Flashback to 6:00 pm yesterday: My head is pounding and pulsating. My heart is racing, but my mind is racing even faster. I am worried about myself as I calculate the odds of safely driving 32 miles from the court reporter's office to my house in this condition. I consider a stroke, a heart attack, or simple hypoglycemia as possible causes. As I slide into the driver's seat, I reassure myself that all of this is only the physical manifestation of extreme stress. After all, who wouldn't be stressed after the week I had—and it is only Wednesday.

As I traverse the traffic out of downtown Miami during rush hour, I reflect on the past three days. I have spent more than a dozen hours analyzing and evaluating thousands of pages of medical records, three hours in a pre-deposition meeting with the lawyers who retained me, five hours in deposition giving testimony about my opinions in the death of an 89-year-old woman, and two hours commuting.

Welcome to a day in the life of an expert legal witness.

The Big Picture

As healthcare professionals, it is our duty to provide proper care to our patients and long-term care residents. When family members tour our facilities, admission directors promise the best care available and reassure family members that they don't have to worry about a thing; our skilled and dedicated staff will take care of it all. Quite often, things turn out well, and we have satisfied families who are forever grateful. But then again, sometimes things don’t go as planned.

In most industries, a dissatisfied customer will write a complaint letter, ask for a refund, or have a defective product replaced. In our industry, dissatisfied customers file lawsuits. Each state has unique laws about litigation involving nursing homes, so some states have bigger problems with this than others.
A trip to ADA’s Public Policy Workshop (PPW) in Washington, D.C. is an adventure like no other. It’s often the little things that bring a smile to your face—dedicated colleagues working for collaboration on issues, students mulling over their first “Hill” visit, actively participating in getting our message to two Ohio Senators and four congressmen, the grandfatherly security guard summoned once again to give directions from a rumpled map of where everything is in town, or the blind African American man on the plane so full of enthusiasm on his way home. It’s all part of the experience that only just begins with PPW, our “kick-off” to another season of advocacy for ADA legislative issues. What happens next is up to each of us...

As dietetics professionals, we are stakeholders in numerous areas of legislation, yet we must focus national attention on three key legislative priorities likely to be addressed in the 109th Congressional Session. These are:

MEDICARE MEDICAL NUTRITION THERAPY ACT OF 2005

BACKGROUND:

Senators Larry Craig (R-ID), Jeff Bingaman (D-NM), and Richard Burr (R-NC) introduced the Medicare Medical Nutrition Therapy Act of 2005 (S. 604) on March 11, 2005. At the time of this article, the House version was scheduled to be introduced by Representative Fred Upton (R-MI) during the week of March 14, 2005. Successful passage would give the Center for Medicare & Medicaid Services (CMS) the authority to expand the medical nutrition therapy (MNT) benefit to any disease, disorder, or condition deemed medically reasonable and necessary. CMS would make an MNT-related decision based on the National Coverage Determination process.

Under current law, a registered dietitian, upon referral by a physician, can only provide MNT to Medicare patients with diabetes and renal disease. However, there are a number of other conditions such as hypertension, dyslipidemia, obesity, and HIV/AIDS for which MNT has proven to be medically reasonable and necessary, as well as cost effective. By giving CMS the authority to expand coverage, Medicare patients will be given access to the best nutritional advice to improve their health.

This new bill does not mandate that CMS approve expanding the MNT benefit, it only gives Medicare the authority to expand the benefit when there is scientific evidence that MNT will prevent or help prevent the onset and progression of more serious diseases, conditions or disorders.

Congress has already recognized the preventive nature and cost-effectiveness of MNT by including it as one of the preventive screens recommended be provided to patients in the new “Welcome to Medicare” physical. However, only the physician can provide nutrition counseling as part of this physical unless the patient has diabetes or renal disease in which case a registered dietitian can provide the service.

The Medicare patients requiring MNT for conditions other than diabetes or renal disease can only get coverage for the nutrition counseling upon the referral of a physician. Since dietitians are paid at a rate of 85% of what a physician would charge for the same service, the new bill will result in a net savings to Medicare.

ADA POSITION:

• Please support improving the health of Medicare patients while also reducing the cost of providing them with proper nutrition counseling. Co-sponsor the Medicare Medical Nutrition Therapy Act of 2005.

COMMITTEE JURISDICTION:

Senate Committee on Finance
House Energy and Commerce Committee
House Ways and Means Committee

OLDER AMERICANS ACT (OAA) Reauthorization:

BACKGROUND:

At PPW, Josefina Carbonell, the Health & Human Services Assistant Secretary for Aging reported that in 2004, 8 million adults and 8 million caregivers received various OAA services. Nearly 3 million of...
Having just returned from ADA’s Public Policy Workshop (PPW), March 1-3 in Washington DC, I decided to share some of the experience with all of you.

Initially, it is exciting to be in Washington DC, the heart of our nation, to see the Capitol and massive government buildings with their columns and marble, to think of the rich historical context that surrounds all that is planned for the conference.

The pace at PPW is much more relaxed than at FNCE. About 400 members, state and DPG leaders, ADA staff and several Board of Directors attended this year’s PPW. The time is divided between presentations from ADA staff, legislators, lobbyists, heads of agencies and preparations for visiting with legislators. The ADA bookstore and several vendors or agencies have display tables and information available. The entire last day is set aside for participants to meet with members of congress or their staff members.

This year’s theme was “Food & Nutrition Matters.” I was surprised to learn that ADA has identified numerous pieces of legislation that involve nutrition, MNT or impact our profession. However, for the 2005 legislative session, ADA has chosen three key issues they feel are “ripe” to discuss with legislators: Medicare MNT Act of 2005, Ryan White CARE Act reauthorization, Older Americans Act reauthorization. More on these in the legislative report.

Cristina Beato, MD, HHS Assistant Secretary for Health Office of Public Health and Science informed us that the new Dietary Guidelines are evidence based and have a scientific backbone. She stressed that a simple, consistent message of “calories in equals calories out” will reach the most people and have the greatest effect for improving lifestyles. The new Guidelines have recommendations for 18 specific populations including older Americans. Each participant received a copy of a brand new resource Toolkit for Health Professionals to use when communicating the new Guidelines. The Toolkits are very new – having been printed only a day prior to distribution at the conference!

Presentations about the Child Nutrition and WIC Reauthorization of 2004 were quite interesting. Did you know that this legislation requires every school district in the country to have a school wellness policy in place by July, 2006? Although many CD-HCF members work with older adults rather than pediatrics, I know that many of us members work in a variety of settings. Certainly a lot of you are flexible enough to participate on a wellness committee – what a great opportunity to help improve the quality of nutrition for students and show your community what a dietitian can do!!

We also listened to a fascinating presentation by Robert Murray, MD, Dept of Pediatrics, The Ohio State University School of Medicine regarding nutritional content of children's diets, what's lacking, which foods supply the missing nutrients, and effective marketing of nutrient dense foods in school vending machines.

Throughout the whole conference it was emphasized by both ADA members and outside speakers that there must be good scientific basis for all nutrition recommendations. I was impressed that government agency speakers also stressed this point and were concerned about building trust among health care professionals and citizens.

Actually talking to legislators or their staff is the highlight of PPW. These appointments are referred to as “Hill visits” by the locals. Even though the hotel is close to the Capitol, getting to legislator’s offices requires a trip on the “Metro” and lots of walking. A city block in Washington DC is a long walk!! I went with others from my state and had the opportunity to talk about the Older Americans Act. We were fortunate to meet face to face with our House representative and with staff for our senators. It was exciting to receive an email after I returned home informing me that our congressman had signed on as an original co-sponsor for the 2005 MNT legislation.

A trip to DC wouldn’t be complete without a little time for sightseeing and I was fortunate to have time to visit the Library of Congress which I discovered is an absolutely gorgeous old building that is open to the public and houses many historically significant volumes. Of course we participated in “waiting in line” – a typical DC experience I had forgotten about!

Issues presented at PPW affect all dietitians regardless of the specific practice area you choose. The most effective lobbying occurs when constituents contact their own legislators. I hope each of you will read up on the legislative issues for 2005 and drop a quick email, letter or phone call to your congressional members asking for their support.

Remember…if dietetics is your profession, politics is your business!!

Georgianna Walker
CD-HCF, Chair
Whether an actual suit is filed or not, the root cause of customer dissatisfaction must be examined if we are to advance as an industry.

The Chain of Events
The chain of legal events often begins with unmet needs and disappointment.

Family members believe that promises were made and broken, and in turn, disappointment becomes dissatisfaction and anger. The anger then turns to allegations and litigation.

Most of the cases I am working on today involve people who died in 1999 or 2000. The staff members involved can hardly recall the resident, much less the details of the care they provided. This leaves the medical record as the only source of information and the focus of discussion. Unfortunately, most charts have documentation issues ranging from incomplete entries and inconsistencies to missing pages that can’t even be located. It is relatively easy to obtain a hefty settlement from a nursing home, because the written documentation often makes it hard, if not impossible, to put the precise story back together again after several years.

The legal process closely examines the minutiae of the daily documentation. Every note on every page is read and analyzed. Although the documentation is reflective of the care a resident received, it doesn’t help us understand why family members are angry enough to sue. Some people sue out of greed or financial reasons, but most only take this serious step because they genuinely believe the system has failed them. If we have failed, it is our duty and responsibility as long-term care professionals to find out where the problems are and attempt to fix them. To do this, we have to carefully listen to what family members say in their depositions about the reasons they are suing.

In another case, the same question was asked to open the deposition testimony: “What are your complaints about the nursing home?” A son told the story about the day he went to the desk and told the nurse his mom needed some help to use the bathroom. The nurse told him someone would be right in to help. After about 15 minutes, his mom had an urgent need to use the bathroom; yet no one had come to help. He returned to the desk and again asked for assistance. This time the person behind the desk told him that no one was available. Now angry, the son told the woman that his mother would end up urinating in her bed if no one helped him. The nurse told him that was fine, and the night shift would clean her up tonight. He was horrified and disgusted.

Unfortunately, several months later, his mom fell while trying to get herself to the bathroom. She fractured her hip and died soon after the incident. He was now suing, because he believed her death could have been avoided if the staff would have been more attentive to her needs. While this seems quite simple on the surface, consider that this resident was 91 years old and had multiple medical diagnoses, including osteoporosis, dementia, and vertigo. Upon examination of the chart, the plaintiff’s attorney found that in the three years she was at this facility, she lost about 20 pounds, fell twice before, had several skin tears, and battled respiratory and urinary tract infections. Suddenly, this lawsuit was about wound care, inadequate nutrition and hydration, inadequate staffing, physician order procedures, infection control, and many other topics.

The records subpoenaed for this case included five years of records from the assisted living facility (ALF) where she resided prior to the nursing home admission, three years of nursing home records, seven doctors’ office records, five hospital charts from three

“Every interaction is a seed. If you plant crab apples, don’t count on harvesting Golden Delicious.” — Bill Meyer

While the attorneys are concerned about the chart and what was and was not documented, family members are often focused on the human care and treatment they and their loved ones received. For example, in a recent deposition, a daughter was asked about her complaint against the nursing home. She replied that she brought in clothing for her mother, but whenever she visited, her mom was in a hospital gown. She complained to the nurse about this, but the nurse didn’t seem overly concerned. The nurse explained that this woman’s mother was often in a hospital gown because they were short-handed. Three years later, this was the first thing on the daughter’s mind. Her main complaint was not about the medical care; it was about the human care. The daughter probably wasn’t even qualified to know if the medical care was good or bad, and she probably didn’t even have an opinion on that. What she recalled was the way she and her mother were treated.

Attitudes Are Contagious: Is Yours Worth Catching?
Continued from page 1

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different hospitals, two policy and procedure manuals, three state surveys, and 17 depositions thus far. Could this have been avoided?

 Humans Caring for Humans
Most of the families we deal with have never before had a relative in a nursing home, and most do not work in the medical field. If this is a person’s first experience navigating the maze of healthcare, how does he or she form expectations? Has this individual thought about what he or she wants for the family member, or is it assumed that the care in the facility will equal or even exceed the level of care at home?

Do we ever ask questions of family members to gain an understanding about how they feel or what they expect? For example, a common complaint from family members during deposition is that it took too long for a call bell to be answered. When asked how long it should take for the call bell to be answered, family members often cannot say. They know they want “good” care but are uncertain as to what that means. It is our duty to provide information and help them through the process.

Communication and courtesy can go a long way in helping someone in an unfamiliar situation. Most family members simply want comfort, understanding, respect, and dignity. Providing this is part of our job, too. It is often said that people do not sue people they like.

The sad reality is that most of our patients in long-term care are heading toward the end of life. This can bring feelings of guilt, depression, and regret—not only to the family but to the facility’s employees as well. Employee burnout can be a serious problem in long-term care, but by building supportive environments, we can help each other and improve care.

Documentation is Key
Proper documentation will always be a key issue, because it is crucial for good care. The medical record provides communication between different shifts and disciplines within the facility. Since nursing homes are busy places, documentation is often left for the end of the shift. But this practice invites errors and omissions. Documentation should be done systematically as care is given.

The actual forms and papers on which we document are often hard to follow or don’t guide the writer. If this is the case, investigate new forms or design your own. Assessment forms and record-keeping forms should be easy to use and provide prompts to guide the writer as to what should be charted. With the advent of desktop publishing, the electronic record, and the numerous companies that produce documentation records, there is no reason for forms to be a hindrance rather than a help (Table 1 outlines additional common problems with documentation).

Replacing old systems and bad habits with new ones is never easy, but it is an important step to producing legally defensible medical records.

The Grassroots Movement
The nursing home litigation crisis is a hot political topic, and many people believe that it is going to take legal reform to do anything about it. That idea can be simply disproved if instead we realize that every individual employee has the power to determine the level of customer satisfaction in his or her own facility. Treat people the way you would want to be treated or how you would want your own family to be treated.

Every personal interaction is an opportunity for you to show your professional attitude to the resident. Every interaction is a chance to leave a good impression. Make sure when the resident and his or her family members reflect on the care they received, they can say “Today at the nursing home I dealt with...”

• Kind, caring, compassionate caregivers
• Knowledgeable people whose training is on par with their duties
• Staff that showed sincere concern and empathy
• Team players
• Good communicators who helped me understand the situation at hand
• People with a professional appearance and presentation
• Someone who recognizes when to step back as well as when to push forward.

Only we can put an end to the nursing home legal crisis, so let’s gear up to fix our industry ourselves. We wash our hands as part of the universal precautions, because we know germs are conta-
Attitudes Are Contagious: Is Yours Worth Catching?

Continued from page 5

gious. Good attitudes are contagious too—but don’t wait to catch it from others. Be a carrier!
Author’s note: Although the cases and examples provided in this article are true, they are composites of many actual cases and not meant to represent a particular person or facility.

Nancy Collins, PhD, RD, LD/N, is a registered and licensed dietitian in private practice in Pembroke Pines, Florida. For the past 15 years, she has served as a consultant to healthcare institutions on issues regarding regulatory compliance, clinical nutrition, and food service management and as a medico-legal expert to law firms involved in healthcare litigation. Correspondence may be sent to Dr. Collins at NCtheRD@aol.com.

Table 1. Examples of Common Documentation Problems

<table>
<thead>
<tr>
<th>Section</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Erroneous or Fraudulent Entries:</strong></td>
<td>A nursing home transfers a resident to the hospital on Monday at 1:00 pm, but someone charts that she ate 75 percent of Monday’s dinner on the meal intake record and initials that she was provided evening mouth care and bed-time care.</td>
</tr>
<tr>
<td><strong>Blame:</strong></td>
<td>A speech therapist charts that she told the dietitian the resident required nectar-thickened liquids, but kitchen staff served regular liquids.</td>
</tr>
<tr>
<td><strong>Conflicting Information:</strong></td>
<td>A nurse charts that the resident has a good appetite and eats 75 percent of meals. On the same day, the dietitian charts that resident has poor-to-fair appetite and eats only half of meals.</td>
</tr>
<tr>
<td><strong>Illegibility:</strong></td>
<td>Chart notes cannot be read because of poor handwriting, poor copy, poor printout, or other problems.</td>
</tr>
<tr>
<td><strong>Unapproved and Misunderstood Abbreviations:</strong></td>
<td>An order for “SF HS” is interpreted as salt-free house supplement when it was intended to be sugar-free Health Shake® (i.e., RESOURCE® No Sugar Added Health Shake®, Novartis Medical Nutrition, Fremont, Michigan).</td>
</tr>
<tr>
<td><strong>Gaps and Omissions:</strong></td>
<td>Notes skip weeks at a time, making it difficult to determine the condition and treatment of the resident during that time period.</td>
</tr>
<tr>
<td><strong>Inconsistent with Required Practice Standards:</strong></td>
<td>Charting should adhere to the facility policy on issues including cross outs, charting in the incorrect resident’s chart, late entries, and other documentation problems.</td>
</tr>
</tbody>
</table>

Register to become a BACFighter

The Partnership for Food Safety Education, of which ADA is a member, has identified resources that can leverage outreach opportunities for the Fight BAC!® campaign, a food safety education program developed using scientifically based recommendations and resulting from an extensive consumer research process. Interested individuals may now sign up to participate in BACFighter, a new outreach campaign, at the Fight BAC!® website—www.fightbac.org. The site also has educational materials available for consumers, teachers, dietitians, public health officials and extension agents.
these clients are able to remain in the community, though they would qualify for nursing home placement. She emphasized that we need to adopt a new model of thinking from “long term care” to “long term living”.

By 2030, 20% of Americans will be age 65 or older, and good nutrition is a major determinant of successful aging. Older adults who routinely eat nutritious food and drink adequate amounts of fluids are less likely to have complications from chronic disease and to require care in a hospital, nursing home, or other facility. Not only is obesity a problem, but also chronic disease, undernutrition, and underweight status. Dietetics professionals are exceptionally qualified to work with older adults in promoting health and functionality to maintain quality of life among the healthy and in providing appropriate medical nutrition therapy (MNT) in disease management strategies. Chronic Disease Cost data from the Nutrition Screening Initiative found that every dollar spent on nutrition screening and intervention saved one health care system $5.63. Those facts make nutrition a cost-effect strategy for improving older adults’ immediate and long-term quality of life.

The Older Americans Act Nutrition Program (OAANP), the largest single component of the OAA, serves 250 million meals per year to 2.6 million older adults. Some programs provide nutrition screening, education and counseling, but such services are not consistently available across the country. Also, while inflation has increased 44.45% since 1990, funding for OAANP has increased by only 24.4%. And the OAA relies on funding not only from federal sources, but state and local sources including voluntary donations. Survey data compiled by Westat, Inc. for the Area on Aging found this program targets areas of greatest need: lower income seniors, seniors at moderate to high nutritional risk, and those likely to be food insecure as 60% report the OAANP meal provides half or more of their daily intake. Home delivered meal recipients exhibit much greater levels of impairment or frailty than the entire 60+ population, suggesting that the program services contribute to maintaining individuals in their homes. Nutritional intake for congregate meal recipients is as good as or better than nutritional intake for the 60+ population, suggesting that congregate meals improve nutritional intake.

Although the OAA reauthorization has widespread bipartisan support, topics expected to arise with the next reauthorization include cost-sharing of services, consolidation of congregate and home-delivered meals funding into a single block grant to states, funding transfers between federal allotments, retention or elimination of the Recommended Daily Allowances for meals served, nutrition education and screening requirements, and funding for resource centers and elder abuse. Also, reauthorization will likely be delayed until after the White House Conference on Aging (WHCoA) scheduled for October 23-26th, 2005. The WHCoA, last held in 1995, with delegates from all U.S. states and territories is tasked to develop recommendations for additional research and potential policy changes in the area of aging.

**ADA POSITION:**

The Gerontological Nutritionists and the Consultant Dietitians in Health Care Facilities DPGs, working with LPPC and staff, identified legislative proposals that would serve to:

- Ensure that someone with specific nutrition expertise and ideally, a registered dietitian, is required to be consulted by the state unit on aging.
- Ensure greater inclusion and integration of nutrition education and, if appropriate, assessment and counseling, in OAA meal programs.
- Allow greater flexibility for meal planning, while maintaining the standard that meals served comply with the most current dietary guidance and meet the recommended daily dietary reference intakes.
- Maintain current structure that separates home-delivered, congregate meal funds and the Nutrition Services Incentive Program.
- Extend nutrition education, assessment and counseling to caregivers of elderly served by OAA programs.
- Require the Assistant Secretary to fund one or more nutrition and physical activity resource centers under Title IV.
In summary, Congress should support and fund amendments to the current Older Americans Act that increase participant access to nutrition screening, education and counseling, and ensure qualified nutrition expertise is utilized in the coordination and planning of meal services.

COMMITTEE JURISDICTION:

Senate Special Committee on Aging
Senate Health, Education, Labor and Pensions (HELP) Committee

House Education and Work Force Committee

Ryan White CARE Act Reauthorization

BACKGROUND:

The Ryan White CARE Act is up for reauthorization in 2005. Currently, medical nutrition therapy (MNT) is not a required service in all titles of the Act. Therefore, patients and families served by these programs have limited, if any, access to life-saving MNT by a registered dietitian.

The benefits of MNT by a registered dietitian for HIV/AIDS patients are numerous. In addition to improving health outcomes in HIV infection and facilitating access to adequate dietary intake, MNT is essential to the adherence and effectiveness of HIV medications. Lifelong pharmacotherapy presents challenges to and can negatively affect nutritional status by introducing potential interactions with food, by changing body metabolism and by causing adverse side effects. Specifically, antiretroviral drug therapy has nutritional implications and side effects that can seriously compromise a patient's response if not addressed by a trained dietitian. MNT helps improve the effectiveness and tolerance of medications, and it helps manage and alleviate adverse drug effects such as nausea, diarrhea, fatigue and elevated blood glucose and lipid levels.

Metabolic and morphological abnormalities or the starvation unique to HIV/AIDS patients, present clinically as lipodystrophy and wasting syndrome, have significant health implications and are associated with increased morbidity and mortality. Symptoms of these conditions, such as high blood cholesterol and triglyceride levels and insulin resistance, can be managed in part by MNT.

According to the Health Resources and Services Administration (HRSA), nutritional interventions, including nutrition assessments, counseling, therapy and access to food can have a positive impact on morbidity, mortality, and quality of life in people with HIV and AIDS. Nutritional interventions can also decrease or delay hospitalizations, emergency room visits and costly and invasive treatments.

ADA POSITION:

ADA has identified legislative proposals that would serve to:

- Elevate the role of MNT in the care and treatment of those served by RWCA grantees.
- Ensure that MNT is more fully integrated into the structure of the program
- Allow nutrition faculty, like other medical and health care professional faculty, to be eligible to receive specific training on HIV and AIDS care through AIDS Education and Training Centers
- Require that registered dietitians be represented on HIV Service Planning Councils under Title 1.

In summary, Congress should support amendments to the current Ryan White CARE Act and provide funding to strengthen the role of Medical Nutrition Therapy and the registered dietitian in programs funded by the Act.

COMMITTEE JURISDICTION:

Senate Health, Education, Labor and Pensions (HELP) Committee

House Energy & Commerce Committee

NOW it’s your turn! Please contact your US Senators and House members requesting their support.
Preparing for a disaster is one of the most critical disciplines you could engage in during the course of managing any healthcare foodservice operation. Not only is this task mandated by State and Federal law, but you as a foodservice professional have an obligation to ensure the patients you are caring for are given sustainable fortitude during a trauma that could have devastating effects on their mental and physical well being.

The goal I have set to achieve as a direct result of this article is to point out some personal experiences during a powerful earthquake that hit the San Fernando Valley area of Los Angeles at 4:29 am on Martin Luther King’s holiday in 1994. The earthquake caused tremendous devastation in the immediate vicinity of the epicenter, spreading in circular motion of approximately forty miles, with minor damage experienced as far as one hundred miles.

The total fatality count was in the low twenties, which was a miracle as had this occurred an hour later or on a normal Monday morning, the fatalities could easily have reached into the hundreds, if not, thousands.

The memory of that morning is still extremely vivid in my mind. Disasters such as this create an indelible image that is seldom obliterated. Fortunately, we suffered only minor damage in our home, but that day changed the way I feel about any natural disaster, predictable or unpredictable, the outcomes can amount to tremendous devastation and intolerable loss of life. Having set the stage, in the global sense of these tragedies, I will now attempt to portray the severity of the situation at “ground zero.”

Communications were down. There was no telecommunication of any kind! Power was out covering a thirty mile radius of the epicenter. Water mains had burst causing street flooding throughout the vicinity of the epicenter. Gas lines had fractured causing fires to break out in the immediate area. Emergency vehicles had difficulty reaching the injured due to debris strewn across the roads. Chaos was not too far from being a reality.

My immediate challenge was to drive to SYSCO Food Services of Los Angeles, establish an emergency center and put into motion our “Disaster Preparedness Plan” as we needed to establish an immediate response to the anticipated problems ahead.

Just a month prior to this tragedy the healthcare department had sent out a Confidential Contact Information Form to over seven hundred of the healthcare customers that were utilizing SYSCO Los Angeles for their foodservice supplies.

We received only forty-six completed forms prior to the earthquake, of which two were from Granada Hills Community Hospital and Northridge Medical Center. Accompanying the contact information was a suggested order guide which had been diligently completed, both hospitals giving SYSCO the authorization to automatically ship product in the event of a disaster.

Unknown to us at the time, both hospitals experienced tremendous damage. Granada Hills Hospital had to be totally evacuated as a 50,000 gallon water tank on the roof had burst, pouring water into every floor of the hospital. Patients had to be hand carried down water-sodden stairs to a temporary triage that had been quickly organized in the parking lot. Their welfare was the primary concern of the skeleton staff that had arrived for the 6:00 am – 2:00 pm shift. The courage of the patients and the hospital associates was incredible. Frail and elderly patients were among the many that were challenged to survive this horrific ordeal.

Northridge Hospital was faced with building separation, in places as much as nearly two feet. The kitchen was like a war zone with numerous large pieces of equipment that were bolted to the floor and wall sent hurtling though the air like feathers in a gale force wind. Product in the coolers and walk in freezers were totally destroyed as the sheer power of destruction from the earthquake caused all the storage shelves to break free from their moorings and collapse onto each other, causing food to scatter and fall on the floor. Here too, patients had to be removed from the wards and placed in the parking lot triage.

During all of this chaos, we had initiated the order selection process and as we were unable to reach anyone in either organization, made the decision to implement the emergency supply chain action plan. Trucks were allocated, drivers were assembled and within thirty minutes products were being loaded, checked and soon to be dispatched. As there was still no communication from either hospital, we sent the trucks on their way. A journey that would normally

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take ninety minutes took over four hours due to diversions and damaged roads.

When the trucks eventually arrived at their destination, they were greeted with applause and thanks. The Dietary staffs from both Hospitals thanked the drivers for their gallant efforts, having totally forgotten that the automatic order process would be activated, based on SYSCO’s inability to communicate with the quake smitten facilities.

During the days that followed, we were involved with scores of facilities who had similar experiences, yet not as severe as those two that were described above.

All of us learned a great deal from this experience, but one thing consistently rings true; no matter how much you train and plan for the inevitable, challenges and opportunities will always arise. The key to overcoming these unanticipated situations, is be prepared for the worst….but be always be prepared!

How do you DO it?

CD-HCF members are encouraged to share how they balance their dietetics career with their home life for the new e-bulletin, FULL PLATE ~ Dietitians Balancing Work and Family. For more information, go to http://workoptions.com/fullplate and click on Submit Your Profile. A sample issue of FULL PLATE can be viewed at http://workoptions.com/fullplate/archives/2005-04-01.htm

Mark the Date!

CD-HCF preFNCE workshop will be held on Saturday, October 22, 2005 in St. Louis. The title for the workshop is: Enhancing Marketable Skills in Today’s Health Care

CD-HCF will also sponsor an Educational Session on Wound Care.

Watch for more information coming soon on dates and times of all of the CD-HCF events. Hope to see you in St. Louis!
A couple of years ago I was approached by one of our professors in Rural Sociology and asked to participate on an Advisory Council for a Farm to School Program. I must admit, (and I am not proud of this), I was very skeptical. I had received inquiries like this before and, from previous experience, was a bit burned by people that wanted to “improve school foodservice” but really didn’t have a clue what day-to-day life is like in a food service nor were familiar with the parameters within which managers of food-service need to work. I said as much to the good professor and his response was “that’s exactly why we want you on the advisory council.” He convinced me that he, the project coordinator and students really wanted to understand the reality of foodservice so that they could successfully build farm to school programs that were economically viable and sustainable.

**Background**

Two years later, not only have we made some serious progress in the local school district, we are currently in the process of expanding the program to a local hospital. So who knows, maybe the long-term-care industry is next. I have since been “promoted” to the Steering Committee and am actively involved in working to integrate Farm to Foodservice programs into local institutions but am always mindful of the impact that such programs have on the day-to-day operations and resources available to foodservice.

I would like to share what I have learned along the way about the challenges and joys of working on such a project and to encourage you to consider integrating a Farm to Foodservice program in your operation.

This project, *The Wisconsin Homegrown Lunch (WHL)*, is a joint project of the REAP (Research, Education, Action, and Policy) Food Group. One of our partners is the Madison Metropolitan School District, which includes 29 elementary schools, five middle schools, and four high schools. We work directly with the Director of Food Service, Frank Kelly, and the production manager, Iris Torado. The primary purpose of the project is to offer equitable access for school children to healthy, nutritious school lunches and to provide a reliable market for local farmers.

For the past two years the WHL has been piloting a program in three Madison elementary schools. This means that special meals, using local produce and products, are planned and served a few times per year at these schools. Last fall, the foodservice, for the first time, offered a locally sourced meal district-wide that served over 7000 students.

**Implications for Foodservice**

No one argues that providing fresh produce and supporting local farmers is a good thing. However, the impact on foodservice is significant and needs to be considered at every step along the way if there is to be any hope that such a program will be truly sustainable. Specific aspects of foodservice that need to be considered are management control plans, resources, functional operations, and outputs.

When considering a Farm to Foodservice project, there are two management plans that need to be taken into consideration. The first is the menu. Here in Wisconsin, certain types of produce simply are not available during the late fall, winter and early spring seasons. So, for the most part, with the exception of some root vegetables our best opportunity to menu the produce is from April to November. This presents a unique challenge in schools, as there is very little activity during the summer months. The Madison District, however, does have a summer foodservice program and our intention is to maximize the local options during those months.

Another menu issue is whether to try to plan entire menus completely from locally sourced items or to work to substitute individual ingredients or menu items as the seasons allow. We started the school program with the full menu approach. For example, the meal served district-wide last fall included a chicken wrap, a vegetable mix of lettuces and baby spinach, a sweet potato muffin and a fresh apple.

*Continued on page 12*
This was a huge production and quite a challenge for
the foodservice in terms of labor and orchestration at
the schools. Currently we are looking to simply sub-
stitute individual ingredients or menu items as the
seasons allow. For example, as the spring
approaches we will look for opportunities to integrate
fresh rhubarb into baked items rather than try to
source an entire menu. Just last night the project
coordinator, Doug Wubben (aka Farmer Doug),
myself, one of my students, and a few volunteers
and I, had a “tastings” potluck to sample recipes that
we think might have potential foron the school lunch
menu. We tried curried vegetables with cous cous;
several varieties of muffins that integrated a number
of fruits and vegetables including carrots, zucchini,
and apples; and three types of carrot salads. We
decided to go ahead and batch up the recipes for
one of the carrot salads and most of the muffin
recipes. Next step is to test the recipes in the
kitchen of the school foodservice and do tastings in
the pilot schools.

A second management plan that needs to be
considered is that of Food Safety and HACCP. To
date, we really have not encountered any food
safety problems but we have had to carefully
consider how and where product is washed and
trimmed. We work very closely with the providers to
ensure that product is handled and delivered using
safe and sanitary methods.

A number of foodservice inputs or resources are
directly influenced when integrating local, fresh
produce ointo institutional menus. For example, the
food itself needs to be available at the time needed
and in a supply that is adequate to meet menu
demand. Most of the providers are not used to pro-
viding the quantities needed for foodservice. For
example, 400# of sweet potatoes are needed just to
make the sweet potato muffins for the schools. Cost
is clearly an issue. The raw food cost of the local
produce can be in line with product
purchased from the national vendors depending on
the season, but labor time needs to be factored in.
Beginning base salary at the school is $12.00
per hour. One additional resource factor is that of
storage. Adequate refrigerated storage needs to be
available and preferably designated for raw produce.
This is clearly a luxury rarely available in institutional
foodservices, especially schools.

From an operations perspective, the function that
gets hit first is that of purchasing. Issues to consider
are, source, supply, sanitation standards, delivery
schedules, and product consistency. These issues
need to be discussed frankly with the provider and
monitored carefully to ensure that food is available
when needed, in adequate supply and within stan-
dards for quality and safety.

Preparation, from a labor perspective is heavily
influenced. Most foodservices buy produce in “food-
service ready” forms. In other words it comes in
cleaned, trimmed and in a form consistent with
recipe needs. These products require little labor,
reduce concerns over food safety and reduce
employee injury rates because the cutting, slicing
and chopping activities are outsourced. Again, these
issues need to be acknowledged and accommodated
within available resources if a Farm to Foodservice
program is to be integrated and sustained over time.

Finally, and most importantly, the service function
needs careful consideration. The logistics of getting
these products to point-of-service and maintaining
quality can be quite the challenge. Then there is
dealing with the chaos of the lunchroom and trying
to explain to 300 kids in 10 minutes what the “green
stuff” is. Menu items introduced in the classroom
such as cherry tomatoes were a hit but some of the
very items that students would try as a classroom
project were not well received in the lunchroom.
Part of this is clearly due to the manner in which
foods are presented (Madison Schools use a
pre-pack system where hot food items are reheated
on site), but we also learned that kids are simply not
familiar with many of these foods and they will have
to be presented several times to get a fair reading as
to whether or not it is feasible to place some of the
items on the menu regularly for district-wide meal
service. We are just now beginning to do customer
satisfaction and plate waste audits to get a baseline
for evaluating product acceptance.

Despite the challenges and setbacks this project
has been one of the most rewarding professional
experiences I have ever had. It has helped me
reassess the complexity of every aspect of foodser-
vice and understand the importance of teamwork,
communication, and respect for everyone’s
contribution to success. I think we will continue to
make progress at the school. We learned that we
just can’t bring product into the schools directly from
the farms because of the labor needed to get the

Continued on page 13
product to a foodservice-ready form. To accommodate this, we are currently working with a local grocery coop that has an on-site kitchen and is willing to do the prep and transportation of the products to the sites. This is obviously easier said than done but, again the enthusiasm and commitment from everyone in the project and at the school keeps us focused and moving forward.

To Learn More:
Beery M, Vallianatos M. Farm to Hospital: promoting health and supporting local agriculture. Center of Food and Justice Urban and Environmental Policy Institute Occidental College. November 2004.

In the Know
iEntree.com is the first ever international job portal for Food Service Directors serving as dietary managers or catering managers in healthcare.
• Designed for job seekers, employers, and recruiters around the world.
• Allows prospective employers the ability to post positions without the clutter of other jobs.
• Positions are directed to an international membership with the desired skill sets.
• Sponsored by HCI, providing access to over 21,000 members worldwide.
• A site for managers and administrators to match skilled and experienced professionals with career opportunities across a broad and growing reach of countries.
• As jobs are posted, there is an automatic match up feature, giving interested members a notice of the position and the opportunity to communicate directly back to an employer.
• Please visit www.ientree.com for more information.

Looking for Good Videos!
The Professional Development Committee of CD-HCF is seeking videotapes for addition to the practice group Loan Library. The video library includes tapes dealing with clinical concerns, food production and safety, and environmental safety. The videotapes currently available are listed in every issue of The Consultant Dietitian.

The committee invites all members to suggest videotapes of value to be considered for addition to the Loan Library. If you have found a valuable resource, please send the reference to the committee for consideration. Please include the title, topic, length, purchase price, and contact information for possible purchase. All tapes will be previewed and approved by the CD-HCF Professional Development Committee before being added to the Loan Library. Thank you for helping your colleagues to have these valuable resources available!

Professional Development Committee
Pat Dahlstrom, RD - 2005-06 - Chair
pdahlstrom@ehcmail.com

Reliable tips on weight loss, exercise at FDA web site
Prompted by recent statistics that more than 60 percent of the U.S. population is overweight, FDA launched an improved website devoted to consumer information on weight loss. The site functions as a gateway to material from FDA and other federal agencies on topics such as meal planning, setting weight-loss goals, approved treatments and diet scams. It also links to information on how to lose weight by adding exercise to your daily routine. http://www.fda.gov/oc/opacom/hottopics/obesity.html
Correctional Menu Changes to Help Meet the RDA’s

By Nancy Guppy, RD, MS

The province of Ontario’s menus underwent major revisions in 2004 to meet the revised Dietary Reference Intakes (DRI’s) issued between 1997-2002. DRI’s were increased for many essential nutrients to minimize the risk of obesity and chronic diseases. Consequently menus fell short of meeting the new Recommended Dietary Allowances (RDA’s) for fibre, omega-3 fatty acids, calcium, vitamins D and E. Correctional menus are higher in calories than those used in long-term and acute care, which makes meeting the majority of the RDA’s much easier.

As dietitians working in the correctional environment, various strategies are used to increase essential nutrients based on population type, budget and type of meal service or feeding styles. A central menu is used in 31 centers across the province and the majority of inmates receive trays and eat in their cells or living areas. There are no central dining rooms where a choice system, or diet card system, can be implemented. This means that all foods in required amounts must be on inmate trays at point-of-service.

Chronic consumption of low amounts of dietary fibre has been associated with constipation, increased risk of CHD, obesity, diabetes and cancer. Most North Americans have low fibre intakes (typically 10-15 grams/day). The recommended Adequate Intake for fibre is 38 grams per day for men and 25 g for women – about twice the typical intake. This is very high and presents a challenge for correctional menus. Table 1 summarizes higher fibre menu items that were incorporated into the menus to meet the new fibre RDA. Use of white bread was entirely discontinued.

The first-time RDA for omega-3 fatty acids, was established at 0.6 – 1.2% of total energy. Obtaining sufficient omega-3 fatty acids is probably the greatest challenge in correctional menus but improvements can be made (refer to Table 1). Facilities that serve better quality, soft, non-hydrogenated margarine; use a canola or soy bean oil in food preparation; and serve more fish and dried legumes (beans, peas and lentils) will find it easier to satisfy this new RDA.

The older version of the menu could not meet the new RDA for calcium or vitamin D. Adult menus have fluid milk at breakfast only and additional calcium is attained from desserts (e.g., pudding on the menu three times per week), cheese and skim milk powder used in cooking and baking. A calcium-fortified fruit drink beverage was added once per day in lieu of more costly fluid milk. We worked with a custom manufacturer to develop an individual portion package juice crystal with acceptable flavor that contains 250 mg of calcium in a readily available form (i.e., calcium lactate).

In Canada all margarine and fluid milk is enriched with vitamins A and D. Inmates in Ontario are not exposed to sufficient sunlight to synthesize vitamin D in required amounts, especially during winter months. We would not be able to meet the new RDA for vitamin D without serving two to three 7 gram portions of margarine per day that contain 2 micrograms of vitamin D each. The vitamin E content of most foods listed in databases of computerized nutrient analysis software packages is frequently not available. Good sources are vegetable oils, margarine, whole grains (not made from de-fatted whole-wheat flour), nuts, seeds and green leafy vegetables. A manual calculation helped determine that menus were in fact meeting the present RDA even though the computer analysis showed an average of 13 mg/day (vs. 15 mg/day RDA).

To help achieve the RDA for vitamin E, omega-3 fatty acids and vitamin D we also teamed with a custom manufacturer of margarine to develop a lower cost blend that had a nutritional profile similar to Becel (i.e., non-hydrogenated and low in saturated fat and trans fatty acids) with “no milk ingredients.” We were able to get a higher quality product at a more reasonable price. We asked our distributor to stop supplying the older formulas that were more economical but much higher in saturated and trans-fatty acids. It would be more difficult to meet the RDA’s for omega-3 fatty acids, vitamins D and E using a lower fat or “heart healthy” menu planning approach which limits total fat calories to a maximum of thirty percent. Caloric value of future menus will be reduced to 2,800-3,000 calories per day from the current 3,200-calorie level. This step will generate cost saving to help support the increased expenditures for more nutrient dense foods that were added. Furthermore, a project is currently underway to review the sodium level of recipes and subsequent revision of recipes to reduce sodium to more acceptable levels. Future nutrient analysis will also examine levels trace minerals that are currently not considered in our dietary analysis (e.g., magnesium, selenium) and will compare to the new RDAs.

Menu improvements cost money and correctional dietitians may find themselves unable to satisfy the current RDA’s without creativity and additional food services funding.

Continued on page 15
Table 1. Computerized Nutrient Analysis of Regular Menu for 2004
- Seven-Day Average and Summary of Changes Required

<table>
<thead>
<tr>
<th>Energy or Nutrients</th>
<th>Actual Menu</th>
<th>Recommended (RDA) Adult Men 19-30 years</th>
<th>Recommended (RDA) Adult Women 19-30 years</th>
<th>Summary of changes required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kcal</td>
<td>3,219</td>
<td>2,700-3,000</td>
<td>2,000-2,100</td>
<td>Reduce calories to 3,000 in 2005</td>
</tr>
<tr>
<td>Protein (grams)</td>
<td>100 g (= 12% of daily calories)</td>
<td>10-35% of calories (RDA 56 grams)</td>
<td>10-35% of calories (RDA 46 grams)</td>
<td></td>
</tr>
<tr>
<td>Carbohydrate (grams)</td>
<td>445 g (= 55% of calories)</td>
<td>ADMR = 362-523 g (or 45-65% of calories)</td>
<td>ADMR = 225-341 g (or 45-65% of calories)</td>
<td></td>
</tr>
<tr>
<td>Total Fibre (g)</td>
<td>38 g</td>
<td>38 g</td>
<td>25 g</td>
<td>Fresh fruit “skin-on” served daily, canned fruit served frequently; all bread 100% whole-wheat; added legumes to salads and soups daily; added more green peas, baked beans and higher fibre vegetables to supper meals; changed to skin-on potatoes for fries</td>
</tr>
<tr>
<td>Total Fat (grams)</td>
<td>125 g (= 35% of calories served)</td>
<td>60-105 g/day-ADMR (acceptable daily macronutrient range) 20-35% of recommended calories</td>
<td>44-82 g/day-ADMR (acceptable daily macronutrient range) 20-35% of recommended calories</td>
<td>No plans to reduce further</td>
</tr>
<tr>
<td>Omega-3 fatty acids</td>
<td>1.6 grams/day</td>
<td>1.6 grams/day</td>
<td>1.1 grams/day</td>
<td>Soft, non-hydrogenated margarine; canola oil for cooking and baking; more fish (twice a week) and legumes in soups and salads every day</td>
</tr>
<tr>
<td>Vitamin A (RE)</td>
<td>1803 RE (9,000 IU)</td>
<td>900 RE (4,500 IU)</td>
<td>700 RE (3,500 IU)</td>
<td></td>
</tr>
<tr>
<td>Folate (mcg)</td>
<td>482 mcg</td>
<td>400 mcg</td>
<td>400 mcg</td>
<td></td>
</tr>
<tr>
<td>Vitamin C (mg)</td>
<td>227 mg</td>
<td>90 mg</td>
<td>75 mg</td>
<td></td>
</tr>
<tr>
<td>Vitamin D (mcg)</td>
<td>10 + mcg</td>
<td>5 mcg (10 mcg)</td>
<td>5 mcg (10 mcg)</td>
<td>Egg yolks and fish are good natural sources. Fortified margarine and milk supplies the majority</td>
</tr>
<tr>
<td>Vitamin E (mg)*</td>
<td>13 mg* (16 mg)</td>
<td>15 mg</td>
<td>15 mg</td>
<td>Added better quality margarine; also present in canola oil</td>
</tr>
<tr>
<td>Calcium (mg)</td>
<td>1181 mg</td>
<td>1,000 (51 years + = 1,200 mg)</td>
<td>1,000 (51 years + = 1,200 mg)</td>
<td>Added calcium fortified fruit drink crystals for night snack; review cheese and skim milk powder used in cooking and baking</td>
</tr>
<tr>
<td>Iron (grams)</td>
<td>25 g</td>
<td>8 g</td>
<td>18 g</td>
<td></td>
</tr>
<tr>
<td>Sodium (mg)</td>
<td>5,206 (or 6,150 mg with salt packets)</td>
<td>3,000-5,000</td>
<td>3,000-5,000</td>
<td>Borderline high – address in future menu revisions</td>
</tr>
</tbody>
</table>

Notes:
2. Vitamin D is a manual calculation to reflect nutritional quality of foods actually used.
3. Figures are averages from analysis of the first seven days of the menu cycle.
4. Vitamin E shown as calculated by the nutrient databases and again in brackets as a manual calculation.
5. Standard Adult Man and Woman = 19-50 years old, moderately active
6. Women and men receive the same menu even though caloric intake exceeds needs for the women.
7. 472 mg in each 1 ml package of salt. Analysis shown with and without salt packets from lunch and supper meals.
Correctional Menu Changes to Help Meet the RDA’s
Continued from page 15

For more information about the above DRI reports, please click on the links for websites below:
National Academy of Sciences:
http://www4.nationalacademies.org/news.nsf/or
Health Canada:
http://www.hc-sc.gc.ca/hpfb-dgpsa/onpp-bppn/diet_questions_e.html

2005 ADA ELECTION RESULTS
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Congratulations to our incoming leadership team!

~ ~ ~ ~ ~

2005 ADA ELECTION RESULTS
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Member Issues...
• We care about the concerns of ADA members.
• Four easy ways to submit your issues:
  - visit www.eatright.org/issues,
  - email issuesmgmt@eatright.org,
  - fax 312/899-4790, or
  - contact your delegate.
• Immediate confirmation.
• Action will be taken within 2 months.
• For more info about the Issues Management Committee, visit ADA’s member home page and click on Member Issues.
One day as I was reviewing the CD-HCF EML, I was drawn to a particular message that the National Institute of Health (NIH) was to make available - a conference on End-of-Life Care in Bethesda, Maryland. The focus was to bring together independent national, and international speakers and experts, to identify for healthcare providers, patients/residents, and others who may be interested in End-of-Life Care. The conference also reviewed issues that could contribute to improved or worsened outcomes for patients/residents and their families during this time. The direction of research in this area was also discussed.

As quality of care at end-of-life is of particular interest, I wanted to attend, but my schedule interfered, making it clear that the trip would not happen. What I was able to do was access the final day on my computer and follow some of the speakers presentations. Technology, what a blessing- in this case!

One of the end results of this experience was being made aware of a wonderful service we all have access to - the ability to see and share in the final conclusions and recommendations by accessing the NIH web site directly. Another benefit was to have access to current information on a topic of great interest to me.

From the December 8, 2004 NIH News, the following excerpts:

“Despite progress in end-of-life research, important aspects of this life stage remains poorly understood, according to a panel convened by the National Institutes of Health. The panel found that for many Americans, a lack of continuity of care and poor communication between healthcare practitioners, patients, and family members make the end-of-life period a struggle.

In light of the projected dramatic increase in the number of older adults who will require end-of-life care, the panel called for the rapid development of research infrastructure to improve our understanding of what works and what doesn’t in different groups of patients, and enhanced resources to deliver quality care to patients and their families at the end of life.”

“We can begin by refining and agreeing upon our definitions of ‘end of life,’ ‘palliative care,’ and ‘hospice’ – the terms have been used inconsistently, and often interchangeably, which hinders not just the research enterprise, but effective communication between providers and patients as well” said panel chair Margaret M Heitkemper, PhD, R.N., F.A.A.N., Professor and Chair of the Department of Biobehavioral Nursing and Health Systems at the University of Washington School of Nursing in Seattle.”

The statement went on to identify that the current design of the Medicare hospice benefits has limitations that can impact on quality of life during the end-of-life stages.

Other comments in the panel’s statement included the need to:

- “Enhance communication” among patients, families and healthcare providers
- Include and recruit “under-represented populations” to be part of future studies so that all backgrounds are represented when trying to “understand health disparities” in end-of-life care
- “Create new and support existing networks of end-of-life researchers and well-defined cohorts of patients to facilitate coordinated, interdisciplinary, multi-site studies.”

Wow! Inspiring comments, at their best.

Quality of life and dignity are focal points of all of our standards of practice, but it appears we still have some milestones to reach. Simple things we are involved with in providing care and services at end-of-life become important.

Clear communication and having clear definitions around decisions that require an action are needed - such as to tube or not?, DNRCC ?, comfort care only? thick or thin liquids? These conversations need...
to take place. This communication is vital to Dignity and Quality of Care of our residents/patients/ family members.

- Is everyone on your Interdisciplinary Team on the same page?
- Are you all talking the same language?
- Do you all have a clear picture of what the resident/patient and family wants or thinks they are wanting?

Careful thought and conversation is required, because there can be unintended misunderstandings without clear communication among all participants.

Using technology to access resources can take you up close and personal without leaving your home or office. There will be many more opportunities brought about by the NIH - check their web site.

The full draft statement of the presentation and list of sponsors is available by accessing the NIH web site www.consensus.nih.gov.

Suzanne is Director of Nutrition Services at The Maria Joseph Living Care Center, a 351 bed LTC facility in Dayton, Ohio.

Carlene Russell Recipient of F. Ann Gallagher Award

Congratulations to Carlene Russell who was recently selected to receive the 2005 F. Ann Gallagher Award!!! This award is given to a member of CD-HCF who has been active in promoting state or federal legislation to advance the profession of dietetics. It includes $1,000 that is to be used to support the legislative efforts of the recipient.

Carlene has a rich history of legislative involvement on the local, state, and federal levels. This includes letter writing, participation in town hall meetings, scheduling site visits with legislators, working with state dietetic association legislative conferences, attending ADA’s legislative conferences and communication with ADA Washington staff and fellow dietitians about legislative issues. Carlene served on the ADA Legislative and Public Policy Committee (LPPC) from 1998 – 2000.

Carlene is also an active member of CD-HCF having served nationally as CD-HCF Chair, Alliance Representative to the CMS Best Practices forum, editor for the Dining Skills Manual, and as one of the key presenters in the highly successful series of Dining Skills workshops several years ago.

Carlene was nominated for the F. Ann Gallagher award by CD-HCF because of her involvement as an advisor to the ADA Washington office of legislative affairs with regard to community nutrition programs for senior adults, legislative changes that are needed, and wording of draft legislation for the Older Americans Act which is due for reauthorization in 2005. Carlene was able to facilitate ADA and the Society for Nutrition Education (SNE) working collaboratively in developing recommendations for the reauthorization of the Older Americans Act. Both CD-HCF and Gerontological Nutritionists DPG provided comments and input into these recommendations.

On the state level, Carlene fulfills a dual role as nutritionist for both the Iowa Department of Elder Affairs and the Iowa Department of Public Health. She is able to impact policies regarding nutrition services and is currently exploring ways to improve reimbursement rates for nutrition counseling. Carlene contributed to the development of a state plan to provide more community based care to older adults. The plan includes a nutrition and healthy aging section and promotes the provision of nutrition screening, nutrition assessment and nutrition counseling. She recently led a campaign to expand the Iowa Nutrition Network’s “Pick A Better Snack” to include an older adult component. Through this program she implemented an innovative nutrition, food safety, and exercise program for older adults that uses a nutrition bingo game to track healthy activities.

Carlene has positively impacted the passage of nutrition legislation that has led to the improvement in health, well-being and quality of life for older adults. She is a role model and inspiration for dietetics professionals throughout the country. Congratulations, Carlene!!
CD–HCF Congratulates the 50 YEAR MEMBERS

The following CD-HCF members have reached their 50 year ADA membership milestone.

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Patricia H. Younie

Area III
Ruby P. Puckett
Jane B. Oakes

Area IV
M. Kathleen F. Koehler-Cresto

Area V
Marjorie J. Blackwell
LouNell McNece Rayner
Jeannine S. Root
Martha D. Smiley

Area VI
Carole S. Lash

Area VII
Helen J. Shannon

CD-HCF hopes to see you at the 2005 FNCE events to help you celebrate.

CD-HCF Members with Over 50 Years of Membership

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Mary H. Huffman Joyce K. Johnson

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Elizabeh D. Taylor Lois J. Wangerman
Rhoda P. Werblin Eileen B. Wilke

CD-HCF Executive Committee and Officers congratulate each of you for your years of service to our profession and wish you well.
Strict New Guidelines Control Sodium and Encourage More Exercise

By Bobbie Randall, MEd, RD, LD

The purpose of the Dietary Guidelines for Americans 2005 is to promote health and reduce risk for major chronic diseases through diet and physical activity. The long-term care industry is very familiar with the list of these illnesses: cardiovascular disease, type 2 diabetes, hypertension, osteoporosis and certain cancers.

The intent of the Guidelines is to summarize and synthesize knowledge for a healthful lifestyle, which can be adopted by the public. A fundamental premise is that basic nutrients should be met primarily through consuming foods. The document states that dietary supplements cannot replace a healthful diet, although people over 50 are encouraged to consume Vitamin B$_{12}$ from fortified foods, such as cereal, or supplements in a crystalline form. Vitamin D supplementation is also recommended for older adults with dark skin or minimum exposure to sunlight.

As in the past, a variety of fruits and vegetables are suggested with a substantial increase noted. Two cups of fruit and 2 cups of vegetables per day are recommended on a 2,000-calorie diet. Nine servings of fruits and vegetables may provide valuable antioxidants, fiber, vitamins and minerals but adding these to a resident's diet may be challenging. A usual long-term care menu provides approximately 2 fruits or vegetables per meal for a total of 6. Additional juices may be the solution to meeting this suggested guideline.

Consuming three whole grain products daily may be new to many Americans, but those in long-term care are accustomed to bread at each meal. The availability of quality whole grain products may put a strain on the raw food cost of a dietary department.

Three cups of fat-free or low-fat milk are available from most dietary department menus, but whole milk will continue to be an excellent source of calories for those who require more.

The guidelines for total fat remain approximately at 35% with a low range of 20%. Less than 10% of fat calories are to come from saturated sources with no more than 300 mg/day of cholesterol per day. Trans fatty acids are to be avoided.

Reducing the recommended guideline of sodium to 1,500 mg a day may be difficult in long-term care. This suggested therapeutic range contradicts the liberalized geriatric menu.

Historically the guidelines are stringently declared, expecting the public to exceed the recommendations. For example, the previous Dietary Guidelines state that Americans need 5 fruits and vegetables a day. In reality, the public falls short and consumes an average of 3 fruits and vegetables per day. By increasing the amount to 9 daily fruits and vegetables, the Department of Health and Human Services and the Department of Agriculture hope that the amount consumed by the general public will increase to 5 to 7 servings per day.

Likewise with the decrease of recommended sodium per day, a reduction may encourage the public to restrict total daily sodium to a healthier limit. Amounts are exaggerated to create a type of pendulum effect in behavior. If a median amount is the goal, extreme targets are aimed at and the total amount is tempered by the average amount consumed. The low salt diet modification on most long-term care menus averages 3 to 4 mg of sodium. Reducing this amount to 1.5 gms per day limits the variety of menu items and affects the palatability of many foods.

Those in long-term care address cardiovascular disease, type II diabetes, hypertension, osteoporosis and certain cancers daily. The revised Dietary Guidelines for Americans 2005 is a combination of medical nutrition therapy and physical activity to avoid these illnesses. Considering the health and weight of Americans, any adherence by the public to this new plan far outweighs the current liberal intake habits of many. Long-term care menus and lifestyle exist in a controlled environment.


Note about the author.
Bobbie has 20 years experience in long-term care and is a past president of Ohio Consultant Dietitians in Health Care Facilities.
She writes a syndicated weekly nutrition newspaper article, is a corporate dietitian for a grocery chain in Ohio and teaches ServSafe and T.I.P.S.
Trans Fat and Teens
By Lisa Kelly, MPH, RD, Communications Director, United Soybean Board*

The dietary choices teens make can lead to eating behaviors that last a lifetime. While fat may not be the first thing that teens consider when choosing a meal or after-school snack, understanding the different types of fats found in the diet may have long-term implications for their health. Because of upcoming federal regulations governing trans fat labeling on the Nutrition Facts label of packaged foods, the public has a heightened awareness of fats in general and trans fat in particular. Dietitians can take advantage of this opportunity to educate teens on healthy fat intake.

Nutrition experts agree that it's important to consider the type of fat when evaluating dietary intake and making food choices. In general, unsaturated fats, such as mono- and polyunsaturated fats are considered "good fats," while saturated fats and trans fats fit into the "bad fats" category. Following is a brief description of different types of fatty acids:

- **Polyunsaturated fatty acid** – An unsaturated fat found in greatest amounts in foods derived from plants, such as soybean, sunflower, safflower and corn. Heart-healthy omega-3 fatty acids are polyunsaturated fatty acids.
- **Monounsaturated fatty acid** – An unsaturated fat found primarily in plant foods including olive, canola and soybean.
- **Saturated fatty acid** – A type of fat found in greatest amounts in foods from animals, such as fatty cuts of meat, poultry with the skin, whole-milk dairy products and lard. Also found, often in lesser amounts, in some vegetable oils, including coconut and palm kernel oils. Saturated fats have been associated with an elevated risk of cardiovascular disease.
- **Trans fatty acid** - A fatty acid that has been produced by hydrogenating a liquid oil to make it more solid in order to increase stability and prevent oxidation.

Trans fatty acids are formed when liquid oil is partially hydrogenated to form a more stable oil that can withstand higher cooking temperatures. Products including trans fat include many teen favorites: cookies and other baked goods, crackers, potato chips, tortilla chips, corn chips, energy bars and French fries. Partially hydrogenated oils were introduced as an alternative to animal fats and tropical oils, which are naturally more stable due to their higher saturated fat content. Newer data suggest that trans behaves similarly to saturated fat in terms of overall effects on serum lipid levels and cardiovascular function, and health advocates are recommending that consumption of trans fats be limited.

It's important to note that non-hydrogenated, liquid versions of cooking oils, such as soybean oil, do not contain trans fatty acids and can be used in a variety of applications that do not require intense heating or heavy frying. Liquid soybean oil provides an excellent oil for teens or their parents to use when making a simple vinaigrette to toss with a green salad or stir frying lean meats and veggies for an easy, nutritious meal. In addition to being relatively low in saturated fat and high in unsaturated fats, soybean oil is also the primary commercial source of vitamin E, an important antioxidant, and it contains a number of phytosterols, which have been shown to lower serum cholesterol.

In the meantime, the American Heart Association’s Nutrition Committee advises that healthy Americans over the age of two limit the fat they eat. Specifically, they recommend limiting intake of saturated fat to less than 10 percent of total calories. Total fat intake should be between 20 and 35 percent of total calories. In practical terms, if teens limit their daily intake of fats and oils to about five to eight teaspoons, the American Heart Association notes they are not likely to get an excess of trans fatty acids.1

While we learn more about the effects of trans fatty acids, the American Dietetic Association’s advice remains to limit total fat intake to no more than 30 percent of overall calories. Trans fatty acids represent a much smaller contribution to the overall diet than that of saturated fatty acids. Selecting a wide variety of healthful foods, incorporating fats in the diet in moderation and enjoying regular physical activity will provide teens with the building blocks toward maintaining good health.


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