

ICD - HCF

Iowa Consulting Dietitians in Health Care Facilities

ICD-HCF Mission Statement: This association is the advocate of the dietetic profession serving the public through the promotion of optimal nutrition, health and well-being.

Spring 2006

Message from the Chair. Char Kooima



The work day started off with seeing hospital patients as usual. Mrs. Smith was not gaining nutritional ground and was on the verge of needing TPN. Her family- frustrated at her lack of nutritional intake- grasping at anything that would make her eat. So, as usual, I visited with Mrs. Smith and her family. We brain stormed again but to no avail, we came to the same conclusion: nothing tasted or sounded good – not even Chocolate Truffle Cheesecake. The family thanked me for my visit and I headed out to chart. The second patient needed a tube feeding consult. This took a fair amount of time as I visited with the family and the patient who was 66 years old. The patient has gastric cancer with esophageal metastasis. The family had struggled with the tube feeding issue, but didn't know what else to do. The physician wrote for the Dietitian to discuss tube feedings with family and start tube feedings. In the meantime, I received a page that my out-patient was here and ready for our visit. I wrapped up what I could and headed towards the out-patient area.

My patient was a young mother of 2. She wanted to visit with me regarding weight management for her as well as making sure she was providing her family with good food options. She

had a notebook full of questions. Most of her information was taken from the internet and random magazine sources. As we went through her laundry list of questions, I was a bit surprised at some of the same 'ol myths still out there. As we sorted through the collage of questions and clippings, she continually indicated that she should "know better". After we examined several other weight loss myths and after me saying that there is nothing magical about weight loss over and over again, we started laughing about the advice her friends gave her regarding weight loss. We set up a healthy, reasonable plan for her and focused on how she can incorporate the plan into her family meals. We wrapped up our visit. She was appreciative and felt better. I felt good too. I was able to help someone.

I had a manicure appointment at the end of the day and was looking forward to that as my hands had started to show the wear and tear of building a house. The house project was finally done, so now to take care of the damages. Not only that, but it feels good to pamper yourself once in awhile too. I was looking forward to a conversation that did not require analysis, troubleshooting, or discussion of nutrition. A conversation of just girl talk. A conversation in which the biggest point of discussion was which nail color I

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would choose.

As I sat down to the manicure table, another client was waiting for her nails to dry. The stylist and I got started with the soaking of my hands and catching up on stories that we shared from last visit. I was feeling good. My arms and hands started to relax and the day's irritations and worries seemed to escape. Then, with one question, the bubble burst. My stylist said "You are a Dietitian. Tell me what I need to do to lose weight". This wasn't the end of the world for her to ask me, but the client that was sitting in the other chair piped up and started talking about the low carbohydrate high protein diet plan. She continued to tell us how she just read a news release on the internet from some medical web site that the diet was safe. She was allowing herself 20 grams of carbohydrate DAILY. (Safe???) She was extremely defensive of the diet and argumentative of all sane nutrition advice that I was trying to give. So much for the relaxing manicure. The client's cell phone rang and luckily she had to go. I was very relieved and so was the stylist. She apologized several times and changed the conversation to which color I was going to choose.

As I was driving home, I thought to myself 'Thank God I listened in Biochemistry class.' It reminded me that as a Dietitian, we need to stay on top of pretty much everything that affects nutritional status. All the way from the current recommendations on breast feeding to the TLC and DASH diets for heart care to consistent carbohydrate diets for diabetes to liberalized diets for the elderly to tube feeding recommendations to medications that affect nutritional status – the list could go on and on. We cover so many nutrition issues and as a Dietitian, we are expected to know everything about food and how our body interacts with it.

The bottom line is that we need to continue our educational processes and expand our knowledge base so that when we are presented with questions and issues, we can respond professionally and with knowledge. Our professional portfolio allows for us to fine tune our leaning needs and seek our educational events to assist us with this. I challenge you to fulfill those learning needs, but to stay abreast at all scopes of nutrition.

Bylaws Announcement- by Rose Hoenig, RD, LD, Past Chair

We will be voting at the spring meeting on a bylaws change. According to the bylaws any changes must be approved by a majority of the members and announced in advance of the vote. This change is shifting the oversight of the ICD newsletter to the past president with the layout and design to continue by the newsletter editor.

Article X - Publications

Section 1. Newsletter of the ICD-HCF.

- (a) Distribution. Members of this Association will receive the ICD-HCF Newsletter quarterly.
- (b) Editors. The ICD-HCF Newsletter Editor (appointed by the Chair-elect) and Association Chair will serve as newsletter editors.

Proposed change to Section 1(b)

The ICD-HCF will have an editor appointed by the Chair. The Past chair will serve as the coordinator of the newsletter with the appointed editor

LifeLong Links

IOWA'S AGING AND DISABILITY RESOURCE CENTER PROJECT

Iowa is one of 43 states that receive Aging and Disability Resource Center (ADRC) funds from the Administration on Aging and the Centers for Medicare and Medicaid Services. The Dept. of Elder Affairs received the 3-year award for Iowa in 2004. Unlike most other states that chose to set up physical centers where aging consumers and consumers with disabilities work with long-term care counselors to learn about and access services, Iowa chose a different route. Iowa's ADRC, now known as **LifeLong Links**, will soon become an Internet web portal that will facilitate access to information, decision-making, and services for every Iowan through Internet access, through providers, and through toll-free telephone service for consumers who do not use a computer or do not have access to the Internet. The project will coordinate existing information and referral resources for older adults and persons with disabilities, provide information for all consumers seeking information about long-term care options and planning, and link consumers to services.

Iowa chose to design a resource that will be used by persons 60 and older and all persons of all ages with disabilities including parents of children with disabilities, caregivers, providers, and the public. Since the resource will provide information and options to persons who are just beginning to think about their long-term care needs, virtually all Iowans may choose the **LifeLong Links** web portal as their initial source of information about long-term care options and planning.

The **LifeLong Links** web portal was created in collaboration with other state agencies and entities involved in programming and policy development for elder Iowans and all persons of all ages with disabilities. The Aging and Disability Resource Center Project Work Group, made up of representatives of all populations served by **LifeLong Links**, guides the work of the project. The web portal **LifeLongLinks.org** will open later this spring.

Iowa's ADRC builds on existing information and referral resources, Iowa COMPASS (disability information and referral,) the Iowa Family Caregiver Program (elder and caregiver information and assistance,) and Iowa 211 (health and human services information and referral,) and other systems development initiatives in Iowa including the Real Choices Systems Transformation Grant (another CMS grant staffed by the Iowa Dept. of Human Services) and the Mental Health/Mental Retardation/Developmental Disabilities/Brain

Injury (MHMRDDBI) child and adult systems redesign efforts. The goals of the project are closely coordinated with the goals of these initiatives, resulting in collaborative decision-making about funding resources.

The **LifeLong Links** web portal will provide a connection between informed consumers and service providers facilitating access to long-term care support services. This connection to services will first be modeled in the aging service system where informed consumers will be linked electronically with Area Agencies on Aging (AAAs) and the appropriate resources available through each AAA.

Project funds have contributed to improvements in the Iowa COMPASS website and database that will soon make it easier for consumers, caregivers, and providers to find and access services, and for facilitation of consumer focus groups to help project planners better understand current and future consumer needs regarding information and referral and access to services. The project contracts with Iowa State University Research Institute for Studies in Education for evaluation services and Iowa State University Extension Educational Materials and Marketing Services for project branding and marketing.

For additional information on the Aging and Disability Resource Connection contact

Mary C. Anderson
Iowa Department of Elder Affairs
515-725-3346
mary.anderson@iowa.gov

There is an opportunity for LifeLong Links to connect clients needing nutrition services with registered dietitians. I have provided the project with information on the ADA National Nutrition Network. For the system to work in Iowa, we need dietitians to register for this free ADA service. Please visit <http://www.eatright.org/> and click on "Find a Nutritional Professional" in the top right corner of the page. At this site you can enter your town or zip code and identify the dietitians who are signed up. Encourage dietitians in your area to sign up so we are well represented in the new LifeLong Links referral system.

Carlene Russell
Carlene.russell@iowa.gov

Legislative Update from Dorothy Riddle

GAO releases report on keys to successful childhood obesity programs

The U.S. Government Accountability Office (GAO) has released a report titled, *Childhood Obesity: Most Experts Identified Physical Activity and the Use of Best Practices as Key to Successful Programs*. In the report, GAO:

- 1) Describes the key strategies identified by experts as most important to include in programs to prevent or reduce childhood obesity;
- 2) Provides examples of how selected programs implemented the key strategies identified and challenges these programs faced;
- 3) Describes the program elements identified by experts as most important to include in programs to prevent or reduce childhood obesity, as well as outcome measures identified as important; and
- 4) Provides examples of how selected programs implemented key elements identified and the challenges these programs faced, as well as examples of possible roles for the federal government.

The program strategy identified by experts as most important to include in programs to prevent or reduce childhood obesity was "increasing physical activity." The second-highest-ranked strategy was the "other" category, in which experts wrote in a variety of responses. The strategy of improving children's nutritional intake did not appear until third in the ranking of importance for programs designed to prevent or reduce childhood obesity by surveyed experts.

The program element identified as the most important was the use of best practice or evidence-based models. Experts also identified other key elements including the suitability and acceptability of the program to the target community, and sufficient financial and human resources. Responses from surveyed experts indicate that there is no consensus on what outcome measures should be used to determine program success.

ADA worked with Senators Christopher Dodd (D-CT) and Jeff Bingaman (D-NM), as well as other members of Congress, to commission this GAO report. The full report is available at <http://www.gao.gov/new.items/d06127r.pdf>. Additional resources on dietary guidance for children are available on ADA's web site at www.eatright.org.

USDA survey shows Americans have access to more food than ever

Economists at the U.S. Department of Agriculture (USDA) say there is more food available for the American diet than ever before, and Americans are eating more food each year.

The amount of food in the U.S. has increased 16 percent over the last 35 years—from 1,675 pounds in 1970 to 1,950 pounds in 2003. This translates into about 2,757 calories per person each day, which is 500 more calories than in 1970. This number was calculated from food production figures and adjusted by extracting food exports and other food losses from spoilage and plate waste.

"The increase in caloric availability is stunning," said Harvard economist David Cutler. Cutler said this availability may be primarily responsibility for increased consumption by Americans. "It's clear that people are eating more," he said. The increase in availability has coincided with an increase in the prevalence of overweight and obesity in the American population.

According to the Centers for Disease Control and Prevention (CDC), the average adult male today weighs 191 pounds, compared with 166 pounds in 1960 and is an inch-and-one-half taller. The average female weighs 164 pounds today, compared with 140 pounds in 1960, and is an inch taller. Obesity rates are two times higher than in the 1960s. To see the information in full, go to: <http://www.ers.usda.gov/News/>

More fresh fruits and vegetables tied to food borne illness trend

Fruits and vegetables are gaining prominence in Americans' diets, but the healthy trend is bringing a higher risk of food borne illness. CDC data, reported in Wednesday's Wall Street Journal shows large-scale outbreaks of food borne illness from fresh fruits and vegetables are rising, so that they now account for more outbreaks of food poisoning than meat, poultry or eggs.

According to the article, the centralization of produce distribution, a rising in produce imports, as well as growing popularity of pre-chopped fruits and vegetables are responsible. Five products have been identified as particularly problematic by government and industry scientists: tomatoes, melons (especially cantaloupes), lettuce, sprouts and green onions.

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USDA announces \$1 million In Food Stamp outreach grants

The Department of Agriculture's (USDA) Food and Nutrition Service plans to award at least \$1 million in grants for public and private entities, nonprofit, community and faith-based organizations to improve awareness of USDA's Food Stamp Program for low-income households.

Grantees will implement community-based outreach strategies that educate people about the nutrition benefits of food stamps, eligibility rules, and how to apply for the program. While numerous agencies and organizations are eligible to apply, USDA is encouraging community and faith-based organizations to apply for the grants.

The Food Stamp Program serves more than 25 million people per month, yet currently reaches only about 56 percent of those who are eligible to receive benefits. Increasing participation of eligible persons is a continuous effort by ADA and other nutrition and anti-hunger groups. The grant solicitation can be found online at <http://www.grants.gov> or on the FNS website at <http://www.fns.usda.gov>. Applications are due April 3, 2006.

Voice of nutrition heard at 2005 White House Conference on Aging

ADA members, working with members of the National Association of Nutrition and Aging Services Programs (NANASP), the American Society for Clinical Nutrition (ASCN), the Society for Nutrition Education (SNE) and the Meals On Wheels Association of America (MOWAA), presented a unified voice of nutrition issues at the 2005 White House Conference on Aging (WHCoA) in Washington.

"We have made tremendous progress since the 1995 White House Conference on Aging," said WHCoA delegate and former ADA President Nancy Wellman, PhD, RD. "We had a presence this year that we have not had in the past."

With a legislative mandate to focus on the aging Baby Boomer generation, conference delegates were asked to vote for the top 50 out of a total of 73 resolutions. Before developing implementation strategies, delegates heard from a number of federal and state officials, corporate executives, former members of Congress and aging experts. Secretary of Health and Human Services (HHS) Michael Leavitt discussed the importance of the Older Americans Act (OAA) and said he looked forward to working with Congress to reauthorize OAA and build on its successes. He focused on prevention as a key compo-

nent of the reauthorized Act. "Focusing on prevention will lead to improved health, hope and happiness. As we move from awareness to action, I hope we can move from anxiety to hope," said Leavitt.

ADA President Becky Reeves, who was a delegate, said she was pleased that the nutrition resolution, which ADA worked in coalition to get advanced to the conference, was ranked 22 out of the 73 resolutions. "The significant support for nutrition shows how its importance to maintaining the health, independence and functionality of older adults is recognized by the broader aging community." The nutrition strategy session produced implementation strategies, such as:

- Integrate food and nutrition services into non-institution-based long-term care, especially for older adults with complex nutrition-related chronic conditions.
- Include medical nutrition therapy (MNT) in coordinated care models to best serve self-care management goals.
- Cover preventive MNT services under Medicare for individuals diagnosed with pre-diabetes, hypertension, dyslipidemia and other conditions where science show it is effective.
- Modify federal Medicaid guidelines to require access to food and nutrition services in home and community-based care programs.
- Increase access to nutrition services through public health programs such as the Ryan White CARE and Older Americans Acts.
- Promote full utilization of the OAA nutrition program by increasing funding for congregate and home-delivered meals and the Nutrition Services Incentive Program.

While only one session focused entirely on nutrition, ADA, SNE, ASCN, NANASP and MOWAA delegates attended numerous others where nutrition was identified as part of possible implementation strategies. Delegates worked to include food and nutrition services wherever possible, such as the sessions on Medicare, Medicaid, long-term care, OAA reauthorization, chronic disease management, end-of-life care and geriatric education for health professionals.

NANASP President and WHCoA delegate Elaine Brovont expressed appreciation for the collaboration between

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the nutrition and aging organizations. "I want to extend my thanks to ADA and others who worked with our Executive Director to find resolutions where nutrition could be highlighted and to help us find the right language to put forth as strategies. All dietetics professionals should be proud that these organizations and leaders can work together for the good of our nation." The top resolutions, a summary of implementation strategies and other information from the WHCoA can be obtained at <http://www.whcoa.gov>.

Summer Food service

The Summer Food Service Program (SFSP) provides free, nutritious meals and snacks to children in low-income areas during summer school breaks. According to Deputy Secretary Chuck Conner, "16 million children that utilize free and reduced-price meals through the National School Lunch Program, only three million of these children have access to these same meals during the summer months." The USDA estimates that these grants will make it possible for as many as 18,000 children will be served at more than 265 rural sites during the summer of 2006. Additional information about the Summer Food Service Program can be found at <http://www.fns.usda.gov> USDA News oc.news@usda.gov.

New major labeling requirements now in effect

Two recent Food and Drug Administration (FDA) actions directly impact the dietetics profession -- trans fat and allergen labeling on food packages is now required.

- Trans fat – FDA now requires that trans fat be listed on the Nutrition Facts panel, in addition to saturated fat and dietary cholesterol, both of which have been required on the food label since 1993. Go to <http://www.cfsan.fda.gov/~dms/lab-cat.html#transfat>.
- Allergen labeling - FDA is requiring food labels to clearly state if food products contain any ingredients that contain protein derived from the eight major allergenic foods. As a result of the Food Allergen Labeling and Consumer Protection Act of 2004, manufacturers are required to identify in plain English the presence of ingredients that contain protein derived from milk, eggs, fish, crustacean shellfish, tree nuts, peanuts, wheat, or soybeans in the list of ingredients or adjacent to the list of ingredients. More information on allergen labeling is available at <http://www.cfsan.fda.gov/~dms/wh-alrgy.html>.

Continuing Education Opportunity

PARENTERAL NUTRITION - FROM START TO FINISH

An introduction to the practice of parenteral nutrition for dietetic and nursing professionals

Tuesday, March 21, 2006

The Outing Club, Davenport 2109 Brady Street, Davenport, Iowa: 12-:2:00 Salad lunch and program

Fees: \$10 for MVDA members, \$15 for non members

CEU: 1.5 hours for dietitians

Registration : call Eastern Iowa Community College 1-888-336-3907(local 563-441-4100)

Give course # 16361 for MVDA members, # 16363 for nonmembers

Sponsored by Mississippi Valley Dietetic Association, Corem Healthcare, Eastern Iowa Community College

Upon completion of this educational activity, the participant will be able to:

- 1. List 3 indications for TPN.*
- 2. Describe 2 nutrition assessment parameters for determining macro/micronutrient requirements for TPN patients.*
- 3. Name the basic components of a TPN solution.*
- 4. List 3 monitoring parameters for TPN.*
- 5. List 3 potential complications of TPN.*
- 6. Determine a TPN prescription*
- 7. Modify a TPN prescription based on clinical status*
- 8. Plan a weaning process onto enteral or oral intake.*

For additional information, feel free to contact:

r.hoenig@mchsi.com 563-289-3221

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Wound Care and Nutrition—a summary of information provided during FNCE 2005
Kathleen Niedert, MBA, RD, LD, FADA

Many Iowans attended FNCE in St. Louis last October. Great presentations were provided concerning the new guidelines on wound care. This article will present a summary of information presented by Dr. S. Kwon Lee and Suzanne Cryst, RD, LD.

Pressure ulcers are defined as any lesion caused by unrelieved pressure that result in damage to the underlying tissues. Friction and shear are not primary causes of pressure ulcers but are contributing factors to their development. Pressure ulcers can occur anywhere on the body, even on those areas where you might typically find other types of ulcers. The common approach to pressure wounds is that it happens from the outside to inside but many wounds can have deep tissue injury but with the skin intact. Animal and human studies prove that there is pressure related subcutaneous and muscle ischemia that can occur under intact skin. Those at risk for deep tissue injury include those incurring prolonged surgery, those patients who cannot be turned, and those suffering unrelenting pressure. It is extremely important to evaluate Stage I and II areas because the area could be a deeper wound that has not declared itself.

F-tag 314 states “a resident who is admitted without a pressure ulcer doesn’t develop a pressure ulcer unless clinically unavoidable, and that a resident who has an ulcer receives care and services to promote healing and to prevent additional ulcers. This definition remains the same but the new interpretation is different.

When a resident enters without a pressure ulcer then he should develop a pressure ulcer ONLY if it is unavoidable. If he enters with a pressure ulcer or develops a pressure ulcer, everything should be done to promote healing, prevent infection, and prevent new areas.

The new guidelines provide extensive definitions and steps for identification and prevention. They articulate the various risk factors; clarify Advance Directives; provide documentation guidance; define criteria for compliance/non-compliance; provide crosswalks to additional tags; and clarify scope and severity levels.

When would the pressure ulcer be “unavoidable?” A pressure ulcer is unavoidable when the resident develops a pressure ulcer even after the facility:

- Evaluated the resident’s clinical condition and risk factors
- Defined and implemented interventions consistent with resident needs, goals, and standards of practice
- Monitored and evaluated the impact of the interventions
- Revised the interventions as appropriate

Dr. Lee felt that facility nurses should not be diagnosing ulcers but that a wound care consultant was the best option unless the physician was willing to come in and assess, diagnose, and document wounds; underlying conditions, ulcer edges, wound bed, location, surrounding tissues, etc.

The presentation went on to include information about nutrition and hydration. Ms. Cryst reviewed the science of wound healing and how nutrition impacts wound healing. Lean body mass declines as age increases. In the long term care population there is a higher percentage of the population that has two or more chronic conditions. Plus, a higher percentage of the long term care populations is either malnourished or at risk for malnutri-

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tion. As dietitians, we know that those with under-nutrition are more susceptible to pressure ulcers. We also know that low serum albumin levels do not consistently indicate pressure ulcer formation risk.

Nutritional deficiencies not only delay healing, but increase the risk of developing pressure ulcers; increase the potential for loss of muscle mass, change the body's immune suppression mechanism, and increase the chances for infection. Dr. Lee's feelings were that protein levels should be at 1.2-1.5 gm/kg. Dr. Lee stated that those critically ill often have protein needs greater than normal intake; that the elderly are at risk for lower protein intake due to poor intake and decreased appetite and that both groups may need protein supplementation.

He stated that protein is essential for optimal wound healing but that more research is needed to show what nutritional products will make a clinical difference in healing wounds. His idea of an optimal protein supplement was one that was: 1) easy to digest 2) contained **all** amino acids, 3) was easy to give and 4) was low in volume.

In addition, he felt anabolic steroid therapy might play a role but that protein is needed first. He suggested that a MVI was probably the best choice since specific vitamins and mineral supplements may or may not be helpful.

Hydration levels should not be ignored according to Ms. Cryst. The resident needs to maintain good skin turgor and blood flow which can usually be done with 30-35 cc of fluids/Kg body weight. This level will need to be adjusted based on open draining wounds, fever, kidney function/fluid restriction needs, and use of certain types of air beds.

Good cares means assessing on every admission—identify risk and co-morbidities, identify causes of the pressure ulcer, assess nutritional needs and assess intake. Provide food first—plan how to accomplish this with calorie and nutrient dense foods and the resident's food preferences. Evaluate level of independence at meal times. Do you need to involve OT, PT, or SLP? How can you maximize independence at meal times? If you use supplements, review time frames when provided.

Educate the resident, physician, family/POA, staff and ancillary services on what the overall plan is. Implement the 3 R's—Review, Reassess, and Revise your plan as needed.

Make sure your nutrition piece "fits." Monitor your process for improvement. Monitor your "teams" process for improvement.



Web Sites of Interest

<http://www.fcs.uga.edu/ext/pubs/food/diabetes.php>
this is a good link to the University of Georgia Cooperative Extension. They have great diabetes powerpoint programs and other resources.

Controlling food costs is a challenging adventure for a dietary director and consultant dietitian. Following, you will find a checklist submitted by Julie Halfpop RD, LD, Nutrition Marketing Director with Martin Bros. Distributing. If you would like any more information or would desire to see the resources that they have available for assisting facilities in meeting their budgetary goals, call her at 1-800-847-2404.

Controlling Food Costs

MENUS:	Yes	No	Notes
Are pre-planned menus followed?			
Are menu changes based on fluctuating facility needs?			
Are market trends and seasonal items incorporated?			
Are there a large number of therapeutic diets?			
Are menu changes of similar cost?			
Are there a large number of large portions?			
Has the menu been costed? Many menu programs provide that information.			
Is a purchase guide that ties into the menu utilized?			
Are convenience options priced & used wisely?			
Is milk sent to residents who do not drink milk?			
SUPPLEMENTS/SNACKS:			
Are supplements served with meals?			
Are supplements consumed?			
Is the supplement list regularly reviewed? Is it reviewed with the nursing staff?			
Is there an opportunity to increase enhanced items such as super cereal or increasing calorie intake through added fats/sugars?			
Could punches or fruit drinks be served for snack time vs. 100% juice?			
Are bulk nourishments and snacks used?			
Are some residents on multiple supplements?			
Is a "med-pass" program in place? Have you considered committed purchases/pricing through a specific manufacturer?			
Would efforts to enhance dining improve meal intake?			
Have other options to increase food intake been reviewed before automatically implementing a supplement?			
How many thickened liquids are ordered? Can they be evaluated?			
Can mechanically altered diets be upgraded or therapeutic diets liberalized?			
Can snacks be served in conjunction with activity programs?			
ORDERING:			
Is an inventory taken before ordering?			
Are census records considered before ordering?			
Are items ordered on contract?			
Are coupons redeemed? Are the coupons useful?			

Are volume purchase incentives met? Could you consolidate deliveries for cost incentives?			
Do sales personnel determine the order?			
Are credits, mis-shipments, and damaged items handled appropriately?			
Are special diet products needed and ordered?			
Are trips to the grocery store minimized?			
Is the dietary director aware of the weekly budget goals?			
Does the dietary director or designee check in the orders?			
Are you a part of a GPO-Group Purchasing Organization? Are you maximizing the program?			
RECORD KEEPING:			
Are invoices accessible? Are there substitutes? Are they costing you more?			
Does the dietary director understand the budget?			
Does the dietary director keep an ongoing record of budget vs. actual expenditures?			
Are costs PPD calculated and compared to industry standards? (See www.martinsmart.com for a food cost calculator)			
Are items purchased for other departments charged to them? (Check into having your food service vendor separate these on the invoices)			
Does the dietary director meet with the administrator to discuss costs?			
Do you have access to a descending dollar report? This is a report that ranks purchases based on where you spent the most money. The 80/20 rule says that 80% of your expenses are in the top 20% of the items purchased. Juices, pasteurized eggs, coffee, breakfast meats, and supplements are frequently where facilities spend the most money.			
PREPARATION/SERVING:			
Are standardized recipes used?			
Are recipes labor intensive? Have you considered a speed-scratch approach?			
Are production guides utilized?			
Does staff serve the portions indicated on the menus?			
Is over-production occurring? (This is frequently a reason for high food costs!)			
Is there a plan for leftovers that will assist with food cost and not just add to it?			
Is staff trained on food preparation principles?			
Is plate waste monitored?			
Are guidelines for pureed food preparation being followed?			
Are special requests extensive?			
Are requests for small portions honored?			

Are portion-packs utilized?			
Has a beverage cart vs. pre-poured beverages been considered?			
Would a dessert cart be appropriate on occasion?			
SECURITY:			
Is the storeroom locked?			
Do you know which staff members have keys?			
Is the kitchen locked at night?			
Are clear garbage bags needed?			
Should video surveillance be considered?			
VALUE ADDED SERVICES:			
Do employees have access to free coffee/juice?			
Do employees receive free meals? Are you recouping your costs on meals?			
Are snacks/beverages available to guests?			
Are special event costs separated?			
Is there a budget established for special events?			
Have options for generating revenue been considered? (meals with local jails, daycares, senior centers or catering, to-go pizzas, cookies, vending, theme events, etc.)			
COMMUNICATION:			
Is the department informed of residents who won't be in the facility for a meal?			
Are late trays, hold trays, diet changes, etc. communicated?			
Are meals sent and not touched?			

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ICD-HCF 2006-2007 BALLOT

The ICD-HCF election of new officers will take place at the Spring Meeting on 1 May 2006. If attending, please bring your completed ballot to the ICD-HCF booth at the meeting. If you are not attending, you may vote by mail – postmarked no later than 29 April 2006 and mail to:

Anne Sposato
612 Rachael St.
North Liberty, IA 52317

Chair-Elect

_____ Anne Sposato _____ (write-in candidate)

Nominating Committee

_____ Theresa Eberhardt _____ (write-in candidate)

Treasurer

_____ Nadine Fisher _____ (write-in candidate)

The results will be published in the Summer ICD-HCF Newsletter

Slate of Officers:

Anne Sposato is a graduate of the University of Nebraska – Lincoln with a BS in Human Nutrition and Food Service Management, and Texas Tech University with a Master’s Degree of Science. She also received a Culinary Arts Diploma from Western Culinary Institute in Portland, OR.

Her current job is a Washington County Hospital and Clinics as Clinical Dietitian serving the LTC residents, acute patients, and out-patients since February 2003. Anne has accepted a small part-time job as Consultant Dietitian for Keokuk County Health Center in April 2005. Her previous job was at Iowa City Rehabilitation and Health Care Center as the Dietitian and Director of the Food Service Director from 2000 – 2002. Anne is also a veteran from the US Navy where she served as Clinical Dietitian in the first gulf war. Her jobs between the US Navy and going back to the Dietetics were working on Chef de Cuisine in long-term facilities and restaurants. She enjoys working out at Curves 4-5 times per week, cooking, and spending all her extra money on travel.

Theresa Eberhardt is currently a consultant dietitian to long-term and residential care facilities. Previous experience includes working in the hospital setting and ICF-MR, teaching classes on the ICN, serving as a preceptor for CDM courses, and proctoring for FSS courses.

Her current and past activities include: member of school wellness policy committee, UIDDA vice president, UIDDA president, UIDDA historian, Area Representative for Upper Iowa, ADA member, IDA member, ICD-HCF member, soccer coach, Sunday School teacher, volunteer at Central Community School (reading and nutrition education) Ladies Guild secretary, and book club member.

Nadine Fisher MS, RD, LD

Nadine is an Iowa City based Nutrition and Technology Consultant and graduate of Iowa State University. Her long-term care consulting experience includes residential treatment and nursing facilities. She is an active Council member of the Iowa Dietetic Association presently serving as the IDA Bulletin Editor and Maternal and Child Liaison. Nadine also serves as the Chair of the Nutrition Entrepreneur DPG Internet Specialty Group and is a member of Dietitians in Business and Communication and Consultant Dietitians in Health Care Facilities. Her special interests focus on small business communication, marketing and web development.

ICD-HCF 2005-2006 Board and Council

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ICD – HCF

Iowa Consulting Dietitians in Health Care Facilities

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Iowa Consulting Dietitians – Health Care Facilities

The Nutrition Puzzle: Putting the Pieces Together

May 1, 2006
Holiday Inn-University Park
Des Moines, Iowa

Featuring:

ZANETA M. PRONSKY, MS, RD, LDN, FADA and SISTER JEANNE PATRICIA CROWE, PharmD, RPh
authors of Food-Medication Interactions. Their presentation will be focusing on Alzheimer's disease and medication interactions specifically focused on this illness.

Laurie Kimball, RN author of The Depression Tool Kit: Practical Ways to Get Through the Day. She will be presenting on work and stress management.

JoEllen Arends RN is the patient care coordinator with Hospice of North Iowa. She will present in depth information on food and fluid issues related to the end of life.

Julie Halfpop RD LD & Beth Samuelson RD LD will be presenting a skills fair educating us on how we can better educate our staff.

Judith Walrod, RD LD, A conference can not be complete with the knowledge and helpful hints from a state inspector.

For more information, call Char Kooima, RD LD CDE @ 712-470-1867 or email rbaxc@mtcnet.net

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