued from page 11

education piece that we provide as I know that many times it will be a nurse providing the information to the client. Even with second party billing for allowed MNT disease codes, the dietitian with a National Provider Identifier (NPI) number can wait months to be reimbursed for diet instructions. As a profession, we need to work our way into the “reimbursement world” like therapists so that our knowledge and expertise will be “billable” and therefore desired by homecare agencies. I would recommend that we as a discipline try to think of ways to show positive outcomes and impact on the homebound clients that we see and “toot our own horns.”
## Ingredients of select multivitamin and mineral supplements and percentage of Recommended Dietary Allowance (RDA) or Adequate Intake (AI) for adults over age 70

<table>
<thead>
<tr>
<th>Each Tablet Contains</th>
<th>Centrum® Silver®</th>
<th>Centrum® Silver® Chewables</th>
<th>Nature Made® for Her 50+ / for Him 50+</th>
<th>One A Day® Women’s 50+ Advantage / Men’s 50+ Advantage</th>
<th>Theragran-M® Premier 50 Plus</th>
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<tbody>
<tr>
<td></td>
<td>Amt&lt;br&gt;Women</td>
<td>% RDA/AI</td>
<td>Amt&lt;br&gt;Men</td>
<td>% RDA/AI</td>
<td>Amt&lt;br&gt;Women</td>
</tr>
<tr>
<td>Vitamin A (IU)</td>
<td>2500</td>
<td>107%</td>
<td>83%</td>
<td>4000</td>
<td>171%</td>
</tr>
<tr>
<td>% as beta carotene</td>
<td>40%</td>
<td>75%</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin C (mg)</td>
<td>90</td>
<td>120%</td>
<td>100%</td>
<td>75</td>
<td>100%</td>
</tr>
<tr>
<td>Vitamin D (IU)</td>
<td>500</td>
<td>83%</td>
<td>83%</td>
<td>400</td>
<td>67%</td>
</tr>
<tr>
<td>Vitamin D (IU) adults 51-70y</td>
<td>500</td>
<td>125%</td>
<td>125%</td>
<td>400</td>
<td>100%</td>
</tr>
<tr>
<td>Vitamin E (IU)</td>
<td>50</td>
<td>222%</td>
<td>222%</td>
<td>70</td>
<td>311%</td>
</tr>
<tr>
<td>Vitamin K (mcg)</td>
<td>30</td>
<td>33%</td>
<td>25%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Thiamin (mg)</td>
<td>1.5</td>
<td>136%</td>
<td>125%</td>
<td>2.2</td>
<td>200%</td>
</tr>
<tr>
<td>Riboflavin (mg)</td>
<td>1.7</td>
<td>155%</td>
<td>131%</td>
<td>2.7</td>
<td>245%</td>
</tr>
<tr>
<td>Niacin (mg)</td>
<td>20</td>
<td>143%</td>
<td>125%</td>
<td>12</td>
<td>86%</td>
</tr>
<tr>
<td>Vitamin B6 (mg)</td>
<td>3</td>
<td>200%</td>
<td>176%</td>
<td>7</td>
<td>467%</td>
</tr>
<tr>
<td>Folic Acid (mcg)</td>
<td>400</td>
<td>100%</td>
<td>100%</td>
<td>500</td>
<td>125%</td>
</tr>
<tr>
<td>Vitamin B12 (mcg)</td>
<td>25</td>
<td>1042%</td>
<td>1042%</td>
<td>25</td>
<td>1042%</td>
</tr>
<tr>
<td>Biotin (mcg)</td>
<td>30</td>
<td>100%</td>
<td>100%</td>
<td>45</td>
<td>150%</td>
</tr>
<tr>
<td>Pantothenic Acid (mg)</td>
<td>10</td>
<td>200%</td>
<td>200%</td>
<td>10</td>
<td>200%</td>
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<tr>
<td>Calcium (mg)</td>
<td>220</td>
<td>18%</td>
<td>18%</td>
<td>200</td>
<td>17%</td>
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<tr>
<td>Iron (mg)</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
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<td>0%</td>
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<tr>
<td>Phosphorus (mg)</td>
<td>110</td>
<td>16%</td>
<td>16%</td>
<td>125</td>
<td>18%</td>
</tr>
<tr>
<td>Iodine (mcg)</td>
<td>150</td>
<td>100%</td>
<td>100%</td>
<td>100</td>
<td>67%</td>
</tr>
<tr>
<td>Magnesium (mg)</td>
<td>50</td>
<td>16%</td>
<td>12%</td>
<td>50</td>
<td>16%</td>
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<tr>
<td>Zinc (mg)</td>
<td>11</td>
<td>138%</td>
<td>100%</td>
<td>15</td>
<td>188%</td>
</tr>
<tr>
<td>Selenium (mcg)</td>
<td>55</td>
<td>100%</td>
<td>100%</td>
<td>22.5</td>
<td>41%</td>
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<tr>
<td>Copper (mg)</td>
<td>0.9</td>
<td>100%</td>
<td>100%</td>
<td>2</td>
<td>222%</td>
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<tr>
<td>Manganese (mg)</td>
<td>2.3</td>
<td>128%</td>
<td>100%</td>
<td>4.5</td>
<td>250%</td>
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<tr>
<td>Chromium (mcg)</td>
<td>45</td>
<td>225%</td>
<td>150%</td>
<td>100</td>
<td>500%</td>
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<tr>
<td>Molybdenum (mcg)</td>
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<td>100%</td>
<td>100%</td>
<td>25</td>
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<tr>
<td>Chloride (mg)</td>
<td>72</td>
<td>4%</td>
<td>4%</td>
<td>0</td>
<td>0%</td>
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<tr>
<td>Potassium (mg)</td>
<td>80</td>
<td>2%</td>
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<td>0</td>
<td>0%</td>
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<tr>
<td>Boron (mcg)</td>
<td>150</td>
<td>NA</td>
<td>NA</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>Nickel (mcg)</td>
<td>5</td>
<td>NA</td>
<td>NA</td>
<td>5</td>
<td>NA</td>
</tr>
<tr>
<td>Each Tablet Contains</td>
<td>Centrum® Silver®</td>
<td>Centrum® Silver® Chewables</td>
<td>Nature Made® for Her 50+ / for Him 50+</td>
<td>One A Day® Women’s 50+ Advantage / Men’s 50+ Advantage</td>
<td>Theragran-M® Premier 50 Plus</td>
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</tr>
<tr>
<td></td>
<td>Amt^b</td>
<td>% RDA/AI</td>
<td>Amt^b</td>
<td>% RDA/AI</td>
<td>Amt^c</td>
</tr>
<tr>
<td></td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>Silicon (mg)</td>
<td>2</td>
<td>NA</td>
<td>NA</td>
<td>4</td>
<td>NA</td>
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<tr>
<td>Tin (mcg)</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
<td>0</td>
<td>NA</td>
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<tr>
<td>Vanadium (mcg)</td>
<td>10</td>
<td>NA</td>
<td>NA</td>
<td>10</td>
<td>NA</td>
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<tr>
<td>Lutein (mcg)</td>
<td>250</td>
<td>NA</td>
<td>NA</td>
<td>250</td>
<td>NA</td>
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<tr>
<td>Lycopene (mcg)</td>
<td>300</td>
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<td>NA</td>
<td>0</td>
<td>NA</td>
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<tr>
<td>Ginkgo Biloba Extract (mg)</td>
<td>0</td>
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<td>NA</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>Coenzyme Q10</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
<td>0</td>
<td>NA</td>
</tr>
</tbody>
</table>

^aPercentages are not % Daily Value. They are % of RDA or AI for adults over age 70 years (amount provided by supplement/gender specific RDA or AI × 100). Except for the case of vitamin D, percentages are also valid for adults 50 to 70 years of age.


NA = Not applicable because an RDA or AI has not been established.
cerned. In nursing, for instance, the trap of performance appraisal is that it may compel workers to attend more to physical tasks and cost-management issues than on the psychosocial skills that are hard to measure and vital to patient care outcome. When the rubber meets the road of corporate effectiveness, revolutionizing performance management is essential.

Fritha S. Dinwiddie, RD, LD
Stone Mountain, GA 30083
frithad@bellsouth.net

Resources


   #5003 $30.00
   Filled with suggestions for the healthcare 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 $15.00
   Excellent cross-training tool for all healthcare professionals who strive to host independent dining skills.

   Now in its 6th 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.

4. NUTRITION CARE OF THE OLDER ADULT, Second Edition #5009 $66.00 ADA Members $50.50
   Covering everything the healthcare 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 CEs hours and a certification of participation. Approved for 21 hours of CPE credit.

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   Material developed by the ADA Long Term Care Task Force and CMS.

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   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.

   Designed for the dietary professional working in the correctional arena. Pertinent to both the newcomer and those familiar with corrections.

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