Clostridium difficile was first recognized as the causative agent of pseudomembranous colitis almost 30 years ago and is now recognized as the major cause of nosocomial infectious diarrhea. The number of C. difficile infections, known as C. difficile-associated disease (CDAD), doubled between 1993 and 2003, with most of the increase occurring from 2000 to 2003. Statistics from the US Centers for Disease Control and Prevention reveal that the diagnosis of CDAD upon hospital discharge has increased significantly from 31 per 100,000 (82,000) population in 1996 to 61 per 100,000 (178,000) in 2003. The overall rate in persons 65 years or older in 2003 was 228 per 100,000, five times the rate for other age groups.

Clostridium difficile is a gram-positive, spore-forming anaerobic bacterium, which is found everywhere in the environment, including the soil, air, water, human and animal feces and on almost all surfaces. C. difficile produces two toxins (A and B), which are responsible for many of the signs and symptoms of infection. While most individuals develop CDAD during or shortly following a course of antibiotics, signs and symptoms may not appear for weeks or even months after treatment has ended, resulting in misdiagnosis in some cases.

The major risk factor for the acquisition of C. difficile and/or the development of CDAD is the use of antibiotics. Antibiotics disrupt the normal flora of the colon, which allows the rapid growth of the C. difficile bacteria once it is ingested. However, use of antibiotics alone is not sufficient to cause CDAD. A “three-hit” model has been proposed. The first hit is exposure to antimicrobials and the second hit is exposure to the C. difficile bacteria. Even after the occurrence of the first two hits, most patients will be colonized with the bacteria, becoming asymptomatic carriers without diarrhea. This has led to the belief that the presence of at least one other factor leading to clinical illness is also required. Other factors that have been suggested include the susceptibility or immunity of the patient, the virulence of the C. difficile strain or the type and timing of the antimicrobial exposure.
We just returned from ADA’s 2007 Public Policy Workshop (PPW) in Washington, D.C. As always, the Washington and Chicago staff did a terrific job with this conference— including providing us with the best weather we have ever had for this meeting! Attending as CD-HCF representatives were JoJo Dantone-DeBarbieris, MS, LDN, RD, CDE; Suzanne Cryst, RD, LD; Carolyn Yanosko, MS, RD, LD (2007 PPW scholarship winner), and me. The meeting “Champion Nutrition - Making Your (RDs) Mark in Washington” started with another dynamic presentation from Mike Dunn on the importance and effectiveness of our participation in the political process. Videotapes of his presentation are available from the Washington office to be used at local and state events. Many RDs gave background information on MNT and the farm bill legislation for us to take our 2007 messages to our own state representatives on Wednesday, April 25.

It is always exciting to hear the current and former members of Congress who take time out from their busy schedules to share with us their recognition of the importance of nutrition issues, and who continue to support nutrition legislation. This year we heard from Rep. Fred Upton (R-MI), Rep. Jo Bonner (R-AL), former Rep. Nancy Johnson (R-CT), and Rep. Debbie Wasserman (D-FL). Rep. Wasserman closed our conference at breakfast by telling us that “good nutrition is not just good public policy, it is good politics.”

2007 Messages to Capital Hill - Medical Nutrition Therapy (MNT)

This year there are three MNT issues we are asking Congress to support:
1. Sen. Jeff Bingaman’s bill (S.1161) and Rep. Xavier Becerra’s bill (no number at time this went to press) to give CMS (Center for Medicare & Medicaid Services) the authority to expand MNT benefits to other disease states if CMS determines it to be “reasonable and cost effective.”
2. Sen. Charles Schumer’s bill (S. 755) to require state Medicaid programs to cover screening and treatment (including MNT) for diabetes and renal diseases.
3. Rep. Diana DeGette’s bill (no number at time this went to press) to add pre-diabetes to the Medicare coverage under Medicare.

Farm bill issues we are asking Congress to support include:
1. Establishment of the National Institute for Food and Agriculture (S. 971), Reps. Peterson, Boustany, Graves bill in the House.
2. Preserve and adequately fund USDA’s Human Nutrition Research Centers,
3. Issue the Dietary Guidelines for Americans every 10 years. Build public education and acceptance and research for future guidelines into the cycle.
4. Support improvements to USDA’s food assistance programs to serve those in need. Help beneficiaries use food stamps for diets consistent with the Dietary Guidelines through incentives and nutrition education.

I will continue to monitor these legislative initiatives and pass them on to CD-HCF members through emails, and forwarding issues of On the Pulse, and postings to the Web site.

PPW DPG Scholarship

Next year the meeting again returns to the winter months, February 4-6, 2008. ADA provides each DPG with a scholarship for registration costs, and CD-HCF provides a $500.00 stipend for our scholarship winner. This can be awarded to someone who has not attended PPW in the last five years. Please contact me for more information if YOU are interested in applying for next year’s scholarship.

F. Ann Gallagher Award

Congratulations to Tammy Heyman, RD, LD, CDE, this year’s F. Ann Gallagher Award recipient. Tammy was recognized at the Awards luncheon at PPW, April 24 with a $1000.00 award from the American Dietetic Association Foundation. She will also be recognized at the Foundation Dinner at FNCE in Philadelphia this fall.

This award was created for CD-HCF members who have demonstrated interest in state or federal legislative issues, and who are not currently on the CD-HCF executive committee. If YOU or anyone you know meets the criteria, please contact me at P.Carleton@msn.com, as next year’s PPW is only nine months away!
The Chair’s Pinnacles  
by Jo Jo Dantone-DeBarbieris, MS, LDN, RD, CDE

BOB, The Best of the Best of CD-HCF, is included in this issue of the Consultant Dietitian newsletter. I hope that you will enjoy this gift from your 2006-2007 CD-HCF Executive Committee (EC). The members of the EC are listed on the back page of this newsletter. The EC members who contributed materials to BOB are listed on the CD.

As this is my farewell article, I would like to take the opportunity to say thank you for allowing me to represent you. You have been so very supportive during my term as Chair. This year has flown by with FNCE in Hawaii being the highlight. Hawaii was only seconded by our April mid-year EC meeting in New Orleans. I know these cities are exciting places to be, but the work we have done while at those meetings is awesome. I would like to list just a few of the accomplishments of your EC during this past year with the lead person(s) on each of these being stated in parentheses. Keep in mind that most things accomplished on the EC is a compilation of efforts from several people or a committee.

1. BOB – of course has to be listed first - given as a FREE member benefit to all members (Jo Jo Dantone-DeBarbieris and Linda Roberts)
2. Taping of the Pre-FNCE Workshop to make it available for purchase along with continuing professional education (CPE) being made available. (Suzanne Cryst, Jo Jo Dantone-DeBarbieris, Brenda Richardson, Linda Roberts, and Marla Carlson)
3. A competitive ballot – to ensure that two candidates are put on the ballot for CD-HCF elections so as to give members a choice of candidates. (Nominating Committee Chaired by Becky Dorner)
4. Change to online voting and change in the timing of CD-HCF elections to coincide with ADA elections. (Suzanne Cryst)
5. Moving forward on the formation of geographical sub-units within CD-HCF. (Mary Vester-Toews)
6. Project to redesign and update of the CD-HCF Web site which will be continuing into the coming year. (Georgianna Walker)
7. Approval of a policy regarding the restrictions and CD-HCF’s responsibility of postings of information on the CD-HCF Web site. (Georgianna Walker)
8. New products released: 
   a. Survival Skills for Nutrition Services (Carolyn Breeding)
   b. MNT Inservice (Cynthia Piland)
9. Continuation of the CD-HCF sponsorship program, without which many of our projects would not exist – THANK YOU SPONSORS! (Cynthia Piland)
10. Development of postcards to be used as information pieces for the marketing committee, corrections sub-unit, and home care sub-unit. (Mary Vester-Toews, Cheryl Bales, Carolyn Yanosko, Cheryl Carson, Cynthia Piland, Marla Carlson)
11. Recognition of a program in the local area that furthers nutrition concerns of the elderly to be given at FNCE each year when applicable. (Brenda Richardson)
12. New award designated for an up-and-coming RD who is new to consulting and has shown outstanding qualities in the business. (Suzanne Cryst, Mary Rybicki)
13. Increase in our contribution to the ADA Foundation. (EC)
14. Support of CD-HCF members contributing to the ADAPAC through email reminders. (Jo Jo Dantone-DeBarbieris)
15. Support of research from Tufts University on assisted living facilities through CD-HCF email. (Jo Jo Dantone-DeBarbieris)
16. All EC materials transmitted electronically rather than in paper form and a standardized report form used for EC member reports resulting in a considerable cost savings. (Marla Carlson)
17. Completion of the MyPyramid Task Force (Linda Roberts)
18. Survey Task Force to survey members and help determine strategic direction for the future of CD-HCF (Carolyn Breeding)

And last - but most importantly – thank you to all the members of CD-HCF who read our newsletters, use our materials, and make the world a better place for our clients, inmates, patients, and residents. Keep up the good work – and remember there is no substitute for hands-on, eyes-on assessments. Make actually looking at and visiting with your clients a priority in your work. It is not only ethically right, it is legally imperative.
As a dietitian, are you at risk of being sued?

Unfortunately, the answer is Yes – You better believe it!

Dietitians are being sued in numerous states – Florida, Texas, California, Mississippi, South Carolina, Kansas, Missouri, Pennsylvania, Ohio, Arizona, Louisiana, New York….

Nutrition neglect cases are increasing nationally. These cases may occur in any health care setting – assisted living, skilled nursing facilities and hospitals. Nutrition centered cases bring big verdicts, in some cases seven digits. With tort reform statutes in many states, there are limitations on insurance coverage. Consequently, aggressive plaintiff attorneys seek additional sources of recovery. In a nutrition case, the RD, consultant RD, Certified Dietary Manager consultant, and the dietary consulting company and/or contracted food-service corporation are at risk. The medical director, director of nursing, administrator, registered nurse, speech therapist, physical therapist, occupational therapist or physician’s assistant may be named in a lawsuit as well.

It is a popular misconception – from a defense standpoint – that nursing home cases inherently have little value, as “old people die.” This is especially true if the decedent had Alzheimer’s disease or some other dementia. The family or plaintiff, however, will argue that the nursing home was negligent and hurt the family’s loved one. The surviving family is entitled to a verdict. Your best defense is to Document, Document, Document. The medical record is the single most important document in a facility’s and your case!

Documents that are reviewed during a lawsuit include:

- Nutrition Assessments
- Progress Notes
- Annual History and Physical Exams
- History and Physicals
- Weight Sheets
- Body Audits/Skin Assessments
- Nursing Summaries
- Personal Caregiver/CNA Flow Sheets/Nursing Assistant Sheets
- Meal Intake/Consumption Sheets
- Vital Sign Sheets
- Physician Order Sheets
- Physician Telephone Orders
- Consultation Notes
- Ambulance Transport Sheets
- Activity Notes
- Social Service Notes
- Treatment Records
- MAR’s
- Oral Assessments Performed
- Full Assessments Performed
- Pressure Sore Assessments Performed
- Nursing Monthly/Weekly/Biweekly Summaries
- Pharmacy Monthly Visits
- Intake and Output Records
- Restraint Assessments Performed
- Incident Reports
- Discharge/Readmission Tracking Sheets
- Care Plans
- Immediate Plan of Care Performed on Admission
- Billing Records
- Admission Face Sheet
- Reports Submitted to the State Involving Serious Injury or Accidents Involving the Victim, as well as Unknown Victims.
- Minutes From Resident Council Meetings
- Minutes From Family Council Meetings
- Grievances Filed by Resident’s Family or Any on Resident’s Behalf
- Admission Nursing Notes
- Admission Skin Assessment/Body Audit
- Care Plan Conference Notification Records
- A Copy of the Nursing Home’s Doctor’s Standing Order
- Therapy Notes/Minutes/Screen/Evaluations that may have been Provided
- Behavior Monitoring Sheets
- Labs Performed
- Photos Taken
- Contractive Assessments Performed
- Consent for Restraints, if applicable
- Physiological Evaluations, if applicable
- Inability to Consent Form, if applicable
- TB Administration Records
- Interdisciplinary Discharge Summary, if Resident was Permanently Discharged From Facility or Deceased while a Resident at Facility
- Medication Error Reports
- Nutrition at Risk Reports
- Referral Lists for RD
- RD Reports
- Policies and Procedures
- Menus

If it wasn’t documented, it wasn’t done!
Clinical Presentation
Most often, CDAD presents as mild to moderate diarrhea, often accompanied by abdominal cramping. Full-blown CDAD is referred to as pseudomembranous colitis and is accompanied by fever, dehydration, nausea and vomiting in addition to diarrhea and abdominal tenderness. Diarrhea is defined as frequent watery loose stools at least 3 times/day for two or more days, but patients with full-blown CDAD may have 10 or more loose stools per day. The most serious manifestation of CDAD, known as fulminant colitis, is life-threatening. Fulminant colitis may result in sepsis, multisystem organ failure, colonic perforation, toxic megacolon, paralytic ileus, hypoalbuminemia and death.

Studies have also shown that CDAD may also complicate the course of other gastrointestinal diseases, such as ulcerative colitis and Crohn’s disease. In addition, 4% to 12% of the diarrhea in AIDS patients is caused by CDAD.

Transmission of C. difficile
C. difficile is transmitted through oral ingestion. Because C. difficile is spore-forming, it can survive for months in the environment. The bacteria can be spread through direct contact, person-to-person spread on hands or clothing and from the environment. In hospitals, C. difficile has been found on caregivers’ hands, cart handles, bedrails, bedpans, toilets, bathing tubs, stethoscopes, thermometers, telephones and remote controls. More than 90% of C. difficile infections in the health care setting occur during or after antimicrobial therapy. Other risk factors include severe underlying illness, advanced age (65 or over), nasogastric intubation, antiulcer medications, recent hospitalization or residing in a nursing home, chronic bowel disease, and previous infection with C. difficile.

Almost all antimicrobial agents have been associated with CDAD. A 1998 meta-analysis suggested that broad-spectrum antimicrobials were most likely to cause CDAD. Specific antibiotics identified include Clindamycin, cephalosporins (Ceftin®, Omnicef®, Rocephin®, Maxipime®), ampicillin and fluoroquinolones (Ciprofloxin, Levofloxacin). Other antimicrobials, including antiviral and antifungal medications, as well as chemotherapy medications, can also increase the risk of CDAD. Unfortunately, studies indicate that antimicrobials are among the most frequently prescribed medications in long-term care facilities, accounting for around 40% of all systemic drugs prescribed. In 1996, statistics indicated that there was a 50-70% chance that a resident in a long-term care facility would receive at least one course of antibiotics over the course of a one-year period.

Diagnosis of C. difficile
C. difficile should be suspected in any patient with diarrhea who is currently receiving, or has recently completed, a course of antibiotics. Only the stools of patients with watery loose stools should be tested because colonization rates are high and a positive result in a normal stool sample indicates colonization, but not necessarily infection.

The gold standard for diagnosis of C. difficile is tissue cytotoxic assay due to its high sensitivity and specificity. Toxins can be easily detected by microscopic examination, however, the results of the assay require 24 to 48 hours to read. A more rapid test known as enzyme-linked immunosorbent assay (ELISA) has been developed over the last several years. The ELISA test is commercially available as a diagnostic kit and does not require specialized personnel. Results are available within a few hours, but are less sensitive and specific than cytotoxic assay.

Medical Therapy for CDAD
The first step in treating CDAD is to stop antibiotic therapy. Up to 25% of patients with CDAD recover without further therapy. Interestingly, therapy for patients who do not improve consists of a course of antibiotics. Metronidazole (Flagyl®) is the first-line therapy. Flagyl® is inexpensive and usually well tolerated.

Continued on page 6
Vancomycin is the second-line defense for patients who do not respond to Flagyl®. Vancomycin is expensive and because of the risk of the development of vancomycin-resistant enterococcus, it is reserved for non-responsive cases. More than 95% of patients respond to antibiotic therapy and show improvement in one to four days, with complete resolution in two weeks.

In the less than 1% of cases that do not respond to antibiotic therapy, surgical intervention is required for the management of bowel perforation or toxic megacolon. Fifteen to 35% of patients will experience recurrent CDAD. The first relapse is treated with a repeat course of Flagyl®. Only about 8% of patients have more than one relapse and supportive evidence for specific treatment strategies is limited.

No therapy is required for asymptomatic patients. Antibiotic therapy for colonized patients generally does not rid them of the bacteria and should not be attempted.

Nutritional Therapy for CDAD
Nutrition-related consequences of CDAD include dehydration, electrolyte imbalance, kidney failure, malnutrition and malabsorption. The primary goal of nutritional therapy is replacement of fluid and electrolyte losses. Older adults are at higher risk for volume depletion due to the diminished circulatory reserve, atherosclerotic occlusion of arteries to vital organs, lowered thirst drive, less effective homeostasis and greater use of diuretics. Comorbidities, including dementia, physical disability or neurological impairment, may impede the patient’s ability to obtain or swallow adequate fluids.

Oral Rehydration Therapy
Oral rehydration therapy (ORT) is a simple, inexpensive treatment for volume depletion which should be initiated as soon as possible in patients experiencing diarrhea. ORT has been shown to be effective in the pediatric population and researchers believe it is likely to be as effective in older adults.

Sports drinks, soda, and fruit juice are hyperosmolar and deficient in electrolytes and are sub-optimal replacements for patients with significant dehydration. Numerous commercial ORT products containing sodium and potassium are available. Available oral rehydration products include the following:

2. Enfamil® Enfalyte® – www.meadjohnson.com
6. Homemade rice-based formula

ORT can be administered by any health-care staff or family member. If the patient is aspirating or having trouble swallowing, an enteral feeding tube may be required. There is no specific dose of ORT that should be given. The goal is to replace the volume of fluid that has been lost in order to avoid volume depletion. The patient should take two to four ounces every two to four minutes. Because the thirst drive is diminished in many older adults, and cognitive impairment may limit the usefulness of the thirst symptom, fluid intake should be encouraged and monitored. Rehydration is considered adequate when the patient is urinating more than 200 cc every two to four hours.

ORT should not be used when the following conditions exist:
1. Anuria or oliguria - Since normal renal function is required to allow the excretion of any excess water or salt, patients who have chronic anuria or oliguria usually require parenteral administration of water and electrolytes. It is important to note that transient oliguria is a feature of dehydration and is not a contraindication for oral rehydration therapy.
2. Severe dehydration with symptoms of shock - In this situation, oral rehydration is too slow and rapid intravenous therapy is necessary. Symptoms of severe dehydration include severe thirst, rapid heartbeat, decreased skin turgor, hypotension, oliguria or anuria, sunken eyes, loss of body weight, convulsions, stupor, and coma.
Nutritional Management of Clostridium difficile-associated Disease in Long-term Care  
Continued from page 6

3. Severe diarrhea - When diarrhea exceeds 30 mL per kg of body weight per hour, the patient cannot drink enough fluids to replace continuing losses.
4. Glucose malabsorption - ORT exacerbates diarrhea and dehydration, resulting in an increase in the volume of stool and osmotic diarrhea.
5. Inability to drink or severe sustained vomiting - Inability to drink may be the result of extreme fatigue, stupor or coma. Parenteral therapy is required.
6. Intestinal obstruction, paralytic ileus or perforated bowel.\textsuperscript{14}

Oral Diet
Elderly patients are at high risk for malnutrition and diarrhea can have adverse nutritional consequences.\textsuperscript{1} Patients with diarrhea may have anorexia with reduced intake for several days, which can exacerbate a compromised nutritional state.\textsuperscript{1} Poor dietary intake may also occur due to the fear of diarrhea and/or incontinence. In addition, \textit{C-difficile} infection may cause protein-losing enteropathy.\textsuperscript{1}

Dietary management should focus on restoring and maintaining nutritional requirements to prevent malnutrition. Fasting may reduce the renewal of intestinal cells, increase intestinal permeability and decrease the absorptive capacity of the intestine.\textsuperscript{15} Early feeding should be encouraged if there are no contraindications.\textsuperscript{12} In addition, adequate fiber intake may help to firm stools and normalize stool weight and alter the intestinal microflora. Suggested foods include starches, such as rice, potatoes, noodles, crackers, and bananas, cereals, soup, yogurt, vegetables, and fresh fruits.\textsuperscript{15} Foods high in simple sugars should be avoided.

There are several dietary factors that may worsen diarrhea by creating an osmotic effect. These factors include:
1. Caffeine - coffee, tea, cola, over the counter headache remedies
2. Fructose (in quantities surpassing the gut's absorptive capacity) - apple juice, pear juice, grapes, honey, dates, nuts, figs, soft drinks (especially fruit flavored)
3. Hexitols, sorbitol, and mannitol - apple juice, pear juice, sugar-free gum, mints
4. Lactose - milk, ice cream, soft cheeses
5. Magnesium-containing antacids
6. Sucrose - table sugar\textsuperscript{16}

Probiotics
Probiotics, which have been described as naturally occurring "good bacteria," have been suggested as a strategy for preventing and treating CDAD.\textsuperscript{xvii} It is believed that the disturbance of the normal colonic flora predisposes patients to colonization with \textit{C-difficile}. Probiotics are believed to restore equilibrium to the intestine by delivering bacteria to the gastrointestinal tract.\textsuperscript{17} Several types of bacteria and yeasts have been proposed in the prevention and treatment of antibiotic-associated diarrhea and CDAD.\textsuperscript{17} However, there is a paucity of research demonstrating that probiotic therapy is effective in preventing or treating CDAD.\textsuperscript{17} In one study, the yeast \textit{Saccharomyces boulardii} appeared to be beneficial in patients with severe CDAD.\textsuperscript{17} \textit{S.boulardii} may also be beneficial in preventing recurrent \textit{C-difficile} diarrhea when used during the first recurrence.\textsuperscript{18} Both \textit{S.boulardii} and \textit{Lactobacillus rhamnosus GG} appear to be effective in preventing antibiotic-associated diarrhea, but not in the prevention of \textit{C-difficile} diarrhea.\textsuperscript{18} Concerns regarding the use of probiotics include lack of a standardized dose, nonviability after manufacture and inclusion of incorrect bacteria species in probiotic products.\textsuperscript{17}

The scientifically tested probiotic agents marketed commercially in the United States are Culturelle (\textit{L.rhamnosus GG}), available at www.culturelle.com and Florastor (\textit{S.boulardii}), available at www.florastor.com. In addition, many physicians report success with lactobacilli anecdotally\textsuperscript{xix} and routinely use yogurt or Lactinex®, which contains a blend of \textit{Lactobacillus acidophilus} and \textit{Lactobacillus bulgaricus} as a preventive measure.

Prebiotics
Prebiotics are non-viable food components (carbohydrates) that selectively stimulate the growth and/or activity of one or a limited number of bacteria in the colon that can

Continued on page 8
Nutritional Management of Clostridium difficile-associated Disease in Long-term Care  
Continued from page 7

improve gastrointestinal health\textsuperscript{20}. Fructo-oligosaccharides (FOS) are one form of prebiotics used in nutritional supplements. In vitro and animal research suggest a possible role for FOS in the prevention and/or treatment of \textit{C. difficile} infections. FOS has been found to suppress the growth of \textit{C. difficile} in vitro, protect cecal epithelial tissue in mice and reduce the incidence of diarrhea in \textit{C. difficile}-challenged mice.\textsuperscript{21} Nutritional supplements with FOS are available in various commercial products.

Other Adjunctive Treatments

Bismuth subsalicylate (Pepto-Bismol\textsuperscript{®}) has been shown to have antibacterial activity against diarrhea-causing organisms.\textsuperscript{1} Use of Pepto-Bismol\textsuperscript{®} has been anecdotally reported to be successful in treating patients with mild symptoms.\textsuperscript{1} Kaolin compounds, such as Kaopectate\textsuperscript{®}, do not have antibacterial activity and are not likely to be effective in treating \textit{C. difficile} infection.

Pro-motility medications, such as Reglan\textsuperscript{®}, should be avoided for obvious reasons. Antidiarrheal meds such as Imodium\textsuperscript{®} and Lomotil\textsuperscript{®} should be avoided also as they may predispose patients to toxic megacolon.\textsuperscript{4} Narcotics should also be avoided if possible in patients with CDAD due to their antiperistaltic effects.\textsuperscript{4}

Nutrition Assessment

Patients with CDAD are at high risk of dehydration, electrolyte imbalance and malnutrition. The dietitian should work with the nursing staff and nutrition department to establish a referral process so that the dietitian is informed of all residents with diarrhea.

A comprehensive nutritional assessment is necessary to develop a plan of care to address the patient’s risk factors. The assessment should include the same factors evaluated for all high risk patients. In particular, the dietitian should conduct a physical assessment of the patient to observe for signs and symptoms of dehydration. Labs should be ordered and evaluated for electrolyte imbalances and skin status should be evaluated for excoriation and breakdown resulting from frequent diarrhea. Medications should be reviewed to identify those that may worsen diarrhea, including antidiarrheal and pro-motility medications.

Fluid needs should be assessed at 35-40 ml/kg body weight for patients with dehydration and/or diarrhea. A hydration plan should be developed to ensure that patients with dehydration receive adequate rehydration. Foods that may exacerbate diarrhea should be eliminated. If clear liquids are indicated, high-calorie/high-protein foods should be added to prevent malnutrition. Lactose-free, low-residue supplements containing FOS may be added to provide additional nutrients.

An individualized plan of care should be developed. The plan of care should include a hydration schedule, which indicates staff responsibility for administering and monitoring fluids. The plan should include quantity of fluids to be offered, frequency and type of fluids to be offered. Dietary modifications should be included in the plan of care to assist staff in identifying foods that are contraindicated. The dietitian should in-service the nursing and dietary staff on the importance of proper fluid intake and dietary avoidances. Staff should also be educated on the need to notify the dietitian when patients are not taking adequate fluids.

Prevention of CDAD

Handwashing is critical to reducing the spread of the \textit{C. difficile} bacteria. However, research on the best method for handwashing is not definitive. One study reported that the use of chlorhexidine (Hibiclens\textsuperscript{®}) was more effective than soap, while another study showed no difference.\textsuperscript{2} Regular hand washing and the use of gloves together have been demonstrated to be effective in preventing spread via hands.\textsuperscript{2} The effectiveness of alcohol-based products has not been addressed. Alcohol-based products are not sporicidal, but may improve compliance with hand washing.\textsuperscript{2}

Universal and contact precautions should be used with patients who have CDAD. Isolation of patients with \textit{C. difficile} in private rooms or cohorting with other patients with CDAD has been shown to be successful in limiting transmission.\textsuperscript{2} Such isolation may be difficult in long-term care facilities because adequate private
The environment surrounding patients with CDAD should be thoroughly disinfected on a routine basis. All potentially contaminated surfaces should be cleaned at least daily. Disinfectants that do not contain chlorine may cause increased spore production, however, studies of various cleaning agents provide only circumstantial evidence of their efficacy. Use of hypochlorite solutions (bleach) has been shown to decrease rates of C. difficile contamination and may lower CDAD rates. Detailed information on environmental cleaning of health care facilities can be found in the Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee, at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5210a1.htm.

Janet S. McKee, MS, RD, LD is the president of Nutritious Lifestyles, a group of RD’s, LD’s, and CDM’s that provide nutrition and foodservice consultations throughout the southeast. She has a BS and MS degree, both from East Carolina University. Ms. McKee is a national speaker and author with areas of expertise including Geriatric Nutrition, Liability Reduction, MNT for Renal Disease, and Pressure Ulcers. She provides nutrition expertise to defense attorneys, and the insurance industry, on a national basis.

Susan Tassinari, MS, RD, CSG, LD/N, received her bachelors and masters degrees in Food and Nutrition from Florida State University. She is the President of Medical Nutrition Consulting, LLC. Ms. Tassinari is board certified in Gerontological Nutrition and is a practicing consultant in long-term care throughout Florida and also provides expert witness services to law firms throughout the United States. She has published articles on bariatric nutrition, protein-calorie malnutrition and nutrition for wound healing and has developed continuing education programs on bariatric nutrition and renal nutrition. She has presented programs on nutrition and liability, wound healing, renal nutrition, bariatrics and long-term care nutrition to audiences of nurses, attorneys, and dietitians.

Meal intake records and weight sheets are often not considered “legal documents,” but remember that they really are legal documents. These can be very helpful to a family, but they can also be incriminating – depending on the quality of the documentation.

When the meal intake records are inconsistent or not completed, it looks as though the facility was neglectful and the resident did not eat for days. If weight sheets are not accurate and completed on a timely basis, weight loss may not be addressed by the RD on a timely basis. Information from these records is vital to malnutrition, dehydration and pressure sore cases. They are used as evidence as to whether nutrition problems were identified, interventions implemented and the intervention effective.

The lack of documentation and quality may indicate the qualifications of staff and whether there is enough staff. Litigation increases as the number of survey citations goes up and RD consultant hours go down.

Standards of Care for Nutrition Services

The following F tags are considered Standards of Care for RD’s: F272, F274, F209, F208, F281, F309, F314, F325, F327, F366, F501. Every state has dietary regulations that are considered Standards of Care. These regulations allow for residents in need of special or therapeutic diets, accommodation of religious practices, appropriate menu substitution, sufficient food and snacks available and offered between meals. The state licensure act also provides Standards of Care. Check with your state to become oriented to these standards. Also be aware of and follow the facility’s policies and procedures. Dietitians are named in lawsuits concerning choking incidents, malnutrition, dehydration, weight loss and pressures sores. Documentation and appropriate medical nutrition therapy are key to liability risk reduction.

Documentation from Referral to Assessment to Implementation

Referrals to the RD should include significant/severe weight loss, pressure sores stage II-IV, non-healing wounds, enteral or parenteral feedings, transitioning from tube feeding to oral feedings, renal disease, liver disease, uncontrolled diabetes, chronic constipation or diarrhea, malnutrition, dehydration, sepsis, malabsorption, chronic food complaints and poor intake for an unknown reason.

Once the referral is made, a comprehensive nutrition assessment should be completed. This assessment should address weight status and changes, abnormal labs, chewing/swallowing issues, skin condition, feeding ability, nutrient needs and whether those needs are being met. Nutrient needs should be re-evaluated with each change of condition. Nutrition interventions should be communicated and implemented in a timely manner. The interventions need to become part of the case plan. Remember the care plan is a “live” document and should reflect the current status of the resident. Resident care plans should be reviewed and revised as needed. Care plans can create problems if they set an impractical level of care. Records of care plan attendance can also be used to show a family’s lack of involvement if the family did not attend.

Communication with the resident and families must be documented. This is especially important when the resident’s family has a complaint with the prescribed medical nutrition therapy. Document non-compliance by resident or family with diet orders or other nutrition therapies. Document any communication with other interdisciplinary team members such as the DON, nurses, ST, OT, or physicians.

Avoid Charting Pitfalls

- Document all contact and conversations with family.
- Record key nutritional interventions.
- Reflect visual checks and observations.
- Do not criticize the facility staff.
- Be sure all entries are signed and dated.
- Avoid inconsistencies and incongruent notes.
- Update care plans with current therapies and expectations.

Examples of inappropriate chart entries:

“Nurse, as usual, forgot to weigh the resident.”
“The resident was alert and unresponsive.”
“The resident had waffles for breakfast and ambrosia for lunch.”
“Neither the resident nor any of his family members are capable of telling the truth.”

Timely, accurate and comprehensive documentation of medical nutrition therapy is the most effective tool to avoid litigation and liability.

Important Terminology

Learn and understand the following documents, which are written and signed:
Investigative Protocols along with the new 2007 Scope and Severity directives, New 331) will continue to impact facilities throughout Unnecessary Meds and Pharmacy Services (F329- Pneumococcal Immunizations (F334) and Feeding Assistants (F369), Influenza & on Activities (F248 & F249), Nurse Staffing (F356), in late 2006 and early 2007. New survey guidance documents the family’s wishes. symptoms and gives emotional support. Get a physician and family that minimizes pain, alleviates withdrawal of nutritional intervention. Do not Resuscitate (DNR): Does not restrict nutritional support. Comfort Care (Palliative Care): Care authorized by physician and family that minimizes pain, alleviates symptoms and gives emotional support. Get a physician order. It is important that the physician documents the family’s wishes. Be Proactive Documentation is critical in minimizing your risk of litigation. The second best defense is happy and satisfied customers. Lawsuits occur as a result of dissatisfied residents and families, noncompliant residents, chronic complainers, guilty family members and angry residents and families. Visit the residents and families. Honor the resident’s food preferences. Be sure you have an understanding of the resident and family’s desires concerning medical nutrition therapy. Go the extra mile to improve customer satisfaction.

Educate the family when decline is inevitable. Explain how the resident will be affected by dehydration and malnutrition. Also educate the family and staff on the resident’s right to refuse meals, supplements and other therapies. Protect yourself – carry malpractice insurance; follow Standards of Practice for your state; do not work with facilities that do not allow adequate RD consulting time; develop tracking systems; and communicate with residents and families. Dietitians ARE being sued – the risk is real. Prevention through documentation and customer satisfaction is your best defense!

UPCOMING SEMINARS – National Institute for Health

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<th>2.0 CEU’s: NHA, RNs, LPNs, ACT. (Specific Topics)</th>
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JUNE 7, 2007 - MID YEAR SURVEY UPDATE

Critical compliance components & survey activity
Presented by: Janis Breedlove, RN, LTC Consultant Facilities should have significant revisions in place based on regulatory changes that were implemented in late 2006 and early 2007. New survey guidance on Activities (F248 & F249), Nurse Staffing (F356), Quality Assessment and Assurance (F520), Paid Feeding Assistants (F369), Influenza & Pneumococcal Immunizations (F334) and Unnecessary Meds and Pharmacy Services (F329-331) will continue to impact facilities throughout 2007. Scope and Severity directives, New Investigative Protocols along with the new Psychosocial Outcome Severity Guide will allow surveyors to increase the severity or deficiency categorization of all F Tags.

Do you know....

* What surveyors are looking for in the next part of 2007 and how to prepare?

* What surveyors are finding to date and the major challenges will be in 2008?

* How these areas will increase severity or deficiency categorization of all F-Tags?

JUNE 14, 2007 - GETTING THE MOST FROM YOUR CHARGE NURSES

Improving Turnover, Compliance & Efficiency
Presented by: Diane Vaughn, RN,C,C-DONA/LTC, LNHA - Pathway Health Services

Holding onto and training top-notch staff is no easy task. With turnover rates skyrocketing, the only key to success is assessing the staff with the most potential. Charge nurses are critical to the success of your departments. Getting the most from your charge nurse is key to improving efficiency and compliance in your facility. This teleconference will address ways of empowering your charge nurses to excel in areas such as leadership, hiring, firing, providing discipline, MDS and Care Planning efficiency, and fiscal responsibilities. Gain compliance & efficiency today!

Continued on page 14
CMS News
by Becky Dorner, RD, LD, Secretary NPUAP, Past Chair CD-HCF

CMS Announces the Arrival of Two New F-tags
CMS announced that it will unveil two new F-tags by fall 2007. In June, skilled nursing facilities should expect to see new survey guidance on how to handle feeding assistants in the form of Eating Assistant (F-Tag 373). Then by late summer or early fall, an accidents and supervision F-tag will emerge. The new fiscal year for CMS which begins late fall should see the release of the much anticipated Sanitation and Nutrition (F-Tags 371 and 325). These were previously slated to be released in the summer of 2007, so we may see them earlier. Watch the CD-HCF electronic mailing list for the most current news related to these important F-Tag releases.

March 2007 Revisions to the MDS 2.0

In other news...
Nursing Home Regulations Plus Web site
This searchable Web site serves as a one-stop location to examine and compare the content of state regulations related to nursing homes, the processes of regulation and exceptions to regulations within a state, recent state changes, innovative nursing-home designs and programs that were accomplished within existing regulations, and innovative state regulatory initiative.

Use this location in multiple ways:
— learn about regulations governing a particular state
— learn about a particular topic nationwide
— consult federal regulations and related codes
— check out the art of the possible
— learn the effects of federal and state agencies
— learn what providers are developing within existing regulations
— view coalitions in states
— find related publications and research
http://www.hsr.umn.edu/NHRegsPlus/

Update from The Joint Commission
The Joint Commission has launched a new branding initiative including a new executive director, a name change (the name has been shortened from the Joint Commission on Accreditation of Healthcare Organizations to The Joint Commission), new logos, Web site design, and newsletter design. Also, e-mail extensions have changed to

“@jointcommission.org”.
http://www.jointcommission.org/AccreditationPrograms/LongTermCare/LTCUpdate/issue_107.htm

The State of Aging and Health in America
The Centers for Disease Control and Prevention (CDC), in partnership with The Merck Company Foundation, recently released The State of Aging and Health in America 2007 report. The report provides an overview of our nation’s progress in promoting the health and well-being of older adults and in reducing the prevalence of behaviors and conditions that contribute to premature death and disability.

Highlighted in the report are “Calls to Action” that address critical public health issues impacting older adults. This feature is intended to stimulate health and aging services professionals, communities, and the public to take steps on critical issues for older adults. The report provides guidance on implementing innovative programs designed to improve the health and well-being of older Americans. In addition, the report includes a spotlight section on falls, which are the leading cause of injuries and injury-related deaths among older adults. An electronic, interactive version allows easy access to national and state-based data searchable by state, health indicator and other variables. http://www.cdc.gov/aging/

NPUAP Has Redefined Definitions and Descriptions of the Pressure Ulcer Staging System
The National Pressure Ulcer Advisory Panel (NPUAP) 2007 Biennial Consensus Conference held in San Antonio was the culmination of years of research and expert discussion related to the pressure ulcer staging system. The NPUAP has redefined the definition of a pressure ulcer and the stages of pressure ulcers, including the original 4 stages and adding 2 stages on deep tissue injury and unstageable pressure ulcers. This work is the culmination of over 5 years of work beginning with the identification of deep tissue injury in 2001.

Source: Becky Dorner & Associates, Inc. Email magazines, February, March and April, 2007. To stay up to date on all the latest news in long term care, feel free to sign up for this free email magazine at www.BeckyDorner.com

THE CONSULTANT DIETITIAN – PAGE 12
Medicare’s Competitive Bidding Program will Change the Delivery of Enteral Nutritional products in Nursing Homes

Within the next few days or weeks, the Centers for Medicare & Medicaid Services (CMS) will open bidding for the privilege of billing for the care of patients receiving enteral nutrition in ten metropolitan areas. Many current suppliers will be surprised by this change. Some of those surprises may be quite unpleasant. The supervision of enteral nutrition to patients in skilled nursing facilities is a central concern to many members of CD-HCF, and the bidding process will change many members’ businesses.

The final regulation was issued in early April, establishing a timeline, defining the product categories and describing geographic areas. CMS has selected a Competitive Bidding Implementation Contractor (CBIC) to assume responsibility for provider education and bid processing. The CBIC Web site (www.dmecompetitivebid.com) is the central focus for provider education, bidding information and, eventually for filing bids.

This new initiative needs to be kept in perspective during 2007 and 2008. Bidding will only occur in only 10 competitive bidding areas during this first phase, roughly 5% of the Medicare market. Two hundred sixty two metropolitan areas and all of rural America will not be included in this first phase of bidding. For those members caring for patients within the ten selected areas, however, new challenges await. Each area consists of a metropolitan area with the surrounding suburbs. The ten areas are:

- Miami, Florida
- Pittsburgh, Pennsylvania
- Riverside, California
- Cincinnati, Ohio
- Cleveland, Ohio
- Kansas City, Missouri and Kansas
- Dallas, Texas
- Orlando, Florida
- San Juan, Puerto Rico
- Charlotte, North Carolina

Members should look at the zip code descriptions of these areas on the CBIC Web site to determine whether their facilities are within these areas or not.

If a CD-HCF member’s organization is providing care for patients using their own supplier number and billing Medicare and receiving payment for enteral products from Medicare, then the member’s organization will be considered a supplier. Suppliers must be accredited by one of the ten accreditation organizations listed on the CBIC Web site. Accreditation must be initiated by early July, and must be completed by August 31.

 Suppliers will also need to complete a comprehensive bidding application, including three years of financial information, and will need to submit a bid for the opportunity to provide enteral nutrition to Medicare beneficiaries in these ten competitive bidding areas. Bids will be based on the 16 Healthcare Common Procedure Coding System (HCPCS) codes for enteral nutrition. The Competitive Bidding Implementation Carrier will evaluate these bids and will discard between a third and a half of bidders.

Other CD-HCF members work under contract with SNF facilities. These facilities submit claims and receive payments directly from Medicare carriers, and are considered suppliers. These facilities will need to be accredited, complete the application materials and submit a bid that will be compared to all other suppliers in the competitive bidding area. Facilities, however, may restrict their bids to care for residents of their facility, while other suppliers must agree to care for patients throughout the competitive bidding area.

This brief article summarizes a complex 400-page regulation. CD-HCF members should watch www.dmecompetitivebid for further announcements.
Food Safety Update  
by John A. Krakowski, RD

Recent discussion on the “Forum eml” on the serving of fluid milk from pitchers brings to mind an important fact in the life of a consultant dietitian – knowing the food safety regulations is a critical component of a successful practice. Leading and managing a food safety operation and creating a culture of safe food handling at all times require several key components including:

• Knowing food safety codes and regulations
• Understanding these codes and regulations
• Developing training programs and competencies for food personnel
• Implementing monitoring procedures to insure compliance
• Evaluating the food safety program

Understanding codes and regulations will go a long way in developing and fostering a food safety culture - the predominating attitudes and behavior that characterize the functioning of an organization – and this will insure compliance with code and more importantly will provide the 24/7 delivery of safe food.

It is critical to have ready access to the code. The Model Food Code provides an extensive and detailed description of the federal regulations for food operations. It is available online (www.cfsan.fda.gov/~dms/foodcode.html) and in printed text form. Access to the written code facilitates research and review. In addition, the state and local codes provide specific guidelines for food operations in a state or local jurisdiction.

Manager training and certification in food safety may be accomplished with the ServSafe™ curriculum.

UPCOMING SEMINARS – National Institute for Health

Continued from page 11

Do you know....
* How charge nurses must direct responsibility down the line?
* The best techniques for observing and monitoring the resident and environment?
* The best way for charge nurses to give direction to your nurse aides?
* How to assess the charge nurses attitude under stress related situations?

JUNE 21, 2007 - CARE PLANNING & DOCUMENTATION
A Whole new Ballgame based on Significant Changes to QOL

THE CONSULTANT DIETITIAN – PAGE 14

This program has several advantages including wide-spread food industry recognition of the curriculum, quality texts at two levels (college level text or course text), instructor resources and guidance materials, and a certification examination. Completion of the class training and successful certification are merely the first steps as continued learning and professional development is required. Consultant RDs have an ideal opportunity to develop the skill sets required to serve as course instructors. There is a newly developed Web site for additional information at www.servsafe.com including information on computer-based training.

Members are encouraged to submit suggestions for future food safety topics foodsafetyrd@optonline.net.

CD-HCF is pleased to welcome John A. Krakowski, MA, RD, CDN, as the Food Safety Editor of The Consultant Dietitian. John has an MA in Foodservice Administration from New York University and a BS in Dietetics from the State University of New York – College at Oneonta. He is a Food Safety Coach and Trainer. John spent 11 years with City Harvest, New York, NY, as an external liaison on issues related to the core mission of City Harvest: policy, research, community education; organization-wide internal consultant on all food and nutrition issues; and a member of the executive team. He served as staff contact at the NYC Office of Emergency Management Disaster Center during WTC Recovery and deployed to Montgomery, AL Joint Field Office during hurricane Katrina recovery.

Presented by: Judi Kulus, MAT, NHA, RN, RAC-CT- Pathways Consultant
As part of new surveyor guidance for Quality of Life, comprehensive care planning, care planning revisions, documentation standards, charting and progress notes must reflect a variety or new standards set forth by CMS. Each function must reflect goals, interests and preferences of the resident while also reflecting the comprehensive assessment. Based on new surveyor training and guidance, your care plan will be reviewed using new criteria that help with determination of compliance. Do you know....
* How each discipline is responsible for incorporating goals?

Continued on page 17
Join CD-HCF for FNCE 2007 in Philadelphia, Pennsylvania! As always, your DPG will be very busy with a myriad of activities for members. September 29 - October 2, 2007

PreFNCE Workshop

**What’s New? Implementing Next Steps of Nutrition Care Process, Cutting Edge of Clinical and Regulatory Update**

Saturday, September 29, 2007
Loews Philadelphia Hotel
Philadelphia, PA

- Aging, Inflammation and the Effects of Protein  
  Kevin Miller, PhD, Novartis Nutrition Sr. Clinical Scientist

- The Aging GI Tract and Nutritional Implications  
  Dr. Robert Martindale, MD, PhD, Oregon Health Sciences University

- Nutrition Care Process—The Next Steps as the Process Moves Forward  
  Carol Elliott, RD, LDN, will share her expertise and experiences with applying the NCP to LTC settings. Carol has worked with the NCP for over a year and now is helping other consultant RDs to learn and apply this process to their work settings. The goal of the CD-HCF preFNCE session is to take the presentation beyond the introductory phase.

- Regulatory Update
  6 hours of Level II CPEs applied for.

Other Important FNCE Events

- Thursday, Friday, September 27 & 28 – Executive Committee Meetings

- Monday 10/1 3:30 -5pm **CD-HCF Sponsored Educational Session**  
  **Protein Supplements: What’s Right for the Long Term Care Patient?**  
  Vickie Castellanos, PhD, RD, and Mary Litchford, PhD, RD, LDN

- Join us on the Exhibit Floor – Sunday – Tuesday - **Booth number: 1614**

- See us at **Product Market Place** – Sunday, September 30, 8 am-4pm

- **HomeCare Subunit** – Sunday, September 30, 5-6pm  
  **Member Reception** – Sunday, September 30, 7-9 pm

- Visit us at **DPG Showcase** – Monday, October 1, 10:30 am-1 pm

- **Corrections Subunit** – Monday, October 1, 5-6 pm

- **Member Breakfast** – Tuesday, October 2, 6:30-7:45 am
How many correctional RDs have encountered male anorexia? Anorexia nervosa is typically defined as an eating disorder, marked by extreme fear of becoming overweight that leads to excessive dieting to the point of serious ill-health and sometimes death. Compound this with incarceration for life. The question is, did the offender come to prison with this disease diagnosed or is it self-induced as a control or manipulation behavior? Regardless, it is a weight loss issue and as the dietitian, your involvement is critical.

Observations on what one multi-level security state prison has been dealing with are captured below. The brief background information is that this offender is in his 30’s and has been incarcerated for nearly 10 years for a heinous crime. The dietitian at this institution has been asked to document the signs of male anorexia that have been observed the past two weeks with this offender. Most literature related to anorexia nervosa will reveal the signs stated below. The observations are documented from the clinical RD at this institution.

Sign: Dramatic weight loss in a short period of time.
Observation: Pieces of toilet paper on bed near tray and frequent hand washing during meals creates suspicion that the offender is chewing food and spitting it out, not swallowing. Obsessive weight concern on the surface with unresolved emotional conflicts.

Sign: Wearing baggy clothes or dressing in layers.
Observation: The offender will talk to staff with a bed sheet covering him.

Sign: Maintain strict control over food intake, and obsession with calories and fat content of foods.
Observation: During all RD visits, the offender asked what foods have sodium nitrates and requested copies of the vegetarian menus with nutritional analysis.

Sign: Keeping food diary or calories consumed, exercise, etc.
Observation: Between meals, the offender writes constantly.

Sign: Deny hunger - turned down snacks and/or nutritional supplement, unlike most offenders. Will hide or flush food down the toilet claiming it has been eaten.
Observation: Suspect offender is chewing food and spitting it out, but not swallowing.

Sign: Pieces of toilet paper on bed near tray.
Observation: Suspect offender drops food into napkin to later discard.

Sign: Requests laxatives and wheat bran for increased fiber.
Observation: Request for laxative is denied. Only bran is provided.

Sign: Obsession with continuous exercise.
Observation: Offender will exercise even during meals and frequently wash hands during meals.

Sign: Unusual food rituals.
Observation: Shifts the food around on the plate to be eaten; cutting food into tiny pieces.

AN IDT APPROACH

The medical and executive team at the institution have met to assess and analyze the possible causes. Is it depression, manipulation, genetics or environmental factors that are triggering this behavior? Diagnostic criteria as outlined by the medical team must also be explored; it includes, but is not limited to the following:

- Refusal to maintain body weight at or above IBW
- An intense fear of gaining weight or becoming fat, even though underweight
- Moderate malnutrition
- Labs (results were normal for this offender)

Anorexia is an avenue for this individual offender to still be in command when he believes he has lost all other control in prison. It is a unique reaction to a variety of external and internal conflicts such as stress, anxiety, unhappiness and feeling like life is lost or extremely out of control. Anorexic behaviors as described above can be a coping mechanism for these emotions. This can and will challenge the healthcare team. Typically, the medical team is not well trained in anorexia especially with the male population.

For the most up to date information, contact the American Dietetic Association about eating disorders or check out information provided by the National Association of Anorexia Nervosa and Associated Disorders or the Harvard Eating Disorder Center.
Ann Gallagher Award Recipient
by Tammy Heyman, RD, LD, CDE

What an honor it is to receive this ADAF award funded by Indiana CD-HCF! Knowing Ann Gallagher’s impact on public policy issues involving our profession, I am deeply humbled by this award in her name. I want to thank my husband, Richard, my family, friends, mentors and peers.

There are several dietitians I want to recognize for their support along the way. First of all, when I was an intern, Pat McKnight, MS, RD, LD, FADA, started it all by engaging me in OH licensure efforts. Next, I joined Missouri dietitians working on RD licensure legislation: Rita Sissel, RD; Beth Huddleston, MS, RD; Connie Diekman, MEd, RD, LD, FADA; Marty Yadrick, MS, MBA, RD, FADA; and Pauli Landhuis, MS, RD, LD to name a few. And when I moved to Oklahoma, my passion for our profession was ignited again when Oklahoma and national CD-HCF members welcomed me so graciously to the executive committee. I especially wish to thank Pam Brummit, MA, RD, LD; Marolyn Steffen, RD, CD; Carolyn Breeding, MS, RD, LD, FADA; Georgianna Walker, MS, LRD; Suzanne Cryst, RD, LD; Marla Carlson, Jo Jo Dantone DeBarbieris, MS, LDN, RD, CDE; and the current Legislative Network Chair (LNC), Priscilla Carleton, MHA, LDN/RD. When serving as CD-HCF LNC, I was blessed to work with ADA Policy, Initiatives and Advocacy (PIA), primarily Mary Lee Watts, MPH, RD, as well as other DPGs and ADA members on the Older Americans Act, Medical Nutrition Therapy, Ryan White CARE Act, Medicare proposed changes and more. I also wish to thank mentors and role models: Ann Gallagher, RD, LD, CD; Charlette Gallagher-Allred, PhD, RD, LD; Esther Winterfeldt, PhD, RD; Lea Ebro, PhD, RD; and Maria Spicer, PhD, RD.

There are many others I have failed to mention and this honor belongs to every one of you also. I’d like to end with a quote from Edmond Burke: “Nobody made a greater mistake than he who did nothing because he could do only a little.” It’s time for each of us to do a little to achieve something big. Thank you again.

UPCOMING SEMINARS – National Institute for Health

Continued from page 14

* How to write concrete interests and preferences in the care plan?
* How each discipline’s documentation affects the success of the entire facility?
* The top 5 methods of documenting, charting and completing progress notes that guarantee success?

JUNE 28, 2007 - SURVEYOR INCIDENT INVESTIGATIONS
Using Root Cause Analysis to Achieve Compliance
Presented by: Janis Breedlove, RN, LTC Consultant & Educator

Regulatory requirements require facilities to investigate incidents and provide a safe environment using a zero tolerance level. The legal climate places blame on the staff for resident negative outcomes, and facilities continue to struggle with the investigatory process that allows them to apply preventive strategies. Incident reports are completed by many, but shed little light as to the cause of the problem. Investigations are applied in a hit-or-miss fashion and seldom prevent further occurrences. This teleconference will train staff on forensic investigative techniques to objectively determine what and why it happened, and how to prevent it from happening again.

Do you know...
* The top 5 “whys” that help staff peel away the layers of symptoms which lead to the root cause of your problems?
* Why aiming corrective measures at root causes is more effective than merely treating the symptoms?
* How to initiate an investigation and gather evidence?

For more information call our Institute at 1-800-886-0241 or go to our Web site at www.thenih.org. To see future teleconferences, go to our Teleconferences page on our Web site.
Did you know that CD-HCF has awards and scholarships available to our members? Member recognition is very important to our DPG! Members may nominate other members or apply for themselves.

The following is a brief overview of what is available – full information, including application forms, can be found on the Web site www.cdhcf.org. At the home page, click on “About” at the top and then “awards.” Applications can be submitted via fax, email, or regular mail.

- **Best Practice Award** - to recognize innovations in practice, communicate practices to the CD-HCF membership, and encourage ongoing efforts that improve practice. Recipient’s will be selected quarterly with the submission published in The Consultant Dietitian and will also receive $100.

- **Distinguished Member Award** - given annually to a CD-HCF member who has made significant contributions to the profession and organization. One distinguished member will be selected from each area annually.

- **Gaynold Jensen Stipend** – this educational stipend is to award scholarships for educational programs that enhance the contributions of the consultant dietitian to health care. The stipend is limited to 75% of the cost for each educational program attended as long as it does not exceed $500.00 and may be applied toward travel expenses to attend the educational event, but may not be used for lodging or meal expenses. In return, the recipient writes a summary of the event for possible publication in the CD-HCF newsletter.

- **Ross Leadership Award** - this is one of the highest honors the practice group can grant to members never having served on the CD-HCF Executive Committee. The honor is awarded for outstanding contributions to their profession and the clients they serve. Only one award totaling $1,000 may be made annually.

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

In addition to these CD-HCF awards, the awards committee works with US Foodservice to promote their 6th annual U.S. Foodservice Outstanding CD-HCF Member Awards. This year, they will be providing one award in each of the following groups:

- CD-HCF member for less than 5 years
- CD-HCF member for 6-10 years
- CD-HCF member for over 10 years

Award winners for the US Foodservice Awards will receive airfare, conference registration, and lodging for FNCE, 2007. Applications can be found at the Web site, www.cdhcf.org, are due by July 15, 2007, and can be returned via email or direct mail.

### Seeking Leaders for CD-HCF

Are you committed to moving the future of CD-HCF forward? Are you willing to offer your time and talents to benefit the profession? The Nominating Committee is actively seeking committed and motivated members for the 2008-09 Ballot. Deadline for submitting names is November 1, 2007. Positions available include the following:

- **Chair-Elect**
- **Secretary**
- **Area I Coordinator** (Alaska, California, Hawaii, Idaho, Montana, Oregon, Washington, Wyoming)
- **Area IV Coordinator** (Arizona, Colorado, Kansas, Nevada, New Mexico, Oklahoma, Texas, Utah)

- **Area VI Coordinator** (Maryland, North Carolina, Virginia, Delaware, Pennsylvania)
- **Nominating Committee** (2)
News from the Areas

News from Area I
Mary Vester-Toews, RD

California: Consultant RDs met at the California Dietetic Association convention in Oakland and voted to form the first geographical subunit of CD-HCF DPG. Congratulations! Even though in the planning stages, the group has elected to put on two workshops in 08 covering the New Survey Process, New F-tags, Preventing RD Law Suits, and Title 22 Survey Updates. Dietitians interested getting involved in the newly organized subunit should contact Mary Vester at: mvester2@aol.com.

Oregon: Consultants met in Portland for their spring meeting on May 18, 2007. Mary Vester-Toews, RD presented “Yes, RD’s are being Sued. How to Protect Yourself from Law Suits.” The other speaker, an RN, covered “Hospice and End of Life Issues.” The Oregon RDs are staying on top of their profession by offering innovative topics. Hats off to Cindy Meir, RD, LD, the CD-HCF chair in Oregon for her 6 years of service as the group’s chair.

Washington: The new CD-HCF State Chair is Erin Morisseau, RD. Welcome aboard! The Washington group just finished the Washington Dietetic Association Meeting in April and is planning for a consultant’s meeting/workshop in October.

Montana: The Montana group met on May 16-18 for the Montana Dietetic Association Annual Meeting in West Yellowstone. Consultant Dietitians gathered during the meeting to network on current issues facing their practice.

Idaho: Consultant RDs met in Coeur-d’Alene April 18-20 for the Idaho Dietetic Association Convention.

Hawaii: The “Aloha State” enjoyed their spring meeting March 30-31. We learned at FNCE, Hawaii knows how to combine educational opportunities, networking and fun better than any other place on earth.

News from Area IV
Anna de Jesus, MBA, RD

The Texas Dietetic Association (TDA) Conference was held in Frisco, Texas on March 30 - April 1. Texas CD-HCF donated scholarship money to TDA Foundation for student scholarships. ($1,040.00)

The Arizona CD-HCF Practice Group Exploratory Steering Committee held their meeting in May 2007. Their goal is to explore the need to re-establish a local CD-HCF chapter. Area IV states that need assistance in forming a local chapter should contact their Area Coordinator, Anna de Jesus at nutriall@aol.com.

New contact persons have been established for the following states:

UT – Lori Holland, MS, RD, CD
NV – Joey Sjostrom, RD

Thanks for volunteering!

News from Area VI
Joanne Zacharias, MS, RD, LDN

On Sunday March 25, 2007 Virginia CD-HCF sponsored a skills development workshop as part of the Virginia Dietetic Association annual meeting. The workshop entitled “Shaping the Future of Nutrition Services for the Elderly” was held at the Inn at Virginia Tech in Blacksburg, VA. Mary Ellen Posthauer, RD, CDE, LD, presented nutritional interventions for treating pressure ulcers and unintended weight loss in the elderly, and how the revised National Pressure Ulcer Advisory Panel (NPUAP) staging system for pressure ulcers will impact on clinical practice for dietitians. Joanne Genest, RD, LD, and Brenda Meredith, RD, presented on methods to improve residents’ dining experience. An exhibit booth was sponsored by VA-CDCHF on March 26th during the meeting for the general membership to provide information and promote membership in the CD-HCF practice group.

Maryland CD-HCF held a networking event on Thursday March 29, 2007 in Fulton, Maryland. The educational session was entitled “Embracing Technology to Enhance Efficiency and Accuracy in Nutrition Consulting. Virginia Darrow-Menegaz, MS, RD, LN, was the speaker for this session. On

Continued on page 20
News from the Areas

May 1, 2007, MD-CDHCF held their spring workshop in Baltimore, MD. Brenda Richardson, MA, RD, LD,CD, presented “Update on Surveys and CMS/Regulatory Survey Issues.” Zaneta Pronsky, MS, RD, LDN, FADA, and Dean Elbe, RPH, presented sessions on “Psychotropic Drugs: Nutritional Weight Management Considerations, and Drug Therapy of Alzheimer’s Dementia.” Beth Bremner, RD, LDN, from the Office of Health Care Quality gave an update on surveys in Maryland.

Pennsylvania CD-HCF held their spring workshop in conjunction with the Pennsylvania Dietetic Association Annual Meeting on 4/29/07 in Pittsburgh. Speakers for this workshop were Dean Elbe, RPH, and Zaneta Pronsky, MS, RD, LDN, FADA. The session was entitled “Food and Medication Interactions.”

Thanks to our 2006-2007 state chairs: Kelly Poole, RD, VA; Sue Noriega, RD LDN CPT, PA; and Angela Fetchero, MBA RD LDN, MD for your dedication and hard work this year!

Presently there are not active CD-HCF groups at the state level in NC or DE, the remaining 2 states within Area 6.

New Hampshire CD-HCF dietitians sponsored a March meeting with topics including hospice, both from a dietitian’s view and a nursing view; a presentation from a speech pathologist on “Swallowing: What can you do to help?”; and a presentation on cultural diversity. The group is looking for a core group of people to plan meetings. Anyone willing to help should contact Mary Ann Wareing, MA, RD, LD, at Maryann.wareing@nhuh.nh.gov.

New Jersey has a dynamic solid group of dietitians who meet 2-3 times a year with wonderful topics. Their meeting in April featured Julie O’Sullivan Maillet, PhD, RD, FADA, who spoke on nutrition diagnosis and on the ethical and legal issue in feeding patients. The group is updating their diet manual and plan to sell the new version at FNCE, 2007 in Philadelphia. More information on their upcoming meetings and the diet manual can be found at www.njnutritionexpert.com.

Maine, New York, Rhode Island and Vermont do not have a formal CD-HCF group that meets routinely. However, CD-HCF members that live in those states are encouraged to attend other state CD-HCF meetings or consider volunteering to organize a meeting. Any ideas or questions about getting more involved in your state CD-HCF meetings, please contact me at MRybickird@aol.com.

CD-HCF meetings include a March meeting featuring an update on osteoporosis and GI issues and a May meeting on disaster planning. Massachusetts welcomes dietitians from other surrounding states and does an annual mailing to New England area national CD-HCF members every fall. For information on upcoming meetings, contact Karen Laper, MS, RD, at KarenLaper@comcast.net.

Connecticut held a successful meeting in March with a varied agenda including a great review of dysphagia/swallowing concerns; a presentation on the emerging field of nutrigenomics; and an enlightening discussion on the evolution of the human diet and its impact on chronic disease. The members meet twice a year and are interested in other nearby states attending or providing ideas on speakers and sponsors. Contact Rebecca Iselin at rebeccaiselin@comcast.net for information on meetings.

Massachusetts. Mass CD-HCF has worked with New Hampshire CD-HCF to sponsor Carol Elliott, RD, LDN, for a fall workshop on the Nutrition Care Process, specific for long term care. She will be speaking in New Hampshire on Thursday, September 13th and in Massachusetts on Friday, September 14th; dates subject to change. Recent MA
ADA Tools

ADA has a tool to help you!
Do you want to EXPAND your practice to include a new skill?
Do you want to change your specialty area?
ADA has a tool to help you!

Have you wanted answers to scope of dietetics practice questions? Questions such as:
• Do you need clarification about whether a new RD is qualified to write TPN orders?
• Do you want to add bedside dysphasia screening to your scope of practice?
• Do you want to change from one dietetics specialty area to another?
• Does a physician question validity of RD documentation in the medical record?
• How can an RD request privileges to write orders for nutrition-related laboratory tests? For tube feedings?

ADA’s Scope of Dietetics Practice Framework (SODPF) resources and decision analysis tool can help you to expand your individual scope of practice with confidence.

Did you know that everyone has an individual scope of practice, much like a unique fingerprint?
Each RD’s and DTR’s individual scope of practice varies by his/her: education; training; credentials; level of experience, skill and proficiency; area of expertise; licensure or certification laws; applicable state and federal laws and regulations; job description; facility/employer policies and procedures; and third party payer requirements. As you can see, no two practitioners will have the same scope of practice. Since one answer does not fit all, ADA has developed SODPF resources and a decision tool. All together, these materials assist members in assessing competency, supporting expansion or advancement of practice, defining individual scope of practice, and answering other questions.

Utilization of the Framework:
• Promotes safe practice
• Contributes to career development

What is the SODPF?
ADA’s SODPF is an umbrella for the resources needed to determine individual scope of practice. The Framework includes an algorithm (Decision Analysis Tool) and suggested resources. All of these resources are located for members on ADA’s Web site (www.eatright.org) via the Practice Page.

To use the SODPF web page:
• Review the overview and framework diagram
• Gather supporting documents (ADA documents are found on this page)
• Complete the Decision Analysis Tool
• Refer to any pertinent definitions in the Definitions of Terms (Section 4B).
• Review the Frequently Asked Questions & Answers, such as the reasonable and prudent test (Appendix D)
• Use the Decision Tree in conjunction with the Decision Analysis Tool or the Tool by itself
• Check the case studies (Appendix E & F) for examples of the process used to find answers to specific questions

What’s next?
Continual changes and developments in healthcare knowledge, medical technology, and federal or state laws necessitate that ADA continue to equip its members with current tools to operate. To this end, ADA regularly reviews and updates the Framework’s Definition of Terms and other decision making tools and resources. The SODPF Web site contains the most current information.

Watch for future Framework articles in this newsletter—up next: Utilizing standardized terms to describe your practice (ADA Definition of Terms-Section 4B of the SODPF).

The SODPF was developed by the ADA Practice Definitions Task Force with input from the House of Delegates, the Commission on Dietetic Registration, and the Board of Directors. It was approved and published in 2005.1

Article submitted by Sally Cohenour, MS, RD, Chair SODPF Sub-Committee of the Quality Management Committee and by Julie Meddles, RD, LD and Jackie Boucher, MS, RD, LD, CDE, members of the SODPF Sub-Committee.

1. Diagnostic criteria for incarcerated male anorexia includes:
   a. Refusal to maintain body weight at or above IBW
   b. Is an avenue for offenders to demonstrate some control over their situation
   c. Is not important because it does not occur in correctional facilities
   d. Excessive weight gain while incarcerated

2. SODPF stands for:
   a. Standards of Dietetic Practice Focus
   b. Scope of Dietetics Practice Framework
   c. Schedule of Dietetic Planning Focus
   d. Scope of Dietetic Planning Framework

3. ADA’s SODPF is:
   a. a single tool that will help you be a better dietitian
   b. a program you can sign up for to develop your practice focus
   c. an umbrella for the resources needed to determine your scope of practice
   d. a workshop you can attended to develop your practice focus and your scope of practice

4. CD-HFC has a new award this year for:
   a. Best innovative practice
   b. An educational stipend to FNCE
   c. Up & Coming Member of the year
   d. Outstanding CD-HCF member

5. It is ethically right and legally imperative to:
   a. Look at and visit your clients
   b. Attend care conferences
   c. Serve fluid milk from a pitcher
   d. Document the nurse forgot to weigh the client

6. The Centers for Medicare & Medicaid Services (CMS) will open bidding for:
   a. Supplying enteral nutrition to all long term care facilities
   b. Supplying enteral nutrition to ten metropolitan areas
   c. The privilege of billing for the care of patients receiving enteral nutrition to all long term care facilities
   d. The privilege of billing for the care of patients receiving enteral nutrition to ten metropolitan areas.

7. Under this new bidding process, suppliers who bill Medicare for enteral products, whether a CD-HCF member organization or a Skilled Facility, must:
   a. Be accredited and be a long term care facility
   b. Be accredited and be in the correct geographic area
   c. Be ready to provide education and be a long term care facility
   d. Be ready to provide education and be in the correct geographic area

8. What are reliable sources for food safety information?
   a. The Model Food Code and ServSafe™ curriculum

9. How can you protect yourself against being sued?
   a. Remember that “old people die”
   b. Take weights only on high risk residents
   c. Be in the facility less time
   d. Document interactions with resident and family

10. Where do you find dietitian standards of care for nutrition services?
    a. State Dietary Regulations and Federal CMS Regulations
    b. Only in the Federal CMS Regulations
    c. Only in State Dietary Regulations
    d. There are no standards available

11. When the CD-HCF representatives attended the Public Policy Workshop in Washington DC they asked for Congressional support for:
    a. Ongoing Public Policy Workshops
    b. Support for Farm Bill and MNT issues
    c. Good Nutrition as a good politics Policy
    d. CD-HCF’s involvement in Public Policies

12. What is the major risk factor for developing Clostridium difficile?
    a. Poor hand washing
    b. Hospital stay
    c. Susceptibility of the person
    d. Use of antibiotics

13. The nutrition-related consequences of Clostridium difficile are?
    a. Dehydration, electrolyte imbalance and malnutrition
    b. Failure to Thrive, dehydration and electrolyte imbalance
    c. Weight gain, bloating and diarrhea
    d. Malnutrition, bloating and diarrhea

14. To reduce the spread of Clostridium difficile it is critical to
    a. Use proper hand washing techniques and universal and contact precautions.
    b. Try another antibiotic and universal and contact precautions
    c. User proper hand washing techniques and try another antibiotic
    d. Isolate the person and try another antibiotic

15. Which of the following will be your primary nutrition therapy for Clostridium difficile?
    a. Give the person a high fat diet
    b. Give the person 2 cups of caffeinated beverages at each meal
    c. Give the person a diet with simple sugars
    d. Give the person fluid and electrolyte replacements
1. **DIETING SKILLS MANUAL**: Practical Interventions For The Caregivers Of The Eating - Disabled Older Adult (3rd Edition, 2001) #5003 $60.00
   Filled with suggestions for the health care team to address eating problems. Utilizes the multi-discipline team approach; RD, RN, OT, and SLP. Updated information on dysphagia, finger foods, checklist for compliance with dining skills, staff competency and more.

2. **DIETING SKILLS**: Restoring Pleasure to Mealtime: Techniques for Helping the Older Adult Video (1993) #5001 $19.95
   Excellent cross-training tool for all health care providers who strive to host independent dining skills.

3. **POCKET RESOURCE NUTRITION ASSESSMENT** — (6th Edition, 2005) #5006 $85.00/$120.00
   Now in its 6th Edition! Spiral-bound; sized to fit in a pocket. Expanded to meet your changing needs. Guidelines are included for: developmentally disabled, anthropometric assessments, medications and labs, basic nutrition requirements, enteral and parenteral feeding assessments and more.

4. **NUTRITION CARE OF THE OLDER ADULT, Second Edition** #5009 $66.00 ADA Members $50.50
   Covering everything the health-care provider needs to know when working with the older adult either at home or in an extended care facility. Covers factors affecting nutrition, nutrition and disease, nutritional assessment, dining challenges and regulatory compliance. Scientifically sound and practical resource for new and experienced professionals includes new forms, resources, the food guide pyramid for older adults and an index of tables.

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

6. **ENTERAL THERAPY POLICY AND PROCEDURE MANUAL** (1998) #5012 $85.00/$120.00
   Tools to develop policies & procedures for implementation of enteral therapy in various settings. Diskette included (MS Word, ‘95 for Windows, MS Word 5.1 for Macintosh and Plain Text.) Developed by CD-HCF and ASCP.

7. **JCAHO: Long Term Care Accreditation Pathway to Positive Nutrition Outcomes** (2005) #5013 $24.95 $19.95
   Revised to reflect 2004 JCAHO standards and Nutrition Care Process. Guidelines for RDs and CDMs working in long term care facilities; understand changes and improve compliance with the review process.

8. **NUTRITION RISK ASSESSMENT FORM, GUIDES, STRATEGIES & INTERVENTIONS** (1999) #5014 $9.95
   Material developed by the ADA Long Term Care Task Force and CMS.

9. **POCKET RESOURCE FOR MANAGEMENT** (2006) #5016 $24.95
   A quick reference for food service management. Essential information for all areas including personnel, education, kitchen design, quality, cost control, survey information, emergency management, etc. Newly updated and revised.

10. **NUTRITION MANAGEMENT & RESTORATIVE DINING FOR OLDER ADULTS: Practical Interventions For Caregivers (2001)** #5021 $10.00
    Resource for guiding & training caregivers of older adults in any health care setting. Interventions to enhance eating environments & rehabilitate older adults with impaired oral function, mobility, cognition & sensation.

11. **DIETETICS PRACTITIONER’S GUIDE TO HOME HEALTH** (2000) #5022 Reduced Price $10.00
    Basic business skills & background of home health care, specific guidelines for nutrition care delivery, quality management, reimbursement, & marketing.

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