Connections

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CPEU

The Association between Late-Life Weight Status and Cognition is Moderated by Race among Black and White Older Adults in the Health, Aging, and Body Composition Study

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Abstract

Objective: To investigate the relationship between late-life weight status and weight change by race on cognition among older adults.

Methods: This secondary analysis of the Health, Aging, and Body Composition Study included 1,140 participants with data for years 1 and 10 (66.5% White). Linear mixed effects models examined the association between BMI and cognition (measured by the Modified Mini Mental State Exam (3MS)) and moderation effects of race.

Results: Black older adults experienced greater 10-year cognitive decline (β =-3.895, p<0.0001) than White older adults (β= -2wwce. Regarding between-person BMI effects, adults with higher normal BMI (18.0 to 25.0 kg/m^2) reported higher 3MS, whereas BMI above 35.0 kg/m2 was associated with lower 3MS scores. These between-person effects of BMI were significant only for Black older adults.

Discussion: Higher non-overweight BMI was associated with less cognitive decline, which was more prevalent among Black older adults.

Learning Objectives

After reading this article, participants will be able to:

1) List risk factors associated with dementia in older adults

2) Explain differences in cognition among Black and White older adults

3) Describe the relationship between weight status, race, and cognition among older adults

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Introduction

As the population of older adults is rapidly growing, the prevalence of Alzheimer's disease and related dementias (ADRD) is also increasing.[1] Dementia is the seventh leading cause of death, and is a key contributor to disability and dependency among older adults worldwide.[2] However, ADRD burden is not equal across populations. In fact, findings from multiple studies indicate that Black older adults in the United States are more likely to develop ADRD compared to their White counterparts.[1,3] Given the increasing diversity of the older adult population in the United States, understanding and addressing these health disparities is paramount.[1]

Dementia risk is multifactorial, with both modifiable and non-modifiable risk factors playing a role. Non-modifiable risk factors for dementia include advancing age, genetics (carrying an APOE ε4 allele), and having a family history of dementia.[1] While non-modifiable risk factors cannot be changed, modifiable risk factors are powerful players in reducing one's risk for dementia. In fact, the 2020 report of the Lancet Commission concluded that as many as 40% of cases of dementia could be attributed to modifiable lifestyle factors, including education, hypertension, alcohol use, obesity, smoking, physical inactivity, and diabetes.[4] These modifiable risk factors may underlie the disparities in ADRD across groups, and they offer targets for interventions to reduce ADRD.

Weight status is a modifiable risk factor for ADRD, and yet its association with cognition is under-studied. Recent research studies have yielded mixed results regarding the relationship between body mass index (BMI) and cognition. For example, one meta-analysis found the association between BMI and dementia to be U-shaped, with an increased risk of dementia for both obese and underweight individuals.[5] However, the studies utilized in the meta-analysis included a wide age range of participants (ages 40-80) at baseline and they did not describe subgroup analyses by race. Other studies have indicated that mid-life obesity is associated with dementia in later life.[6] However, little research has been conducted to evaluate the impact of late-life weight status and weight change on cognition among diverse populations. This is particularly relevant for Registered Dietitian Nutritionists (RDNs) who work with older adults in long-term care settings, where as many as 49% of residents are diagnosed with ADRD,[7] and where weight change is routinely monitored as an indicator of quality of care.[8]

Considering the many health disparities in the United States, the development of interventions and guidelines for different subgroups in the population is warranted. This aligns with the National Institutes of Health 2020 Nutrition Strategic Plan, which focuses on addressing health disparities and modifiable risk factors to develop tailored interventions to reduce disease.[9] Therefore, the purpose of this secondary data analysis was to investigate the relationship between late-life weight status and cognition among Black and White older adults in the United States.

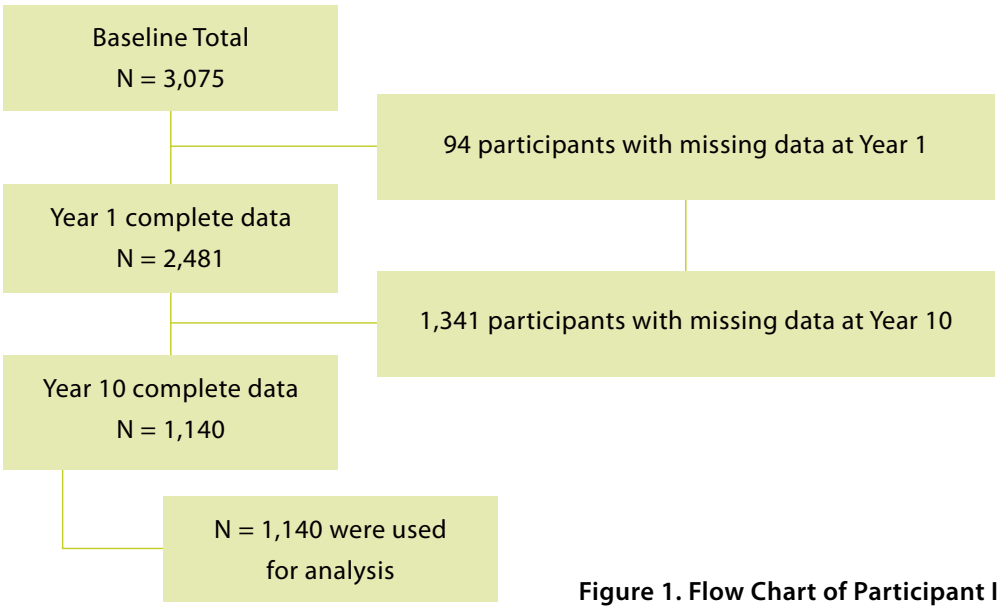

Figure 1. Flow Chart of Participant Inclusion

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The Health ABC Study focused on risk factors for the decline of function in older individuals who were healthy at baseline. As previously described,[11] data collection included repeated clinic visits to collect anthropometrics, laboratory data, cognitive measures, and self-reported demographic and medical history information. Weight was measured in kilograms using a calibrated scale. Height was measured using a wall-mounted Harpenden stadiometer. BMI was calculated as weight in kilograms divided by squared height in meters. Sitting systolic and diastolic blood pressure (in mmHg) was measured twice using a standard protocol. The average of the two readings was used in the analysis. Blood was drawn to measure fasting glucose and cholesterol (both were reported in milligrams per deciliter) and to determine apolipoprotein E *(APOE)* genotype by standard single-nucleotide polymorphism (SNP) analysis. Participants were classified as *APOE* ε4 carriers if they had at least one ε4 allele.[12] Cognitive assessment was conducted using the Modified Mini-Mental State Exam (3MS).[13] This cognitive function test is a widely used test among older adults. Scores may range from 0-100, with higher scores indicating better cognitive health. Participants self-reported their race, gender, level of education, and family income during the interview process. In accordance with nomenclature in the data usage guidelines for the Health ABC Study data from the National Institute on Aging, racial categories in this analysis are described as Black and White. All participants gave written informed consent to participate in the Health ABC study. The protocol for this secondary data analysis was approved by the Institutional Review Board at the University of Alabama (Protocol #20-04-3503).

Statistical analysis

Linear mixed effects models were used to examine the association between changes in BMI and 3MS score. Covariates were chosen based on previous associations with 3MS.[14] Random intercept was used to capture dependence among repeated measures. The variance of the random intercept was allowed to vary by race. The Likelihood ratio test ($\chi^2 = 71$, $p < .0001$) suggested that the model with heterogeneous variance delivered a better fit than the model with homogeneous variance.

Explanatory variables with the potential to change over time included BMI, fasting cholesterol, fasting glucose, sitting systolic and sitting diastolic blood pressure. These time varying variables were person-mean centered. The resulting variables contained only within-person variations and therefore captured within-person effects (e.g., how change in BMI is associated with change in 3MS scores). Individual-specific means of time-varying variables were incorporated as person-level explanatory variables. Individual-specific means contained only between-person variations and, therefore, captured between-person effects. Explanatory variables that were measured at baseline and did not change over time included race (Black vs. White), sex (male vs. female), education (< high school completion, high school diploma, and postsecondary education), annual income (<10k, 10k-25k, 25k-50k, 50k+ United States Dollars), and *APOE* ε4 genotype (yes vs. no). The moderating effects of race were examined via interactions.

Results

Of the 3,075 participants in the parent study, 1,140 who had complete data for years 1 and 10 were included in this analysis. Of the 1,140 participants included, 66.5% (n=758) were White, while 33.5% (n=382) were Black; 47.9% (n=546) were male and 52.1% (n=594) were female. 3MS scores averaged 92.2 in year 1 and 89.5 in year 10 (average change = -2.7, p<.001). BMI averaged 27.4 in year 1 and 27.2 in year 10 (average change = -0.2, p =.002). See Table 1 for descriptive statistics of variables used in the study.

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Table 1. Characteristics of Participants (n = 1,140)

Variable	Category	Percentage	Mean (SD)
Race	White	66.5	.
	Black	33.5	.
Gender	Male	47.9	.
	Female	52.1	.
Education	< HS diploma	18.7	.
	HS diploma	31.4	.
Family income	Postsecondary	49.9	.
	<10k	9.3	.
	10k-25k	35.6	.
	25k-50k	34.9	.
	50k+	20.2	.
APOE genotype	ε2ε2	.8	.
	ε2ε3	13.5	.
	ε2ε4	2.9	.
	ε3ε3	57.8	.
	ε3ε4	23.2	.
	ε4ε4	1.8	.
3MS Score	Year 1	.	92.2 (6.7)
	Year 10	.	89.5 (9.9)
BMI (kg/m2)	Year 1	.	27.4 (4.6)
	Year 10	.	27.2 (4.8)
Fasting total plasma cholesterol (mg/dL)	Year 1	.	202.8 (37.5)
	Year 10	.	186.8 (41.9)
Fasting serum glucose (mg/dL)	Year 1	.	102.0 (30.8)
	Year 10	.	101.9 (25.7)
Average sitting systolic BP (mm Hg)	Year 1	.	134.4 (20.3)
	Year 10	.	134.7 (19.7)
Average sitting diastolic BP (mm Hg)	Year 1	.	70.9 (10.9)
	Year 10	.	70.7 (10.2)

Note. HS = high school; < HS = less than high school diploma; Postsecondary = attended postsecondary education; Family income in United States Dollars per year; 3MS = Mini-Mental State Exam score; BMI = Body Mass Index; BP = blood pressure.

Within-person effects.

An increase in BMI between years 1 and 10 was associated with an increase in 3MS (β= .665, p<.0001) (Table 2). The effect of time appeared to be moderated by race, where the time effect was higher for Black older adults (β= -3.895, p<.0001) than for White older adults (β= -2.002, p<.0001). This result suggested that between years 1 and 10, Black older adults experienced greater cognitive decline than White older adults.

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Table 2. Within-person Effects on 3MS Between Years 1 and 10

Variable	β	S.E.	p
Within-person effects			
BMI	.665	.095	<.0001
Cholesterol	-.004	.005	.457
Glucose	-.011	.008	.146
Sitting systolic BP	-.015	.012	.195
Sitting diastolic BP	-.067	.022	.002
Time, year 10 vs.1	-3.895	.395	<.0001
*Time (year10) * Race (White)*	1.893	.474	<.0001

Note. BMI = Body Mass Index; BP = blood pressure. [a] Within-person effect of time among White: β = -2.002, p < .0001.

Between-person effects.

The between-person effect of BMI was approximated with a quadratic term which appeared to be moderated by race (BMI*Race, p=.005; BMI2*Race, p=.008) (Table 3).

Table 3. Between-person Effects on 3MS by Race

Variable	β	S.E.	p
BMI	2.634	.588	<.0001
BMI2	-.042	.010	<.0001
Race, White vs. Black	42.119	11.084	<.001
*BMI * Race (White)*	-2.150	.754	.005
*BMI2 * Race (White)*	.034	.013	.008
Cholesterol	.025	.012	.037
*Cholesterol * Race (White)*	-.026	.013	.049
Glucose	-.006	.007	.403
Sitting systolic BP	-.010	.012	.419
Sitting diastolic BP	.029	.023	.208
Gender, male vs. female	-2.037	.397	<.0001
Education, postsecondary vs. <HS	9.631	.949	<.0001
HS vs. <HS	5.870	.949	<.0001
*Race (White) * Education (postsecondary)*	-3.754	1.136	.001
*Race (White) * Education (HS)*	-2.281	1.187	.055
Family Income, <10k vs. 50k+	-1.582	.857	.065
10k-25k vs. 50k+	-1.530	.521	.003
25k-10k vs. 50k+	-.278	.467	.552
***APOE* ε4, Yes vs. No**	-.834	.398	.036

Note. BMI = Body Mass Index at baseline; BMI2 = Body Mass Index at 10-year follow-up; BP = blood pressure; < HS = less than high school diploma; Postsecondary = attended postsecondary education; Family income in United States Dollars per year; 3MS = Mini-Mental State Exam score.

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[a] Between-person effect of cholesterol among White: β = .001, p = .911.

[b] Others contrasts between income groups: β = -.053, p = .945.

This result suggested that the association between BMI and 3MS was non-linear and differed by racial groups. In Black older adults with BMI ≤ 25 kg/m2, individuals with a higher average of year 1 and 10 BMI reported higher average 3MS (Figure 2); however, in Black older adults with BMI ≥ 35 kg/m2, a higher average of year 1 and 10 BMI was associated with lower average 3MS.

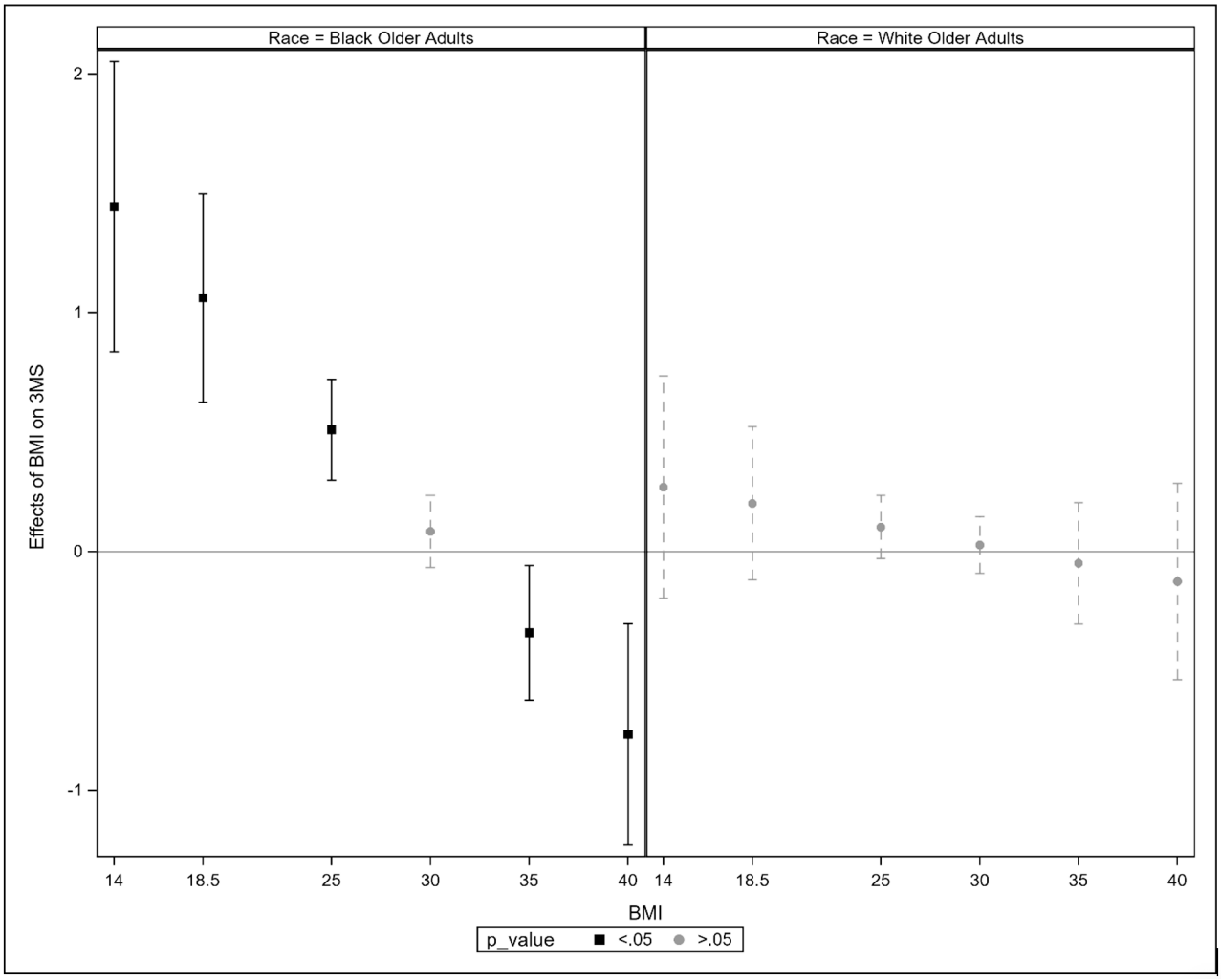

Figure 2. Between-person Effects of BMI on 3MS with 95% CI

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In contrast, there was no evidence of a between-person association between BMI and 3MS among White older adults. For BMI ranging 25-35 kg/m^2, BMI was not associated with 3MS in either Black or White older adults.

Discussion

After adjusting for covariates known to be associated with ADRD, increasing BMI between years 1 and 10 was associated with higher 3MS scores, irrespective of race. However, the between-person association between BMI and cognition was only evident for Black participants. Although higher BMI was associated with greater maintained cognition among Black older adults who did not have obesity, higher BMI was associated with worse cognition among those with BMI of 35 kg/m2 or greater. These results suggest that maintaining a higher normal BMI in older adulthood may be protective against cognitive decline, particularly in Black older adults, as long as BMI does not exceed 25 kg/m^2.

Although average 3MS scores declined across the 10-year follow-up, an increase in BMI over 10 years was associated with improved cognition among the entire cohort. However, this within-person effect of BMI was not moderated by race. In contrast, the effect of time was moderated by race, indicating Black older adults experienced greater cognitive decline compared to their White counterparts. These results suggest that factors beyond BMI and weight change accounted for greater declines in cognition among Black participants. For example, a previous analysis of Health ABC data showed that adjustment for demographic, psychosocial, health-related, and socioeconomic factors explained 86% of the differences in DMS scores between Black and White older adults.[15] Our analysis took into account known risk factors including education, income, *APOE* ε4 genotype, and biomarkers of chronic cardiometabolic disease. However, it is likely that other social determinants of health underlie racial disparities related to ADRD.[16] Even socioeconomic variables such as education and income cannot account for early life experiences.[17] Because all participants were ages 70-79 at baseline, they would have grown up amidst segregation and civil rights abuses in the United States. Albeit beyond the scope of this study, future studies should examine social determinants such as racial discrimination and early life experiences as risk factors for developing ADRD.

Results of this study suggest that BMI up to 25 kg/m^2 appears protective against cognitive decline; however, higher BMI is no longer protective at > 35 kg/m^2. These findings mirror each other in Black and White older adults, but the association between BMI and 3MS was only significant in Black older adults. These findings complement other studies evaluating the relationship between BMI and cognitive decline among Black and White older adults. For example, when Arvanitakis et al compared cognitive decline among Black and White older adults by percentile of BMI (5th, 50th, or 95th percentile), they found that lower baseline BMI was associated with faster global cognitive decline over 12 years.[18] These findings, however, were not moderated by race. In comparison, Aiken-Morgan et al analyzed the relationship between changes in BMI and cognition among 671 Black older adults in the Minority Aging Research Study.[19] In comparing the first and third BMI quartiles (26.1 kg/m^2 and 33.5 kg/m^2, respectively), they reported that higher BMI was associated with slower decline in global cognitive function over an average of 6 years . Additionally, they reported that greater fluctuations in BMI were associated with more rapid cognitive decline (fluctuations of 4.3 kg/m^2 vs. 1.5 kg/m^2, respectively). Beyond the influence of race, the relationship between BMI and cognitive decline remains. In a meta-analysis reporting on results from 15 prospective cohort studies, low, overweight, and obese BMI in midlife increased dementia risk compared to normal BMI;[20] however, maintenance of BMI in late life was not associated with dementia. The potential influence of weight stability on cognition is further supported by reported associations between change in BMI (gain or loss) in late life and dementia or faster cognitive decline.[19,21]

These findings add to the body of research on the importance of weight status among older adults. Low BMI in older adults is associated with greater mortality risk and decreased functional status.[22-24] Conversely, overweight and obesity among older adults are associated with greater chronic disease burden, greater mortality, and decreased functional status.[23,25] Results from this study build on the evidence that obesity in older adults is also associated with cognitive decline, particularly for Black older adults.

These results suggest that maintaining a higher BMI in late-life may impart some protection against cognitive decline, as long as BMI does not exceed 25 kg/m^2. This is relevant for RDNs who work with older adults, as RDNs may be asked to provide recommendations on weight status and dietary intake for older adults, particularly those in long-term care settings. As such, RDNs should continue to recommend maintaining a BMI at the higher end of the normal

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range, acknowledging that underweight and obesity are not only associated with functional decline and increased mortality, but also with cognitive decline.

This study was strengthened by a relatively large sample size of Black and White older adults followed for changes in cognition over 10 years. The study was also strengthened by standardized measures to assess BMI at each follow-up visit and inclusion of a variety of covariates assessed both at baseline and across time. However, there are several limitations to acknowledge. The analyses were limited to data collected from the parent study and the variables they assessed. To that end, BMI is known to be an imperfect measure because it estimates body fatness rather than measuring body composition;[26] this is magnified in older adults, who tend to have reduced lean body mass and increased fat mass compared to their younger counterparts.[23] Additionally, mid-life BMI of participants was not considered in the analyses, and the time points used in this analysis reflected a long time gap and did not capture weight fluctuations within the two time points. The 3MS tool for evaluating cognitive status can be a limitation if it is administered repeatedly to older adults, as they may experience a 'learning effect', whereby their scores improve or remain stable over time, reflecting repeated exposure to the measure rather than true cognitive maintenance or improvement.[27]

In longitudinal studies of cognitive decline, the potential for survival bias must also be acknowledged. Major cognitive decline has been associated with increased mortality in community-dwelling older adults.[28] Well-recognized U-shaped associations between BMI and mortality may also confer selective survival bias.[29] There is also a potential for bias due to missing data, as the analyses only included participants with complete data at Years 1 and 10.

Taken together, these results suggest that a higher normal BMI may be associated with less cognitive decline in adults ages 70 and older, and this effect appears stronger in Black older adults. However, the protective effect is lost starting at BMI of >25 kg/m^2 and BMI of 35 kg/m^2 (Class II Obese)30 and above is inversely associated with 3MS. Irrespective of BMI, Black participants still experienced greater cognitive decline than White older adults across the 10-year follow-up. While social determinants of health other than income and education were beyond the scope of this study, the findings demonstrate that further research is needed to investigate additional factors associated with cognitive aging. In particular, future research on health disparities between Black and White Americans should examine the possible impact of early life experiences and other social determinants of health in addition to income and education.

This article has been approved for 1.0 hour CPEU.
Access the quiz here.

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Chair Update

How Will DHCC Grow and Thrive? Future Success in Post-Acute and Long-Term Care Nutrition Through Nurturing New Dietitians

Sue Linja, RDN, LD

Greetings, DHCC Members!

You are going to want to read this newsletter from top to bottom. Not only do we have a special CPEU article and a review of the IDDSI Level 7 Easy to Chew diet, but we also have great information on navigating the landscape of nutrition reimbursement, disaster planning, and a review on proper glove use. I have to admit, though, the write-up I am most jazzed about is our Member Spotlight. Sara Orr, our highlighted member, is especially important to us. As your leaders in DHCC, we are making a concerted effort to educate students and new dietitians about the amazing careers in post-acute and long-term care (PA&LTC). This inspiring member is proof that "early practitioner" dietitians can and do get excited to join our DPG, especially once they realize who we are, the broad skills we possess and the value we bring to our communities. Watch DHCC's new promotional video here.

As I sit down to write this short message to you, I can't help but reflect on how our field has evolved over the years. I am not one to reveal my age, but let's just say I've been around long enough to remember when the MDS was not a thing and yes, we documented nutritional assessments using the SOAP note format. We also had a collection of dietitians, both new and seasoned, eager to dive into the world of skilled/long term care and corrections. Today, not so much!

I suspect you are acutely aware of the current challenge our profession is facing related to recruitment of students into RDN programs? The number of dietitians entering our PA-LTC niche is an especially pressing concern. I just did a quick search on Indeed and LinkedIn and I think there are more job listings for RDN's in our setting than there are TikTok videos on how to apply eyeliner. Okay, that's A LOT. So, how do we overcome this challenge? What can each of us do to help encourage more dietitians to join our noble area of nutrition and to join the DHCC DPG?

Perhaps as DHCC members we can begin with a focus on one or more of these action items? Together, we are better and stronger.

1. **Raise Awareness:** First and foremost, we need to spread the word about the rewarding opportunities in our segment of dietetics. Many budding dietitians simply aren't aware of the incredible work we do in nursing homes, subacute rehab, corrections and beyond. What makes your job unique and appealing? Is it the flexible schedule and the evenings/weekends off, the satisfaction of brightening a resident's day or the higher compensations compared to the area hospitals and health clinics? Whatever it is…let's tell our stories.

2. **Share and Mentor - Take Someone Under Your Wing:** DHCC members (YOU!) have a wealth of knowledge and experience. Let's share our insights with the next generation of dietitians. Organize shadowing opportunities, host webinars, invite possible prospective dietitians to participate in local and state meetings, and don't be afraid to talk about all the cool things you do as a dietitian in PA-LTC. We all have someone who served as our guiding star, showing us the way, and helping to direct our career path. Who was that person for you? Was it a wise colleague, a professor or preceptor, or just someone who took you by the hand and supported you ever step of the way? Share your mentorship story and inspire others to follow in your footsteps. Let's pay if forward.

3. **Network With Gusto:** Attend local and national dietitian conferences and make your presence known. Write a speaker proposal and get in front of an audience of dietitians. Engage with student dietitians and share your enthusiasm for our unique corner of dietetics. A strong professional network can go a long way in recruiting new talent.

4. **Collaborate with Educational Institutions:** Partner with local high schools (even middle schools), colleges and universities to create awareness and encourage students to consider dietetics and specifically post-acute and long-term care as an exciting career option. Offer to be a guest speaker for your local dietetics program and share the wonders of our area of dietetics. Share job openings with graduating classes and crash their recruiting events to show them how the cool kids do dietetics.

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5. **Scholarships to Help Support Student Dietitians:** A gift to the Academy's "Make it a Million Scholarship Campaign Fund" supports Foundation efforts to award $1M in scholarships annually and provide hundreds of students with assistance to get and education in dietetics. Every dollar helps, so please consider donating!
6. **Participate in Internship Programs:** If your community has a dietetic internship program, get involved! Hosting interns can be a great way to introduce students to the exciting world of our profession. Who doesn't remember their best preceptors? Mine was the one who worked as a consultant in long-term-care….

Please help the DHCC executive committee spread the word about the great opportunities we have in PA-LTC. Take a moment to watch (and share) the new video about PA&LTC and the opportunities for new dietitians entering our field and joining our practice group. https://dhcc.eatrightpro.org/home

By nurturing and mentoring the dietitians of tomorrow, we can ensure the future of our field is bright and that our residents continue to receive the care they deserve. Together, we are better and stronger.

Enjoy reading the entire publication and from the bottom of my heart, THANK YOU for being a valued member of DHCC!

Best regards,

Sue Linja, RDN, LD
DHCC EC Chair

Editor's Column

Ellen Turk, RDN, LD

Ellen Turk, RDN, LD

Happy 2023 DHCC Members! I hope you all have had a great start to your year. Thank you for reading this edition of the Connections Newsletter. I wanted to give a special thank you to all of the authors who submitted articles for this edition of the newsletter. This edition is filled with great information we can use to improve our everyday practice. For our next newsletter, DHCC will be focusing on hydration and fluids.

If you have any topics you would like addressed or if you would like to write an article for the newsletter, please send me an email: ellenturk33@gmail.com.

We appreciate your opinions and would love to hear from you!

Are You Ready for Disaster?

Kim Fremont, MSED, RD, LD

Kim Fremont, MSED, RD, LD

COVID-19 taught us that not all disasters come from mother nature. Illness can cause a disaster and stress our communities' resources for supplies and labor.

The time to decide how you will handle a crisis or disaster is before it strikes not after. Good planning can go a long way to minimize stress and keep everyone safe.

"The U.S. Centers for Disease Control determined that the elderly accounted for only 15% of New Orleans' 2005 population, but 70% of the deaths from Hurricane Katrina. The disastrous storms of 2004-05 highlighted the consequences of the planning failure to integrate nursing homes into a national disaster response system[1]."

This clearly points out that all long-term care facilities (LTC) must plan for any type of disaster. Planning guides give these critical steps for proper planning:

1. Communication systems to all personnel
2. Staffing planning for a reduced workforce
3. Emergency Supply planning
4. Emergency Menu Planning
5. Identification of resources and suppliers for an emergency
6. Comprehensive policies and training of all staff on roles and responsibilities in an emergency

Step one: Set up a Communications System

In the first step we must identify all the types of communication systems that will be needed. This usually starts with the formation of a committee to develop the crisis management plan.

Next, we would identify a list of contacts for staff, food suppliers and Emergency agencies: FEMA, RED Cross, Health Department etc.

The crisis management committee will write a plan on how staff will be notified in the event of a disaster and identify each staff member's role and responsibilities. The dining services should

determine a chain of command (COC) to run operations in the event of an emergency and provide a checklist of items "to do" if an emergency were to occur. To ensure coordination, the COC of dining services would report to the overall command of the facility. Food and water are basic survival needs and communication is vital to ensure proper use of resources.

Step Two: Identify staff resources available in an emergency.

In the second step identify staff available to work to keep basic functions running. For example, a disaster at night when there is less staff at the building. This will require a mobilization of available staff to be called in vs. a disaster during the day when most staff are already at the facility. Pandemic illness may mean that many in the workforce might also be affected; therefore, staffing must include how to cope with a drastically reduced workforce. Each type of disaster should be evaluated for the anticipated number of staff available along with a contingency plan for a drastically reduced force.

Step Three: Evaluate what resources for food, water and power would be available during an emergency.

The third step is to plan for the resources of food and supplies. The evaluations should review what is routinely available on hand in normal supplies plus evaluate for each type of emergency/disaster what would be needed in a secure, dedicated emergency supply. The question to answer is does the facility have enough food, potable water, chemicals, and paper supplies to be self sufficient for 3 days? A checklist can be used to answer the question "what resources do you have?"

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Are You Ready for Disaster?

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Disaster Preparedness Plan Template for Long Term Care Facilities *

EMERGENCY CHECKLIST

DIETARY/FOOD SERVICES

DATE: _____ TIME: _____

Completed Initials

_____ _____ 1. Check water and food for contamination.

_____ _____ 2. Check refrigeration loss if refrigerator or food lockers are not on emergency power circuit.

_____ _____ 3. Recommend 7 – 10 day supply of food storage for residents and staff.

_____ _____ 4. Ensure availability of special resident menu requirements.

_____ _____ 5. Assess needs for additional food stocks.

_____ _____ 6. Secure dietary cart in sub-dining room or small, enclosed area.

_____ _____ 7. Assemble required food and water rations to move to evacuation site, as necessary.

Signature: _____

(Source: Missouri Department of Health: Disaster Planning)

You will want to make a grid for the supplies you would have for each type of disaster. You will also have to assess what type of power you might have for each type of disaster and the implications on the staffing, cooking and menu that will be needed for that type of disaster.

Kitchen Resource Survey Form

(Adapted from Public Health Agency of Canada: Emergency Food Service Manual)

Facility: _____

Address of _____

Telephone _____

In Case of Emergency _____

Manager - Name _____

Address - Telephone _____

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Are You Ready for Disaster?

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Personnel Number Maximum Capacity for Meals Prepared per Hour

- Cooks	_____	1- 50	_____
- Assistant cooks	_____	50- 100	_____
- Servers	_____	200- 500	_____
- Dishwashers	_____	800- 1000	_____
- Cleaners	_____	1000+	_____

Energy Sources Capacity Functional

Kitchen Equipment Electricity Gas

- ovens
- steamers
- hot plates
- coffee urn
- kitchen range (stove)

Warehouse Quantity Capacity Functional

- reserve (dried foods)
- refrigerators
- cold rooms
- freezers

Food Service

- meal covers
- serving utensils
- counters
- serving tables
- trays
- miscellaneous

Type of Seating _____

Maximum Capacity (seating) _____

Date: _____ Signature: _____

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Are You Ready for Disaster?

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Most facilities contract to have an outside agency supply water in the event of a loss of potable water supply. However, as our client facility and Hurricane Katrina demonstrated, some disasters will prevent help or suppliers from getting to the facility quickly. Federal and State Disaster planning manuals seem to agree that 1 gallon of water per person per day (resident and staff and any ancillary guest's ore personnel must be accounted for) is needed for drinking. Bottled water should be kept on site in a safe, cool location and rotated every 6 months or in accordance with dating on the container. A back up plan would be to be prepared to purify or boil water to create potable (water that is safe to drink) water. Remember, in the event of a disaster that interrupts the water lines all ice should be considered contaminated and to plan for a 3-day supply.

Water Purification: Boiling (From Missouri Disaster Guide for LTC)

Contaminated water should be allowed to sit before boiling to permit suspended particles to settle to the bottom. The water should then be filtered using several layers of paper towels or clean cloth.

Boiling is the safest method of purifying water and ensures destruction of bacteria and some protozoan organisms such as Giardia and Cryptosporidium that are resistant to chemical sanitizers.

Water should be brought to a rolling boil for ten (10) minutes and allowed to cool. Water should be dispensed promptly into clean, sanitized containers and tightly sealed.

Caution:

If water has been contaminated by a chemical spill disaster, boiling will not remove chemicals.

Water Purification: Chlorine It is not necessary to treat water for storage if the water comes from a safe water supply. If stored properly, this water should have an indefinite shelf-life, but you may want to rotate and replace this water every 6-12 months with fresh, safe water.

To kill and prevent the growth of microorganisms, purify water with liquid bleach that contains 5.25 percent sodium hypochlorite and no soap. Some containers warn, "Not For Personal Use." You can disregard these warnings if the label states sodium hypochlorite is the only active ingredient and if you use only the small quantities in these instructions.

Purification of Drinking Water With Chlorine Bleach*			
Type of Water	**Chlorine Bleach**	**Amount of Chlorine**	**Time Required for Treatment**
Clear/Cloudy	5.25%	4 drops/quart	30 minutes
Waterbed	5.25%	1/4 cup / 120 gallons	30 minutes

**Chlorine bleach should have sodium hypochlorite (5.25%) as the only active ingredient.*

Water Purification: Iodine Iodine is available as tablets and as "Tincture of Iodine." Use one (1) iodine tablet per quart of water; two (2) tablets per quart if water is cloudy. "Tincture of Iodine" should have 2% U.S.P. iodine (read label). If concentration is weaker or stronger than 2%, adjust amount to be added by the following formula: Drops of Iodine = 80 per GALLON (%tincture of iodine)

Purification of Water With Iodine - 2 Percent U.S.P.		
Type of Water	**Amount of 2%U.S.P.**	**Time Required for Treatment**
Clear Water	2 drops	30 minutes
Cloudy Water	40 drops	30 minutes

Seal container holding iodine-treated water, let stand 30 minutes. This water supply is safe for an indefinite period. Avoid recontamination after opening.

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Are You Ready for Disaster?

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Step Four: Plan a Menu for No power and no water.

The fourth step is to have a menu for each type of disaster. The menu must be planned to account for special needs such as allergies, textures, and special diets, for example: gluten free that cannot be suspended during a crisis. The stock for this menu should be kept in a secure place, labeled, and rotated every 6 months. Some facilities use the changing of the clocks for daylight savings time as a reminder to rotate the emergency supply stock. The stock should be isolated from regular supplies and clearly labeled that it is for "emergency use only". Sources vary on the number of supplies needed from one day to three days. The Federal Homeland Security Agency recommends that all health care facilities be prepared to be self-sufficient for a minimum of 3 days. In the event of a crisis that interrupts the power supply the general rule is to use all cold foods in the refrigerator first. Temperature of potentially hazardous foods should be verified as less than 41 degrees Fahrenheit or if above 41 degrees Fahrenheit not for more than 4 hours. If there is any doubt or it cannot be verified that cold foods have been out of the danger zone for 4 hours or less, they should not be used and be discarded. Supplies from the freezer are used next after performing the same temperature and safety check and last the emergency supply is used.

At minimum menus are generally written to assume no power no water. The water supply for cooking will come from the emergency supplies unless the safety of the facility water source is assured. If there is power or water the menu can easily be prepared using the available resources or by using normal everyday working supplies. Sample policies and menu are available in the DHCC "Survival Skills for Nutrition Services" 2006, page 156-162.

Step Five: Identify your emergency suppliers.

In this step the facility will identify suppliers that will provide additional water, food, refrigeration equipment and paper and chemical supplies in the event of an emergency. It is customary to have a main supplier and back up to use if the main supplier is compromised during an emergency.

Step Six: Plan out policies and train all staff on roles and responsibilities during an emergency.

This might be the last step but is the most critical. Panels of experts that have studied crisis' such as Katrina found problems with lack of planning and training that led to poor outcomes during the crisis. The time to plan is before the crisis hits. Dry runs and in-service education on a periodic basis are vital. A trained work force using a practiced and well thought out plan can minimize additional stress, injury and even deaths in the event of a natural or man-made emergency. A disaster plan is not a book on a shelf but a document that every staff member should have a working knowledge of where to locate the plan and how to execute their role.

There are many sources on the web to assist in creating a comprehensive disaster plan including:

- CDC: Disaster Checklist for LTC
- Red Cross: Preparedness Tips
- Building an Emergency Kit: FEMA

Hopefully it will never be needed but as recent events have shown, a well thought out and executed plan can literally save lives. So, the question is are you ready for a disaster? Now is the time to find out!

References:

1. Caring for Vulnerable Elders during a Disaster: National Findings of the 2007 Nursing Home Hurricane Summit May 21 - 22, 2007 St. Petersburg Beach, Florida. Convened by The Florida Health Care Association.
2. FNS Disaster Assistance: http://www.fns.usda.gov/disasters/disaster.htm
3. FEMA: How do I get food, water in a disaster: http://www.fema.gov/rebuild/recover/foodandwater.shtm
4. National Food Safety Council: National Recommendations for Disaster Food Handling: http://fycs.ifas.ufl.edu/foodsafety/HTML/tn001.htm
5. https://health.mo.gov/emergencies
6. RD411 Checklist for Disaster Planning: www.RD411.com
7. Servsafe®: Crisis Management, Servsafe® Essentials: Fourth Edition pages 10-12 to 10-18.

Gloves On or Off? A Handy Review for Healthcare Food & Nutrition Services

Sue Linja, RDN, LD

Sue Linja, RDN, LD

Our hands are among the most dynamic parts of our bodies. They are in a perpetual state of activity, helping us navigate our daily routines and, unbeknownst to many (especially the untrained food service employee), playing host to a thriving community of germs, bacteria, and viruses. As you read this article, your hands are engaged in their relentless proliferation. Some of these microorganisms, such as E-coli, Salmonella, and Norovirus, have the potential to cause severe food-borne illnesses.

Over the years, the discussion and practices surrounding glove-use in healthcare food services has continued to be a hot topic. In the realm of safe food handling, we know that washing your hands is the key to eliminating these germs and the transmission of food borne illness - but another crucial practice is the appropriate use of gloves. This article will provide you with a general review of glove use for handling food in high-risk populations. It can be used for staff education and to share with your administrators and others if you wish.

The latest version of the FDA Food Code, published in January of 2023, cites the following regarding hand washing and glove use:

3-301.11 Preventing Contamination from Hands.

A. FOOD EMPLOYEES shall wash their hands as specified under § 2-301.12.

B. Except when washing fruits and vegetables as specified under §3-302.15 or as specified in (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT.

C. FOOD EMPLOYEES shall minimize bare hand and arm contact with exposed FOOD that is not in a READY-TO-EAT form.

*The FDA Food Code forms the basis for food regulations in various states and counties, however several editions remain in use across the country. For precise requirements, it is advisable to consult with local regulatory agencies.

Gloves act as a protective barrier between a food handler's hands and the food they handle. It is important to note that gloves should never replace hand washing. Instead, they are an adjunct to good hand washing in the prevention of food-borne illnesses.

So how does this work in practical terms?

1. Each facility should have a written policy on washing hands and glove use. The RDN should review and understand this policy.

2. Education and skills testing of staff for hand washing competency and proper glove use is crucial. It is recommended for the RDN to observe and report on appropriate food handling upon each entry into the food services department, preferably at least weekly and at a minimum of monthly.

3. Adhering to the correct glove-wearing technique includes:
   - Begin by washing your hands for a minimum of 20 seconds.
   - Put on single-use gloves, ensuring they fit properly. Never blow into the gloves.
   - Once the glove is on, check for rips or tears.
   - Complete a single task within the kitchen.
   - Carefully remove the gloves by turning them inside out as you take them off and dispose of them appropriately.
   - Wash your hands once more.
   - Repeat the process as needed.

4. Provide guidance to staff regarding when gloves are required per your facility's written policy. The following are the typical times gloves are worn in healthcare food service, but remember, your policy may indicate something different.

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Gloves are required when touching or preparing any ready-to-eat (RTE) item:

- Vegetables and fruit served raw
- Salads and salad ingredients
- Cold meats such as deli meat/cheese
- Sandwiches
- Bread, toast, rolls, baked goods
- Garnishes such as parsley, lemon, pickles, lettuce
- Ice served to a resident/customer
- Any food not thoroughly cooked or reheated after preparation

Gloves are required when the employee has one of the following:

- Cuts, burns, open wounds
- Nail polish
- Fake nails

5. Understanding when gloves should be changed is crucial. Glove changes are typically done in the following circumstances:
   - Immediately after they become soiled. Examples include after handling used utensils or equipment, touching a doorknob/handle, a cell phone (yes, imagine that!), or any part of your body except clean hands and arms
   - Before commencing a different task
   - If torn or the integrity is altered
   - After coughing, sneezing, using a handkerchief
   - At least every four hours during continuous use, with more frequent changes as necessary
   - After handling raw meat, seafood, or poultry, and before handling RTE food
   - If allergies exist in the facility, after handling any food on the allergen list

It is also important to understand that hands must be washed between every glove change

6. Every kitchen should be adequately stocked with a range of disposable gloves in various sizes. When procuring gloves, it is essential for managers to ensure that they are designated for food handling. Gloves should be utilized for a single task and then properly disposed of; reusing or washing them is poor practice. Additionally, it's important to consider latex allergies, so non-latex glove options should be available to accommodate individuals with sensitivities.

Even though it seems straight-forward to those working in the industry for years, recognizing when gloves (or other protective measures) must be used, when they might be useful, and when foods can be handled with bare hands is pivotal for the inexperienced/untrained food service worker. Here are a few questions I have encountered over the years and some considerations for each. How would you answer these questions for your staff?

1. Do I have to wear gloves on tray line or not?
   a. What does your policy say?
   b. If the policy does not specify and you are using another "suitable utensil" (see FDA food code) to serve RTE foods, gloves would not be required.

2. Do I need to change my gloves between cutting different types of vegetables and fruits, ie- potatoes, lettuce and strawberries?
   a. Has the produce all been washed/cleaned?
   b. Do you have any allergies in your facility to any of the items being prepped?
   c. Do you have to go back into the walk-in to get each produce item?
   d. If the items are washed, there are no allergy issues and you have them all out ready to chop together, you would not need to change gloves between each item unless the chopping process is greater than 4 hours.

3. Do I have to wear gloves if I am chopping onions that will go into several dishes, including a meatloaf? Can I mix the meatloaf with my bare hands?
   a. What other uses do you have for the onions?
   b. Will they all be cooked or are any served raw?

   Technically, you would not need to wear gloves to chop the onions if they are only to be used in the meatloaf or other cooked items. Even though it is unusual not to wear them, the gloves do not need to be worn when mixing the meatloaf. (Remember to check your policy)

4. Can I use hand-sanitizer on my gloves?
   a. No, the use of sanitizer on the gloves is not recommended. Hand sanitizer can never replace proper hand washing and should only be used after properly washing hands in the kitchen.

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5. I watched Chef John do this yesterday and need to know if it is ok? While preparing potato salad, he stirred the mayonnaise, mustard, onions, and celery together with his gloved hand. He then rinsed his glove in the prep sink and started chopping the cooked potatoes.

   a. Did Chef John wash his hands before he put on the gloves?

While stirring the mayo and other items together with a gloved hand is uncool and unorthodox, it does not breach food code practices. Rinsing the glove and moving on to cut the potatoes would be a concern, as the gloves were not changed when they become "soiled".

6. Why can't I wear several pairs of gloves over each other and just pull them off when I soil one?

   a. Great thought for saving time, but totally not ok! Food handling standards direct that hands must be washed before/between donning gloves to initiate any task that involves working with food.

In conclusion, just as hands are ceaseless in their activities, our commitment to maintaining food safety and health to our residents should be unwavering. This article has shed light on the critical role gloves play as a protective barrier, while emphasizing that they should never replace the indispensable practice of handwashing. As RDN's in healthcare, the education and oversight of these practices should be regarded as one of the most vital responsibilities we undertake.

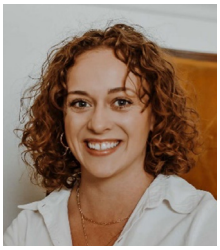
References:

U.S. Department of Agriculture

Food and Drug Administration

IDDSI Spotlight: Level 7: Easy to Chew

Libby Reynolds-Johnson, MBA, RDN, LD/CD



Libby Reynolds-Johnson, MBA, RDN, LD/CD

Not to be confused with the IDDSI Level 7 counterpart of "regular", Level 7, Easy to Chew is meant for those individuals who may have difficulty chewing their meals. Easy to chew foods should be tender in texture and free of any characteristics that could classify as difficult to chew. These characteristics include (but are not limited to) any food that is: crunchy, chewy, stringy, fibrous, crumbly, or hard. All foods within this level should not have seeds, husks, or bones. Foods at this level do not have any size specifications, only that they should be easily cut with the side of a fork or spoon and can be easily squished or smashed with the back of a fork or spoon without returning to its original shape.

Easy to chew food specifications and preparation:

Meat/fish should be tender, avoid cuts of meat that are characteristically tough (for example, substitute pork loin or roast over a pork chop as able). Some tips for easy to chew meats are: slow cooking, reheating/steaming, pre-cooking tenderization (via acid or manual methods). Vegetables should be cooked. Slow roasted/steamed vegetables are the preferred method of preparation; stir fried vegetables may prove difficult to serve on this level. Ensure all food items pass the fork/spoon pressure tests. Mixed consistencies are permitted for the easy to chew texture as per clinician discretion; individuals who are not approved for thin liquids may only

have liquids/mixed consistencies of the permitted liquid viscosity. Breads (as allowed per clinician discretion), pastas and grains should be soft and devoid of hard lumps, crusts, nuts, or seeds. Soft fruits are permitted assuming they pass the fork/spoon test; fibrous parts of fruit are not appropriate for the easy to chew texture.

Special Considerations:

It is of note that the level seven, easy to chew texture is meant specifically for individuals with difficulties chewing their foods. Individuals with a history or diagnosis of dysphagia are at increased risk for choking on this level as there are no specifications to the particle size of the foods. Individuals with a history of swallowing difficulties should be properly evaluated by a qualified clinician prior to the prescription of this diet type. Visit IDDSI.org for more in-depth guidance on this level.

References:

IDDSI. (2023). https://www.iddsi.org

Do You Know? A Legislative Overview

Cynthia A Wolfram, RDN, LD, FAND
Policy and Advocacy Liaison

Cynthia A Wolfram, RDN, LD, FAND

In these interesting times in the political arena, we may ask what we can do to help support nutrition for seniors? The Policy Initiatives and Advocacy staff provide support and guidance for issues related to many areas of nutrition.

Advocacy is critical for achieving a world where people thrive through the transformative power of food and nutrition. Academy members work on a broad range of issues, improving communities' nutrition and health issues and health status in the US and worldwide.

The Public Policy Priorities for the Academy of Nutrition & Dietetics include:

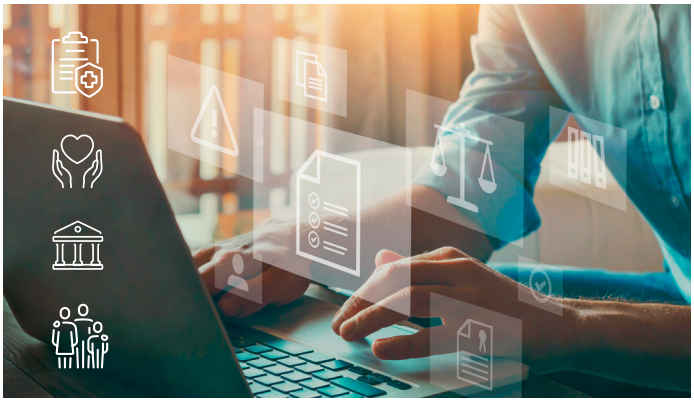
- **Well Being and Prevention** includes support of Medical Nutrition Therapy, Evidenced Based Practice, to name a few areas.
- **Diversity & Inclusion** works to support efforts with nutrition related to health disparities.
- **Nutrition Security and Food Safety** priority work to increase access to affordable healthy foods for all.
- **Nutrition Care & Health Systems** works to ensure awareness of nutrition services as an essential component of high-quality health care throughout the life cycle and must be patient centered.

More detailed information for each priority area is available on www.eatrightpro.org under the Advocacy tab.

As a member of DHCC, you can participate in our advocacy efforts by providing practice examples in the areas we work in, respond to Action Alerts, be an expert for potential legislation efforts, and more. If interested in participating with our efforts, email me at: Cwolframrdld@gmail.com. We are working to maintain a list of members willing to support the efforts in senior care.

Action Alerts

Action alerts allow us to bring the Academy's policy issues to the attention of members of Congress and help to raise awareness and add legitimacy to a particular priority issue. Available to both Academy members and the public, it literally only takes a minute to support specific bills or topics, share your view with your elected officials and advocate for strong nutrition policy. Action Alerts are announced via *Eat Right Weekly* and Latest News, posted to social media, shared with dietetic practice groups, member interest groups and affiliate associations, and may be emailed to all or some Academy members, depending on geographic location or specialty. (Members who promote Action Alerts to non-members may use this link to the Public Advocacy Action Center.)



Supporting the Political Action Committee is another way to impact the access to political candidates and an opportunity to discuss issues important to the profession.

What is a Political Action Committee?

A political action committee, called a PAC ("pack"), is a group that collects contributions from its members and then uses the pooled funds to support political candidates. ANDPAC is the Academy of Nutrition and Dietetics Political Action Committee – and is the only political action committee broadly focused on food, nutrition, and health. It ranks amount the top health professional political action committees in the country.

Whether we like it or not, it is part of the process to have a seat at the table. There are levels of participation that can be considered, but ANY contribution helps our efforts for access to the candidates, including current members of Congress. For more information on the levels of participation, look under the ANDPAC area.

On a personal note, I have been active in the political process since the mid 90's and see the growth in this area and the opportunities that allow us to have access to provide our expertise and knowledge as decisions are made that will serve our clients, families, and friends.

Navigating the Complex Landscape of Medical Nutrition Services Reimbursement

Coreyann Poly Geracie, PhD, RDN, CDE, ACE-CMES
Nutrition Services Payment Specialist

Coreyann Poly Geracie, PhD, RDN, CDE, ACE-CMES

The role of the Registered Dietitian Nutritionist continues to be critical in improving the health outcomes of our population. As nutrition professionals, we know firsthand how diseases such as obesity, diabetes, heart disease, and certain cancers, are heavily influenced by diet. Furthermore, research has shown that Medical Nutrition Therapy (MNT) significantly reduces the burden of these disease not just by improving overall health but by reducing the cost impact of these comorbidities. So why the ongoing fight to have MNT services reimbursed?[1,2,3] And how can we, as the nutrition professional, navigate the landscape of Medical Nutrition Services Reimbursement?

One main issue is that reimbursement for services is vastly different among the thousands of insurance companies and plans. In addition, requirements/guideline vary greatly in each state. That's what make it difficult for nutrition professionals to receive information from the national level as it applies to them in their state. As a private outpatient practitioner in the state of Massachusetts, I have become somewhat of an expert in understanding my patients' nutrition services benefits for the various insurance companies here. However, even though Massachusetts has made strides in recognizing the importance of nutrition in overall health, reimbursement for services among the various insurance plans continues to vary largely. And of course, every year changes to insurance plans further complicate matters. In this article, I hope to offer insights into best practices to maximize reimbursement in your state.

Best Practices for Maximizing Reimbursement:

1. **Stay Informed:** Nutrition professionals need to stay well informed of changes in your state. Being up to date on policy changes of MNT reimbursement not only supports your patients understanding of benefits but prepares you for needs to be done regarding policy change. Further your knowledge regarding coding, and coverage on the national level to support initiates to advance nutrition practitioners' coverage with state level third party payers. Regularly check for updates from state health departments and insurance providers to adapt to evolving reimbursement scenarios.

2. **Build Strong Relationships with Payers:** Establishing strong relationships with insurance companies can be instrumental in navigating the reimbursement landscape. Work with your individual insurance companies. Building strong relationships with payers can reduce the resistance in paying for services especially when you share positive outcomes through documentation such as improved glycemic control and weight reduction. Do not be afraid to reach out directly to the insurance companies to communicate why nutrition services is needed for your patient. Communication is key; nutrition professionals should engage with payers to understand their specific requirements as well as negotiate fair reimbursement rates.

3. **Utilize Technology:** Embrace technology to streamline the documentation and billing process. Nutrition professionals should invest in a nutrition-specific electronic health record (EHR). Leveraging technology can improve reimbursement rates and timing of payment by enhanced document accuracy. An EHR systems can also help reduce paperwork and improve efficiency in managing patient records and billing information.

As nutrition professionals we can play an active role in advocating for policy changes that promote fair reimbursement for MNT services. Engage in discussions with professional organizations and policymakers to address systemic issues and create a more supportive environment for medical nutrition therapy. By addressing these challenges head-on, we can ensure that MNT services are properly supported with fair reimbursement rates across the spectrum of insurance plans.

References:

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2. Marincic PZ, Hardin A, Salazar MV, Scott S, Fan SX, Gaillard PR. Diabetes self-management education and medical nutrition therapy improve patient outcomes: a pilot study documenting the efficacy of registered dietitian nutritionist interventions through retrospective chart review. J Acad Nutr Dietetics. (2017) 117:1254–64. 10.1016/j.jand.2017.01.023 [PubMed]
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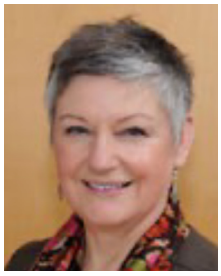
A House of Delegates Update: Marching Forward Together



Cora Martin, RDN, CSG, LDN

With your support through sharing of ideas and future visions for our field of nutrition and dietetics, the Academy of Nutrition and Dietetics can serve as a vessel to integrate this wisdom into communications that powerfully advocate for advancing us in our professional paths.

2023 was an exciting year in the House of Delegates (HOD)… and I anticipate 2024 to be even more thrilling! We are seeing the benefit of the transition to monthly Real Time Dialogue virtual meetings in June of 2022. The discussions occurring are timely, informative, and immersive. Critical issue submissions are reviewed quarterly and discussed by the entire House of Delegates in attendance during the monthly 2-hour sessions.

What have Academy members been successfully submitting? Issues that they believe meet 4 criteria:

- have strategic importance to the Academy and dietetics practice
- can cut across multiple discipline areas or relate to a specialized practice area
- have immediate or intermediate impact on the profession (3 or more years)
- reveal novel threats and opportunities in a VUCA (volatility, uncertainty, complexity, and ambiguity) environment, and often require a systems approach or solution.

Critical Issues that have been discussed at Real Time Dialogue sessions and since I became the DHCC Delegate in June of 2022 include:

- **Elevating the skillset and scope of Registered Dietitian Nutritionists (RDNs) and NDTRs:** This includes promoting RDNs and NDTRs as the resource for credible nutrition information on social media platforms. The initial Subject Matter Expert (SME) group has concluded initial work based on current Academy initiatives and information. Academy staff are working to evaluate operational implications and needs of recommendations to help better evaluate the most effective ways to implement recommendations which center on creating resources for professional development outside of the dietetics profession. The House of Delegates may revisit this item to expand on recommendations.
- **Increasing awareness and visibility of the Nutrition and Dietetics Technician, Registered (NDTR):** The Subject Matter Expert (SME) group has concluded their work and made recommendations that are being evaluated by Academy Organizational Units on how best to implement recommendations which center around a toolkit for employers on how to utilize NDTRs.
- **Making Academy Membership Indispensable:** The initial Subject Matter Expert (SME) group has concluded initial work based on current Academy initiatives and information. Academy staff are working to evaluate operational implications and needs of recommendations to help better evaluate the most effective ways to implement recommendations which center mostly around more effective communications to potential members. The House of Delegates may revisit this item to expand on recommendations.
- **Increasing Student Enrollment:** Over 1,600 Academy members responded to the survey soliciting member input to help understand what draws people to the profession and gain insights into any barriers today's students are encountering. Thank you to all DHCC members who responded. A key question discussed during the September 2023 Real Time Dialogue session was "How can we reimagine the profession and the role of the RDN in healthcare to attract more individuals?" The notes from the delegate discussions that evening were captured and shared with the Subject Matter Expert Group. Outcomes will be shared in DHCC E-Blasts.

One of the newest Critical Issues focuses on the impact of **Artificial Intelligence (AI) and Large Language Models** (LLM) on our dietetic profession. My question is, with the potential for AI algorithms to reduce "middle" managers (as is occurring in other professions), will the NDTR and the Masters-degree RDN roles exclusively be our future. Thank you to all DHCC members who participated in the survey examining the incorporation of AI in our workplaces. More updates to come on the progression of this Critical Issue in DHCC E-Blasts.

I hope you are among the DHCC members that have submitted potential critical issues using this online link. Once there, sign in to the EatRightPro Website and scroll down the page to find the submission form. I am pleased with the number of great ideas and areas of potential focus received from Academy members and the response of the House Leadership Team. They triage all submissions and those which are not within the Scope of the HOD are forwarded to the Academy arm most appropriate to explore and act on the submission.

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A House of Delegates Update: Marching Forward Together

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You can also become more involved in these exciting discussion by requesting to audit a Real-time Dialogue session or be even more involved by volunteering to serve as a Note Taker. Participating as a note taker brings you to the front lines of how leaders work together to shape the direction of the profession and the Academy. Interested members should be:

- an active member or student member of the Academy
- able to synthesize information and type the information in an online workbook, capturing key concepts and paraphrasing ideas
- comfortable verbally communicating with our leaders as they may be asked to recap discussions
- adept in technology, including Zoom and document editing programs (such as Google docs).

Please see the HOD Tips for Note Takers for more details about this volunteer opportunity. If you or someone you know would like to serve the HOD as a note taker for one of the Real-Time Dialogues, please contact hod@eatright.org.

Lastly, the proposed changes in the Delegate-At-Large Positions passed in November with 96% of the votes for the proposal. There are 7 Delegates-At-Large in the HOD but only 3 will be impacted by this action. They are:

1. The "30 and Under" representative is now the "Early Practitioner (credentialed 5 years or less)" representative. This action should improve the ability of this Delegate to reach their constituents as this sector is easily identified through CDR and having the constituency tied to years in practice rather than age allows Academy staff to support engagement efforts without compromising member privacy.
2. The Student representative, transitions from a 1-year term to a 2-year term and will remain appointed by the President- Elect and Speaker-Elect. Due to the fast nature of the work of the HOD, 1- year terms are not effective in ensuring the highest level of involvement and align with other student volunteer term lengths. A second year as a Student representative will help with the continuity of outreach and representation as well as allow for more thorough training/support of each incoming Delegate at Large.
3. The CDR representative (a non-voting HOD Delegate) will move from a 1-year term to a 2-year term and will remain appointed by CDR. A second year as a CDR representative will help with the continuity of outreach and representation as well as allow for more thorough training/support of each incoming Delegate at Large.

I encourage you to reach out to me, as your delegate, with any questions as well using this email link. I have received many excellent, detailed communications from DHCC members.

Thank you for your support of the dietetic profession and our Post-Acute, Long-Term Care and Corrections healthcare communities.

New Member Spotlight:

Meet one of our Newest Members, Sara Orr, RDN!

Dana Fillmore, RDN, DHCC Membership Coordinator

How long have you have been a RDN?

Since February 2023

How long have you been a DHCC member:

Since June 2023

Title and place of employment:

Clinical Dietitian in two locations for Ensign Healthcare.

Tell us about your job:

I complete all assessments from the standard new admissions, annuals, change of condition to quarterlies. I attend the weekly weight/skin meeting and complete all the nutrition clinical documentation for the meeting. I complete all MDS's, CAA's, Care Plans, and the monthly weight loss report. Additionally, I assist with ordering food and supplies other tasks with the dietary manager as needed and provide education for monthly meetings as requested.

How has DHCC helped you be successful in your professional journey?

DHCC has helped keep me informed on the latest trends in healthcare. I appreciate all the tools available - they help me to be more effective and efficient in the long-term care arena.

What do you love the most about your job?

I love being able to see nutrition interventions work when a resident comes to the building with crazy wounds and discharge with skin intact-beautiful!

What experiences and past roles have led you to where you are today?

I was a dietary manager for over 20 years in long term care. I worked with many dietitians who inspired me and shared their knowledge over the years. I will be forever grateful to all of them.

What do you like most about being a DHCC member?

Working for a company and being the only RD can make you feel like you are in a silo; having the DHCC provides support.

Do you have any hobbies?

I love to learn, being outside in the summer, and I love to search for a good mom and pop restaurant. I call that eating like the locals!

What are you reading or listening to?

I recently started a new book by Anita Phillips called The Garden Within.

Best restaurant you've ever been to?

My daughter and I went on a road trip and stopped at a restaurant in downtown Kansas City called Cafe Gratitude. It was a plant-based restaurant and everything on the menu was a positive affirmation: if you wanted the soup of the day "I am thriving"- you order it by menu name. So much fun!!!

Are you a morning person or a night owl?

I strive to be a morning person; it is my goal every day. One day I will wake up full of energy and ready to take on the world.

Dietetics in Health Care Communities (DHCC) Executive Committee 2023-2024

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**Elected DHCC EC member with voting privileges.*

Connections

The publication of Dietetics in Health Care Communities (DHCC), a dietetic practice group of the Academy of Nutrition and Dietetics.

Viewpoints and statements in this publication do not necessarily reflect policies and/ or official positions of DHCC/ Academy of Nutrition and Dietetics.

If you have moved recently, or had a change of name, please notify Academy Membership Team as soon as possible by emailing membership@eatright.org or at Academy's Website at www.eatright pro.org/ "Edit Profile."