Future Dimensions
In Clinical Nutrition Practice

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IN THIS ISSUE

Food Insecurity in the United States: Prevalence, Consequences, and What Hospital Systems Can Do to Support Food Insecure Patients

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Introduction

Each year, millions of Americans experience food insecurity. Food insecurity disproportionately effects households with children, individuals that identify as Black or Hispanic, and households living below 185% of the poverty line. Food insecure individuals are more likely to suffer from chronic health conditions including diabetes, heart disease, and cancer. With the elevated rates of chronic disease, food insecure individuals on average have higher overall healthcare costs when compared to food secure individuals. At the nexus of food insecurity and chronic disease management, food-insecure individuals often must make difficult choices about paying for medications or paying for food. Notably, individuals experiencing food insecurity are more likely to report cost-related medication underuse, often continuing the cycle of poor health.

Because food insecurity is intertwined with overall health outcomes, hospital systems have an obligation to identify and address food insecurity within its patient population. Once a validated screening tool is implemented within the hospital system, providers can then make appropriate referrals to community resources. Many hospitals are establishing on-site resources such as food pantries or advocating for systematic changes such as Medicaid reimbursement for produce prescriptions. Given the number of ways hospital systems can get involved in combatting food insecurity, it is important that the intervention be tailored to the needs of the community in which the hospital exists.

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This paper will review recent statistics of food insecurity in America, the connection between food insecurity and chronic health problems, and several ways hospital systems can address food insecurity. A case study of an on-site anti-hunger intervention at a hospital in Northeast Ohio will be presented.

The Basics of Food Insecurity

The United States Department of Agriculture (USDA) defines food security as access by all people at all times to enough food for an active, healthy life.[1] Most U.S. households are food secure; however, some households experience food insecurity at times during the year, meaning their ability to obtain adequate food is limited by a lack of money and other resources. Since 1995, the USDA has been collecting data on the prevalence and severity of food insecurity in the U.S. through the Food Security Supplement survey. Food-insecure households are classified as having either low food security or very low food security depending on the number and type of positive responses to food-insecure questions within the Food Security Supplement.[2] Households classified as having low food security report reduced diet quality and multiple problems attaining food. Households classified as having very low food security report the same information, in addition to disrupted eating patterns and reduced food intake because of inadequate resources to obtain food.[2]

In 2021, 10.2% of the U.S. households were food insecure.[2] This is not significantly different from 2020 when 10.5% of households were food insecure. Notably, in 2021, 6.4% of households experienced low food security and 3.8% of households experienced very low food security.[2] Rates of food insecurity in 2021 were significantly higher than the national average in households with children, households with children headed by a single care provider, adults living alone, households with one or more individuals that identify as Black or Hispanic, and households with incomes below 185% of the poverty threshold.[2] Compared to the national average, food insecurity is higher in principal cities compared to suburban areas outside of principal cities.[2]

Food security status is strongly related to the likelihood of chronic disease in children, adults, and seniors[3]; it is well documented that poor nutrition in general can play a role in the development and exacerbation of many chronic health conditions such as diabetes, heart disease, and cancer. Gregory & Coleman-Jensen (2017) examined the association between the severity of food insecurity status and ten chronic health conditions (hypertension, coronary heart disease, hepatitis, stroke, cancer, asthma, diabetes, arthritis, chronic obstructive pulmonary disease, and chronic kidney disease). The researchers found a statistically significant increase in the prevalence of all ten chronic diseases as food security status worsens among working-age adults in the U.S., with the highest relative probability increase for individuals in very low food secure households.[4]

Notably, individuals in very low food security households are more likely to have diabetes than those who are food secure.[5] These individuals are more likely to have inadequate glycemic control compared to their food-secure counterparts.[6,7] Furthermore, these individuals reported statistically significant more events of hypoglycemia and were more likely to attribute the events to the inability to afford food.[7]

Not only are individuals living in food-insecure households more likely to have chronic disease, but they are also more likely to report cost-related medication underuse compared to individuals in food-secure households.[8,9] Cost-related medication underuse includes one or more of the following: unable to afford a prescription, delaying a prescription due to cost, skipping doses due to cost, and taking less medication than prescribed due to cost.[9] Herman et al. (2015) found that compared with those with high food security, non-senior adults with very low food security had approximately four times higher odds of cost-related medication underuse. Similar findings have been noted within the senior very low food secure population.[10] A study of Feeding America food bank clients found that 66% of households choose between paying for food or paying for medicine and medical care each year.[11]

Aside from food insecurity being linked to poor chronic disease management, it is also associated with higher healthcare costs. In 2016, approximately $52.9 billion in healthcare costs were associated with food insecurity among American adults and children.[12] These costs vary across states and counties; therefore, food insecurity programs and policies should be tailored to bioregional needs.[12,13] Stakeholders including insurance payors, healthcare providers, the social service sector, and the nutrition and public health sector have an obligation to work together to address food insecurity, reduce healthcare costs, and improve people's health.

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Hospital Systems Role in Addressing Food Insecurity

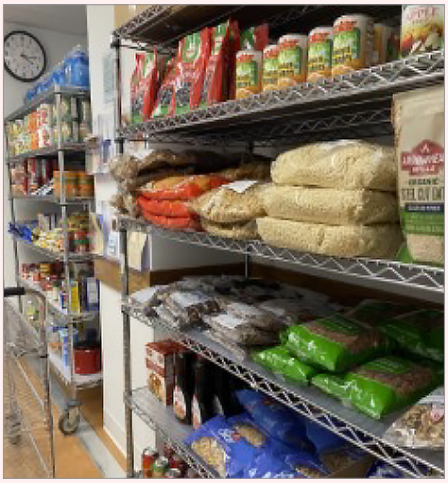
Food insecurity is one of the many social determinants of health. The research highlights a direct link between food insecurity, chronic disease, and cost-related medication underuse. To better improve patient health outcomes and reduce healthcare costs, food security status must be addressed by hospital systems; and to address food insecurity, it must first be identified. Screening all patients for food security can help to overcome the stigma of food insecurity, tailor clinical care to patient needs, identify a vulnerable patient population, reduce the prevalence of food insecurity and its effects in the community, and has the potential to reduce healthcare costs.[14]

There are several validated food security screening tools available, including the 18-item U.S. Household Food Security Survey, which is considered the gold standard.[15] In healthcare settings, an 18-item screening tool may not be feasible or efficient. The most succinct, sensitive, specific, and valid tool is the two-item Hunger Vital Sign™. The Hunger Vital™ was developed based on the 18-item U.S. Household Food Security Survey and offers clinicians the ability to rapidly screen and identify patients for food insecurity.[16] Patients are identified as food insecure if they answer that either or both of the following two statements is 'often true' or 'sometimes true:'

> "Within the past 12 months we worried whether our food would run out before we got money to buy more."
>
> "Within the past 12 months the food we bought just didn't last and we didn't have money to get more."

Once patients are identified as living in a household experiencing food insecurity, then they can be referred to appropriate resources. First, patients' *immediate food and nutritional needs* must be addressed. This includes referrals to emergency food resources such as food pantries, mobile distributions, and hot meal services. Second, a patient's *continuing food and nutritional needs* should be addressed. This includes connecting patients to federal nutrition programs for which they qualify, such as the Supplemental Nutrition Assistance Program (SNAP), Women, Infants and Children (WIC), senior congregate meals, and community produce vouchers programs.[17] Because many individuals that are food insecure do not qualify for federal nutrition programs, many hospital systems are taking the extra step to facilitate successful connections to anti-hunger resources[18], including having on-site resources available. This encourages participation and can effect long-term positive change.

One common option growing within various hospital systems is to partner with area food banks to distribute food items to food



insecure patients via on-site food pantries. Because food banks often receive donations of shelf-stable, canned, and pre-packaged goods, the food items are not always appropriate for therapeutic dietary needs. Many hospitals with on-site pantries are establishing nutrition standards or policies as a strategy to improve the nutritional quality of the food distributed[11] and hence improve the health outcomes for patients. Other strategies include farm gleaning, farmers market gleaning, and on-site community gardens to provide fresh and local produce to those in need. Produce prescription boxes and medically tailored meals have also been gaining popularity as food-based interventions to help prevent and treat chronic disease. The research shows that these interventions can improve food security, improve dietary intake, and support mental health.[19,20,21] Specifically, produce prescriptions are associated with improvements in blood pressure, hemoglobin A1c, and diabetes self-management[22,23], and medically tailored meals are associated with reductions in healthcare utilization and spending, as well as improvements in disease-specific clinical outcomes.[24,25]

Some hospital systems have taken one step further in the fight against food insecurity by addressing the root cause through advocacy and local and state policy changes. The root of food insecurity is complex and oftentimes multifaceted. When hospitals begin by completing a community needs assessment to understand the issues individuals within their communities are facing, they can tailor interventions that provide the greatest benefit.[18] Often, causes of food insecurity include poverty, unemployment or low income, lack of

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affordable housing, chronic health conditions or lack of access to healthcare, and systemic racism and racial discrimination.[26]

Hospital systems engaged in addressing food insecurity often encounter time, personnel, and financial hurdles that must be overcome. Applying for grants and hospital philanthropic funds is common; however, sustainability of the funding is not guaranteed. One way to address these concerns is through standardized healthcare terminology and codes to document assessments and interventions for food insecurity within the electronic health record.[27] Coding for food insecurity may increase the complexity of the hospital stay, potentially improving reimbursement. Additionally, Medicaid and Medicare reimbursement for programs like produce prescription boxes and medically tailored meals continues to gain traction within some states and localities.[28] There continues to be room for expansion; policy pathways are emerging within the US healthcare and food systems to scale access to produce prescriptions nationwide.

Addressing Food Insecurity in Practice – An Ohio Hospital's Impact

Cleveland Clinic Akron General is a 511-bed urban non-profit acute care teaching hospital with a level 1 trauma service located in Northeast Ohio. There are two other large teaching hospitals in the same county, all 3 in a 10-mile radius. A recent community needs assessment[29] identified healthcare access and food insecurity as a concern for the county. Our local State representative worked to obtain funding connecting the local Food Bank with the hospitals to address these community disparities. This is our story of how we developed a program and lessons we learned along the way.

Pairing with a primary care physician group that has a large population of Medicare patients in the higher risk zip codes identified in the needs assessment, a screening for food insecurity using the Hunger Vital Signs™[16] 2-question survey was implemented. The physician office staff (social worker, care manager, physician, CNP (Certified Nurse Practitioner)) would discuss client needs when identified and refer the client to come to our on-site food pantry. The pantry is coordinated by an RDN (Registered Dietitian Nutritionist). This serves multiple purposes with the primary reason being the ability to do on the spot education and coaching for food selections to help address chronic health conditions.

The full-time RDN is responsible for all aspects of running the pantry. All food orders from the Food Bank and any individual foods brought in to accommodate special dietary needs are managed by the RDN. The RDN utilizes their food safety awareness and ServSafe® knowledge base in the daily management of the pantry. Knowing what foods will be available, recipes and other educational information can be assembled for client use in the pantry. As an RDN, access to the electronic medical record enables communication between referring physicians and other health care workers who identify food insecure patients and want to connect them to our pantry. Special dietary needs can be identified to individualize the patient's needs when coming to the pantry through this route. Clients coming in without a direct referral are also able to get this nutritional guidance if they share their needs with the RDN. Additional needs and projects are addressed including an electronic wish list for pantry items, working with an inpatient team to help identify ways to get food to patients being discharged that are identified as food insecure, and working with communications department for media and public relations opportunities. Lastly, the Pantry Dietitian represents our facility as a food insecurity expert.

Initially, business hours were 5 days a week, 9:00 am – 3:00 pm daily with a break for lunch. Deliveries are once a week in the afternoon. We worked with our volunteer department to get assistance with putting food away while still providing services to clients. Wayfinding cards were printed to provide directions for people coming in from various entrances of the hospital. Our Women's Board offered to help with the pantry and are providing us with zippered handled bags that clients can bring back and reuse at follow up visits to the pantry. Word of our pantry spread quickly, and our volumes grew from two households representing three total individuals the first week to an average of 131 households representing 3[17] total individuals per month now after one year of implementation (Table 1; Table 2; Image 1).

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Table 1. Cleveland Clinic Akron General Food Pantry Monthly Statistics from June 2022 through October 2023

Month	Total Number of Households Served	Total Number of Individuals Served	Total Number of Meals Provided	Total Pounds of Food Delivered to Pantry
June 2022	2	3	27	511
July 2022	22	74	666	674
August 2022	26	73	657	1369
September 2022	52	139	1251	1408
October 2022	68	193	1737	2905
November 2022	98	255	2295	2681
December 2022	83	221	1989	2311
January 2023	124	302	2718	3334
February 2023	165	451	4059	3681
March 2023	203	504	4536	3001
April 2023	231	538	4824	4387
May 2023	279	586	5274	5857
June 2023	186	406	3654	3403
July 2023	268	611	5499	5703
August 2023	135	304	2736	2312
September 2023	157	411	3699	2372
October 2023	306	808	7272	6141

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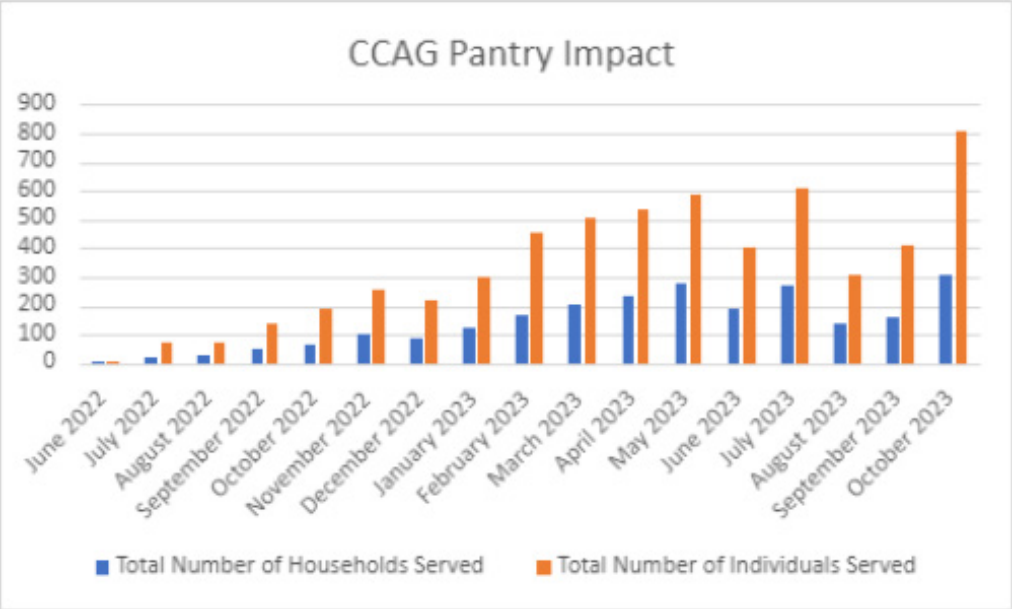
Image 1. Cleveland Clinic Akron General Food Pantry Impact on Households and Individuals Served



Note: The Cleveland Clinic Akron General Food Pantry had shorted hours during the months of June 2023, August 2023, and September 2023, resulting in lower impact during those months.

Our first food order was just over 200 pounds for a week. Our current orders run 3400-5800 pounds per month (Table 1; Image 2).

Table 2. Cleveland Clinic Akron General Food Pantry Average Monthly Statistics from June 2022 through October 2023

Initiation of Pantry to Present Date (06/2022-10/2023) Metrics	
Total Number of Households Served	**2,405**
Total Number of Individuals Served	**5,879**
Total Number of Meals Provided	**52,893**
Total Pounds of Food Delivered to Pantry	**52,050**

Average Monthly Metrics	
Average Number of Households Served	**141**
Average Number of Individuals Served	**346**
Average Number of Meals Provided	**3,111**
Average Pounds of Food Delivered to Pantry	**3,062**

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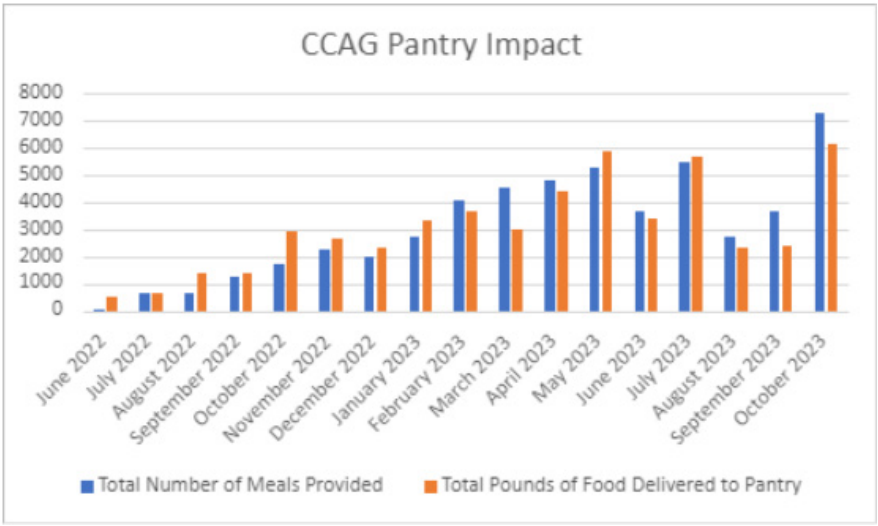
Image 2. Cleveland Clinic Akron General Food Pantry Impact on Meals Provided and Food Delivery



Note: The Cleveland Clinic Akron General Food Pantry had shorted hours during the months of June 2023, August 2023, and September 2023, resulting in lower impact during those months.

Our inpatient RDN and DTR staff work to identify malnutrition in our patients and to get interventions in place. Helping patients have access to food can be part of this intervention. The clinical staff have helped connect both in and outpatients with our pantry RDN. Our oncology offices have staff bringing patients over when they identify food insecurity. We see veterans and families who do not qualify for other food assistance programs but struggle to have enough to cover their household expenses, including food. We have learned how even people who are employed still may qualify for this assistance, particularly if they have others in their household that depend on the single income.

Conclusion

Food insecurity is a complex problem that does not exist in isolation. Individuals and families experiencing food insecurity are more likely to also be affected by housing instability, high utility costs, lack of reliable transportation, unemployment, and poverty. Individuals and families often face tradeoffs between paying for healthcare or paying for food. The complex association between food insecurity and health outcomes creates the environment for hospital systems to intervene. Many hospital systems are already establishing interventions to identify and address food insecurity within their communities. Medicaid and Medicare reimbursement have historically been limited in addressing food insecurity, although advocacy for policy changes has been leading to expansion of coverage, resulting in overall reduced healthcare costs. It is essential to remember that health is influenced by factors beyond receiving medical care and medicine. The time is now for hospital systems to assess, identify, and intervene in food insecurity to promote true healing for patients.

CPEU

This article is approved for 1 hour self-study CPEU. Access the quiz here. Quiz results are reviewed at the end of each month and CPEU documentation is emailed if the quiz score is 80% or higher.

Author bio:

Claire Loose MA, RD, LD is the Clinical Manager for Cleveland Clinic Akron General, Lodi and Union Hospitals in Ohio. She obtained her BS in Allied Health Professions from the Ohio State University and her MA in Community Health Education from Kent State University, working in the Akron area for 38 years. She has been instrumental in getting the Akron General Food Pantry implemented through collaboration with community resources and funding over the past 2 years.

Nichole Opet, RD, LD is the Food Pantry Dietitian at Cleveland Clinic Akron General. She is pursuing a Master of Science in Sustainable Food Systems and a Master of Business Administration in Sustainability Leadership from Prescott College. She is set to graduate with both degrees in May of 2024. Prior to her role with the therapeutic food pantry, she worked in clinical dietetics empowering patients with acute and chronic disease to improve their health through food. Her work in the food pantry sits at the nexus of clinical nutrition and community health.

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From the CNM Chair

Whitney Duddey, MHA, RD, LD
2023-2024 CNM DPG Chair

Happy New Year! As we enter the new year, we have much to look forward to as members of the Clinical Nutrition Management DPG. The volunteer leaders of the DPG are hard at work checking in on our 2023-2024 goals and have already started to plan for the next fiscal year.

We are in the midst of Academy and DPG elections. Our nominating committee put together an excellent slate of candidates. I strongly urge you to take the time to vote; it is your opportunity to impact and influence the direction of these professional organizations.

Registration is open for our virtual 2024 Symposium, "Inspiring Clinical Leaders: Driving Change," which will take place March 19th and 26th 12-2:30pm EST both days. The agenda features five CPEU total from six expert speakers on a variety of topics including: RDN staffing, compensation, onboarding and training, Lead RDs, culturally appropriate care, feeding tube placement, and workplace resilience. We are also looking forward to reviewing the Quality and Process Improvement (QPI) posters that you have submitted! Registration is available on our website. Don't miss early bird pricing available until February 16th. We are also offering registration stipends for 20 active members and 20 student/retired members; applications are due February 10th and more information can be found on our website.

Our Outpatient Workgroup continues to meet every other month. Last month, the group discussed charting templates and efficiency in documentation. On March 6th, the group will discuss telemedicine. No need to register in advance, just access the zoom link and passcode on our website in advanced of the meeting. If you missed a meeting, session handouts and recordings are also available on our website.

National Nutrition Month® 2024 is right around the corner. This year's theme is "Beyond the Table." Visit the Academy's website and download the toolkit for ideas. Don't forget that March 13th is Registered Dietitian Nutritionist Day and March 14th is Nutrition and Dietetics Technician, Registered Day. This is a great opportunity to express our gratitude for our clinical teams and their dedication to the profession.

I hope you enjoy this Winter issue of *Future Dimensions*. Our CPEU article discusses hospital systems' roles in food insecurity. We also have articles related to oncology nutrition programs, digital health entrepreneurship, and artificial intelligence. Don't forget to check out updates from the Professional Development committee, Nominating committee, and Pediatric Sub-unit.

Thank you for joining our social media channels; please share pictures of your RDN day celebrations. If you have feedback on additional resources you would like to see the CNM DPG offer its membership for 2024-2025, please reach out to the Executive Committee via the website or to me directly at whitneymsanders@gmail.com. Wishing you all a happy and healthy 2024!

From the Editor

Agnieszka Sowa, MS, RD, LD
Future Dimensions in Clinical Practice Managing Editor

Happy New Year 2024!

I hope everyone had a wonderful holiday season filled with love, happiness, and warmth.

With the beginning of a new year, it is a common tradition to come up with resolutions. Commonly, these resolutions include improving a diet, starting an exercise regimen, and making other changes to improve our physical wellbeing. I would like to encourage everyone to also consider your mental health while making your goals this year. We are all busy with work and personal life and sometimes forget to take care of our emotional and psychological health. Remember to be kind, patient and compassionate to yourself. Practice mindfulness, get enough sleep, reach out to family and friends, and seek help when needed. Taking care of your whole self can truly set you up for success.

I hope you enjoy this edition of the newsletter. As always, if you have any feedback or would like to submit an article to our newsletter please don't hesitate to reach out.

Artificial Intelligence and Nutrition

Susan Juechter, MS, RD, CDN, CDCES (not written by ChatGPT ;))
Senior Registered Dietitian III; Phelps Hospital Northwell Health

Artificial Intelligence (AI) is transforming industries across the globe and nutrition is no exception. Before we consider the concerns of AI, let's consider the benefits. It is a predictive tool. Prediction is the heart of decision making under uncertainty. Predictive tools can facilitate strategies, increase productivity and improve communications among many other opportunities. It is also imperative to protect the integrity of data collection and usage throughout the development of AI technology. This will require global participation for guidelines and safeguards.

AI in nutrition may transform education, enhance content and improve productivity, but it is not a human replacement. AI can capture data, but not the nuances. Bias awareness, ethical considerations around privacy and fact checking for example, requires the expertise of the Registered Dietitian.

One of the most proposed uses for ChatGPT in nutrition is diet creation and dietary advice. Here are a few working examples of how AI assists Registered Dietitians:

- **Tracking, Analyzing and Monitoring:** to provide personalized nutrition: *LoseIt, My Fitness Pal, Foodvisor, Fitbit, Nutrino*
- **Research and Knowledge Synthesis:** to assess data and identify evidence-based practice: Iris.ai, Semantic Scholar
- **Identify Nutrient Deficiencies:** to assess micronutrient gaps based on eating patterns: *Cronometer, Wholesome*
- **Predictive Analytics:** analyze historical data to predict potential health risks and recommend preventative measures: *IBM Watson Health*
- Immersive Virtual Reality (iVR): interactivity to improve nutrition knowledge related to meal preparation and portion control: *Immersive Virtual Alimentation and Nutrition* (IVAN)
- Behavior Change: person-person connection is most effective, but ChatGPT supportive tools assist private practice: *Lark*

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Leveraging Quality Initiatives to Build an Oncology Nutrition Program

Kristin Cuculovski, MS, RDN, CSO, LD/N
Clinical Nutrition Coordinator – Oncology Nutrition

In 2020, the Commission on Cancer (CoC) included Oncology Nutrition Services as a required standard for achieving cancer program accreditation. It is essential for Clinical Nutrition Managers (CNMs) to understand the requirements to meet the new CoC standard to ensure compliance for their program's accreditation efforts. This article will review how CNMs can leverage this new standard to start or grow an oncology nutrition program at their facility and various considerations for developing or expanding a program.

Commission on Cancer Overview

The CoC is an accreditation program of the American College of Surgeons and has approximately 1,500 accredited cancer programs in the United States and Puerto Rico. The program is designed to recognize cancer care programs for their commitment to providing comprehensive, high quality, and multidisciplinary patient-centered care. The CoC is dedicated to improving survival and quality of life for cancer patients.[1]

The CoC emphasizes multidisciplinary cancer care and aims to have every discipline represented in the CoC, with more than 100 members representing multiple disciplines. This commitment is evident with the established recommended standards designed to support multidisciplinary and comprehensive cancer care. The CoC conducts site visits at cancer programs to assess compliance with these standards. They also champion standardized data collection from CoC-accredited organizations. This data is used to measure cancer care quality and to monitor treatment patterns and outcomes.[1]

Accredited programs must have an established cancer committee, which is responsible for multidisciplinary program leadership and represent the full scope of cancer care and services at the facility. The committee is required to meet at least quarterly, with specific standards reviewed and documented in the meeting minutes on an annual basis. Registered Dietitian Nutritionists (RDN) are a strongly recommended member of the cancer committee and an annual review on Standard 4.7: Oncology Nutrition Services is required to be presented at a cancer committee meeting.[2]

The most recent CoC standards for accreditation can be reviewed at - https://www.facs.org/quality-programs/cancer-programs/commission-on-cancer/standards-and-resources/2020/.[2] With these recent updates, oncology nutrition services became a

required standard for program accreditation. Nutrition is included in Standard 4.8: Survivorship Program – nutrition is a part of the survivorship program team and as a suggested service line to be offered by a survivorship program. Nutrition is also included in Standard 8.2: Cancer Prevention Event – nutrition is an option for a cancer prevention event that focuses on a change in behavior that can reduce cancer risk.[2]

Standard 4.7 – Oncology Nutrition Services

Standard 4.7 states that, "oncology nutrition services are provided, on-site or by referral, by Registered Dietitian Nutritionists (RDN). The cancer program defines and identifies the nutrition services provided on-site or by referral. Nutrition services not available at the facility must be provided through a referral relationship to other facilities and/or agencies." The standard specifies that components of oncology nutrition services include, but are not limited to, screening and nutrition assessment for risk and diagnosis of malnutrition, nutrition-related problems, and overweight and obesity; medical nutrition therapy; nutrition counseling; nutrition education; and management and coordination of enteral and parenteral nutrition.[2]

The standard also includes information on monitoring and evaluating nutrition services and requires that "each calendar year, the cancer committee must monitor, evaluate, and make recommendations for improvements to on-site oncology nutrition and hydration services and/or referral services. Content of the review and recommendations for improvement must be documented in the cancer committee minutes. It is recommended that an RDN attend the cancer committee to lead the discussion and provide the report." The annual report should

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also include a list of the policies and procedures that are in place for providing nutrition services along with any documentation of program evaluation.[2]

Now that the CoC has included Nutrition Services as a requirement for accreditation, CNMs can use this as an opportunity to start or grow an oncology nutrition program. This standard also provides language that can be used to update or create a policy that will support an oncology nutrition program or department.

Policy and Procedures

Policies and procedures are required documentation for CoC reporting. It is best practice to keep a list of the most up-to-date nutrition policies and procedures that may involve cancer care for inpatient and outpatient services. Follow your institution's guidelines for how often the policies need to be reviewed.

The following is a partial example of a policy and procedure for a CoC accredited cancer program.

POLICY:

Registered Dietitians (RDs) are available upon referral and/or through XX Hospital / XX Hospital Cancer Center. Components of oncology nutrition services, performed by an oncology RD, may include, but are not limited to, nutrition assessment, medical nutrition therapy, nutrition education, nutrition counseling, and/or assisting with the management and coordination of enteral and parenteral nutrition as indicated by the patient's needs. RDs will document in the patient's electronic medical record (EMR) or paper chart per clinic protocols.

PROCEDURE:

- Referrals for nutrition consultation may be made by a physician, physician's assistant, nurse practitioner, nurse, allied health professional, or at the patient's request. Ongoing screening by oncology RDs will be conducted to monitor for any changes of the patient's nutrition risk status.
- Nutrition referrals for XX Hospital / XX Hospital Cancer Center that do not have an assigned oncology RD are processed as outlined below. The RD will document in the referring clinics EMR where it will be accessible to the physician and nurses at the clinic.

Using Quality Initiatives to Build an Oncology Nutrition Program

Our oncology nutrition program began as a quality metric for our cancer committee in 2013. The cancer institute was focused on including support services throughout the cancer institute and we were able to launch the nutrition program with 1.6 full time equivalents (FTEs) covering approximately ten cancer clinic sites out of approximately 30 sites within the system. The cancer program continued to grow with new clinic openings and clinics joining the healthcare system, increasing the number of providers and patients that needed access to nutrition services.

As of November 2022, RD staffing increased to 14.6 FTEs providing coverage at 48 cancer clinic sites. We were able to grow our program by building relationships with our providers, patients, the quality team, and program administration so that nutrition services are involved in different initiatives that provide value to the organization in addition to satisfying the CoC accreditation standards.

Quality Improvement Initiatives

One of the most effective ways we grew our program was leveraging another quality standard of the CoC – Standard 7.3: Quality Improvement Initiative, which states, "the cancer program must measure, evaluate, and improve its performance through at least one cancer-specific quality improvement initiative each year."[2] In late 2018, the oncology nutrition team proposed a nutrition-related quality improvement (QI) initiative. In 2019, our cancer committee accepted the proposal for a QI study on "Assessing the Utilization of Nutrition Services and Timeliness of Care for Patients with Head and Neck, Esophageal, and Pancreatic Cancer."

As a result of this study, we were able to increase referrals to nutrition services for high-risk cancer patients by 38% and improve timeliness of care by 30 days to provide medical nutrition therapy from the beginning of their cancer treatment instead of a reactive approach to nutrition care. This study became a poster that was accepted at two national meetings. Reference Figure 1. It was also featured in the cancer program's annual report and a provider newsletter highlighting how nutrition was elevating the patient experience at our cancer institute.

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Figure 1: Assessing the Utilization of Outpatient Oncology Nutrition Services and Timeliness of Care for Patients with Head and Neck, Esophageal, and Pancreatic Cancer abstract accepted at the 2020 Oncology Nutrition DPG Symposium and Clinical Nutrition Management DPG Symposium

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Assessing the Utilization of Outpatient Oncology Nutrition Services and Timeliness of Care for Patients with Head and Neck, Esophageal, and Pancreatic Cancer

Kristin Cuculovski
MS, RDN, CSO, LD
Department of Clinical Nutrition
Northside Hospital

Background

Early nutrition assessment for high malnutrition risk patients improves oncology treatment outcomes. Currently, ambulatory standards of nutrition care remain inconsistent across health care settings and access to nutrition care is often left to the discretion of individual entities or providers.

Northside Hospital Cancer Institute (NHCI) uses a physician consult-based model to refer oncology patients to nutrition services. Inconsistent nutrition consults for high risk cancer diagnosis patients were leading to underutilization of nutrition services and delays in care were identified as opportunities for improvement.

In January 2019, NHCI implemented a new quality measure for medical oncology to refer to nutrition services for patients with head and neck, esophageal, and pancreatic cancer within 30 days of their initial office visit to increase nutrition consults and to improve timeliness of care for these high risk oncology patients.

Aims

Assess the utilization of nutrition services for head and neck, esophageal, and pancreatic cancer patients using a consult-based referral model with physician driven nutrition consults based on high risk cancer diagnosis.

Evaluate the timeliness of care provided by nutrition services.

Methods

This was a retrospective chart review. Patients were selected randomly based on year of initial office visit and by cancer diagnosis. Inclusion criteria: cancer diagnosis of head and neck, esophageal, or pancreatic cancer, receiving chemotherapy treatment within Northside Hospital Cancer Institute, and the date of the initial medical oncology visit determined group selection; July–December 2018 and January–June 2019. n=90.

Analysis: Completed a descriptive analysis on data collected to determine the samples baseline and distribution. Completed a t-Test: Two-Sample Assuming Unequal Variances.

Results

Figure 1: Nutrition consult rate within 30 days of 1st OV increased by 38 percentage points from 2018 to 2019; 2018 = 49% (n=22) to 2019 = 87% (n=39).

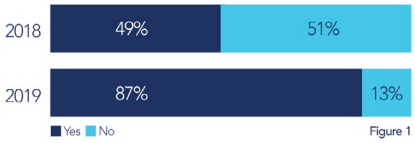

Figure 1

Figure 2: The average number of days from 1st OV to RD consult decreased from an average of 38.9 days in 2018 to an average of 7.61 days in 2019 (p = 0.01). The number of days between 1st OV to RD appointment/visit decreased from an average of 48.91 days in 2018 to an average of 18.55 days in 2019 (p = 0.01). The average number of days between the RD consult being ordered to RD appointment/visit decreased from 10.81 days in 2018 to 9.34 days in 2019 (not statistically significant).

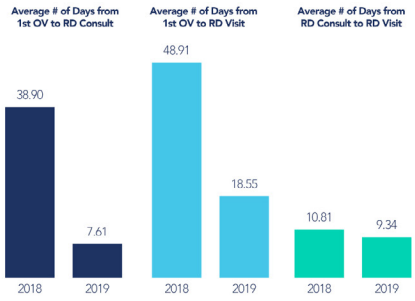

Figure 2

Figure 3: Nutrition involvement in patient care increased by 18 percentage points from 2018 to 2019: 2018 Nutrition involvement = 75% (n=34) to 2019 Nutrition involvement = 93% (n=42).

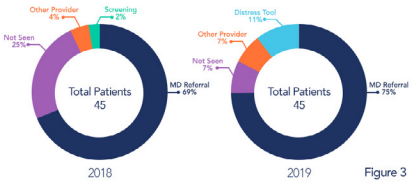

Figure 3

Conclusions

When the quality measure was implemented to refer to nutrition services for patients with head and neck, esophageal, and pancreatic cancer within 30 days of their initial office visit there was a positive impact with increased utilization of nutrition services compared to before the quality measure and improved timeliness of nutrition care.

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Staffing Considerations

Career advancement and career ladders are always a hot topic amongst RDNs. Some healthcare systems already offer different levels of job class codes for specialty services, but many do not. The Commission on Dietetic Registration (CDR) offers a certification to become a Board Certified Specialist in Oncology Nutrition (CSO). This certification requires that a clinician be an RDN for a minimum of two years, documentation of 2,000 hours of practice experience in the specialty area within the past five years, and successful completion of an examination.[3] At our program, the RDNs on the oncology nutrition team are all Clinical Dietitian - Level II. This is an increase in title and pay within the clinical nutrition department. We do require that these dietitians obtain the CSO credential within two years of their hire date.

A helpful resource when developing job descriptions, roles and responsibilities, and competencies is the Academy of Nutrition and Dietetics: Revised 2017 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists in Oncology Nutrition.[4] These standards provide a guide for expectations on a variety of tasks based on level of competency.

There is very limited staffing data available to determine staffing needs for outpatient services. It is estimated that 90% of cancer treatments are provided in outpatient clinics but many programs have limited resources for outpatient nutrition services. A national survey in 2019 found the mean RDN-to-patient ratio was 1:2,308 analytic patient cases and that RDNs evaluated and/or counseled an average of 7.4 + 4.3 patients/day during an eight-hour work day.[5]

As a CNM, you can work with your cancer committee and/or quality team to determine how many analytic cases your program has annually so you can determine your own RDN-to-patient ratio to compare to the published data. This will help to provide a benchmark for your own program and can support your staffing requests for additional FTEs. Reference Table 1 as an example.

Table 1. RDN Staffing Benchmark Comparison for RDN-to-Patient Ratio

Year	2017	2018	2019	2020	2021
Total Nutrition Encounters	**7233**	**8778**	**11679**	**13633**	**18455**
% Growth	**25%**	**21%**	**33%**	**17%**	**35%**
Analytic Cases	**Xx.xxx**	**Xx.xxx**	**Xx.xxx**	**Xx.xxx**	**Xx.xxx**
# of RD FTEs	**8.0**	**8.4**	**9.4**	**10.8**	**12.8**
RD FTE: Analytic Case Ratio	**1: 1,287**	**1: 1,126**	**1: 1,214**	**1: 1,215**	**TBD**

Annual Report Examples for CNMs

CNMs should work with their program's quality team to determine what information is most valuable to the cancer committee for evaluating nutrition services. This will help to shape the outline for your annual report.

Data is a powerful tool to use when evaluating nutrition services and could include the program's total patient encounters for nutrition services (Table 2) with a breakdown of the services provided (Table 3) including how you received the referral (provider order, screening, patient request, etc.), and the average number of visits per patient or by cancer type. You can also highlight how many RDNs you have on the team, the clinics or areas that the team covers, and the top cancer sites where the team is providing care.

Table 2. Cancer Committee Report: Total Nutrition Encounters

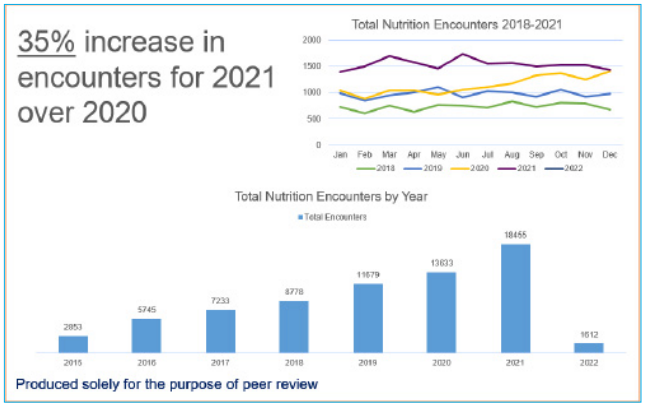

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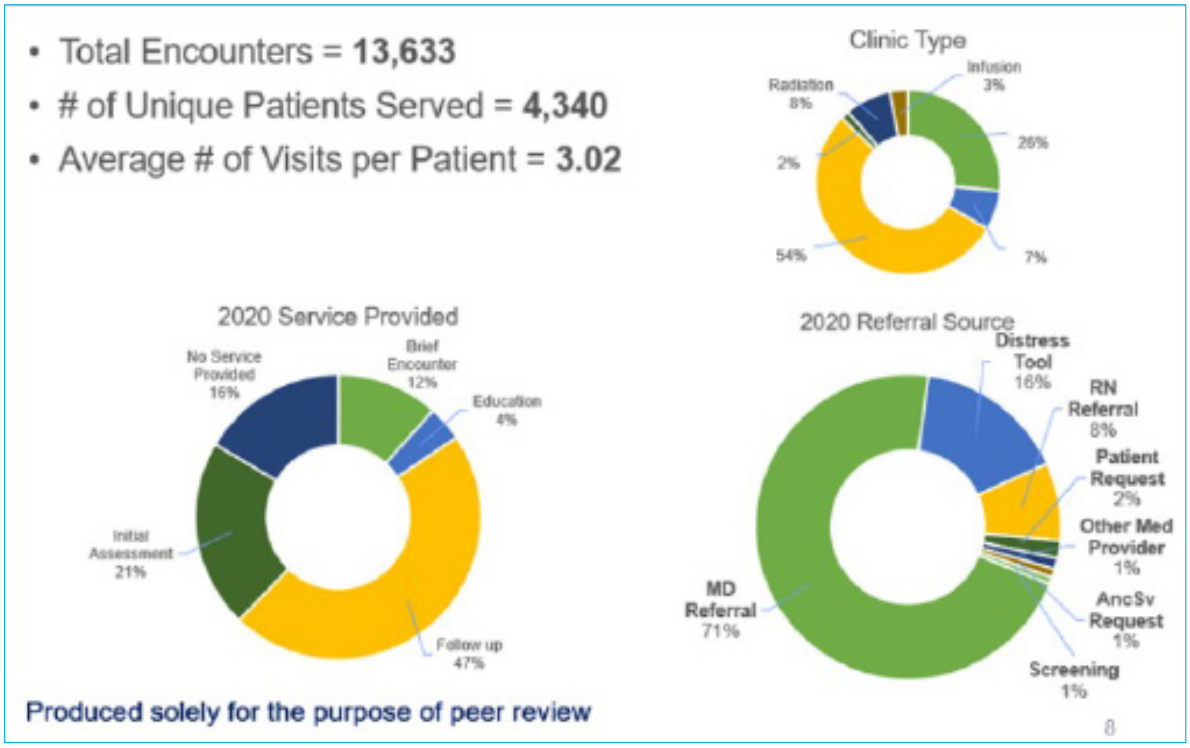
Table 3. Cancer Committee Report: Oncology Nutrition Services' Encounter Breakdown by Referral Source, Service Provided, Clinic Type



The annual report is also the ideal time to present any QI initiatives the program has been working on. Examples might include how you receive referrals for services, scheduling processes, timeliness of care once a referral is received, expanding services, clinical initiatives, or patient outcomes.

Summary

Understanding and utilizing the new CoC standard for oncology nutrition services can help CNMs start or grow an oncology nutrition program to support their facility's program in complying with the accreditation criteria. Building relationships and working closely with the quality team can provide guidance on what data to collect and what information is valuable to present during the annual cancer care report. These partnerships can also provide opportunities to participate in quality initiatives that can elevate your department and enhance patient care and outcomes.

Author bio:

Kristin Cuculovski, MS, RDN, CSO, LD/N has worked with Unidine as the Director of Nutrition and Wellness for Healthcare and Corporate Culinary Groups since June 2023. She oversees the clinical nutrition, wellness, and patient services for Unidine partnership hospitals around the United States. She provides guidance and assistance to all managers, district managers and corporate support center through Unidine. Previously, Kristin worked for Northside Hospital in Atlanta, GA as a Clinical Nutrition Coordinator for Outpatient and Outpatient Oncology programming, leading a strong clinical team of 22 Registered Dietitians.

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From Registered Dietitian to Digital Health Entrepreneur

Whitney Isola, MBA, RD, CDCES

Traditional Career in Nutrition

Hi wonderful CNMs! My name is Whitney Isola and I'm going to tell you a bit about my journey as an RD to entrepreneurship. A quick bit of background on me. From the time I was in high school I wanted to be in healthcare, ultimately majoring in nutrition at Boston University. In my junior year we took an intensive six credit business course and I found that I just loved learning about business. At that point I wanted to open my own practice so I figured this would come in handy.

Upon graduating the combined masters and dietetic internship program, I started on what I think of as a 'typical' path in nutrition and started work as a clinical dietitian in a community hospital. I worked on multiple units in the hospital but rounded every day in the ICU with 3 pulmonologists who ran a local multi-disciplinary medical practice. One day, I approached them about offering nutrition services and they bit. After about six to eight months of getting the credentialing and insurances in place, I made the jump to outpatient care. I found myself loving the administrative side of setting up referral processes, training front office staff, and designing education materials, etc. those first few months but as my role shifted to a greater emphasis on billable hours and counseling, I found that that work simply didn't fulfill me. It was the first time I really felt lost about my career. All I had wanted was to run my own practice and here I was getting to do that work with the security of an established practice with strong referral streams and I found the work itself emotionally exhausting.

It was the time to reset and re-evaluate. I turned to LinkedIn and took on some consulting jobs in my spare time to learn more about other areas in nutrition. One of those projects led me to meet the person who would later become my co-founder. This is where the story splits a bit. I think of it as two tracks in my life. I continued to follow my 'work life' path following that traditional career model going on to work as a Clinical Nutrition Manager for several years and eventually taking on a director of Food and Nutrition Services role within a large hospital system. Simultaneously, I would fit in as many hours a week as I could following my 'startup life' path. Meanwhile I also completed a one-year Executive MBA program at the University of Tennessee in 2019. This program gave me many more tools in the toolbox for both pursuits. Looking back, I'm not sure how I did it all because just about every minute of my day was accounted for from 4-5 AM to 10 PM for several years. It was only about a year and a half ago that the business was finally in a place where I could step away from my 'work life' and fully focus on my 'startup life'.

While my day-to-day timing and commitments eased and I was able to accomplish more as a wife and mother and entrepreneur, I will say that making that leap is not for the faint of heart. I still constantly feel that our company is always a quarter away from failing. But every time I get a little tempted to have the security blanket of a 'work life' again, the team comes up with an innovation or we get amazing feedback from patients and it's just the fuel I need to double down.

Digital Health and the Start-Up World

My first foray into the digital health world was when I worked on a project building an automated recommendation engine that could be embedded into a grocery store's website to suggest healthier alternatives for items that customers placed in their cart based on a food category, health interests and needs, plus macronutrient and micronutrient profile algorithm. It was a fascinating project and though we were able to book a few very big meetings with major retailers, the company imploded because this was before online grocery retailing was a norm (it was really about eight years ahead of its time when Instacart didn't exist and people rarely used PeaPod), grocery margins are razor thin to begin with, and we had a bad tech partner. It was a great failure and a great learning point for me. However, I was officially bitten by the bug and quite frankly, surprised that this bit of work we did in our evening hours and largely remotely could land us in front of important decision makers at large companies that were always interested in innovation.

The person that I worked with on that project became the co-founder for Witty Health. We completed market research and spoke with many healthcare leaders. We identified a need to support community oncologists in their treatment decision making, largely due to significant drug development and reports of increased provider burnout. We decided to build a provider platform with a proprietary drug lookup tool, remote patient monitoring, and telehealth capabilities. As we iterated the product and continued to get user feedback, we saw an immense interest for patients to help manage their own care, and thus started building a patient facing app and web platform.

This product has become OncoPower, a free supportive cancer care application that helps patients from the comfort of their homes with nutrition guidance content by RDs, meditation and mindfulness content, social and emotional support, an education library full of vetted resources, clinical trial matching, and much more. OncoPower works to increase care access for patients, unburden providers from challenging and low-to-no revenue care, and matching patients to active

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clinical trials based on their profile inputs with intuitive clinical trial mapping. We can leverage artificial intelligence (AI) tools coupled with high quality information to personalize care navigation, in turn empowering the patient to take more control of their cancer care journey. We had grown the community to over 6000 users and identified a strategic partner for acquisition, a great move for both sides of the deal.

With that hand-off completed, I am on to the next venture so stay tuned! Entrepreneurship is a hard road but also difficult to shake. I am advising a few fantastic companies to operationalize early growth and think strategically about their offerings in the ed-tech, climate-tech, and nutrition spaces.

Lessons Learned

While there are so many things I could say here, I'd like all RDs that are interested in entrepreneurship to be better than me and learn from my mistakes, so I'll give you a mix of flowery and concise advice here based on my own experience.

1. Your co-founding team is a partnership so there must be immense trust and communication there. Cultivate it, fight for it, and trust your gut.

2. Technical competence makes a world of difference. We lost about two years and a significant amount of money on bad technical vendors because nobody on the co-founding team had a technical background. It took us time to find the right vendors and partners and there are a lot of sharks in the water. If you are building a technical or digital health product, find an advisor with that technical or IT background that can help guide your early decision making.

3. Time spent planning is time well spent. There is a lot of 'work fast and break things' mentality that gets pushed in the startup world, but every time we took that extra month (or two or three) to plan out a technical sprint and beat up on every aspect of the user experience (UX), everything went smoother, and less rework happened. It feels more stagnating to take this extra time when you're used to the 'go-go-go' of startup life but exercising just the right amount of restraint makes a big difference.

4. Don't build it and they will come. Get to the simplest MVP as quickly as you can and have an immense number of conversations with on the ground users and players that might want to pay you for what you have to offer, even if they seem tangential early on. Customer insight is your best weapon in the early stage of the company.

5. Bootstrap as much as you can, even if it takes longer. Being beholden to investor money is a significant responsibility and the second you step on the fundraising merry-go-round; you will be constantly either raising funds or preparing for your next round. While financing instruments will always take up 15% of your headspace, once you start taking money from investors, that doubles. Be ready for it.

6. Trust your gut and where able, let data guide your decision making. Early on you will not have much data to use to make business, marketing, or budget decisions but as you build out systems within your business, try to think through what information would be most helpful for continuing to make decisions down the road and capture it.

Entrepreneurship can be challenging but is also very rewarding I hope that my story helps to inspire you to explore your dreams and non-traditional career options. I am happy to serve as a resource or support to anyone looking to take a leap into the digital health world.

Author bio:

Whitney Isola, MBA, MS, RDN, CDCES is a digital health entrepreneur and Registered Dietitian with a passion for designing and launching innovative and technology-based products, building strong teams, and stripping away the silos in traditional healthcare. Whitney has an MBA from Haslam School of Business (University of Tennessee) and both an MS and BS from Boston University and spent her career in Food & Nutrition roles in NYC. At home, Whitney can be found cooking, hiking, doing a DIY project, or traveling with her husband, son, and dog.

CNM Member Spotlight

Monica Klemm, M.S., M.Ed., RDN, LDN,
Regional Director of Clinical Nutrition Development & Deployment
Current Employer: Aramark
CNM-DPG Sub-Committee: Informatics

Briefly describe your current job and relevant past positions/jobs.

As the Regional Director of Clinical Nutrition Development Deployment, my role encompasses a wide range of responsibilities. I provide clinical services expertise and support to ensure compliance with regulatory requirements. I play a key role in creating and assisting in the implementation of clinical nutrition services programs and policies. Part of my job also involves creating and overseeing training for Registered Dietitian Nutritionists (RDNs). I ensure adherence to regulatory standards and support hospitals in preparing for regulatory agency visits. Lastly, I establish and maintain client relationships and provide clinical expertise to the new business development team. This multifaceted role allows me to make significant contributions to the field of clinical nutrition. Previously, I was an Interim Food Service Director, Clinical Nutrition Manager, Clinical Dietitian for in-patients and out-patients and Consultant Dietitian in LTC and Dialysis Units.

What do you love most about your job?

IIn my role, I have the privilege of making a significant difference by mentoring clinicians who directly influence the health and well-being of patients. This mentorship not only enhances their professional growth but also improves patient outcomes. The field of clinical nutrition is dynamic and constantly evolving, requiring me to engage in continuous learning. Staying updated with the latest research and regulatory standards is crucial to ensure the highest level of care. Problem-solving forms a major part of my responsibilities, particularly when it comes to identifying issues in compliance and training and recommending effective solutions. My role also involves collaboration and leadership, as I collaborate with a diverse team of clinicians and managers, guiding them towards common goals. Building and maintaining strong relationships with key customers is another important aspect of my job, ensuring their satisfaction and fostering long-term partnerships.

What is the most challenging part of your job?

Regulatory compliance is a significant aspect of my role, requiring me to keep up with changing regulations and ensure that all operations are compliant, which can be a complex task. Training and development form another crucial part of my responsibilities, as I ensure that all new hires complete the required onboarding and training programs, fostering their continuous professional development. Balancing multiple responsibilities, such as clinical nutrition site assessments, program implementation, and maintaining client relationships, can be challenging but is integral to the role. Change management is another key area, particularly when implementing new policies or changes in the clinical nutrition services programs, which might meet resistance and require effective strategies. Lastly, maintaining client satisfaction is paramount. Meeting the expectations of key customers, while also adhering to professional practice standards and regulatory compliance, can be a delicate balance to achieve, but it is essential for success.

What advice do you have for dietitians new to management, or for those interested in becoming managers?

Developing leadership skills is crucial in a management role. This includes the ability to motivate and guide your team, make decisions, and resolve conflicts. It is also important to understand the business side of healthcare, such as budgeting, strategic planning, and operations management. The field of nutrition is constantly evolving, so staying updated with the latest research, dietary guidelines, and regulatory standards is key. Communication is another essential skill; you will need to communicate effectively with your team, other healthcare professionals, and clients. Embracing technology, which is increasingly becoming integral in healthcare, can improve patient care and operational efficiency. Networking is also beneficial; building relationships with other professionals in your field can provide support, shared experiences, and new opportunities. Pursuing continuing education opportunities, such as workshops, conferences, or additional certifications, can further your professional development. Lastly, seeking mentorship from experienced managers, and being willing to mentor others, can provide valuable insights and guidance.

Describe what you think the ideal role of the RDN should be 30 years from now. What do you think we need to do as a profession to get to that point?

In 30 years, the role of a Registered Dietitian Nutritionist (RDN) could evolve significantly due to advancements in technology and the growing emphasis on preventive healthcare. RDNs could provide personalized nutrition plans based on an individual's genetic makeup, lifestyle, and health status, thanks to advancements in biotechnology. They might leverage technology to monitor patients' nutritional status in real-time, allowing for more timely and precise interventions. As leaders in preventive healthcare, RDNs

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could guide individuals and communities towards healthier lifestyles to prevent chronic diseases. They might also contribute to innovative research in nutrition science and have a stronger voice in public health policy. To reach this point, the profession will need to embrace technology, pursue lifelong learning, collaborate with professionals in other fields, advocate for the role of RDNs, and engage in research.

If you couldn't be a dietitian anymore, what profession would you choose?

I would be an Instructional Designer. Instructional design involves creating educational experiences that make the acquisition of knowledge and skill more efficient and effective. RDN skills, such as understanding complex information and translating it into easy-to-understand formats, is highly beneficial. I could leverage my healthcare background to design educational programs related to health, nutrition, and wellness, to create impactful learning experiences.

CNM News to Use

Nominating Committee Report

Linda Jean, MS, RDN, LD, CDCES
Nominating Chair

The CNM DPG nominating committee had a very successful nomination campaign for the offices of Chair Elect, Secretary and Nominating Committee. The elections will be held on February 1, 2023. The candidates for election include:

Chair-elect:

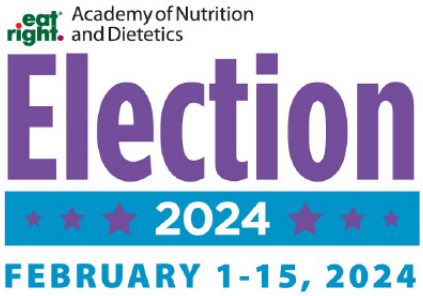
Angela Lago, MS, RD, LDN, FAND
Renee Welsh, MS, RD, LD, CNSC

Secretary:

Sarah Gallo, MS, RD, LD
Arrianna Johnson, RD, LD
Carrie Smith, MS, RD, CSP, LD

Nominating Committee: (elect 2)

Daya Cherian, MS, RD, CSO, LD, CNSC
Amy Denslinger, MS, RD, LD
Kerry McMillen, MS, RD, CSO, CD, FAND
Darcy Mundell, MHSM, RDN, LDN



We have also been working diligently with soliciting nominations for upcoming Academy Honors and Awards and are thankful for everyone's efforts as we work to recognize successful and dedicated CNM members.

For more information and to inquire about volunteer opportunities please contact the CNM DPG Nominating Committee Chair, Linda Jean at lindafayebj32@gmail.com.

Symposium

The 2024 Clinical Nutrition Management DPG Virtual Symposium is right around the corner! This year's symposium will take place over two half days, Tuesday March 19th and Tuesday March 26th.

The virtual symposium, *Inspiring Clinical Leaders: Driving Change,* is designed for CNMs that may not have the ability to make it to an in-person conference, yet desire to level up their leadership skills. As a clinical leader, you can expect dynamic and informative presentations on topics such as Innovative Strategies to Attract and Retain Top Talent, Inspiring Your Clinicians to Practice Culturally Appropriate Care, and Mastering Workplace Resilience.

We anticipate that the 2024 Virtual Symposium will provide 2.5 hours CPEU per session. We may have additional hours for submitted posters.

Learn more and register here.

CNM Pediatric Sub-Unit ("CNM-Peds") Annual Update

Caroline Steele, MS, RD, IBCLC, FAND
CNM-Peds Chair

Update from FNCE® 2023

The CNM Pediatric Sub-Unit was thrilled to connect again in person for a dinner meeting and networking session at FNCE® 2023. Our event was sponsored by Reckitt/Mead Johnson Nutrition and began with an update from them on Clinical Resources available for pediatric clinicians. The remainder of the time was spent discussing current pediatric management challenges and hot topics and networking with others. Feedback from attendees was positive and members felt that the time connecting with peers was valuable. Thank you to all who were able to attend!

Pediatric Staffing Survey

As a reminder, the CNM-Peds Staffing Survey 2023 is available for CNM members! For more information, please visit the CNM website and download your copy. This is an extremely valuable tool to help compare your facility to similar organizations and to use as a tool to help with planning and budgeting.

If you notice any errors in your hospital's data, please download the survey, make the corrections in Excel, highlight the corrected cells in yellow, and email the spreadsheet to Caroline Steele carolinesteele.rd@live.com.

We are in the process of updating the data collection tool for this survey to make analysis easier. We will continue conducting the survey every other year, so watch for a request for information in fall 2024!

CNM 2023-2024 Executive Committee

Chair
Whitney Duddey, MHA, RD, LD

Chair-Elect
Donna Belcher, EdD, MS, RD, LDN, CNSC

Immediate Past Chair
Kerry Clark, RDN, CD, FAND

Treasurer
Angela Hasemann Bayliss, MS, RDN, CSP

Secretary
Sophie Kauffman, MS, RD

Delegate
Barbara Lusk, MFCS, RD, LDN, FAND

Nominating Committee
Linda Jean, MS, RDN/LD, CDCES (Chair)
Amy Downey, RD, LD (Chair-elect)
Lauren Sullivan, MSAN, RD, LD

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Quality Process Improvement Subunit
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Administrator, CNM Electronic Mailing List
Deb Hustler, MS, RD, LD

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Renee Welsh, MS, RD, LD, CNSC

Nutrition Services Payment Specialist
Val Shurley, MBA, MS, RDN, CS, FAND

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Fundraising Committee
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Academy Manager, DPG/MIG/Affiliate Relations
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