Registered Dietitians (RD) and Dietetic Technician, Registered (DTR), along with all LTC providers are actively preparing to implement the new MDS 3.0 effective October 1, 2010. The Centers for Medicare & Medicaid Services (CMS) has stated that the new MDS 3.0 will introduce advances in assessment measures, increase the clinical relevance of the assessment items, improve accuracy and validity, increase resident voice, and increase user satisfaction. Whereas MDS 2.0 used Resident Assessment Protocols (RAPs) for more comprehensive assessment of triggered areas, MDS 3.0 will be using Care Area Assessments (CAAs) for more in-depth assessment. It is important for RDs and DTRs to note that while there are some similarities there are also differences between RAPs and CAAs.

According to CMS, “The purpose of the Care Area Triggers and Care Area Assessments is development of a resident-specific care plan based on identified problems, needs, and strengths. “Since the MDS is a preliminary screening tool and not a comprehensive assessment, the CAAs provide for a more comprehensive assessment process. The goal of the comprehensive assessment is to promote the highest practicable level of functioning for the resident through an assessment of triggered care areas (Care Area Triggers or CATS) on the MDS. After these areas are triggered, a further assessment will allow an understanding of the causes and contributing factors and determine if there is a problem in each of these areas.

When completed, the MDS 3.0 Section V: Care Area Assessment (CAA) Summary lists which care areas were triggered and if further assessment determined the need for care planning.

ASSESSMENT PROCESS IN MDS 2.0 VS MDS 3.0
How is the assessment process in MDS 3.0 different from that in MDS 2.0? The following comparison can be made:

<table>
<thead>
<tr>
<th>MDS 2.0</th>
<th>MDS 3.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Care Areas Screened</td>
<td>20 Care Areas Screened.</td>
</tr>
<tr>
<td>* Triggers alert to possible care need issues</td>
<td>* The two new CAAs that are part of MDS 3.0 are “Pain” and “Return to the Community.”</td>
</tr>
<tr>
<td>RAPS must be used to conduct the assessment</td>
<td>No mandated tool for assessment</td>
</tr>
<tr>
<td>Criteria established for documentation</td>
<td>Criteria established for documentation</td>
</tr>
</tbody>
</table>
The major difference between the old MDS 2.0 process and the MDS 3.0 process is that facilities must now use validated practice standards, not mandated forms, for their further assessment of the Care Area Triggers. Chapter 4 of the MDS 3.0 Resident Assessment Instrument (RAI) manual provides very specific information on the care areas and the CAA process. The MDS is the starting point in development of the individualized care plan. The information gained after completing the MDS will identify actual or potential areas of concern. These areas become highlighted as Care Area Triggers.

**CATS AND CAAs**

The CATs replace the MDS 2.0 triggers and identify potential problems, needs, or strengths. The CATs all come from the resident’s current MDS 3.0 except the two for “Delirium” and “Mood” that look back to the resident’s previous MDS. The CATs provide flags for the interdisciplinary team (IDT) and are the link between data and further assessment. Depending on which MDS items are triggered by the CAT logic, the care areas needing further attention are then determined. As the CAT is the link between the data and the assessment, the CAA is the link between the assessment and care planning. Further investigation will then identify whether these areas of concern are a problem or risk requiring interventions and care planning.

All triggered CAAs must be addressed in Section V but may or may not be addressed in a care plan. CMS states, “The RAI is not intended to provide diagnostic advice, nor is it intended to specify which areas may be related to one another or how those problems relate to underlying causes.” The IDT, along with the resident’s physician, needs to look at the assessment findings and determine these interconnections.

Although MDS 2.0 demanded that the RAPs be used for this further investigation, there are no mandated forms that must be used for the CAA process in MDS 3.0. The facility is instructed in the RAI Manual, “To identify and use tools that are current and grounded in current clinical standards of practice, such as evidence-based or expert endorsed research, clinical practice guidelines, and resources.”

While there are no mandated forms, CMS does supply facilities with CAA Resources in Appendix C of the RAI Manual. The appendix includes care area specific tools that the assessor can use for each of the 20 care areas. Each tool is between three to five pages long, guides the interdisciplinary decision-making, and provides a place to document the process. The benefit of using the tools in Appendix C is that it gives a comprehensive, reliable assessment that has good rater reliability.

Appendix C also includes a Care Area General Resource list. None of these tools or resources is mandated but according to CMS, “Nursing homes should ensure that whatever assessment and care planning resources are used are current, evidence-based, or expert-endorsed research, and clinical practice guidelines/resources.” The facility should also be able to provide surveyors with the resources that were used in the decision-making process. The evidence-based resources from ADA and DHCC offer RDs and DTRs tools to use with the CAA process. RDs and DTRs need to make sure they are involved in determining the nutrition resources the facility includes in the CAA process.

The decision as to who fills out the CAAs depends on facility protocol. Facilities must have input into the CAA process that results in good clinical decision-making. Based on state regulations, licensure and certification laws and other factors the facility must make sure that further assessment in a particular area is within the scope of training or practice of the discipline filling out the section. Facilities have been informed that if an evaluation beyond the assessor’s scope is needed, it must be obtained from the appropriate discipline.

CMS expects the CAA process to be interdisciplinary. The whole team, the resident, and/or the resident’s representative must have input into this process for the assessment to be reliable and valid. The concerns,
quality of life and then determine the areas that require care planning. From that point, the determination is made for further tests, consultations, and interventions.

Documentation of the CAA findings can be anywhere in the resident’s record. They can be part of discipline-specific flow sheets, progress notes, care plan summaries, a CAA narrative, etc. The only requirement is that the facility fill out the “Location and Date of CAA Documentation” column on the CAA Summary in Section V of the MDS 3.0. The documentation should show how the IDT came to the conclusion it did.

Once the CAA identifies the causal or risk factors, then the care plan is completed. Since the goal of the care plan is to promote the resident’s highest practicable level of functioning, the interventions should work toward improvement where possible and the maintenance/prevention of any avoidable decline. The IDT must work together to make sure that they see the causal relationship between data, cause, and care plan, and that they are all on the same page, working toward the same goals.

As we assess, we need to remember that an issue is different from a finding. It is the findings that need to be care-planned. CMS does not require that each care area triggered be care-planned separately. Goals and approaches for each problematic area may overlap or may stand alone. The care plan must be driven by not only the issues and conditions that were identified during the assessment process but also by the resident’s strengths, needs, and unique characteristics. The resident and/or representative must be a part of this important process.

The MDS 3.0 will be revised frequently and it is important to keep current by checking the CMS website for updates and revisions in the process. You can copy and paste the following link to get the most current updates to the RAI manual and training materials.


Effective October 1, 2010 the facility has greater freedom to use a wider range of resources when making CAA decisions. RDs and DTRs must be actively involved in identifying the nutrition resources used in this new decision-making process. It is critical that each facility can support the decisions they make with evidence based data. ADA’s Evidence Based Nutrition Practice Guidelines, position papers, etc., are the resources offered to all ADA members. The ADA Evidence Analysis Library’ (EAL) is a synthesis of the best, most relevant nutritional research on important dietetic practice questions in an accessible, online, user-friendly library. The EAL offers research with diseases and conditions, nutrients/foods, nutrition care process, life cycle (includes senior nutrition), etc., Utilizing Evidence Based Practice (EBP) will support your Care Assessment Area decision, enhance your credibility with other healthcare team members and will help you be more effective and efficient in your practice.

Another reason of why membership in ADA and DHCC is so very important.

REFERENCES CITED:

I can truly say that I was proud to be part of the Association of Correctional Food Service Affiliates (ACFSA) 2010 Annual International Conference, San Diego, California, August 22-26, 2010. It was very well attended and included a wealth of presentations that are pertinent to the current issues affecting correctional food service. As in all corners of industry, budget issues and how to accomplish your job and live within a shrinking dollar was foremost on the agenda. There were sessions covering celiac disease, menu planning for religious diets (and not break the bank) and numerous sessions on menu planning and purchasing. This coupled with networking opportunities and equipment/product reviews from the industry vendors at the trade show made for a great conference and training experience.

The Dietitians in Corrections meeting was highlighted with a luncheon on Monday and was the largest we have had in several years with 23 dietitians in attendance. Our speaker was from the Bureau of Prisons (BOP), who spoke on his complete statistical nutritional analysis of the BOP menu and the surprising results that he had learned in the course of completing this review. This led to our discussion on “What nutritional guide to use in menu planning”, which led to the question of what nutrients do you review and what is an adequate level for each?

Primary Question for Dietitians in Corrections:
This topic is of course what we in corrections have been discussing for over a year, and with the efforts of Barbara Wakeen, MA, RD, LD, CCFP, CCHP, has gone from an obscure question to a question being discussed by American Dietetic Association (ADA), National Commission Correctional Health Care (NCCHC), Public Health Physicians and other important health care and correctional associations and organizations. ACFSA is still working on a survey to establish data on this and other related issues. We also discussed “Why it can be important to belong to both DHCC and ACFSA or Get More Bang for Your Buck” (Further discussion at a later time).

Our next Corrections sub-unit meeting will be in Boston on Sunday November 7th, 4:00-5:00 pm at the Hancock room at the Westin Waterfront Hotel. We hope to have as lively of a discussion as we had in San Diego and expect to see even more Dietitians in Correction members.

In addition to Dietitians in Corrections meeting and networking, I was asked to serve as the Chair of the ACFSA Professional Alliance Committee. As chair I will be working with the ACFSA Dietitians in Corrections Chair, Barbara Wakeen, MA, RD, LD, CCFP, CCHP, to expand ACFSA’s presence with other non-commercial food service and health care organizations promoting the furtherance of industry wide accreditation and training standards for the correctional food service industry.

As you can see this conference was packed with lots of events and educational opportunities (15 hours of continuing education credits) beyond the information and training from the sessions.
The day-to-day of a Home Health Dietitian
As a registered dietitian (RD) in the home health area, my days are sometimes unpredictable and require flexibility. Home visits entail helping patients manage their diabetes, improve their outcomes during cancer treatment, heal quickly from complex wounds, balance unintentional weight changes or desired weight changes, and so on. But my job consists of more than making home visits to patients. I also market my services, provide staff education, develop patient educational material, organize enteral nutrition supplies with local durable medical equipment (DME) suppliers and follow-up with long-term patients. My agency includes nurses, occupational/physical/speech therapists, social workers, and home health aides who all help the patient to reach their goals at home. There are four areas (for four different levels of care) that I work with under our home health agency:

1) Skilled nursing/therapy,
2) In-home care,
3) Assisted living, and
4) Medical supplies.

Most patients I see fall under the first area of requiring short-term skilled nursing and/or therapy until they have reached their goals of independency in the home. Patients that I see that fall under the second area require long-term additional help with personal care. For example, this might include a patient with mild dementia living at home; perhaps there is a spouse or child involved but they are not able to provide all the care the patient requires day-to-day. The third area is an assisted living facility that we operate. I do not oversee the meals served in this setting but do provide nutrition education for these residents when needed. Last but not least is our medical equipment supply company. Because of Certified Medicare Service (CMS) requirements for enteral nutrition patients, I also help provide nutrition services for patients receiving enteral nutrition products.

Prior to a Visit
Before a visit is made, a number of things happen including the referral initiation, orders obtained, background information gathered, patient/family contact, and education material preparation. My agency utilizes a nutrition screening tool with all new patients to help our healthcare clinicians (primarily nurses and therapists) identify individuals who would benefit from nutrition services. This tool is based on the DETERMINE checklist. A “severe” nutritional risk generates an automatic RD referral. Other referrals come as patients request nutritional services or clinicians’ opinions warrant nutritional services. A doctor’s order is also necessary prior to my visit. I gather background information on the patient from the clinician who wrote the referral as well as anything helpful that I can find out from the patient’s electronic records. In addition to contacting the patient and/or family to set up a visit, I often attempt to obtain their perceived nutritional issues. Any information I am able to gather ahead of time helps me customize and better prepare for my visit. Useful information: literacy/education level, primary language spoken, past medical history, past nutrition education, and living/financial information.

During the Visit
The visit itself is not unlike other settings where medical nutrition therapy is provided; however, there are some key differences. The benefits of seeing a patient in their home setting is that you have the opportunity to observe foods available, sanitation in the home, and means of preparing foods & portion sizes. This helps give a more accurate picture of what is going on in the home. The disadvantages of seeing a patient in their home setting is that visits usually take longer and you may not always have the material you want with you.
I do carry around a bag which contains hand sanitizer, CPR mask, and a few commonly used nutrition resources but this does not guarantee that I always have the material I need with me. If a patient has questions or issues that I am not prepared for, I will talk them through things and mail or send out written information with the next clinician’s visit.

After a Visit
There is always charting to complete following a visit. Depending on the patient and their needs there may also be follow-up material to send out, phone calls, or more visits to make. It is also important to relay back to the other members of your healthcare team what you and the patient worked on because they can also help reinforce your interventions. The number of times I contact or visit a patient varies greatly depending on their needs, their interest or motivation to change, and the length of time they are in our services. Traditionally I do not see patients who are not also being seen by another one of our healthcare clinicians.

Bethany Morris, RD, LD, lives in Iowa and has worked in the area of dietetics for 2 years. She received her bachelor’s degree in nutrition from Oklahoma State University and attended the University of Minnesota, School of Public Health and completed my Dietetics Internship for Graduate Students. She has completed coursework for her master’s degree in public health nutrition and is currently working to finish her final master’s project/thesis

HOME HEALTH CORNER – Chair’s Message

Greetings to All,

As the current DHCC Chair, I would like to share that DHCC is committed to growing and supporting our members who practice in the Home Care setting. To support this practice area, we need help from those that are actively working in Home Care. I would like to schedule a conference call with any of you that would be wiling to share your ideas of how DHCC can support you in your practice.

We are also looking to develop a committee of DHCC members to help direct our Home Care Sub-Unit in planning DHCC programs.

If you are practicing in Home Care and would be willing to help, please contact me at brendar10@juno.com. Please provide information on the type of Home Care work you are doing, your experience and any Home Care professional organizations you are members of.

Thank you.

Brenda Richardson, MA, RD, LD, CD
Chair, DHCC

Below are some resources that may be of value to you practicing in Home Health:

DHCC Publication:
Nutrition Essentials for the Home Care Dietitian 2008. This 184 page manual includes Chapters on Home Care Basics, Billing for MNT, Regulations and Accreditation, the RD and the Healthcare Team, Screening and Assessment Tools, Staff Education, Nutrition Care Process, Specific Disease Management and Hospice Services.
Home Health & Hospice Medicare Quality Regulations


Medicare Home Health & Hospice Coverage and Payment Policies


Clinical Tools and Training

- OASIS-C Best Practice Manual
  This manual contains recommendations on best practice strategies, practices and tips for generating more accurate OASIS assessments. The contents of this manual is intended to serve as the foundation for OASIS trainings and for informed decision making by clinicians when collecting OASIS-C data. [www.fazzi.com/oasis/OASIS-C_Best_Practice_Manual.pdf](https://www.fazzi.com/oasis/OASIS-C_Best_Practice_Manual.pdf)

- CHAMP Program
  The National Association for Home Care & Hospice (NAHC) is a member of the National Advisory Panel for the CHAMP program to improve the nation’s geriatric homecare practice. CHAMP (Curricula for Homecare Advances in Management & Practice) is an evidenced-based best practices program specifically designed for frontline nurse and therapy homecare managers at Medicare-certified home health agencies. The CHAMP program web site [www.champ-program.org](http://www.champ-program.org). This site includes such things as best-practice information, online courses, and an opportunity for clinicians to share knowledge and experience via an online national forum to support quality improvement efforts by home care organizations.

- Dementia Care Practice Recommendations for Professionals Working in a Home Setting.
  This manual offers best practice recommendations for professionals providing care in a home setting. The recommendations represent the latest research as well as the experience of care experts. [www.alz.org/national/documents/Phase_4_Home_Care_Recs.pdf](https://www.alz.org/national/documents/Phase_4_Home_Care_Recs.pdf)

- Medicare Quality Improvement Community: Home Health (MedQIC) Web site is a free on-line resource for quality improvement interventions and associated tools, toolkits, presentations, and links to other resources [www.qualitynet.org](http://www.qualitynet.org)

Continuing Professional Education: Are you looking for credit hours?

Registered dietitians (RD’s) and dietetic technicians, registered (DTR’s), are always searching for continuing education credit. The reasons are twofold: to maintain registration, RD’s need 75 hours every 5 years and DTR’s need 50 hours every five years; education is needed to stay on top of your profession.

DHCC offers two CPEU hours with each issue of Connections quarterly newsletter. The articles are marked with a CPEU symbol both in the Table of Contents and in the title of the article itself. To receive credit:

- Go to [www.dhccdpg.org](http://www.dhccdpg.org) and sign in
- Then go to CPEU Credits online

Be sure to follow through all the steps. Your certificate will be available to download when complete.
DHCC Webinars – this year we have a full schedule of webinars planned. We have an overview posted on the DHCC Web site. To sign up for webinars, go to www.dhccdpg.org, then Events. Here you can register for upcoming webinars as they become available as well as archived webinars. Through the electronic mailing list (EML) Forum there are opportunities posted by other members.

ADA offers a wide range of learning opportunities.

<table>
<thead>
<tr>
<th>This from the ADA Web site:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Center for Professional Development</strong></td>
</tr>
<tr>
<td>The ADA Center for Professional Development is the premier choice of food and nutrition professionals for lifelong learning, offering a full array of resources to increase knowledge and cultivate skills through multi-disciplinary learning opportunities, enhanced technology and high-quality programming.</td>
</tr>
<tr>
<td><a href="http://www.eatright.org/Members/content.aspx?id=8370">http://www.eatright.org/Members/content.aspx?id=8370</a></td>
</tr>
</tbody>
</table>

Under *Distance Learning* you will find teleseminars, webinars and self-study options. Explore the options! Quality learning experiences are available without ever leaving your office!

---

**Customer Service – how do you rate?**

**Digna Cassens, MHA, RD**

Customer service is defined as meeting or exceeding your customer’s expectations. Dietetic practice is more complex and multifaceted than ever before, and while you’re busy ensuring compliance and meeting deadlines, your customers may not notice your accomplishments and high service level. An entrance conference with the department heads (administrator, director of nursing services, dietary supervisor) at the start of each visit allows you to learn their needs and set goals; an exit conference at the end of each visit provides you the opportunity to give an update on what was accomplished for them. It is not sufficient to identify problems and provide solutions, complete medical nutrition therapy (MNT) documentation and perform kitchen inspections. Today’s Registered Dietitian and Dietetic Technician, Registered, must market their skills, expertise and service level. Collaborating with the facility’s leadership team is important to understand their needs and know their goals. The following case study illustrates my point.

During your weekly visit to one of your most challenging communities you are informed by the dietary manager that she was directed to develop selective menus to support the administrator’s new marketing plan of increasing Medicare census and Rehab residents, as well as attracting private pay admissions. The dietary manager is ready to implement the new menus the following week. Increased admissions and acuity will require more hours, and the current hours contracted will not be enough to complete all documentation. Additional time to work on the selective menu process compounds the problem.

The best course of action is to assist the facility and participate in the project enthusiastically, demonstrating your expertise and ability to provide guidelines and help to implement a successful program. Even though it would have been much better to be involved at the beginning, there is still time to correct
errors and train staff. Establishing routine entrance meetings and asking administrators about their plans and needs may avoid last minute damage control because of poor planning. Since the change in resident mix affects your time, address concerns about sufficient hours immediately. Willingness to be flexible and innovative in our approaches is helpful during any negotiations. (*DHCC has an excellent guideline* “How to Talk to an Administrator” *that should be part of everyone’s tool kit*).

Providing your clients and/or employers with what they want and establishing a dialogue demonstrates your willingness and ability to be flexible and work on their priorities, and will keep your clients and employers happy with your work.

**How do I justify clinical hours?**
We all wonder how to overcome budgetary constraints when proposing clinical hours needed. I find that communication is enhanced when I find common ground and use meaningful language and terminology. When proposing hours to administration bear in mind that the highest expense in any business is labor and justification is essential. Using a combination of workload required, benefits derived and regulatory requirements is one of the most effective method to receive approval for additional hours.

Years ago I developed a simple grid to calculate clinical hours needed. It is a straightforward tool to present to the administrative team when requesting additional time. When marketing plans change, resident mix, numbers of admissions, average length of stay and payor source often change—These changes, even if in small numbers, affect carefully planned schedules. For example, a 59 bed skilled facility is budgeted for 16 clinical hours per month, but as in the example above, Medicare and Private census is increased, new managed care contract is negotiated, an aggressive rehab company is contracted, and the rehab room is expanded for more square footage. This brings additional Medicare admissions, shorter lengths of stay, a higher acuity, more complex menu, and higher risk residents. Suddenly, the clinical hours needs increase dramatically as admissions go from 10 to over 40 per month. How do you prove to administration that so much has changed and that your hours must increase? Discuss the benefits to the facility and residents of having your expertise available to assess and develop MNT, and to maintain regulatory compliance. A simple cost vs. benefit comparison also helps administration realize that the RD’s clinical expertise improves quality of life and/or quality of care, prevents skin breakdown, undesirable weight changes, and complications stemming from diabetes, renal failure, hypertension, allergies, and many others. If the cost of penalties and sanction is added to these, such as in the case when a facility receives a ‘G’ scope and severity deficiency, or an immediate jeopardy (IJ) ruling, the clinical time more than pays for itself in the end. Try using the Clinical Hours Guidelines form below and developing your own guidelines.
# Clinical Hours Guidelines

<table>
<thead>
<tr>
<th>TASKS</th>
<th>ESTIMATED MINUTES PER TASK FOR EACH ADMISSION</th>
<th>NUMBER PER MONTH</th>
<th>HOURS PER MONTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Screening &amp; Assessment of new admissions</td>
<td>45 to 60 minutes</td>
<td>25</td>
<td>18 ¾</td>
</tr>
<tr>
<td>2. Annually, change of condition: (¼ of ADC* or your actual numbers)</td>
<td>30 to 45 minutes</td>
<td>24</td>
<td>12</td>
</tr>
<tr>
<td>3. Quarterlies; Progress note &amp; care plan (¾ of ADC minus Enterals, monthly high risk)</td>
<td>15 to 20 minutes</td>
<td>30</td>
<td>7 ½</td>
</tr>
<tr>
<td>4. Monthly high risk assessments: (Enteral, potential weight variance, PU*, dialysis)</td>
<td>20 to 30 minutes</td>
<td>17</td>
<td>5 ¾</td>
</tr>
<tr>
<td>5. Mandatory facility meetings attendance: <em>MDS, IDT</em>, Weight Variance, RCP*, PPS*, meal rounds, other</td>
<td>15 to 60 minutes/mtg</td>
<td>10</td>
<td>2 ½</td>
</tr>
</tbody>
</table>

**TOTAL PER MONTH**: 106 ½ 71 ½

*Estimated number of hours based on 6 month time-study conducted with clinical staff.*

*See abbreviations at end*

## Clinical Hours Worksheet

<table>
<thead>
<tr>
<th>FACILITY NAME:</th>
<th>ADMISSIONS</th>
<th>ADC</th>
</tr>
</thead>
<tbody>
<tr>
<td>TASKS</td>
<td>NUMBER PER MONTH</td>
<td>ESTIMATED HOURS PER MONTH</td>
</tr>
<tr>
<td>1. Admissions per month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Annually, change of condition (¼ of ADC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Quarterlies (¾ of ADC minus Enterals, monthly high risk)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Monthly high risk assessments: (Enteral, potential weight variance, PU, dialysis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Mandatory facility meetings attendance: *MDS, IDT, Weight Variance, RCP, PPS, meal rounds, other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL**

ADC – Average daily census  
PU – Pressure Ulcer  
IDT – Interdisciplinary Team

RCP – Resident Care Plan  
PPS – Prospective Payment System

Digna Cassens, MHA, RD, received her BS in Science from Barry University, Miami, FL, and her Master's in Health Care Administration from the University of LaVerne, LaVerne, CA. She has been VP Nutritional Services, Country Villa Health Services, Los Angeles, CA, since 2001. Digna has a small, private business as expert witness for abuse, neglect, hydration, pressure sores. She has served on the 2004 State Advisory Committee (SAC) for the Food & Nutrition Conference & Expo (FNCE) in Anaheim, 2009 CDA Annual Meeting Program Committee, 2007-08 CDA Website Review Committee - under Communications Council. She has been a reviewer for various ADA publications including *Spanish for the Nutrition Professional, 2nd Edition.*
DHCC Awards 2010

**Abbot Leadership Award**
Terri Raymond, MA, RD, CD, Auburn WA

**Distinguished Member Award**
Loraine Cira, MS, RD, Parker CO
Anna de Jesus, MBA, RD, Tempe AZ
Suzanne Cryst, RD, CSG, LD, Dayton OH
Joanne Zacharias, MS, RD, LDN, Brunswick MD

**Up and Coming Member of the Year**
Hanna Kelly, RD, CD, Muncie IN

**Chair’s Scholarship** *Sponsored by Medical Nutrition USA, Inc.*
Judith M. Wolfe MS RD LD, Mableton GA

**Circle Award:**
Gordon Food Service

---

Thank you to the DHCC Sponsors

**Connections Newsletter**
Abbott Nutrition

**Member Reception – Dietetics in Health Care Communities and Healthy Aging**
US FoodService
Nestle Nutrition USA
Lemon-X
GA Food Service, Inc.
Advance Food Co.

**DHCC PreFNCE Workshop: REDEFINING NUTRITION SERVICES FOR THE AGING**
Medical Nutrition USA, Inc.
Cargill, Inc.
Nestlé Professional
 Sysco

**Other Sponsors**
Gordon Food Service
Rubicon Foods, LLC
Provide Nutrition, LC
Serve the Vittles but hold the Viruses
Shelley Feist, Partnership for Food Safety Education

“It was impossible to get a conversation going; everybody was talking too much.” This quote is attributed to former American Major League baseball player and manager Yogi Berra. And if you have a cell phone, land line, computer at work, laptop at home, handheld device, television (or two), and radio, and maybe a house full of kids, well, this quote might actually start to make sense to you. It’s true! Everyone is talking - or typing – too much!

For many of us our job is to get a conversation going and to keep it going. In my case, as Executive Director of the non-profit Partnership for Food Safety Education, the job is to encourage dialogue with consumers about the importance of safe food handling to good health and the particular risks pathogens in food can pose to certain high-risk individuals. But sometimes I feel like Yogi – how do I get a conversation going with all of the talk that is going on?

Fortunately here in Connections there is space to start a conversation with you on the subject of our mutual interests in helping others understand the importance of safe food handling to their good health. This is a conversation that you are uniquely positioned to take up and carry through to the most vulnerable consumers because dietitians serve in many different settings where young children, pregnant women, the elderly, and other immune-compromised individuals receive care.

To start with I want to highlight some of the credible food safety education resources you can refer to and, most importantly, rely on as accurate. The consumer-tested, science-based and actionable messages of Clean, Separate, Cook and Chill are the foundation for consumer education in the United States. Behind these messages – and the campaigns of Fight BAC!® and Be Food Safe, are details of practices that consumers can put into action at home to reduce their risk of food borne illness. When you use these materials as the content basis for your own publications, blogs, newsletters and social media messaging, you are helping to cut through the confusion and to convey messages consistent with those of the Federal agencies, and the Partnership.

Recently I found an article on a website that was expressly about food and consumers. The article contained this piece of advice* about washing produce:

Experts in food safety recommend washing all lettuce and produce thoroughly in a sink full of water before using. To be extra cautious, they also recommend adding vinegar to the water, as vinegar kills germs.

This advice might sound reasonable to a consumer. But in fact these practices as described (other than the point that all produce should be washed thoroughly) do not resemble the science-based, actionable recommendations for consumers on the topic of washing produce as developed by the US FDA and the Partnership:

- **Rinse fresh fruits and vegetables under running tap water, including those with skins and rinds that are not eaten.** Packaged fruits and vegetables labeled “ready-to-eat”, “washed” or “triple washed” need not be washed.
- **Rub firm-skin fruits and vegetables under running tap water or scrub with a clean vegetable brush while rinsing with running tap water.**
• Whole fresh fruits and vegetables should be washed under running tap water, not in standing water in the sink.

Yes, everyone is talking. But not everything being said is accurate, or, in some cases, even helpful. The source for food safety education information matters.

**Have your safe food handling questions answered**
The Federal agencies have terrific resources in place to answer questions directly from the public and professionals about safe food handling and other aspects of food safety. The USDA Food Safety and Inspection Service virtual representative, “Karen,” is available 24 hours a day, at AskKaren.gov. Ask Karen is a good place to go if you want a quick check on a safe food handling fact. The USDA Meat and Poultry Hotline is not just for Thanksgiving! You can reach a real person with meat and poultry safety questions at 1-888-MPHOTLINE (1-888-674-6854), Monday through Friday, 10 a.m. to 4 p.m. ET.

For food products other than meat and poultry products the FDA hotline is a great source. The hotline operates at 1-888-SAFEFOOD (1-888-723-3366), Monday through Friday, 10 a.m. to 4 p.m. ET.

Quick download of materials for consumers is a strong point of the website at www.fightbac.org. It is a go-to destination for food safety and health educators, and includes a store for purchase of consumer education materials.

Finally, the best place for timely information on recalls and food borne illness outbreaks is www.foodsafety.gov. They are combining important food safety information from the USDA, FDA and the CDC.

**Making our conversation 2-way**
Through all the media buzz we need to find our entry points for broadening the conversation on science-based food safety practices, and the special attention caregivers must take to reducing risk of infection. If we are to be the leaders in consumer food safety education we can do more to open up our work to colleagues and exchange information about where we can collectively have the most impact on individuals at greatest risk for serious illness. It is also critical that we respond to consumer advice in the media that may be inaccurate or even risky.

For two years the Partnership has publicized home food safety mythbusters as a way of addressing common practices that many believe may reduce risk of food borne illness. We took on the following common practice:

- **Myth:** Putting chicken in a colander and rinsing it with water will remove bacteria like Salmonella.
- **Fact:** Rinsing chicken in a colander will not remove bacteria. In fact, it can spread raw juices around your sink, onto your countertops, and onto ready-to-eat foods. Bacteria in raw meat and poultry can only be killed when cooked to a safe minimum internal temperature, which for poultry is 165 °F, as measured by a food thermometer. Save yourself the messiness of rinsing raw poultry. It is not a safety step and can cause cross-contamination.

We have found mythbusters to be an effective way to get the media engaged in highlighting common home food handling practices that turn out to be not-so-safe.

We need to do more to encourage two-way exchange of information with dietitians who are a critical user group of Fight BAC! The Partnership needs to hear from you to understand better what your needs are in integrating foodborne illness prevention programming in your work. We have an active Partnership Facebook page where you can always post news, views or new ideas, and we always welcome email at info@fightbac.org.
In the coming year we will be working to improve communications and program creation with the more than 9,000 BAC Fighters who regularly receive Partnership e-mails. Approximately 30% of these BAC Fighters are dietitians.

Consumers are consistently bombarded with health messages of all kinds. With so many people talking about so many health topics how can consumers possibly hear and act on all of them? We need to get creative in reaching consumers and to get serious about supporting them as they navigate health information so that risks of food borne illness are clearly articulated.

There is no healthy eating without safe preparation. With each of us playing a part to publicize credible, consensus food safety messages we can help consumers feel more empowered to address risks when preparing food at home.

Shelley Feist is the Executive Director of the non-profit Partnership for Food Safety Education. www.fightbac.org and www.befoodsafe.org. The ADA is a participating member of the Partnership.

DHCC – WIIFM?
Dana Fillmore, RD, CP-FS

Did you ask yourself “What’s in it for me?” (WIIFM) when you were choosing whether or not to renew or initiate your membership in the Dietetics in Health Care Communities (DHCC) DPG? Over 4000 of you liked the answer and renewed membership or became a new member! Returning and new members alike made a conscious decision to be a part of a dynamic DPG dedicated to excellence in practice because there is so much in it for you!

So, what exactly is in it for you to belong to DHCC? See below for a list of benefits you can expect as a member.

**Online Resources**
- Comprehensive Website with Value-Added Resources for Members [www.dhccdpg.org](http://www.dhccdpg.org)
- Member Marketplace
- Active Electronic Mailing List (EML) for Questions & Answers
- Video Loan Library

**Publications**
- **Connections** (published quarterly)
- **UPDATE!** (A mini electronic newsletter published up to 4 times per year)

**Personal and Professional Development**
- CPEU opportunities through newsletter, publications, seminars and webinars
DHCC is currently working on several exciting projects for our members, some of which are highlighted elsewhere in this newsletter.

- Validation of the Nutrition Risk Assessment
- Developing and strengthening networks with allied organizations
- Revision of DHCC Standards of Practice & Standards of Professional Performance (SOP/SOPP)
- Support and participation in the global initiative for nursing centers nutritionDay in the U.S. on November 4, 2010. Facilities who plan to participate should have already completed steps to obtain Institutional Review Board (IRB) approval. To learn more about obtaining IRB approval PRIOR to engaging in any research, visit the ADA nutritionDay page.
  [http://www.eatright.org/Members/content.aspx?id=8008](http://www.eatright.org/Members/content.aspx?id=8008)
- Updating and improving the In-service Modules. Stay tuned for more information and date they will be available for purchase.
- Exciting FNCE and Pre-FNCE sessions
- And many more to come!

Your ideas and/or volunteer time are always welcome, so please do not hesitate to reach out. Communicate your needs and available talents through the listserv or our website at [www.dhccdp.org](http://www.dhccdp.org).

**MNT Provider**

The *MNT Provider* newsletter is an essential practice management resource for registered dietitians. The *MNT Provider* includes articles on business skills, technology, coding and coverage, nutrition practice guidelines, Medicare, Medicaid and more. Each issue contains expert analysis from CMS officials,
consultants, legal counsel, and ADA staff. Unlike other policy and practice management newsletters, *MNT Provider* is specifically tailored to registered dietitians.

Thanks to financial support and recognition from the ADA board of directors and three Dietetics Practice Groups (Diabetes Care and Education; Renal Practice; and Medical Nutrition Practice), the newsletter is free to all ADA members and can be accessed at:  [http://www.eatright.org/mntprovider/](http://www.eatright.org/mntprovider/)

All questions and comments to the editor can be sent to reimburse@eatright.org.

Current Issues that can be found at the eatright.org site are listed below:

**October 2010**
In this issue:
- Where to Turn When Family Politics and Patient Privacy Collide
- Medicare Brief: ADA Response to CMS 2011 Rules
- RD Perspectives: In the Market for an RD?
- Question Corner

**September 2010**
In this issue:
- Steps to Remedy Rejected Claims
- RD Perspectives: Don’t Miss the Social Media Boat
- Question Corner
- 2010 Medicare Fee Schedule

**AUGUST 2010**
In this issue:
- Medicare Brief: Utilization of Medicare MNT Declines
- RD Perspectives: How to Make the Most of Phone Consultations
- Question Corner
- Precautions to Protect Patient Data

**JULY 2010**
In this issue:
- Medicare Brief: Proposed CMS Rules for CY 2011
- RD Perspectives: The Business-Savvy RD
- Question Corner
- How to Connect with Physicians

**JUNE 2010**
In this issue:
- A message from ADA President Judy Rodriguez
- Making Nutrition Your Business
- RD Perspectives: Do you have what it takes?
- Question Corner
- Medicare Brief