Multiple studies have shown that in many U.S. nursing homes, feeding assistance is inadequate and of poor quality (Blaum et al. 1995, Kayser-Jones et al. 1999, Simmons et al. 2002, Simmons et al. 2003). Nurses’ aides report that they lack sufficient time to adequately help all of the eating-dependent residents for whom they are responsible (Kayser-Jones J. 1996; Kayser-Jones J. and Schell E. 1997). Most nursing home residents in need of mealtime assistance do not receive enough feeding assistance to ensure adequate nutrition and hydration (Simmons et al. 2002).

Concerns about the adequacy and quality of feeding assistance care and staffing shortages of certified nurse aides (CNAs), led to action by the Centers for Medicare & Medicaid Services (CMS). On September 26, 2003, CMS published a Federal Register notice enabling long-term care facilities to use paid feeding assistants (PFAs) to supplement the services of CNAs during mealtimes. The legislation, “Requirements for Paid Feeding Assistants in Long-term Care Facilities” (68 FR 55528), had two immediate goals: to increase the availability of staff during mealtimes, and to mandate minimum training and supervision standards for paid feeding assistant programs. However, various stakeholder groups—for example, the National Citizen’s Coalition for Nursing Home Reform, Service Employees International Union, and Alzheimer’s Association—raised concerns about the new law’s implications for patient care and safety, and for staffing configurations (Federal Register 2003; Remsburg 2004).

Therefore, in June 2004, CMS and the Agency for Healthcare Research and Quality (AHRQ) sponsored a nationwide study to: 1) determine the degree of implementation of PFA programs nationally, 2) understand the characteristics and design of these programs; and 3) examine whether the use of PFAs increases the quality of care in nursing homes. Abt Associates Inc. and its partner, the University of California at Los Angeles (UCLA) Borun Center for Gerontological Research, were awarded the opportunity to design and implement “The Study of Paid Feeding Assistant Programs.” Following is a summary of the major results of this study (Simmons et al., 2007). The findings are organized around general
FNCE 2007, what an exhilarating experience! Philadelphia presented us with wonderful weather and gracious hospitality. Thank You, to Pennsylvania CD-HCF, for your warm welcome to the Executive Committee (EC) and our many sponsors and supporters. I appreciate the comments and recommendations from those who I was able to talk with and meet during the conference.

The EC met on September 27 and 28th with a packed agenda and decisions to make on where our organization is heading. Our strategic planning is stronger due to the results of the survey that you participated in earlier in the year. We want to thank you again for helping to provide the direction of our DPG. In this newsletter, we will share the results of this survey.

Just prior to FNCE, I received a report on the Nutrition Risk Assessment (NRA) study. Dr. Judith Beto had been compiling data to assess the validity of this tool that many of you use. The conclusion per Dr. Beto’s report of this pilot study is that “the use of the NRA is a valid predictor of nutrition risk in long-term care facilities when examined over 12 consecutive months of care in a pilot study of 54 patients.” This sets the stage for the next phases of the validation process. Thank you to those who participated in the data collection for this report. Watch for more information as we move forward.

CD-HCF received notification the week before FNCE that our financial reserves were in excess of ADA’s guidelines. During the Executive Committee meetings, we looked at upcoming projects, brainstormed on where to fund the monies, examined avenues that benefited the membership and areas that would sustain the DPG and be inclusive of ADA and CD-HCF Mission, Vision and strategic goals. The Executive Committee identified 3 areas where the reserves will be channeled:

- Fund the next phase of the NRA validation process with the assistance and guidance of the ADA Quality Committee
- Fund improvement of the website to offer more member services, benefits and upgrade its usage for current and future members
- Develop an endowment through the ADA Foundation and fund over the next five years for scholarships for CD-HCF members to further their education. Over time, this would be self-sustaining and relieve the annual budgeting of scholarship monies. The EC has made this commitment in honor of the dedication and hard work of the past, present and future CD-HCF leadership and members.

FNCE also saw the current Executive Committee establish ties, working relationships and some friendly competition with each other and within the committees. Reports will be forthcoming in the Winter UPDATE! and newsletter. There will also be more reviews of the FNCE activities and the annual report.

As always, we will continue to watch for regulatory changes and forward them to you as soon as they are released.

Suzanne
Many of us have just returned from FNCE in Philadelphia. It is such an exciting time to be a dietitian, as so many things are happening in the food and nutrition arenas, and CD-HCF is such an active DPG! Public policy issues continue to be in the forefront and CD-HCF recognizes the importance of our members’ involvement in these issues by funding participation. Each year, the Chair, Chair-elect and Public Policy Coordinator attend the Public Policy Workshop (PPW) in Washington. It is always an invigorating experience! ADA needs a broad base of individuals invested and trained in public policy and advocacy, guided with consistent messaging and quality materials, to support a recognized “brand” of dietitians and other ADA members. Opportunities for CD-HCF members to attend have expanded, so please take advantage of one of the following:

Chair’s Scholarship funded by Medical Nutrition USA, Inc.
It is exciting news that one of our corporate sponsors, MNI, has created annual funding for one of our active or student members to attend either the Public Policy Workshop or the House of Delegates Spring meeting each year! The focus will be to provide a new educational experience and promote leadership within the organization. Guidelines and application for the award are available on the CD-HCF Web site (www.cdhcf.org).

2008 F. Ann Gallagher Award
This award was created by the Indiana Dietetic Association in Ann’s name for a CD-HCF member who has demonstrated interest in state or federal legislative issues, and who is not currently on the CD-HCF Executive Committee. A $1000.00 award is given each year through the American Dietetic Association Foundation. If you or anyone you know meets this criteria, please contact me or ADAF (www.adaf.org) for an application.

Some of you may have noticed the increased use of the term “public policy” versus “legislative” in recent months referring to ADA’s initiatives. This was done to more accurately reflect the impact of not just legislative, but regulatory issues on our business of dietetics. CD-HCF changed the name of this column over a year ago to reflect these issues. Think USDA, FDA, CMS. There is also an increased interest and push for us to become involved at the grassroots level - remember, “all politics are local.” A new grassroots structure was approved by ADA’s Board of Directors in February 2007 to strengthen the grassroots of the association so that ADA and its affiliates are more effective in bringing members greater recognition, respect and remuneration, consistent with ADA’s mission and vision. The intended outcomes of this process are:

- Streamlined processes
- Improved internal communications
- Empowered members
- More effective grassroots, capable of reaching key legislators and other state contacts—both proactively and at critical moments
- Increased overall visibility and recognition for the affiliates and the professions.

You may wonder, “How do I get involved?” Moms and Dads, or grandparents can get involved with their children’s and grandchildren’s school wellness policies; you can get in touch with your state’s Public Policy Coordinator, State Policy Representative or Public Policy Panel to see how you can help; you can stay current with your own regulatory agencies, as we well know, not all states do things the same way; read the On the Pulse report I send out each week on the CD-HCF electronic mailing list (EML) from ADA’s Washington office; check the CD-HCF Web site frequently for CMS updates; and subscribe to your representative’s email updates. Our nutrition issues are many, not just licensure or medical nutrition therapy.

I hope to see many more of you in Washington, DC, February 4-6, 2008 at the Public Policy Workshop!
patterns that emerged in the data that are related to stakeholders’ concerns and to overall program implementation.

METHODS
Site visits were conducted in seven facilities in three states that were selected as a result of a nationwide telephone inventory conducted with representatives of state Departments of Health. Data was collected via face-to-face interviews with NH employees including upper-level staff (e.g., administrators and staff trainers, 32) and assistants (i.e., CNAs, 54; PFAs, 39), and with observational protocols. Observations were conducted at each site during all three scheduled meals (breakfast, n = 71; lunch, n = 98; dinner, n = 74). Residents were primarily selected for observation based on whether or not they received assistance from CNAs or PFAs; however, some residents who did not receive assistance were included because it was hypothesized that they may be eating poorly on their own and would benefit from staff attention. On occasion, residents who were assisted by family members were also included in the observations.

RESULTS
PFA programs are generally viewed positively with no significant concerns noted.

Overall, upper-level staff in the facilities visited had no concerns about their PFA programs, and had plans to continue and/or expand the programs. Three respondents remarked that they had initial concerns, such as CNAs taking advantage of PFAs and inappropriate resident assignment, but their concerns had been quelled through proper training and appropriate resident assignment. Ninety-six percent of CNAs reported that they considered the feeding assistants “helpful” for one or more mealtime tasks, in addition to feeding assistance care provision; and, 92% reported that they had “no concerns” about the PFA program within their facility.

Some variation found in the adequacy and quality of assistance provided by PFAs versus CNAs. Based on observations of 196 resident-meals, we found that PFAs spent significantly more time providing feeding assistance to residents, as compared to nurse aides. A significantly higher proportion of residents ate less than half the meal served, and received less than one minute of assistance when assisted by CNAs, as compared to when assisted by PFAs (Table 1). In terms of how staff responds to residents with poor intake during the meal, our observations revealed that one-third of the time, neither PFAs nor CNAs offered the resident a substitution when he or she ate less than half of the meal.

<table>
<thead>
<tr>
<th>Feeding Assistance Care Process Measures</th>
<th>CNAs n = 126 resident-meals</th>
<th>PFAs n = 70 resident-meals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Resident eats &lt; 50% and receives &lt; 1 min of assistance</td>
<td>9%* (11)</td>
<td>1% (1)</td>
</tr>
<tr>
<td>2. Resident eats &lt; 50% and not offered a substitute</td>
<td>33% (42)</td>
<td>29% (20)</td>
</tr>
<tr>
<td>3. Resident receives &lt; 5 min of assistance and a supplement</td>
<td>1% (1)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>4. Resident independent but receives physical assistance</td>
<td>24% (30)</td>
<td>29% (20)</td>
</tr>
<tr>
<td>5. Resident receives physical assistance without verbal cue</td>
<td>3% (4)</td>
<td>1% (1)</td>
</tr>
</tbody>
</table>

*p<.05

Source: Abt Associates Inc.
**Supervision of PFAs and resident assignment may not consistently meet Federal requirements.**

Although facility staff reported that licensed nurses were present in the dining room during mealtime, the on-site research team observed licensed staff in the dining room only 66% of the time. Further, nurse educators and the directors of nursing (DON) at all sites reported that only residents “without complicated feeding assistance care needs” were assigned to PFA staff, but PFAs were observed providing assistance to residents with modified texture diets (i.e., ground, mechanical soft, or pureed texture), reflecting possible swallowing and/or chewing difficulties.

**PFAs rarely provide assistance with aspects of resident care beyond mealtime feeding tasks.**

Of the 39 feeding assistants interviewed, most reported helping with mealtime tasks (e.g., meal tray delivery, set-up, pick up; food and fluid intake documentation). This finding demonstrates the advantage of having extra hands available during mealtime to perform other tasks in addition to assisting with eating. However, a minority of PFAs also reported helping existing nurse aide staff with other aspects of resident daily care (e.g., transferring in or out of bed; toileting assistance). It should be noted that with one exception, the PFAs who reported helping residents get in or out of bed or providing toileting assistance were also CNAs.

**Most PFA programs recruit and employ existing, non-nursing staff and report no changes in staffing levels.**

Eighty-four percent of trained PFAs in our study had been recruited from existing staff in non-nursing departments including social services, activities, dietary, administration, housekeeping, and laundry. They reported that they enjoyed working as PFAs, and were comfortable with their resident assignments. Administrators and DONs reported being more comfortable recruiting from existing non-nursing staff because they are known to residents and their families. One hundred percent of the upper-level staff reported that “no changes” had been made to existing nurse aide or licensed nurse staffing levels following PFA program implementation, and all upper-level staff interviewed said that they planned to continue the PFA program and train additional staff.

**DISCUSSION**

In summary, the results of this CMS- and AHRQ-sponsored preliminary study revealed positive effects of the PFA program on dining care process quality with no negative effects on staffing levels. The use of non-traditional but trained staff to provide assistance to residents during meals may pose a potential solution to concerns about NH staffing shortages and feeding assistance care quality problems. Our data show that PFAs provided care comparable to, and in some instances significantly better than, the care provided by indigenous CNAs. However, it was also revealed that full compliance to some aspects of the Federal Regulation was lacking; at some sites licensed supervision of PFAs was not always provided, and PFAs were observed feeding residents with complicated needs.

To validate the findings reported in this study, and to assess dining quality care processes and resident outcomes, CMS and AHRQ have funded a small randomized intervention study of PFAs. Abt Associates and its partner Vanderbilt University (former from UCLA) are conducting the trial in two locations that have had no prior experience with the PFA program. It is anticipated that the results of this training study will serve to inform the development of an operational manual to guide facilities as they implement the feeding assistant program.

**References**


Continued on page 6
The Study of Paid Feeding Assistant Programs

Continued from page 5


Prepare for Public Policy Workshop

Collaboration between the American Dietetic Association’s (ADA) Dietetic Practice Groups (DPGs) and the association’s policy initiatives and advocacy program has been the source of several of the most significant nutrition and health breakthroughs in the past three years. In Washington DC and the states, issues affecting dietetics practice in all specialty areas continue to bubble up.

“This kind of liaison was at the heart of ADA’s legislative work on the Older Americans and the Ryan White CARE Acts,” said Mary Hager, PhD, RD, FADA, who is part of ADA’s Washington team. “To create these kinds of collaborations, ADA reaches out – with DPG meetings at every Food & Nutrition Conference & Expo (FNCE), multiple conference calls with DPG leaders, extended conversations on practice issues and collaborations on legislative and regulatory affairs.”

The scope of these conversations frequently is specific to DPG interests. “But there is one meeting where ADA focuses on the big picture, with attention going to strategic priorities for all practitioners,” Hager said. “Every DPG needs to be represented at ADA’s Public Policy Workshop to hear and see how public policy affects food, nutrition and health, and to be trained in messages and tactics for taking our causes to a higher level.”

In 2008, PPW is scheduled for February 4-6 in Washington DC. To ensure broad representation and a legacy of informed advocacy, ADA again will offer each DPG a scholarship to cover the cost of registration for one of their leaders.

“In 2008, PPW will be in the middle of the 110th Congress, it’s an important time for dietitians to look at the status of issues we care about, and to work for results while in Washington. Also, our dates coincide with Presidential primaries – and we’ll be in a place to witness landmark events,” she said.

Health care for Americans, nutrition and food safety issues, access to nutrition care services and food assistance are topics likely to dominate national headlines next year.

In 2007, PPW hosted a session on some of the emerging and ongoing issues ADA members face in their areas of specialty. Join the discussion and be part of ADA’s voice on Capitol Hill and through out the country. Go to www.eatright.org/ppw to register and for other details, or call ADA’s Washington office at 1/800/877-0877.

ADVERTISEMENT

How to Calculate % Eaten

Arkansas CD-HCF has for sale:

How To Calculate % Eaten - (booklets, posters, pocket cards)
- Record meal intake more accurately
- Be in compliance

Can be viewed with Order Form Available Online at http://www.arkansaseatright.org/default.aspx?pid=55

or write to: Project Chart
PO Box 1381
Rogers, AR 72756
An online membership survey was conducted in late spring as an effort to find out about the demographics of our members, our members' areas of practice and how CD-HCF needs to evolve to meet its members' needs. The validity of any survey is based on the level of responsiveness by the audience being surveyed and with 34% of the membership responding, the Executive Committee (EC) of CD-HCF has good insight in planning for the future.

### Demographic Information

<table>
<thead>
<tr>
<th>Practiced as RD/DTR</th>
<th>UNDER 15 YEARS</th>
<th>16 – 24 YEARS</th>
<th>26 – 35 YEARS</th>
<th>&gt; 36 YEARS</th>
<th>&gt; 46 YEARS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25%</td>
<td>23%</td>
<td>40%</td>
<td>12%</td>
<td>4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AREA OF PRACTICE</th>
<th>ALL</th>
<th>35 – 44 YEARS OLD</th>
<th>26 – 34 YEARS OLD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled care/rehab</td>
<td>71%</td>
<td>84%</td>
<td>77%</td>
</tr>
<tr>
<td>Assisted living/retirement communities</td>
<td>34%</td>
<td>36%</td>
<td>38%</td>
</tr>
<tr>
<td>Acute Care</td>
<td>31%</td>
<td>19%</td>
<td>30%</td>
</tr>
<tr>
<td>Alzheimer's/Memory impairment</td>
<td>27%</td>
<td>34%</td>
<td>31%</td>
</tr>
<tr>
<td>Private practice</td>
<td>14%</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Mental health/Mental retardation</td>
<td>10%</td>
<td>7%</td>
<td>9%</td>
</tr>
<tr>
<td>Home care</td>
<td>9%</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>Wellness</td>
<td>8%</td>
<td>7%</td>
<td>11%</td>
</tr>
<tr>
<td>Education</td>
<td>8%</td>
<td>8%</td>
<td>4%</td>
</tr>
<tr>
<td>Corrections</td>
<td>4%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMPLOYERS</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Self employed</td>
<td>41%</td>
<td>32%</td>
<td>28%</td>
</tr>
<tr>
<td>Continuing care facility/company</td>
<td>19%</td>
<td>28%</td>
<td>25%</td>
</tr>
<tr>
<td>Hospital System</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td>Private or Public owned business</td>
<td>14%</td>
<td>17%</td>
<td>16%</td>
</tr>
<tr>
<td>Government</td>
<td>11%</td>
<td>8%</td>
<td>4%</td>
</tr>
<tr>
<td>Consulting firm</td>
<td>10%</td>
<td>13%</td>
<td>14%</td>
</tr>
<tr>
<td>Non-profit agency</td>
<td>9%</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Educational institution</td>
<td>5%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Retirement</td>
<td>5%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>Home care/Corrections</td>
<td>4%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Corrections</td>
<td>1%</td>
<td>&lt;1%</td>
<td>&lt;2%</td>
</tr>
</tbody>
</table>

Of the 8% that listed the “other” category, dialysis centers, contract management and food distributors were the most frequent responses.

Based on the years of practice, it is not surprising that the 47% of the DPG members are in the 45-55 age range. Twenty-three percent are in the 56-65 age range while 16% represent the 35-44 age range. Currently, the “under 35 years of age” member comprises ten percent of the membership.
All geographic areas of the US were equally represented with Area 2 and Area 5 reflecting 18-19% of the respondents. Other areas reflected 10 to 15% of the survey respondents.

The composite survey results reflect that:
- 28% of the current membership has been members “5 years or less”
- 26% have been members 6-10 years
- 19% are equally distributed for the 11-15 years and 16-24 years of membership
- 9% have been members greater than 25 years
- The “5 years or less” percent is 43% for the 35-44 age group and 87% for the 26-34 age group.
- Over a third of the 35-44 age group have been members for 6-10 years.

What Services are Valued?

When asked to list the top three services or programs provided by CD-HCF that are of most value to you, the Newsletter was the top service with a 93% response. This response remains constant (92% and 91%) in the respective age groups. Continuing professional education programs/seminars and professional resource materials were the next two highly valued programs (approximately 75%), regardless of age. Nearly one fourth of the respondents listed the electronic mailing list (EML) as one most valued. FNCE annual meeting, awards/scholarships and legislative advocacy were the least valued (1-7%).

The offering of regional onsite workshops as a new service was the top choice by members (70%) in keeping them committed to the DPG. Approximately 40% of the respondents listed webinars, teleseminars, and electronic newsletters as additional services that would be of value to them. When evaluating the age group responses, regional workshops remained the top choice, but over 50% listed webinars as a preferred service, followed by teleseminars and electronic newsletters. Other suggestions of interest included:

- Mentoring, local meetings, audio CPE for Mp3 players/podcasts, improved or additional CPE hours in newsletter, access to nutrition research appropriate for LTC consulting, more “how to” books, support for state associations, team of experts to answer questions online, electronic access to forms, study course for geriatric certification exam, survey of salary/compensation/hours per bed, Wikipedia of resources to share, subunit on being an expert witness, provide EML in digest format (this is now available), and member directory.

Member Involvement
- Over 80% of the members responding to the survey listed “member only” as their level of involvement and this was considered regardless of the age groups.
- Approximately one fourth of the respondents are EML participants.
- 17% are involved in a state CD-HCF groups (drops to 12% for the specific age groups)
- 13% are annual meeting participants (7-9% for the age groups)
- Less than 2% of the respondents have been a newsletter contributor, committee chair/member or award recipient
- In the 35-44 age group, only one listed involvement on the EC or award recipient
- Of the 133 “26-34 age members” completing this question, none have contributed to the newsletter, been an award recipient or been on the EC
- Only two members of the 26-34 age group listed committee involvement.

Barriers to Participation
- Over 50% of the respondents listed family and work commitments as existing barriers to involvement in CD-HCF
- Approximately 20% of the respondents stated that they “had never been asked” (increases to 30% for the under 35 age group)
- Involvement with other DPGs, health related associations or non-health groups were listed as barriers by 15% or less of the members
- Non health or health related groups were listed more frequently as “barriers” than “other DPG involvement” (2%).
- Only 2% of the membership (regardless of age) listed “current activities do not interest me” as a barrier to participation
- Other frequently listed barriers were location (some are international members) and being unaware of opportunities for participation.
State CD-CHF Participation
Of the members listing participation in state CD-HCF practice groups, over 40% indicated involvement as a committee member or officer.

Other ADA DPG Membership
Other DPGs of which CDHCF members are currently members include:
- Healthy Aging (formerly Gerontological Nutritionists (GN)) - (40%)
- Diabetes Care and Education-23% (15 % for the age specific groups)
- Dietitians in Nutrition Support and Weight Management-12%
- Sports, Cardiovascular, and Wellness Nutritionists- 11% * (15 % of the 26-34 age group involved in SCAN and Nutrition Entrepreneurs)

The other DPGs listed reflected a 10% or less involvement by CD-HCF members. However, frequently mentioned practice groups listed under the “other” category included:
- Renal Dietitians
- Clinical Nutrition Management
- Medical Nutrition Practice Group
- Oncology Nutrition

Planning for the Future
Identifying situations/trends that may have a positive as well as negative impact on the practice of a CD-HCF member provides some insight on the “Yin and Yang” of the profession and area of practice. The aging population will provide the opportunity for growth in the area of caring for the older adult, but with the recognition that the way dietitians practice will need to change! Not only the way long term care services are delivered due to the Baby Boomers mantra of “we will never age,” but the continued introduction and adoption of electronic charting and the Nutrition Care Process that will change the way consultant dietitians deliver service. The increased use of technology, especially computerized charting and access to nutrition information electronically was mentioned frequently. Other trends listed by members, especially under age 45 included:
- Societal acceptance of healthier lifestyle choices and healthy eating
- Focus on wellness; more government agencies requiring RDs
- Need for project management skills
- Inclusion of the RD in practical weight management programs
- Evidence based preventive programs
- Reshaping of the traditional “retirement living” – cultural changes in long term care

However, the evolution of care will not be without the continuing challenges of regulations, reimbursement and recognition of the value of the registered dietitian in the health care settings. Lack of reimbursement for services and decreased funding from government were frequently listed as negative influences on the practice of dietetics. Other factors included:
- Easy access to nutrition information creating more “mis-information” and self treatment
- Continued lack of recognition by the public on the value of a registered dietitian
- Other professionals or non-professionals providing nutrition care
- Fear of being sued
- Nutrition Care Process
- Increased levels of obesity and chronic disease
- Fear of emphasizing quantity of work on quality (nutrition assessment daily rate)

The Changing “Face” of CD-HCF
When asked of members what CD-HCF will need to “look like” as an organization over the next five years, the responses were numerous but the main themes centered on:

Value of the profession
- Need to look like a professional organization that stays current with field application, not just trends
- Be on a “first to know” basis for it members— getting the information out to the members quickly so they can answer administrators’ and dietary managers’ questions with comfort and confidence
- Continue to show the value of profession in all environments; need to be more vocal about what we know and how we can help
- CD-HCF needs to promote itself more; provide more networking opportunities
Information and technology

- More “electronic” everything and more webinars/teleseminars
- More continuing education programs (accessible)
- Hands-on application seminars; continuing education should be top priority
- Web site could contain more resources and provide a place for communication without joining an EML
- E-learning, e-newsletters, revamping of the newsletter needed

Advocacy

- Be more proactive in promoting good nutrition in LTC settings; enhance job search tools, supply assistance and support for the RD for reimbursement and regulations
- Promote quality, evidenced based nutrition care in LTC
- Lobby for nutrition services reimbursement for LTC services
- Communicate to seniors and health care workers the advantages of complying with treatment relating to dietary disorders
- Greater guidance as an advisory source for the ever-changing clientele
- Need to get further involved in law making and advocate for insurance companies be more responsible to their participants
- Create a joint DPG that addresses continuum of care

Marketing of the Profession

- Better marketing of our services to compete
- Increase marketing skills for RDs
- Become more public
- Find ways to improve business and public speaking/media skills of its members
- Cover a broad spectrum of issues as dietetics practitioners such as how to make RDs noticed as the true professional and what we can do improve systems
- Provide more networking opportunities
- Look to making a bigger presence in home care and hospice
- Generate own revenue for teaching certified and other dietary managers training programs

The Name of the DPG

In the composite survey, 77% of the members replied that the name CD-HCF is representative of the current membership. When looking at the specific age groups, 77% of the 35-44 age group concurred that the name remained appropriate while 85% of the 26-34 age group were in agreement. Despite the positive responses, the 337 responses that wrote comments about why the name was not appropriate centered around the main theme of “many of us are not consultants, we work full time for organizations” and the term facilities does not identify all the health care settings in which DPG members are working. Also, the term “dietitian” does not reflect the DTRs that are members of this practice group. A couple of comments saw the name as a deterrent to membership as one member stated that “there is a misconception that you can belong to this group only if you are a consultant dietitian or have your own business.” Another member states “I find it difficult to convince my employers that membership in CD-HCF is of benefit to them, (hospital) as it appears to be geared toward my “other job” (consulting in LTC). I would like to see it called something else so that I can remain a member.” Several names were offered as alternates:
- Dietitians in Health Care Facilities
- Dietitians in Long Term Communities
- Dietitians in Extended Care Facilities
- Consultant Dietitians for Health Care (or Health Care Organizations)
- Dietitians in LTC
- Nutrition Consultants in Health Care Facilities
- Nutrition Services Dietitians in Health Care Facilities

Summary of Findings

Despite the variety of settings in which the CD-HCF members practice, long term care still remains the main venue. Currently, 40% of the membership is self employed, but that percentage drops to under 30% when evaluating members of ages 44 and under. Approximately 25-30% of members under the age of 45 are employed by long term care facilities.

Fifty percent of the members are in the 45-55 years of age group and 40% of the members have prac-
Consultant Dietitians in Health Care Facilities DPG
2007 Membership Survey  Continued from page 10

Listed “never being asked” as the reason for not being more involved. In order for CD-HCF to maintain its service and promote growth, a focus on member retention and engagement will be needed. Members cited numerous opportunities and challenges that will impact the practice of dietetics over the next several years. It is noted that CD-HCF needs to be proactive in addressing the issues, centering their activities on advocacy, education and marketing the value of the dietitian in the changing world of healthcare. As CD-HCF continues to evolve to meet the needs of its members, the branding and image of the group must be evaluated. Despite the fact that over 75% of the members cited that the current name was reflective of the membership, only 30% of the younger members identified themselves as self employed. “Respect the past, but build for the future” will need to be the underlying theme of CD-HCF as it addresses the needs of its members and the changing dynamics of the health care environment.

What’s New in Home Care?  by Carolyn Yanosko, RD, LD

Hopefully, many of you interested or working in Home Care have signed up for the electronic mailing list (EML) from the CD-HCF Web site. The list is just active enough to keep up with! One of the recent threads has been the electronic medical record. The agency I work for has been transitioning the field staff (nurses, physical, occupational and speech therapists, and medical social workers) onto a laptop system for the past 18 months. The process has been quite a learning curve for them, but a great asset for the dietitian.

I have the opportunity to work from the office as well as the field. I do not have a laptop to input information at the visit, but with computer access at the office, I can find out everything I need before the visit. I can see a history of vital signs, wound measurements, appetite and nutrition issues, elimination issues, blood glucose records, etc. Before the utilization of the laptops, this info was extremely hard to obtain. This advance in documentation is becoming more and more prevalent in the home care industry.

Since Medical Nutrition Therapy (MNT) services are not required or recognized as a condition of participation by the Centers for Medicare & Medicaid Services (CMS) or Joint Commission, the electronic medical record system companies have not included MNT assessments or charting opportunities in the systems they have created. This leaves dietitians to “pasting” notes into the system by free texting. At the agency where I work, we are looking at making a template to paste into the record using the Nutrition Care Process (NCP). We have just started this process, and I imagine it will take some time. You, too, can work with your informatics group to be included in the electronic record. The field staff has gotten so used to communicating via their laptops, communication and co-ordination of care seems to be on the increase, which can only result in better care for the patient.

There are opportunities to be had here in this area. Work with your agencies, contact the companies creating the systems, and be proactive. Have your voice heard!
CMS News
by Becky Dorner, RD, LD, Secretary NPUAP, Past Chair CD-HCF

CMS Releases New F Tag for Paid Feeding Assistants
CMS released draft guidance for F Tag 373, which covers nursing home use of paid feeding assistants and took effect August 17, 2007.

Under F-tag 373, surveyors will determine noncompliance in any of the following cases:
* The feeding assistant has not completed a state-approved training program
* The feeding assistant isn’t properly supervised
* The facility has not selected an appropriate resident to receive paid feeding assistance
* The facility has not maintained records indicating all paid feeding assistants have completed a training course.

To get the materials from CMS, go to http://www.beckydorner.com/pdf/CMS.pdf
For the training guide, visit http://www.beckydorner.com/pdf/training.pdf

In other news...

Dementia Care Practice Recommendations for End of Life
The Alzheimer’s Association has released End-of-Life Recommendations for Assisted Living Residences and Nursing Homes. The Recommendations focus on improving the end of life experience for people with Alzheimer’s and other dementias by offering concrete suggestions for addressing issues unique to people with dementia at the end of life. They emphasize the importance of consistency in individualized and person-centered care approaches; development of relationships between staff and residents; and increasing staff knowledge of individual resident needs, abilities and preferences. For the complete set of guidelines, please visit:

End-of-Life Dementia Care Practice recommendations: http://www.alz.org/documents/DCPRPhase3_.pdf


State Collaborative Boasts 70% Reduction in Pressure Ulcers
Those who are trying to improve their wound care programs, take note: A pressure ulcer collaborative in New Jersey recently reported a 70% reduction in the incidence of new pressure ulcers after a nearly two-year effort.

The New Jersey Hospital Association’s Pressure Ulcer Collaborative, which is composed of 150 hospitals, nursing homes and home care agencies, met more than 22 months ago to develop and share standardized preventive strategies. It tracked data from September 2005 through May 2007.

Facilities used common improvement techniques over the study period. These included complete skin evaluation within eight hours of admission; evaluation of the risk of skin breakdown using the internationally respected Braden scale; implementation of preventive strategies, such as proper positioning and use of assistive devices; and ongoing observation of the condition of patients’ skin, particularly for those identified as being at high risk for developing a pressure ulcer.

For more information on the collaborative, please visit http://www.njha.com/press/PressRelease.aspx?id=5187

New Free Software from FDA
The FDA has released a new tool to help members of the food and foodservice industries determine the vulnerability of individual food facilities to biological, chemical, or radiological attack.

The software program, called CARVER + Shock walks a user through a customized risk assessment to identify where the risks and vulnerabilities are. The name of the risk assessment software is derived from the acronym CARVER, which refers to six attributes used to evaluate targets for attack (Criticality: Accessibility: Recuperability: Vulnerability: Effect: Recognizability). By downloading the free software from the FDA website, you can follow a step-by-step tutorial to complete an assessment of your operation in a few hours, says the FDA.

For more information, please visit http://www.cfsan.fda.gov/~dms/vltcarv.html.

Taken from Becky Dorner & Associates, Inc. 2007 Email magazines.
Moving Towards an Improved Researcher-IRB Partnership
by Richard Mattes, PhD, RD

Which is the committee everyone most loves to hate? For those engaged in human subjects’ research, the Institutional Review Board (IRB) often tops the list. This is the committee charged with ensuring researcher compliance with federal, state and institutional regulations that guide the ethical conduct of research involving human beings. It is my contention that much of this animosity is misguided and misplaced, resulting in unnecessary aggravation and delays in research. This view reflects experiences over my 25 years as a clinical researcher and serving about half that time on IRBs. Currently I am the chair of the Purdue University IRB, but I write now not in that capacity, only as one who has some familiarity with both sides. My goal in this column is to offer perspectives on a number of common issues that will hopefully facilitate an improved rapport between dietetics researchers and the IRBs with which they work.

It is probably worthwhile to briefly review the purpose and function of IRBs. Most, but not all, branches of the federal government that provide funding for research that involves human beings have adopted a set of regulations that must be met before federal funds can be used for such work. When institutions engaged in federally supported research request funding, it is provided on the stipulation that a mechanism be in place to ensure compliance with the applicable regulations. The establishment of an IRB (or contract with a commercial IRB) is the mechanism for such assurance. In the case of an institutional IRB, it is supported (space, staff, member training) by the institution. However, there are standard operating procedures that assure the independence of the decision-making process. The institution may have a strong interest in certain areas of research (i.e., there is abundant funding waiting to be directed to them), but if the design is not compatible with federal regulations and the IRB denies the application, the decision cannot be reversed by any institutional entity. By the same token, if a protocol is deemed acceptable from an ethical perspective, the institution can still reject the study. For example, universities may have policies governing the use of alcohol or tobacco on campus and, despite an appropriate research design, simply will not allow a project that requires students to use such products on campus. Thus, protocol approvals are a two step process and while each entity may deny a protocol, often the IRB is incorrectly viewed as the obstacle since they were the application recipient.

One of the fundamental issues IRBs must evaluate is whether a research protocol actually entails human subjects research (HSR). It is possible to use humans to gather information without them being research participants. Such a scenario would not require IRB review. An operational definition of HSR is the systematic collection of information about people with the intent to create generalizable knowledge. Course and program evaluations do not constitute HSR because they do not yield generalizable knowledge. Thus, they do not require IRB review. It is important to note that the word “risk” is not in the definition of HSR. Often researchers believe their protocol should be exempt from review because their procedures involve little or no risk. However, risk only determines how a protocol is reviewed, not whether it is or is not HSR. If it is HSR, by federal regulations (not by IRB perversity), it must be reviewed. Incidentally, all research has risk. If you knew with certainty the outcome of your activity, you would not do it. With uncertainty there is risk. It may be no more than what one would experience in every day activities, but there is risk. So, one should never say on an application that there is no risk associated with participation. This will result in a returned application.

As noted above, the IRB is often viewed as an obstacle to research progress. This stems from the fact that IRB approval is often one of, if not the final approval needed for the release of funds to support the research. Thus, it is very visible and definitive. However, some honest appraisal should temper this view. If one considers the length of time required to generate a novel, scientifically meritorious research question, write a grant to get the funding to pursue the work, wait for a funding agency decision, work out the logistics of a study and the length of time it actually took the IRB to review the protocol, most often the last step will be far shorter than any of the others. So, it may be unfair to blame the IRB for delays in work. It might be added that it is not necessary to wait until all other steps are complete before submitting to the IRB. You can submit early, based on a reasonable expectation of design, and

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get approval. Then, if revisions based on evolution of the project are necessary, approval of revisions can be requested and this typically takes much less time than the initial review.

The fact that your colleague can conduct a certain research activity does not mean that you can or should. By design, IRBs are partly comprised by members that are not scientists or physicians. The goal is to have a broader perspective on the proposed activities and to have some consideration of local custom and ethics. These can vary from one site to another so, the decisions by the different IRBs may appropriately vary. As an extreme example, it may pose little concern in the United States to query female students on campus about the number of live pregnancies they have had. It would a very different level of risk if this same activity were conducted in China where policies on birth control differ and a breach of confidentially would have very different implications. Thus, the IRBs in each setting could reach different conclusions about the cost/benefit ratio of the proposed work and make different decisions. It is perfectly reasonable to inform an IRB about discrepancies and request re-evaluation in light of additional information, but recognition that uniformity is not a goal of IRB’s should relieve some confusion about the process.

Speaking of providing supplemental information to IRBs, it is best to consider members of the IRB as educable, but not necessarily knowledgeable. To facilitate decision making and logistics, IRBs are generally comprised of a limited number of members. On a college campus, they do not have representation from all possible disciplines, yet they may be asked to make judgments on applications from researchers in areas that are not represented on the committee. It is the IRB’s responsibility to evaluate the science of a protocol to the extent that they can assess risks and benefits and can determine the work is scientifically meritorious. However, because of the diversity of research they review, they may not be sufficiently familiar with a particular area to know what procedures are routine. Incorporating information targeted at the level of the committee’s knowledge should improve processing time by reducing instances where they ask for more information. Further, should you receive follow-up questions that seem naïve or inappropriate, recognize them as a need for education rather than an active attempt to stifle your work. Ultimately, the IRB’s purpose is to protect the rights and welfare of study participants; would you want to make decisions about procedures that you did not understand that could be administered to your family or friends? Why would they? Incidentally, by protecting study participants, the IRB ultimately is protecting researchers (you) and institutions from litigation and ensures a continued relationship of trust between potential participants and researches thereby preserving the research enterprise.

Finally, if you are really angry, I recommend you ask to serve on your IRB. If you think you don’t have the time, consider that most IRB’s are comprised of other researchers like yourself that have devoted their time to further your work. If asked to serve, it is my near universal experience that within a few meetings, the most discontented researcher realizes that the other committee members are actually doing their very best to facilitate research while fulfilling their obligation to ensure researchers comply with federal regulations. Over the span of my participation on IRBs at different institutions and exposure to continual turnover of members, I have never witnessed a malicious attempt by a member to undermine a line of work or researcher. Even if such a person was a member, they represent only one vote where a simple majority rules and others on the committee would likely recognize this bias.

In the end, it will serve your purpose best to build a constructive rapport with your IRB rather than an adversarial relationship. Review of HSR is not negotiable, but the tenor of negotiations is largely under your control. Good luck and may approvals be with you.

This article was reprinted with permission from the Research DPG and originally appeared in the Spring 2007 (Vol. 42, No. 2) issue of The Digest.
I had the pleasure of representing CD-HCF as the Association of Correction Food Services Affiliates (ACFSA) Network Representative at the ACFSA International Conference, August 5-9, 2007, in Ontario, California. This organization is a corrections dedicated food service organization with members worldwide. There were many topics from food safety to medical and religious diet issues presented.

As Chair of the Dietitians in Corrections (DIC) for ACFSA, I coordinated and conducted a DIC networking luncheon on Monday August 6th. This was sponsored by a food distributor that offers specialty foods conducive to the corrections environment and its specific needs and has supported this networking luncheon for the past few years.

We had 27 dietitians in attendance at the luncheon from the US, Canada and Puerto Rico. We discussed common problems and practices in our environment:
- Meeting nutrient needs while controlling costs
- Child Nutrition and Wellness Programs
- Frozen microwavable diet entrees
- Allergy diets
- Increased cost of milk
- Soy products

The CD-HCF Corrections Subunit was promoted to potential members along with member benefits. Current members were reminded of the changes in the Web site and the re-subscription to the electronic mailing list (EML) referencing the CD-HCF Web site. The Corrections Sub-unit meeting on Monday October 1st at FNCE was also announced.

On Wednesday August 8th, I led two panel presentations – Compliance in Medical Diets and Compliance in Religious diets. Our panel consisted of Sue Summersett, MPH, RD, Food Administrator California Department of Corrections; Thomas Issermoyer, Food Administrator Federal Bureau of Prisons; and myself. Sue and Tom presented from the perspective of their governing agencies. I presented from the perspective of private and government jails and prisons nationwide. We had contributions from Canada and Puerto Rico members and a supplier of kosher entrees. Attendance was excellent in both sessions.

New vendors to our arena were visited and will be exhibiting at FNCE. One new vendor will be offering frozen therapeutic diets.

WANTED

Your Expertise

Your Experiences, Your Knowledge in the Field

The Newsletter Editors are inviting you to submit articles for the newsletter on areas of interest to our membership. If you are hesitant to write and have a great idea to share, let us know and we can help with the writing. Articles on what you are doing in the field, reimbursement, culture change and anything pertinent to our membership is welcome.

Due to space and time limitations, some articles will be edited and not appear in their entirety. Contact marilyn@stepping-stonesconsulting.com for more information or to submit articles.
**News from the States**

CD-HCF’s Executive Committee (EC) hosted a luncheon with chairs and/or contact persons from state consulting groups at this year’s ADA Food & Nutrition Conference & Expo. This was made possible through an educational grant from Abbott Nutrition. The EC hopes that this will become an annual event!

**Area I Update**

**Lynda Glutch, RD, LD**

**Iowa:** Char Kooima is the contact for the state.

**Michigan:** Beth Ann Nickelson is the state chair.

**Minnesota:** Bridget Doyle is the contact for the state. At the state meeting this year, native Minnesotan Gaynold Jensen’s professional efforts in the initial formation of CD-HCF were honored. Lisa Brown is the newsletter editor and is involved in planning the next state meeting for November 1, 2007.

**Missouri:** At this time, there is not a designated contact for the state. Any CD-HCF members interested in organizing a state group should contact me for further discussions.

**Nebraska:** Brooke Reilly is the contact for the state.

**North Dakota:** Jerilyn Wass is the contact for the state.

**South Dakota:** Karen Klinkner is the contact for the state.

**Wisconsin:** Vaishali Zala is the state contact. A state meeting has been scheduled for April 16, 2008. Tentative speakers include a speaker from the Wisconsin bureau of Quality Assurance to discuss F-tags and a state surveyor to discuss the MDS and the survey process.

**Area III Update**

**Lynn Moore, RD, LD**

**Alabama**

The Alabama Consultant Dietitians in Healthcare Facilities (AL CD-HCF) had their annual Spring Banquet on March 13th in conjunction with the Annual Alabama Dietetics Association Spring Meeting Exposition and Food Show. Jan Trapan, BSN, CDE, from Innovex discussed “New Diabetic Approaches in Long Term Care.” Approximately 25 dietitians attended. Everyone enjoyed the meeting and look forward to hearing more on this topic. AL CD-HCF encouraged all dietitians, dietary managers and administrators to attend the US Foodservice Healthcare Seminar and Food Show on September 10 and 11th in Birmingham. This seminar replaced what AL CD-HCF has done for the past 25 years. Contact Chris Bowers at cbowers1960@bellsouth.net for information.

**Mississippi**

The Mississippi Consultant Dietitians in Healthcare Facilities held a workshop prior to the annual Mississippi Dietetic Association meeting in March. Analynn Skipper, RD, Chairman of the ADA Nutrition Care Process Committee, presented “The Nutrition Care Process-Are We Speaking the Same Language?” Approximately 60 dietitians attended the workshop. A workshop is being planned on wound care for 6 CPE hours for the spring of 2008. Contact Heather Crawford, Chair, at Hcrawfordrd@aol.com or 601-583-7081 for information about Mississippi activities.

**Florida**

In July of 2007, Florida CD-HCF sponsored a seminar at the Florida Dietetic Association conference on the “New QIS process, Litigation and the RD.” The speaker was Karen Goldsmith, attorney at law. A business meeting followed in which the new officers for 2007-2008 were installed: Chair: Janet McKee, Chair-elect: Kathryn Smith, Secretary: Lisa Garay, Treasurer: Arturo Molina, Legislative Chair: Kathryn Smith, Newsletter Chair: Kathy Weigand, Advisor: Kathy Weigand, Treasurer/Membership Elect: Naomi Watts, Webmaster: Peggy O’Neill.

In the last quarter of 2007, Florida CD-HCF will host a teleconference for its members to earn CPEU on “Nutrition Assessment, MNT and Care Planning for ABT and C-Diff Induced Diarrhea.” A short business meeting will follow. Contact Janet McKee, Chair, at Nlifes8314@aol.com or (407) 894-1444 for details.

**Georgia**

Georgia CD-HCF held their fall meeting at the Crown Plaza Ravinia in Dunwoody on October 18th, 2007. Lynn Moore, RD, LD, Area 3 Coordinator and ADA Liaison to the National Pressure Ulcer Advisory Panel (NPUAP) provided an update on CD-HCF

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News from the States  Continued from page 16

activities and the new NPUAP pressure ulcer staging guidelines. Edna Cox, MS, RD, LD, former Area III Coordinator gave a presentation on Litigation. CPE units were provided. Contact Lisa Eckstein, State Contact, at 678-443-6788 or lisaecksteinrd@yahoo.com for more information.

South Carolina
South Carolina CD-HCF is planning a fall seminar on the Nutrition Care Process for LTC. A date for the seminar has not been set. Contact Edna Cox, Acting Chair at 803-996-0312 or ecoxrd@alltel.net for more information.

Area IV Update
Anna de Jesus,MBA, RD

The following Area IV states are holding workshops during the following months:

October 2007 – Arizona and Texas
November – Kansas and Oklahoma

Area IV states that need assistance in forming a local chapter, please contact your Area Coordinator, Anna de Jesus at nutriall@aol.com.

Thanks for volunteering!

News For You from ADA

Research your value with ADA’s new salary survey... Based on the third nationwide survey of dietetics practitioners, ADA’s latest salary survey results are in. An easy to use summation of the findings, entitled the Compensation and Benefits Survey of the Dietetics Profession 2007, is now available for purchase, at the member price of $20.

ADA and CDR again teamed up to collect up-to-date information regarding dietetics salaries and benefits. This comprehensive report details the compensation for dozens of core dietitian and dietetic technician jobs, broken down by job title, region, education, experience, supervisory responsibility, and much more. Of particular interest to practitioners will be the salary calculation worksheet, which offers the user an estimation of what professionals with similar characteristics and in similar situations earn, on average.

The 2007 survey was enhanced in response to member input, adding new items regarding patient/client risk, unionization, and reasons for non-employment in dietetics. The questions on credentials held and benefits offered were significantly expanded. Finally, a new position (Director, Clinical Nutrition) was added to the position descriptions list.

Practitioners can use this expansive salary data to better understand the market as it relates to the salary and benefits compensation for a variety of dietetics positions. Know your compensation package and what is negotiable. If your organization is not able to provide salary or performance increases, it may provide professional development benefits, such as reimbursement for association dues or funding to attend continuing education programs. Use the survey to research your market value and investigate the factors that lead to higher salaries. For example, salaries increased in proportion to number of years of experience, level of supervisory responsibility, budget responsibility, and practice area (consultation and business paying more than clinical). The Compensation and Benefits Survey of the Dietetics Profession 2007 is available now through the ADA catalog online or call 800/877-1600, ext. 5000, and ask for Publication #356808.

Dietetics practitioners who envision a future where the RD and DTR are well compensated for your value and performance must take action today.
CD-HCF was started in 1975 and is the oldest ADA dietetic practice group. CD-HCF is built upon the knowledge and expertise of our long-standing members. We would like to recognize one of our most dedicated members who has been with CD-HCF since its inception. Following is an excerpt from Etna Doyle, RD:

Thank you for your personal letter inviting me to meet with you in Philadelphia. My original plans were to attend this meeting, but as time progressed my Dietetic Internship Class from Hines V.A. Hospital planned a 50 year reunion in Chicago. I elected to attend that as I knew that group would be closer in memories than any of the individuals attending the FNCE meeting. I received a list of 50 year members from the ADA and there were only 2-3 people that I recognized. Our internship class met in Chicago September 7-8 and had 8 in attendance. Four spouses also attended. My husband’s comment is “you gals talked all week-end!!”

We had quite a few old pictures and one member compiled a booklet of biographies submitted by many of the group, including those who could not attend the reunion. They also will receive the booklets. I think many of us will have a few names added to our Christmas card lists and e-mail addresses.

I have enjoyed my 50 years in practice. Some time was spent in local hospitals, 3 years in the Residence Hall Food Service at the University of Illinois, Champaign-Urbana and most of my practice as a consultant in Long-term Care in Iowa and Illinois. In Iowa I worked independently and in Chicago joined C. Chow and Assoc. Since retirement in 1999 I have kept up with Continuing Education and find many very good programs sponsored at the U. of Kentucky. We live 45 miles from Louisville and equal distance from Lexington. It is easy to reach either place. Even though I’m not working, I find it very interesting to keep up with changes in the field. In fact, sometimes I wonder how things can change so fast.

Thanks again for the invitation.
I hope you have an interesting session in Philadelphia. I still enjoy my interest in the field of dietetics and continue to think of myself as a RD even though not working outside the home.

As ever,
Etna (Jean) Doyle
Etna Doyle, RD

Etna (Jean White) lives in rural Chaplin, KY, with her husband, Jim. They retired in KY to be close to their oldest son and 2 granddaughters. Jean’s other two sons live in Miami and Dallas. Besides family activities, she and her husband volunteer at a nearby hospital in Bardstown, KY, and keep active with exercise programs and cultural programs in Louisville.

Jean graduated with a BS in food and nutrition from Iowa State University at Ames IA. She completed her dietetic internship through the Veterans Administration at Hines VA Hospital in Illinois. While her husband went to graduate school at the University of Illinois at Champaign-Urbana, Jean worked for the University’s food service department. Jean spent 10 years at home raising small children, and went back to work in 1973 in the long term care industry. She worked for nursing homes in the Elgin, IA, area, and later worked for Cynthia Chow and Associates, a food management firm, in the Chicago, IL area. Jean retired in 1999 and has maintained her ADA membership and registration. She has belonged to the long-term care practice group Consultant Dietitians in Health Care Facilities since its inception. She joined the MNPG 2 years ago when her husband was diagnosed with celiac disease. Jean thinks it is great how the field of dietetics has expanded. “We need to keep pushing to be a force in the food industry,” she states, “and we need to introduce ourselves into new areas of practice.” She remembers when an RD working for the food manufacturing industry was kind of scandalous, like a conflict of interest. Fortunately, that has changed. Now, after 50 years, dietitians contribute significantly in all areas of nutrition.
Menu Planning Beyond MyPyramid
by Linda Roberts, MS, RD, LDN - Task Force Chair

Meeting the nutritional needs of the institutionalized elderly through conventional foods may prove to be unachievable.

A task force was formed by the CD-HCF Executive Committee to develop menu planning guidelines for long-term care (LTC) practitioners. The impetus for this action was the publication of the MyPyramid recommendations for seniors, which increased the number of servings of most food groups. Practitioners expressed concern that the increased volume of food would not be consumed by the institutionalized elderly and so was not the best way to optimize the nutrient intake of this population.

The task force forwarded the membership’s concern to Alisa Overgaard, RD, of the Centers for Medicare & Medicaid Services (CMS) requesting clarification of F363. In response CMS issued this statement: “CMS does not mandate a particular menu planning guide be used, but instead encourages facilities to tailor their meal plan to meet the nutritional needs of their unique resident population. Our interpretive guidance suggests several reputable resources for information and guidance on this issue, including the American Dietetic Association.”

This response provided the task force with vital information: 1) Menu planning for the institutionalized elderly need not mirror MyPyramid and 2) the American Dietetic Association (including CD-HCF) is a reputable resource for menu planning guidance. As part of the process of developing a new menu guide for long term care, the task force commissioned a study by researchers Victoria Castellanos, PhD, RD and Melissa Ventura-Marra, PhD, RD, LD/N, at Florida International University to review menus that are currently used in LTC for nutrition composition and adequacy. Based on those findings, the FIU team was asked to determine a menu pattern that would provide the RDAs for nutrients as stated in F363.

Preliminary Menu Plan
Ms. Ventura-Marra completed a nutritional analysis of 10 existing LTC menus from providers and others that write menus for LTC. She found that all of the menu plans failed to provide the updated RDAs/AIs for vitamin E, magnesium, potassium and dietary fiber. Some menus also fell short of the RDA/AI for calcium, folate and vitamin B6.

As a next step Ms. Ventura-Marra worked backward to determine the minimum servings of foods that would be needed to provide the RDA/AI s. She found that compared to current offerings, we would need to increase the amount of green vegetables, orange vegetables, legumes, fruits, whole grains and milk provided in most, if not all, LTC menus.

Her analysis showed that provision of the current RDA/AI s through conventional foods alone will necessitate an increased number of servings of several types of foods. Ms. Ventura-Marra warns, “While appropriate for the general healthy population, increasing the quantity of foods, particularly foods of low energy density such as fruits and vegetables, may not be practical or advantageous for LTC residents with compromised eating and for whom energy intake needs to be maximized.”

Based on the menu study results and the wording of F363, the task force concluded that a single menu plan cannot meet the needs of all long term care residents. The task force recommends using the Tufts Food Guide Pyramid for Older Adults as the starting point for menu planning with individualization for the facility’s resident population. The menu guideline is as follows:

- 2 - 3 servings milk/ dairy
- 5 - 6 ounces meat/protein
- 5 servings fruits/vegetables
- 6 servings grain

It also recommends the use of a vitamin/mineral supplement for those residents requiring nutrient supplementation.

Moving Forward
During the course of this project CMS did amend F363’s interpretive guidelines. Although subtle, it was a substantive change in language “. . . the menu meet basic nutritional needs by providing daily food in the groups of the food pyramid system. . .” This further clarified that menus need not reflect the number of servings recommended by MyPyramid rather utilize its identified food groups in menu planning.

The task force’s final recommendation is for ADA to publish a position paper addressing the contradictions in nourishing the long term care resident while Continued on page 20
meeting the RDA/AIs and offer a research based guideline – menu planning for the institutionalized elderly.

References

Staying Positive in a Negative Environment
By Julie Fuimano, MBA, BSN, RN, Executive Coach

Probably one of the hardest things we must do as leaders is to stay positive when everyone else around us is negative. It's not easy to maintain a positive attitude and not be drained or consumed by the negativity that surrounds you. But as a leader, that's exactly what you must do. You have the opportunity to be the beacon of light for others around you. You can demonstrate and teach by your actions and responses how to behave in an appropriate, positive and professional manner.

It's easy to be positive in a positive environment. It's when things are emotionally draining and negative that you are challenged to step up to the plate and behave differently. By doing so, you make a difference—a positive impact that sends ripples throughout the community in which you work. The fact is that positive energy catches on just as quickly as negative energy. Sometimes, people are simply stuck in a habit or pattern of behavior. They are accustomed to acting a certain way. If the environment is really caustic, then it's been that way for a long time. This is what people are used to; it's familiar to them and it may be all they know. In addition, by the very fact that it's been happening this way for this long and no one has done enough to change it, it's considered "acceptable" even though it's not.

It takes some time and effort on your part, as well as a commitment to do something different in order to create sustainable change. You must be willing to identify and stop tolerating what's not working, do the right thing even if it's unpopular at first, and then teach others to do the same.

Here are five things you can do to be the positive force in your workplace.

1. Observe yourself in action. In what ways are you contributing to the negativity around you? Are you listening to gossip or participating in conversations where the only focus is to denigrate, diminish or criticize people or things? If the conversation feels bad, it's probably negative. Stop being negative! Stop saying or doing anything that is negative. It all starts with you. Language matters. Everything you say has an impact and when you say something negative, not only does it dishonor the person you're speaking about and the person you're speaking with, it makes you feel bad even if you don't realize it. Putting someone else down is disrespectful of them and it disrespects you. Learn to respect people's humanity and their right to be themselves. Complaining without end does not focus on creating solutions; rather its impact is only to perpetuate and magnify the problem wasting everyone's precious time and energy.

2. Recognize negativity when it occurs around you. Sometimes, you can even feel your energy being drained by the words being spoken. Again, if it feels bad or uncomfortable then it's negative. These feelings are your inner messengers. They are a form of intelligence similar to a tap on the shoulder letting you know something is not right. How do you feel? What is happening? What behavior is being displayed? If you can identify what is happening, then you can make good choices about handling it. The first step is awareness.
Staying Positive in a Negative Environment
Continued from page 20

3. Speak up! Tell the other person how you feel. Use the words, “This doesn't work for me.” It's non-judgmental and it's about you, not them. People often don't realize they are being negative. Point out to the person that they are being negative in a gentle and caring way. “Do you realize you are complaining?” Sometimes, just bringing it to their attention is enough to shift the conversation. Over time, people will learn what they can and cannot talk about with you and it won't be an issue. If you say nothing, then your silence gives them permission to continue.

4. Make your conversations constructive, meaning that the conversation should be positive, meaningful and beneficial. What's the point or purpose of the conversation? Is it to hurt or help? And at the end of the conversation, what would you like to have happen? Is there an action step to take? Constructive conversations feel good. They are empowering and have the effect of leaving people a little better off from having participated in them. Become the kind of person who takes your time seriously and who takes your words seriously!

5. Offer praise! It's amazing what a few words of praise and acknowledgement can do to make people feel good. You want people to feel good after being in your presence. You want to be the kind of person people gravitate to because they know they will be uplifted by you, not put down or drained of their life-sustaining energy.

Learning how to be positive as you navigate through life is part of life's lessons. And no matter what is going on around you, you control your inner environment and how you choose to respond to external events and situations. It's your responsibility to become the kind of person you enjoy being and with whom others enjoy being around. It takes a true leader to walk a path different from the crowd. So when others are negative, stretch your boldness muscles and be positive in spite of what others do or think. It's the only way to create a ripple of change. And we know that from small beginnings come great things. If each of us does our part, then slowly but surely, we will make a difference our work environment and the community at large.

Reprinted with permission. Julie is the author of the life manual and confidence builder, The Journey Called YOU: A Roadmap to Self-Discovery and Acceptance. You may contact Julie at t (610) 277-2726 or write to Julie@NurturingYourSuccess.com or visit her website www.NurturingYourSuccess.com

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