# Connections

Dietetics in Health Care Communities

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## Nutrition in Older Adults

CPEU

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The American population is aging. By the year 2030 it is estimated that about 21% of Americans will be 65 or older. According to the United States Census Bureau, in 2017 there were almost 51 million adults 65 years and older in the U.S. That is a 45% increase from 35 million in 2000.[1] Correspondingly, the number of older adults in the acute care setting is increasing. Older adults have different nutrition needs and issues than their younger counterparts. It is important that the clinician is aware of these differences to ensure their nutrition needs are met.

### Characteristics of the Aging Population in the US

To set the stage here are some interesting data from Senior Report 2019, American's Health Rankings by United Health Foundation.[1]

**Compared with 15 years ago, the health of young seniors (65-74) is:**

- Better: Early death is 22% lower, 16% fewer are smoking, and self-reported high health status is 11% higher.
- Worse: Excessive drinking is 42% higher, obesity 36%, diabetes 36% and suicide 16%.

**National Successes:**

- There has been a 14% decrease of food insecurity since 2017.
- SNAP (Supplemental Nutrition Assistance Program) reach has increased 13% since 2015.
- Between 1999 and 2014, age-adjusted death rates for all causes of death among people age 65 and over declined by 20%.[2]
- Death rates declined for heart disease, cancer, chronic lower respiratory disease, stroke, diabetes, influenza and pneumonia.


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**National Challenges:**

- There has been a 19% increase of depression since 2018.
- 5.2% of adults over 65 have reported not seeing a doctor sometime in the past year due to cost.
- Death rates increased for Alzheimer's disease and unintentional injuries.

### Impact of Aging on Nutritional Status

It is important for the clinician to be aware of how aging affects the body so that nutritional interventions are relevant and effective. Aging affects the body in many ways, which can seriously affect older adults' nutritional status. One of the principal nutritional concerns with older adults is unintended weight loss, which should be prevented if at all possible. Research shows unintended weight loss increases morbidity and mortality in older adults. Unintended weight loss affects 13% of home dwelling older adults and between 50-60% of nursing home (long-term care) residents.[3]

Food insecurity may also be a concern for older patients; the clinician needs to be aware of financial and social challenges to ensure the discharge plan addresses this. There are many options available such as Meals on Wheels, local food banks, and other senior nutrition programs to assist with providing nutritious meals to the older adult population. Taking the time to ensure this information is shared with the patient is essential in cases where food insecurity is an issue. See Figure 1 for a list of resources.

### Nutrient Needs

Older adults have unique dietary needs. They need fewer calories because they aren't as physically active as they once were, their body composition has changed and their metabolic rate is slower. But despite the decreased need in calories, the older adult's body still requires the same or higher amounts of micronutrients. It is therefore important that the older adult eats nutrient dense foods and avoids empty calorie foods.

The Academy of Nutrition and Dietetics' (the Academy) Dietitians in Health Care Communities Dietetic Practice Group lists the energy needs for adults 65 years of age and older below.[4]

- Healthy older adults: women 18-22 kcal/kg; men 20-23 kcal/kg
- Acute or chronically ill: women 18-22 kcal/kg; men 20-23 kcal/kg
- Underweight (BMI < 20) caloric needs may be as high as 27-28 kcal/kg
- Underweight (BMI < 20) and unintended weight loss: women 25-35 kcal/kg; men 30-40 kcal/kg
- Healthy and unintended weight loss: 25-30 kcal/kg (add kcals for weight gain).

Older adults also have an increased need for protein. While the Dietary Reference Intakes (DRIs) are still set at 0.8 g/kg per day for

adults of all ages, most gerontologists believe that a higher protein intake between 1 – 1.2 g/kg per day is beneficial to enhance muscle anabolism and reduce age-related loss of muscle mass. Experts now recommend that consuming 24 – 30 g of good quality protein (~ 10 g essential amino acids) at each meal can help decrease muscle loss.[5]

Some DRIs have specific guidelines for older adults, which are broken into two categories – ages 51 to 70 years and those older than 70. Although the DRI for vitamin B12 is the same for all adults, supplementation of vitamin $B_{12}$ is often recommended in the older population. Some nutrient needs increase with age, such as vitamin D and calcium, while other nutrients decrease, as with iron and chromium. Table 2 summarizes the differences in micronutrient needs between younger and older adults.[6] Of note, although the potassium and sodium needs are the same for all adults, in 2019 the DRI for potassium was decreased from 4700 mg/d to 2600 mg/d for all adults and sodium increased from 1300 mg/d for adults 51-70 and 1200 mg/d for 71+ to 1500 mg/d for all older adults. In addition to the changes in nutrient needs due to aging, remember that many medications impact nutrient absorption so care should be taken to review all current medications.

### Physical Changes

Many physical changes occur with aging that can significantly affect one's ability to eat, as well as absorb and metabolize nutrients.

**Bone Mass**

Bone mass decreases with age. Bones reach peak mass between 25 – 35 years of age and then start to decline.[7] Most older adults have reduced exposure to sunlight, decreased skin synthesis, and decreased capacity of kidneys to convert vitamin D into its active form, so vitamin D deficiency is prevalent. Additionally, many older adults consume less than the recommended amounts of calcium due to lactose intolerance or avoidance of high fat foods. These all contribute to a higher risk of osteoporosis, especially among females, which leads to an increased risk of fractures.

It's a common concern of those that work with older adults that a fractured hip is often the beginning of a downward cycle. This fear of fractures influences the older adult in many ways. Going out of

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the house to shop in cold weather where there may be icy conditions, getting up in the middle of the night to use the bathroom, and even preparing meals all increase the risk of fracture for older adults and can affect their daily habits. Preparing meals might be problematic which may lead to increased use of convenience foods, many of which are high in fat, carbohydrates and preservatives. Older adults often stop consuming beverages later in the day to avoid trips to the bathroom during the night, which increases the risk of dehydration.

**Interventions:**

***Vitamin D:*** As previously mentioned, the DRI for vitamin D is increased for those over the age of 70 and since many older adults are deficient, supplementation is often recommended. Cholecalciferol is preferred due to it being more bioavailable to maintain adequate concentrations of 25-hydroxyvitamin D.[5] Vitamin D supplementation of 1,000 IU to 2,000 IU daily is often recommended for those with poor milk intake or limited sunlight exposure.[8]

***Vitamin C:*** Research shows intakes of vitamin C above the DRIs may be beneficial in reducing hip fractures, improving healing after some fractures, increasing bone density, and decreasing risk of osteoporosis.[9,10] RDNs should evaluate current intake to determine if vitamin C intake meets the patient's needs. Supplementation may be beneficial if intake is low.

***Calcium:*** There are many good options for low fat dairy products in addition to dark green leafy vegetables to help meet the increased calcium requirement. Calcium supplements may be recommended for those who don't meet the recommended daily amount through diet. A common recommendation for older adult males aged 51-70 is 1,000 mg/d, and for men older than 70 it is 1,200 mg/d. The recommendation for woman aged 51 and older is 1,200 mg/d.[8]

**Muscle Loss**

Muscle loss is a natural part of aging. Age-related muscle loss begins around 40 years of age and muscle mass can decrease by as much as 8% per decade depending on the activity level of the individual. After 70, muscle loss accelerates to approximately 15% per decade.[11] Sarcopenia, the age related loss of muscle mass, strength and function, was recognized by The Centers for Disease Control and Prevention (CDC) in 1999 as one of the top 5 major health risks facing the US population.12 Loss of muscle and strength can lead to frailty. Frailty is theoretically defined as a state of increased vulnerability resulting from aging-associated decline in reserve and function across multiple physiologic systems such that the ability to cope with every day or acute stressors is compromised.13 Frail older adults are at higher risk of malnutrition, falls, incident disability, hospitalization and mortality. In fact, because of the risk of sarcopenia, the Academy cites a BMI of less than 22 for persons over 65 years of age (versus 18.5 for younger adults) as an indicator of lower than recommended weight levels when determining a nutrition-related diagnosis.[14]

Identification of sarcopenia in the overweight or obese older adult (sarcopenic obesity) is often missed due to the misconception that sarcopenia only occurs in the frail elderly. Older adults with sarcopenic obesity are at higher risk for adverse outcomes including cardiovascular disease and functional impairment. Complicating the matter is whether these individuals should be prescribed a weight loss program. When people lose weight, they lose muscle in addition to fat. The Dietary Guidelines state that older adults (65+) who are overweight or obese are encouraged to prevent additional weight gain. For older adults who are obese, particularly those with cardiovascular disease risk factors, intentional weight loss can be beneficial, and result in an improved quality of life, reduce the risk of chronic diseases and associated disabilities.[15]

***Interventions:*** Since loss of lean mass occurs with aging, any weight loss is a concern for older adults. Consuming adequate protein and calories is especially important to delay sarcopenia. As stated above, recent evidence-based guidelines recommend higher protein intakes than stated in the RDAs. Intakes of protein of 1 – 1.2 g/kg of actual body weight are associated with delaying decreases in strength, overall functional status, and sarcopenia. Dr. Paddon-Jones's published research in 2009 that shows evenly distributed protein across the day, approximately 30 g protein per meal, 3 meals a day, provides the best benefit for protein synthesis.[16] The benefit is stronger when combined with routine weight bearing exercise.[17] Consuming adequate protein can be challenging for some older adults because animal protein can be expensive. And while beans and legumes are high in protein they often produce flatulence and therefore are not consumed often.

**Renal / Urinary**

Kidney function diminishes about 1% per year after age 40. Glomerular filtration is often diminished by almost 50% by the time a person reaches old age.[5] Many patients with chronic kidney disease (CKD) are older adults. In 2011, 48% of all new patients with CKD were 65 years or older. The mean age of new dialysis patients was 65 in 2008 and the 75+ age group is now the fastest growing age group for this disease.[18]

Dehydration is a real concern for older adults. Older adults do not feel as thirsty and they don't drink as much as when they were younger. Polypharmacy has also been associated with dehydration in older adults.[5] Older adults often need assistance with drinking, or they may be on thickened liquids due to swallowing difficulties. It is estimated that approximately 30% of people over 65

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years of age experience bowel and/or bladder control loss. Loss of bladder control often causes the older adult to drink less. All these factors together put the older adult at high risk for dehydration. In fact, one study showed that only 1 in 40 older adults in post-acute care consumed an adequate amount of liquids.[19]

**Interventions:**

Assessing hydration status is imperative for all older adults given the risk of dehydration. Evaluate lab values and symptoms to determine the cause of dehydration so that interventions can be most effective. Fluid needs should be carefully assessed if the patient has a history of cardiac problems to avoid fluid overload. The Academy's Evidence Analysis Library reviewed three methods of determining fluid needs but no evidence was found to validate these three equations. The three methods are:

1. Holliday-Segar weight method: 100 mL/kg for the first 10 kg body weight + 50 mL/kg for the second 10 kg body weight + 15 mL/kg for the remaining kg body weight.
2. RDA method: 1 mL/kcal.
3. Fluid balance method: Urine output + 500 mL/d.

The Academy's Nutrition Care Manual suggests using a target of 30 mL/kg/day fluid intake for healthy older adults.[20]

The primary conditions that most often lead to nutrition risk so therefore should be addressed in CKD include protein-energy wasting, hypertension, renal osteodystrophy, and anemia.[21] For older adults with CKD, research shows that blood pressure control, protein restriction and phosphorus restriction can delay kidney disease progression.[22] However, the risk of protein restriction in those already protein depleted may outweigh any short-term benefits. Preserving lean body mass and preventing malnutrition are the main objectives when prescribing protein restrictions in predialysis clients.[22] Therefore, if the older adult shows muscle mass loss and is at risk for malnutrition, protein restriction may be contraindicated. Diet liberalization is often necessary for older adults due to poor appetite and weight loss.

**Gastrointestinal**

Aging affects intestinal absorption of many nutrients. Carbohydrate, protein, fat, folate, vitamin B12, vitamin D, iron and calcium all have reduced absorption, while absorption of cholesterol, vitamin A and vitamin C increase. Age related changes in the gastrointestinal (GI) track include delayed gastric emptying and reduced gastric acid secretion, which may result in decreased calcium and zinc absorption, increased prevalence of gallstones and diminished pancreatic enzyme production.[20]

Changes in GI function often result in low vitamin B12 levels which can cause anemia, neuropathy and cognitive impairment. A decrease in stomach acid production is common in older adults. This plus the use of stomach acid blockers and metformin contributes to decreased absorption of vitamin B12 and iron. The ability to

produce intrinsic factor, which is needed to absorb vitamin B12, also decreases with age. It is estimated that as much as 20% of people over 50 years of age may be low in vitamin B12.[23] As many as one-third of all hospitalized older adults may have some type of anemia. Anemia has been associated with many concerns including functional impairment, physical decline, reduced mobility, decreased quality of life, depression, falls, decreased activities of daily living, worsening comorbidities, increased hospitalization and morbidity.[24]

Constipation, a common complaint of older adults, leads to a feeling of being full which often causes decreased intake. Constipation may result from decreased fluid intake or as a side effect from many medications. Certain analgesics, antidepressants, antihistamines, calcium channel blockers, anti-parkinsonism drugs and high doses of iron and calcium can also contribute to constipation.[5]

Polypharmacy in older adults is common and often adds to the list of negative consequences associated with aging, especially in the GI tract. Multiple medications have adverse side effects which affect the older adult including dry mouth, decreased (or increased) appetite, nausea, satiety, constipation, etc.

***Interventions:*** Since vitamin B12 can be supplemented, it is advised for clinicians to evaluate low hemoglobin/hematocrit and high mean corpuscular volume (MCV) values and recommend further testing to rule out deficiency. If vitamin B12 is found to be low, oral B12 supplements are appropriate if adequate levels of intrinsic factor are produced. If that is not the case then monthly injections of B12 are recommended. Working with the interdisciplinary team to identify any anemia type and treatment is important to the well-being of the patient. See Table 2 for strategies for managing other GI symptoms.

**Oral / Pharyngeal**

Poor dentition and periodontal disease affect a significant number of older adults. Roughly 25% of older adults are edentulous. An added complication is that dentures can be cost prohibitive for some older adults. For those who can afford them, proper fit can become an issue especially if weight loss occurs. Poor dentition often results in the need for mechanically altered foods that can negatively affect food appearance. Older adults also produce less saliva so xerostomia is very widespread. Saliva is needed to wash

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bacteria away so when there is less of it, teeth and gums are more susceptible to decay and infection. Xerostomia can make speaking, swallowing and even tasting food difficult.[5]

Dysphagia, defined as a dysfunction with any phase of the act of swallowing that results in the sensation of food, fluid, or medications being delayed or hindered in the passage from the mouth to the stomach, is common among the older adults.[25] Studies show the frequency of dysphagia is as high as 22% of healthy adults 50 years old. This increases to 40% in those 65 and older with a dramatic increase in prevalence of those 85 years, and older.[26] Dysphagia may result from neurologic disorders, degenerative diseases, cancers, or intubation trauma. Dysphagia is a serious concern that affects quality of life and can lead to aspiration pneumonia and malnutrition.[20]

***Interventions:*** The nutrition intervention and diet order for patients with dysphagia should be based on the results of a swallowing evaluation conducted by a Speech Language Pathologist. The severity of the dysphagia dictates the level of texture modification needed. Texture modifications include liquid consistencies and solid food modifications. The IDDSI (International Dysphagia Diet Standardisation Initiative) provides a framework that consists of a continuum of 8 levels (0-7), where drinks are measured from Levels 0-4, and foods are measured from Levels [3-7].[27]

As previously mentioned, sometimes patients have chewing difficulties due to missing teeth not related to dysphagia. This is usually managed by providing a puree or mechanically altered diet that includes foods that require very little or no additional chewing. Attention should be paid to the visual appearance and the taste of all foods that are modified for consistency. Remember that appetite is stimulated by the appearance of the food. As mentioned, these patients are at high risk for malnutrition so food should be attractively presented. For patients with xerostomia, serve moist, temperate foods and limit salty and dry foods.

### Sensory

Aging affects the senses starting around the age of 60 with vision, taste, smell and hearing changes. Age-related macular degeneration (AMD) is the most common cause of blindness in the older adult population.[28] Eyesight changes can diminish the appearance of foods and the ability to recognize them. The capacity to taste sweet and salty may diminish sooner than the ability to taste bitter and sour. It is not uncommon to see an older adult use a lot of sugar to sweeten their food to cover the bitter taste. Decreased sense of taste and smell often leads to decreased intake because food is less appealing. As mentioned, the sensation of thirst decreases with age which may result in decreased fluid intake and dehydration. Impaired hearing is very common in older adults. Because hearing aids are very expensive and easily lost, it's not uncommon for an older adult to have difficulty hearing properly.

***Interventions:*** Allowing patients to add taste and flavor in a manner that appeals to them, no matter how peculiar it seems to others, helps increase intake. If intake is poor or unintended weight loss is an issue, restricting the patient's access to sugar becomes counterproductive because food is only nourishing when it is consumed. For patients that are visually impaired, colorful foods that contrast with the plate can increase consumption and pleasure in meals. Additionally, increasing the contrast between the plate and cup color and the table setting color also helps the visually impaired patient. For the hearing impaired patient talk slowly and watch for understanding. If patient is unable to hear adequately, it is important to have a family member involved.

### Cognitive Changes

Cognitive health declines for many but it is not considered a normal part of aging. There are many causes for decreased cognitive health including diabetes, obesity, smoking and hypertension. Decreases in cognitive health can lead to depression, decreased intake and decreased ability to chew/swallow foods. As cognition declines, it's not uncommon for the frequency of meals to decrease or increase because patients forget when they've eaten last. Recognizing foods, remembering favorite foods and unfortunately, eventually remembering how to eat, will affect intake. Some people with dementia have an increased need to move or pace. This continued movement adds to their daily nutrient needs, which becomes a challenge when sitting down for a meal is not on their agenda.

***Interventions:*** Offering frequent small meals and/or snacks helps reduce stress with patients who don't remember if they just ate or not. Talk to family members to obtain a list of the patient's favorite foods to try to spark interest in eating. For the individuals with increased movements, finger foods are often a good solution to ensure adequate intake. Monitor closely for weight loss. If weight loss occurs, interventions such as fortified foods or oral nutrition supplements should be considered.

### Social Changes

In addition to physical and cognitive changes, there are also many social changes that can impact the older adult. Decreased income, loss of a spouse, loss of a driver's license and change in living environment are frequent changes that affect our older adults. Finances frequently cause apprehension in older adults, as Social Security Benefits are often the sole source of income.[5] Increased medical treatment costs and lack of insurance compound this concern. Many older adults are unaware and therefore do not use the many community nutrition programs that are available to them. Limited finances drive food choices. Since animal protein and fresh

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fruits and vegetables are usually more expensive, people with a limited income often consume an abundance of carbohydrates and processed foods. The inability to drive makes getting to the store on a consistent basis more difficult, which also may lead to a pantry full of carbohydrates and convenience food instead of fresh fruits/vegetables, low fat dairy products and fresh meat, which all spoil more quickly.

All these social changes can lead to depression. People with depression and feelings of loneliness often have a loss of appetite, which can lead to avoiding meals. Many older adults become the primary care giver for their significant other, which can compound the changes mentioned above. If the wife's health fails first and the husband becomes the primary care giver, this role reversal can cause much stress and anxiety, particularly for this older generation.

***Interventions:*** Most older adults will not voluntarily admit to financial concerns, inability to access fresh foods, or depression. Clinical team members including nursing, case management and registered dietitian nutritionists (RDNs) / nutrition and dietetic technicians, registered (NDTRs) should ask the patient questions that will help draw out these answers. Nutrition therapy should not stop when the patient leaves the hospital. Working with social services and other support services to identify concerns and solutions will help continue the nutrition care plan after discharge.

**Liberalized and Individualized Diet Interventions**

Since risk of unintended weight loss is high with older adults, many interventions utilized are focused on ensuring adequate intake to prevent further weight loss or regain recently lost weight. Liberalized diets are often preferred because therapeutic diets can have a negative impact on flavor and variety of foods provided. Liberalized diets are used to encourage good intake and provide favorite foods. Recently the movement of liberalizing diets for older adults has started to reach the acute care environment. This is a hard concept for many acute care RDNs / NDTRs to grasp as our training focuses on utilizing therapeutic diets to prevent/control chronic disease states. But, if an 85 year old patient who is only consuming 50% of her meals wants a menu selection that is higher in sodium than her diet allows, should we really restrict that item? The Academy Position Paper on Individualized Nutrition Approaches for Older Adults states that quality of life and individualized nutrition approaches are important.[29] This includes the use of the least restrictive diet for older adults to make quality of life and their right to make choices a priority over improving their health or increasing their longevity.

Food first (over the use of oral nutritional supplements) is a focus of the Centers of Medicare and Medicaid Services in the long-term care environment.[30] In acute care, where the stay is much shorter, nutritional supplements can provide an effective way to increase calories and protein to the patient. Interventions should be tailored individually to each patient with the consideration that this intervention should follow them after they are discharged from the hospital. For example, if unintended weight loss occurred,

then oral nutritional supplements might be the best intervention. However, if the patient is low-income and will not be able to afford commercial oral nutritional supplements after discharge, then consideration should be given to a less expensive alternative such as homemade milk shake products. This scenario shows the importance of knowing the patient and customizing interventions to their needs. If food insecurity is a concern, then working with the hospital discharge planner and social worker becomes imperative to ensure the patient has access to nutrient rich foods.

Another condition that often benefits from diet liberalization is for older adults with diabetes. Risk of hypoglycemia is one of the most important factors to consider when determining the treatment plan for older adults with diabetes. The American Diabetes Association provides a framework for treatment goals especially for older adults with the recommendation that hypoglycemia should be avoided in older adults with diabetes.[31] Hypoglycemia should be assessed and managed by adjusting glycemic targets and pharmacologic interventions. Preventing hypoglycemia is important to reduce the risk of cognitive decline and other major adverse outcomes.[32] Treatment goals for older adults should be based on overall health, food preferences, life expectancy and anticipated clinical benefit.[32]

**Conclusion**

Aging affects the body in multiple ways which can make adequate nutritional intake a challenge for the older adult. Changes in the GI system, renal function, bone mass, and oral status, along with the risk associated with unintended weight loss are all important for RDNs to consider when assessing an older adult patient. Interventions provided must be individualized and have the ability to span to the potential different post-acute care centers. It is important for the RDN to ask the right questions during the nutritional assessment to ascertain the nutritional quality of the diet and/or if there is a concern regarding food insecurity. If the RDN doesn't ask the right questions and dig a little deeper, the nutritional concerns may go undetected. The entire interdisciplinary team needs to work together to put together the best discharge plan to help the older adult patient continue to progress in improving their nutritional status. Understanding how the older adult's nutritional needs are different from when they were younger is important for the RDN to know in order to modify the nutrition plan and interventions to be the most effective.

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Figure 1. Resources for older adults facing food insecurity

National Council on Aging (NCOA)

Programs of All-Inclusive Care for the Elderly (PACE)

Area Agencies on Aging (AAA)

National Institute on Aging

Meals on Wheels

Local: check county food banks, local churches and local Meals on Wheels

Request free nutrition supplement samples and give to high-risk patients

Table 1. Micronutrient DRI differences for older adults[6] *IU – international units

| Age (yrs) | | PVitamin D IU/d* | Vitamin B6 mg/d | Calcium mg/d | Iron mg/d | Chromium µg/d | Chloride mg/d |
|---|---|---|---|---|---|---|---|
| 19-50 | Women | 600 | 1.3 | 1000 | 18 | 25 | 2.3 |
| | Men | 600 | 1.3 | 1000 | 8 | 35 | 2.3 |
| 51-70 | Women | 600 | 1.5 | 1200 | 8 | 20 | 2 |
| | Men | 800 | 1.7 | 1000 | 8 | 30 | 2 |
| > 70 | Women | 800 | 1.5 | 1200 | 8 | 20 | 1.8 |
| | Men | 800 | 1.7 | 1200 | 8 | 30 | 1.8 |

Table 2. Strategies to manage GI related symptoms

| Problem | Intervention |
|---|---|
| **Mouth pain** | • Avoid acidic and coarse foods, vinegar, hot peppers, caffeine, temperature extremes and alcohol<br>• Modify food consistency as needed<br>• Moisten foods with gravies or sauces<br>• Use oral mouth rinses, lidocaine, artificial saliva and straws<br>• Maintain good oral hygiene |
| **Xerostomia / thick saliva** | • Consume fluids with meals, frequently throughout the day<br>• Eat moist foods<br>• Avoid dry, excessively salty foods<br>• Use saliva stimulants - sugarless candy or gum, tart foods (if no mouth sores)<br>• Drink club soda, seltzer water or papaya nectar to thin secretions<br>• Maintain good oral hygiene |
| **Altered taste perception** | • Rinse mouth with tea, ginger ale or salt water before and after meals<br>• Cold foods may be more acceptable<br>• Season foods with herbs, spices, sauces, marinades<br>• If averse to meats, eat other proteins such as eggs, dairy, nuts, seeds, poultry<br>• If metallic taste, use plastic utensils and avoid canned foods<br>• Check serum zinc levels and supplement if low |

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Table 2. Strategies to manage GI related symptoms

| Problem | Intervention |
|---|---|
| **Anorexia** | • Eat high calorie/high protein foods, small frequent meals<br>• Keep nutrient dense snacks on hand<br>• Don't fill up on low calorie foods/beverages<br>• Drink fluids between meals<br>• Light exercise/activity if possible<br>• Create pleasant eating environment: set table, play music, eat with friends or family<br>• Drink oral nutrition supplements |
| **Early Satiety** | • Eat high calorie/high protein foods, small frequent meals<br>• Keep nutrient dense snacks on hand<br>• Chew thoroughly and eat slowly<br>• Don't fill up on low calorie foods/beverages<br>• Drink fluids between meals<br>• Low fat foods may be better tolerated<br>• Intake may be best at breakfast<br>• Light exercise/activity if possible<br>• Take medications between or after meals if possible |
| **Nausea** | • Eat small frequent meals<br>• Avoid foods with strong odors<br>• Avoid strongly seasoned, greasy/high fat, excessively sweet foods<br>• Eat dry foods (crackers, toast, dry cereal) every few hours<br>• Cold or room temperature foods may be better tolerated<br>• Drink liquids between meals<br>• Use anti-nausea/anti-emetic medications (scheduled, not PRN) |
| **Diarrhea** | • Avoid high fat, high fiber foods, alcohol and caffeine<br>• Eat small frequent meals<br>• Drink adequate fluids, especially water or oral rehydration solutions<br>• Eat high potassium foods<br>• Eat foods high in soluble fiber (banana, applesauce, white rice, pasta)<br>• Consider limiting high lactose foods<br>• Consider using a probiotic if altered gut flora suspected, as with antibiotic use<br>• Avoid medications/foods with high osmolarity and sugar alcohols (sorbitol, mannitol, xylitol)<br>• Take anti-diarrhea medications |

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### About the Author:

Maureen Janowski, RDN, CSG, LDN, FAND is a Licensed Dietitian Nutritionist in Illinois, and is a Specialist in Gerontological Nutrition (CSG). She is a past chair of Healthy Aging DPG and has presented at multiple professional conferences on the subject of nutrition and wellness in the older adult. She is currently the Corporate Director of Malnutrition Program with Morrison Healthcare.

Amy Gautraud, MS, RDN

# Chair Update

I have enjoyed serving as the DHCC Chair over the past year. It has been inspiring to work alongside an Executive Committee focused on serving our members through different methods and channels. Not only did we have our first Virtual Conference this winter, but we also maintained a very active EML and a robust offering of webinars throughout the year. I am very excited for the upcoming transition of our Executive Committee with Rena Zelig DCN, RDN, CSG, CDE as Chair and Sue Linja RDN, LD as Chair Elect. They already have exciting member benefits in the works, including a DHCC Workshop prior to this year's FNCE® in Orlando (stay tuned for details).

I would also like to acknowledge all the time, expertise and service provided by our other EC members including:

- Julie Driscoll, RDN, CSR, CSG, Past Chair
- Bailee Troskot, RDN, LD, CDM, Communications Coordinator
- Drisana Clifton, MPH, NDTR, Chair, NDTR subunit
- Joanne Zacharias, MS, RD, LDN, Delegate

Lastly, I would be remiss if I didn't take the opportunity to encourage our members to get more involved with DHCC leadership opportunities. We are often seeking volunteers for committees or initiatives.

Marcus F. Sam
MS, RDN, LDN

# Editor Column

Thank you for taking the time to read this edition of *Connections*. The information provided is a product of RDN's from across the country taking their experiences and knowledge and putting them in writing.

Do you have a practice-focused article you are wanting to get published? An in-depth CPEU article ready for editing? Do you know an RDN who exemplifies what it means to be a leader in the DHCC community and want to recognize that person? Do not hesitate to reach out to the DHCC Newsletter Editor at mfsam@dietitiansforhealthcare.com.
We want to hear from you!

# NDTR Update

Drisana Clifton, MPH, NDTR

Drisana Clifton, MPH, NDTR

**Happy Spring fellow NDTRs and DHCC members,**

Did you hear? NDTRs will have their own day during National Nutrition Month®! This is a huge step for camaraderie and recognition of our credential that I am very excited about. You can read more about the Academy's announcement here.

As this membership year comes to a close, the DHCC leadership team and I would like to share an update. We have noticed spread out engagement of NDTRs across DPGs, as well as a wide variety of practice areas just within our own subunit. Based on this information, and the lower engagement we have had in the subunit, we have decided to dissolve the NDTR subunit. We want to ensure the activities and resources available are truly helpful to all NDTRs and it seems it will be more impactful for members to engage among the practice and interest areas that are most important to them.

I hope this empowers you to find ways to connect with NDTRs and RDNs in your interest and practice areas to further increase value in your membership.

It has been a pleasure serving as the NDTR subunit chair over the past two years. I've truly enjoyed the virtual meet-ups, collaborative newsletter articles, and connections I have made during my time. I will miss this cohort but look forward to seeing growth in specific interest areas.

Please feel free to reach out to me at any time: Drisana.Clifton@gmail.com. I look forward to celebrating NDTR day with all my fellow NDTRs next year!

Sincerely,

Drisana Clifton

Across DPGs, here are the numbers of NDTRs involved in each DPG:

| | |
|---|---|
| Behavioral Health Nutrition | 16 NDTR members |
| Business and Communications | 5 NTDR members |
| Cardiovascular Health and Well-being | 30 NTDR members |
| Nutrition Support | 6 NTDR members |
| Diabetes | 26 NTDR members |
| Food and Culinary Professionals | 32 NTDR members |
| Healthy Aging | 18 NTDR members |
| Hunger and Environmental Nutrition | 23 NTDR members |
| Integrative and Functional Medicine | 30 NTDR members |
| Management in Food and Nutrition Systems | 18 NTDR members |
| Medical Nutrition Therapy | 26 NTDR members |
| Nutrition Education for the Public | 12 NTDR members |
| Nutrition Educators of Health Professionals | 3 NTDR members |
| Nutrition Entrepreneurs | 20 NTDR members |
| Nutrition Informatics | 13 NTDR members |
| Nutrition Support | 3 NTDR members |
| Oncology Nutrition | 9 NTDR members |
| Pediatric Nutrition | 14 NTDR members |
| Public Health/Community Nutrition | 24 NTDR members |
| Renal Dietitians | 5 NTDR members |
| Research | 2 NTDR members |
| School Nutrition Services | 24 NTDR members |
| Sports and Human Performance Nutrition | 39 NTDR members |
| Vegetarian Nutrition- | 27 NTDR members |
| Weight Management | 21 NTDR members |
| Women's Health | 12 NTDR members |

# LEAP Ahead

## Maximize your DHCC Membership

Dana Fillmore, RDN, Membership Coordinator

Dana Fillmore, RDN

Are you looking to get ahead in your career? Joining DHCC is a great first step, giving you access to valuable, leader building benefits! To assure you are getting the best out of your membership, follow these action items!

### Look for news you can use

Keep our eyes out for e-blasts, monthly e-updates and this newsletter with the latest and greatest news curated specifically for DHCC membership. Information will include current hot topics, upcoming webinar offerings, new resources and other information related to our member interests. You can find current and archived issues of the e-blasts, e-updates, and Connections newsletter on our website. Remember to search out the Continuing Professional Education Unit (or CPEU) article from each newsletter. Take the quiz, which is available on our website at the end of the month. If you score 80% or higher, your CPEU documentation will be emailed to you.

### Engage in digital networking

Engage personally with our vast membership of experts through email and social media. We have 3 separate electronic mailing lists (or EMLs). It's a great way to ask questions! You'll find the link to subscribe on our website. You can join our regular EML and one (or more) or our subgroup EMLS – corrections and dietetic technicians. We have a Facebook page – make sure to like us! And connect with us on LinkedIn. You will find links to our social channels on our website to make connecting easy.

### Access leading industry publications

Take advantage of the DHCC publications available through our website and the EatRight Store; members receive discounted prices. For example, check out the *Nutrition Care of the Older Adult and the 2021 DHCC Inservice Manual*, which includes 27 lessons with short quizzes.

### Participate in topline educational programs

DHCC has a robust live and on-demand educational program, including in-person events, webinars, and newsletter CPEU articles (as mentioned earlier). You can always find the latest details on upcoming events on our website under "professional development". Scheduled webinars can be found on our event calendar and are listed in the monthly E-updates. These activities have typically been approved for 1 hour of CPEU. The Academy/CDR also allows recorded webinars as eligible for CPEU! You can claim over 50 hours in a 5-year period. DHCC currently has over 20 archived webinars and 8 self-study newsletter articles available for self-study! Perhaps most intriguing of all, DHCC offers stipends to members for professional development. Keep an eye out in our communications for opportunities!

We trust you will each find a variety of member benefits that will help you meet your career goals. We also welcome your participation in volunteering. In fact, volunteering your time and talent in organizations such as DHCC is a great way to give back, and raise your professional profile at the same time. Let us know if you'd like to volunteer with newsletter articles, social media, planning educational events, sponsorship and so much more. Please email us or call our office at 206-935-5104.

**L.E.A.P.**
Ahead in your Career
with DHCC

**L**ook for news you can use
**E**ngage in networking
**A**ccess leading publications
**P**articipate in topline programs

# Post Pandemic Workforce Challenges

## Recruitment, Retention, and Reimagining Your Career Possibilities

Yolanda Scott, RDN and Dana Fillmore, RDN

The challenges our healthcare systems face come as no surprise as we work to navigate the unprecedented events over the past two years. The recent COVID-19 surge related to the Omicron variant demands continued resilience from healthcare and senior living staff; and we know as healthcare professionals, this industry will always demand resilience. That reminds us of the importance of recognizing the high risk for staff burnout and resulting staff turnover. As more and more organizations face job vacancies, managers and operators are looking to hire, retain and offer challenging career development opportunities in an effort to stay relevant and maintain progressive work environments.

We convened a panel of professionals across a broad spectrum of health care entities to take a deep dive into the dynamics of staffing in this new post pandemic era. Our distinguished panel of professionals include:

**Dana Fillmore, RDN** is the Healthcare Marketing Manager for Gordon Food Service where she provides industry guidance shaping sales and marketing strategy in healthcare and senior living, assuring relevant products, tools, and solutions meet customer business needs. Dana will provide a national and supply industry perspective in working with a variety of clients from across the country.

**Yolanda Scott, RDN is a Lead** Dietitian for Foundations Health Solutions, a long-term care company that operates over 50 LTC communities in Ohio. Yolanda will provide perspectives from a post-acute care view.

**Antoinette (Toni) Watkins, MS, RDN** is the System Food, Nutrition and Environmental Service Director a healthcare system in which she oversees 12 facilities with a span of control in both acute care and senior living. Toni represents a food service perspective. And of special note Toni is this year's International Food Service Manufacturers Association (IFMA) Gold Plate Winner.

**Susan Branning, MBA, RDN, CNSC, CDN** has been leading clinical nutrition teams for over 20 years and is currently a Regional Clinical Nutrition Manager with Trinity Health supporting hospitals in New York and New England. Susan represents a clinical perspective.

### Q: What are you seeing in the industry and in your organization as it relates to workforce trends?

**FILLMORE:** It is hard to find workers. According to US Bureau of Labor Statistics (BLS) data on labor force participation rate, there are three million fewer Americans in the workforce now compared to pre-pandemic.[1] This is reflective of the ongoing concerns we are seeing with staffing levels.

A recent industry survey showed that nearly every nursing home (99%) and assisted living community (96%) in the US is facing a staffing shortage.[2] Another survey had the majority of respondents saying hospital food and nutrition services are working up to 30% short staffed.[3] That's up to three unfilled positions for every ten spots.

And once you do get workers in the door - it's proving hard to keep them. The BLS shows record high quit rates, especially for healthcare and foodservice related jobs, indicating people are going from job to job searching for a better offer, or leaving the industry altogether.

Working short-handed has a cascading impact on the team members that are there. The stress of being overworked brings erosion of service quality, increased turnover, resulting in overall financial costs. The current supply chain disruption complicates the challenges of the workforce shortage, exacerbating the feeling of burnout. Many experts agree that these labor and supply challenges

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## Post Pandemic Workforce Challenges

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are likely to last well into 2022 or longer. Operators really need to have creative recruitment and retention strategies to help make it through this.

**SCOTT:** The reasons why we are in a pandemic workforce shortage has been discussed and theorized by industry leaders at length. However, knowing why we are in a shortage doesn't address the problem of how we navigate our way out of it. In our organization, we saw roughly a 10% combined clinical/dietary manager turnover during the height of the pandemic. Some turnover during the first quarter isn't unusual, however the most significant challenges were twofold: our metropolitan and urban health care communities were receiving very few applicants, and our rural health care communities were unable to find any experienced applicants.

### Q: Today's labor challenges are forcing operators to work differently. What successful approaches have you identified?

**WATKINS:** More emphasis on technology has been critical during this time. Technology can be used to augment productivity or replace live labor. Be open to how technology can help you create more efficient and reliable results. For example, we are implementing an app in our retail operations to decrease lines and wait times.

Flexibility with scheduling staff has also proved to be helpful during these times. Adjusting shifts to meet the changing personal demands of your team members helps you get people to show up and shows appreciation for them at the same time. We continue to adapt even with Omicron. Dietitians are working from home as needed to mitigate exposure.

Lastly, being open to adapting the menu, recipes, and products you purchase is very helpful. Organizations are being challenged to revisit menu options and work with vendors to make adjustments or substitutions for shortages with the current supply chain challenges. Planning ahead together with your prime vendor to address known shortages is proving to be a valuable time saver and stress reducer. Aligning the types of products, we purchase with available labor is just as helpful. For example, we are introducing sous vide proteins for our new International Dysphagia Diet Standardization Initiative. We are able to have a quality product without the need for extensive labor to prepare the product.

**BRANNING:** The popular acronym, "VUCA," springs to mind here. VUCA stands for Volatility, Uncertainty, Complexity and Ambiguity. The term refers to the act of providing strategic leadership within a "volatile, uncertain, complex and ambiguous global environment".[4] These words remind us that leaders need to adapt to a VUCA environment by being aware and sensitive to the rapidly changing and unpredictable situations. We need to take time to assess and adapt.

Flexibility around supplies and nutrition regimens is a good example. Unpredictable availability of feeding tubes, pumps, and other supplies demands a clear plan with an agile approach to assure patients get the best care we can give them.

As Toni mentioned, improved collaboration with primary care providers is critical, as well as with other disciplines. Registered dietitians encountered clinical scenarios in critical care COVID-19 patients such as varying opinions on the ability to enterally feed patients in the prone position, with compromised gastrointestinal, renal, and respiratory function, in addition to formula, pump, and tubing shortages. These combined scenarios require increased collaboration among primary care providers, nursing, nutrition, pharmacy, and respiratory professionals, as well as supply chain and clinical engineering, to determine the best way to meet the nutritional needs of the patient when the most appropriate enteral formulas and supplies may not be available. Flexibility was vital in these scenarios as well as the ability to accept a flexible nutrition care plan when the most appropriate regimen wasn't always possible.

**SCOTT:** We were presented with an opportunity to find an applicant for one of our less metropolitan areas. We had an applicant who did not have any long-term care (LTC) experience, and her background up until that point was very specialized. However, she was highly motivated to transition into LTC and willing to put in the work. We organized our orientation packet into a one- month training course that consisted of two full days of training, one hour weekly virtual training, and daily feedback to provide intense on-the-job training on our best practices, documentation, the MDS and CMS regulations.

Before the pandemic we may have passed on an applicant who had no LTC experience. The pandemic forced us to reimagine what training looks like. We re-defined our onboarding program and as a result we were able to obtain an employee who has proven to be a tremendous asset to the facility.

### Q: What are operators doing to attract workers and reduce turnover?

**BRANNING:** We hear a lot from workers that they like the option to work from home. The acute care and hospital setting may offer less flexibility to RDNs in regard to virtual/work from home environments. However, there are several opportunities I have been able to offer in the hospital setting, such as flexible scheduling to

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## Post Pandemic Workforce Challenges

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meet childcare needs (weekend or early morning/evening work hours). We learned that those non-traditional schedules worked during the pandemic, so why not continue them?

**SCOTT:** Our Director of Clinical Nutrition Services, Pam Mink RD, summed it up by saying

"The team approach is what we always do at Foundations…we just have to keep adapting what is needed and then deliver."

We have focused on developing our employees, by asking the difficult question of "what is important to you" and then working to go above and beyond the standard benefit package that produces an environment for personal growth and advancement. This includes a two-prong approach:

Dietitians and Diet Technicians:

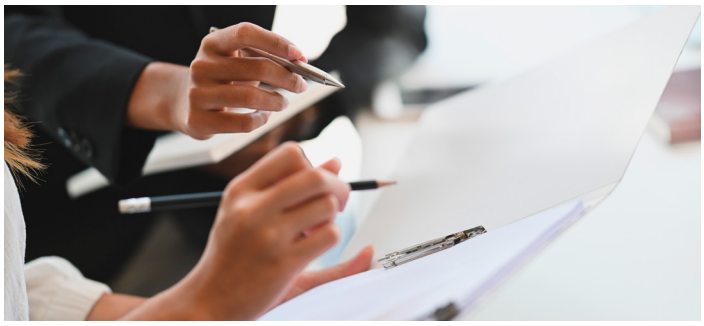
- Bi-annual regional meetings to review the latest in clinical research and provide continuing education credits
- Promotion opportunities into lead regional positions
- Development opportunities for career advancement in areas such as dialysis, developmentally disabled communities, and vent units
- Resources and support from other seasoned clinicians
- Working with the nursing clinical team on mock surveys and developing clinical resource materials
- Cross-training in clinical and food service skills for those that want to broaden their skill set

Foodservice Managers:

- Certified Dietary Manger (CDM) education reimbursement with in-house preceptors
- Promotion opportunities to lead CDM regional positions
- Menu meeting presenters
- "Last tray standing" company-wide competition with cooks and dietary managers in which standard menu items were transformed into a meal which later appeared on our cycle menu company-wide

**WATKINS:** Fair pay is an important factor in recruiting and retaining good workers. My organization moved to a starting pay of $15 per hour for food service workers effective January 2022. We are also planning pay adjustments for team members who are in a position with a starting pay range of greater than $17 per hour. The adjustments may be applied as a compression adjustment, market adjustment or larger merit increase.

**FILLMORE:** Focus on your new employees. In today's fast paced environment, find a way to quickly but thoroughly onboard your new staff - don't skip key training. Organizations with a strong on-



boarding process improve new hire retention by 82% and productivity by over 70%.[5] Furthermore, over half of organizations report most new hire attrition happens during the first six months of employment.[6] So focus on providing a great training for those first 180 days! Think of onboarding as your on-ramp to long term success with each employee. Here are a few onboarding tips:

- *Don't rush it and don't take shortcuts*
- *Consider assigning a peer as a "buddy" and a mentor to new employees*
- *Assign new hires a few projects to help get them some quick "wins"*
- *Encourage new hires to observe and ask questions before jumping into projects*

Be purposeful regarding continued training and development for your whole team as they grow with your organization. In fact, a 2021 Work Institute retention survey found that the number one reason people leave a job is because there's a lack of learning and development.[7] This has been the same reason for 11 years in a row, and even with the turmoil around COVID, it is still reason number one. Upskill your team by providing targeted training that improves an employee's skill set. Many believe that this will make them happier and motivate them to be more productive and ultimately more loyal to your organization.

### What is your workplace doing to stand out in recruiting staff?

**SCOTT:** We started a new program called Daily Pay, and it is exactly as it sounds. Employees have access to money earned at the end of their work shift if they choose to access it. I asked our VP of Business Development and Culture at Foundations Health Solutions, Robert Speelman, STNA, LNHA, what led him to implement such a revolutionary benefit for our employees.

"I have to be honest; I was skeptical about adding Daily Pay and didn't think it would be a big benefit. In fact, I thought it would not be good for our current employees because I thought it would keep them from budgeting and saving and they would get into issues with having enough to pay their bills. With regard to recruiting, I thought it potentially could help but these new employees

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## Post Pandemic Workforce Challenges

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would run into the same issues that I feared our current employees would have. Nick Anderson, one of our Regional Directors of Operations, believed in it and felt it would be a huge perk for our employees. He was right and I am now a believer. What we have found out is that it is mainly being used by our frontline staff. They enjoy the flexibility it provides when they have a bill that is due, pay for an unexpected expense like a car repair, and have seen it encourages employees to pick up an extra shift and immediately be able to access those extra funds. It just goes to show you that it's good to listen to people and to try new things, although just recently rolled out, is proving to be a big hit."

**WATKINS:** We continue to review our pay schedule ensuring we meet and exceed market standards. As stated earlier, my organization is differentiating itself from our surrounding competition by offering a starting hourly rate of $15.00 per hour. By addressing the compensation factor, we have been successful in attracting applicants for our open positions. Bonus referrals are also in place.

**FILLMORE:** I am seeing a variety of creative recruitment strategies in our industry. One approach that particularly stands out as innovative is partnering with local trade schools and colleges to offer both formal internships and informal experiences for the students. This exposes the students to our industry, plus gives you a chance to get to know a student that might just be your next best hire. Be creative here and think outside the box about how your organization could do something similar.

Using social media to highlight your team is also gaining strength as a top recruitment strategy. Share your story about how the work your team does makes a difference. Talk about what makes your place special and unique. Spread the word through popular social media channels that your potential workers are likely using.

Most importantly, organizations that take action to show they value the well-being of their employees are winning the recruiting race. This includes tangible benefits, such as resources to manage mental and physical health, as well as a solid company culture that prioritizes employee well-being.

**Q:** How has telehealth affected the work setting and how have you been able to leverage it to enhance employee engagement/satisfaction?

**BRANNING:** With the 2020 pandemic waivers for telehealth, telehealth outpatient medical nutrition therapy has emerged with overwhelming benefits for both patients and providers.

We have successfully navigated the telehealth work environment with positive outcomes:

- Decreased no-show and cancelation rates
- Improved patient engagement
- Increased employee engagement and satisfaction
- Work from home capabilities

**WATKINS:** We are able to use telehealth (nutrition) to help fill vacancies and provide much needed schedule flexibility. The clinicians were able to achieve a sustainable work life balance during this time, and as a result of providing telehealth it is now viewed as a positive outcome of the pandemic.

**Q:** What is your best advice for those pursuing new career opportunities in today's environment?

**SCOTT:** In pursuing new career opportunities in today's climate, one must be intentional. I have outlined six intentional steps for success in LTC.

- Educate yourself on the company. This involves research of the company's core values and culture.
- If you are a new graduate, review high risk conditions and be able to demonstrate critical thinking and competence on the following:
    - Assessment criteria for high-risk residents
    - Unintentional weight loss
    - Pressure injury
    - Dialysis
    - Tube feedings
- Determine your needs and comfort level regarding work schedule flexibility. Do you feel you need remote work, a flexible work- day schedule, or would you prefer to go to more than one facility?
- Sharpen your communication skills. Can you communicate effectively with the MD, resident, and the family? Can you be empathic and effective in expressing yourself?
- Recognize how important customer service is and be able to verbalize what that looks like in LTC. Everyone is your customer, from the resident and their family to administration and housekeeping.
- Exhibit confidence and have a positive attitude.

Show you have what it takes to be a good match for the job you are applying for, and you possess the talent and skill sets necessary to fill that position.

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## Post Pandemic Workforce Challenges

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**FILLMORE·** We've already talked about how learning and development programs rate high in retention surveys. So, when searching for employers, be on the lookout for those that offer formalized employee development programs. Ask about it in your interviews. This gives you insight that the organization cares about their team members and may be a good company to work for. Then, once you work there, take advantage of the opportunities to broaden your skill set. On the flip side - those of you that are already in a position to do so, be that mentor to help folks newer to our industry by providing opportunities for them to develop. Make it part of your regular day to invite others to participate in activities to help them learn.

**Q: Knowing what you know today, if you could plan all over again, what changes would you make?**

**WATKINS:** I would remember to be nimble and stay flexible. Resilience is crucial. I remember the African proverb "if you want to go fast go alone, but if you want to go far, go together", meaning that it takes a team to produce sustainable results and outcomes.

**SCOTT:** I would continue to embrace change and challenges. It is because of the ever-changing landscape of the LTC industry that we are uniquely prepared to adjust, pivot and re-engineer our ability to provide the best in resident care.

In closing, the pandemic of 2020 has upended the country in ways we could have never foreseen, and the impact on the country's healthcare system will be felt for years to come. But through it all we have been given an opportunity to flex our creative muscles and reimagine our communities and set new courses for recruitment and retention. It has been our collective goal that you can utilize some of the strategies presented here to improve your staffing challenges.

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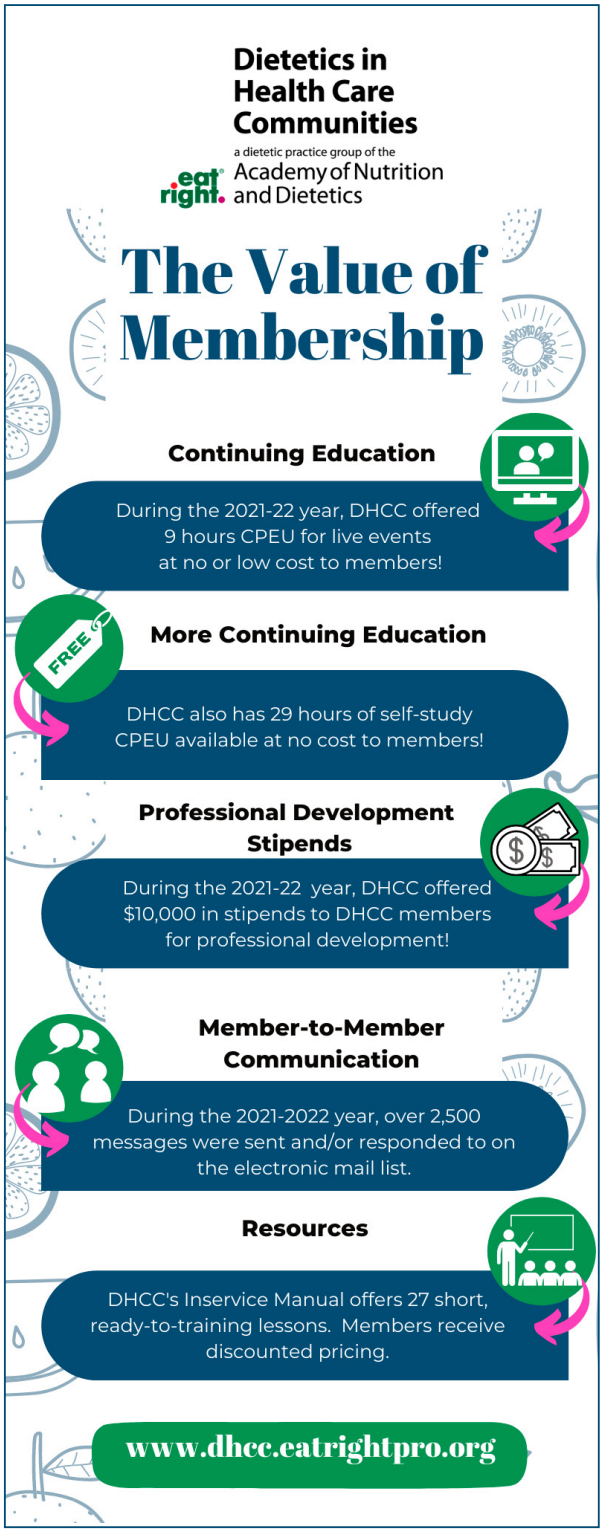

# The Role of the Registered Dietitian Nutritionist in California Group Homes for Weight Stabilization of Individuals with Intellectual and Developmental Disabilities

By: Romana Brennan, MS, Jacqueline Larson, MS, RDN, Alexis Deavenport-Saman, DrPH, MPH, and Cary Kreutzer, EdD, MPH, RDN, FAND

## Research Snapshot

**Purpose:** The purpose of this study was to: 1) examine changes in BMI of adults with intellectual and developmental disabilities (IDD) residing in group homes with a Registered Dietitian Nutritionist (RDN) consultant and 2) to determine if time in the group home was associated with these changes.

**Key Findings:** Limited research has been published that evaluates nutrition adequacy of individuals with IDD residing in group homes in the United States. There is evidence supporting the notion that having an RDN consultant to serve those with IDD living in group homes may be an effective way to ensure these individuals receive adequate nutrition, as reflected by weight stabilization and normalization. However, further research should be conducted to evaluate if the provision of appropriate nutrition services and screening provided in group homes by an RDN, which is required in California, promotes weight stabilization.

## Abstract

**Background:** Research is lacking that evaluates nutrition adequacy as related to body mass index (BMI) of individuals with IDD residing in United States group homes.

**Objective:** This study aimed to illuminate the protective factors provided by an RDN through oversight of food and nutrition services in California group homes in weight stabilization and normalization (approaching "normal range" from either underweight, overweight, or obesity).

**Methods:** A retrospective cohort study was conducted using 8 years of data for 459 residents (ages 20-82 years) in 86 Southern California group homes, with time in the group home ranging from 1 month to 8 years. A Wilcoxon signed-rank test was used to examine changes in BMI and a chi-square analysis examined how time in the group home influenced BMI.

**Results:** Change in BMI from entry to endpoint decreased slightly (median 24.13 vs. 23.95) but was not significant (P = 0.19). Adults staying 5 years or more versus 4 years or less were significantly less likely to be classified as obese (42.9% vs. 57.1%) but were more likely to be overweight (72.9% vs. 27.1%) and within normal range (64.3% vs. 35.7%) (P = 0.001).

**Conclusion:** This study provides evidence that having an RDN serve those with IDD living in group homes may be an effective way to ensure individuals are receiving adequate nutrition, reflected by weight stabilization and normalization. Further research is needed to evaluate if provision of appropriate nutrition services and screening provided by an RDN in group homes, required in California, promotes weight stabilization.

## Introduction

Intellectual and developmental disabilities, or IDD, exist everywhere and across all racioethnic groups. In 2016, it was estimated that 7.37 million people in the United States had some intellectual and/or developmental disability.[1] IDD are often present at birth but can originate and be diagnosed up until the age of 22 and can impact an individual's physical, intellectual, and emotional development by affecting several body systems. Intellectual disabilities describe problems related to learning, reasoning and problem solving, as well as adaptive behavior, namely social and life skills.[2] The category of developmental disabilities is broader and includes both intellectual and physical disabilities. Some IDD may be degenerative, impairing an individual's skills and abilities as they age. Because the term IDD includes a wide array of disabilities, there is an even greater variety of known and unknown causes, including genetic disorders, nutritional inadequacies, malnutrition, complications at the time of birth during labor and delivery, and infection, to name a few. Examples of IDD include cerebral palsy, Down syndrome, Fragile X syndrome, autism spectrum disorders (ASDs), and Rett syndrome.[3]

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## The Role of the Registered Dietitian Nutritionist in California Group Homes for Weight Stabilization of Individuals with Intellectual and Developmental Disabilities

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In 2002, the U.S. Surgeon General deemed the improvement of nutrition for adults with IDD a national priority.[4] Nutrition services play a pivotal role in comprehensive care for individuals with IDD and special healthcare needs. These services should be interdisciplinary, family-centered, community based, culturally competent, and lifelong in order to promote wellness, improve quality of life, maintain good health, and reduce risk and cost of comorbidities and complications.[5] Unfortunately, despite the growing prevalence of intellectual and developmental disabilities, little standardization exists within the United States in terms of providing care for and seeking to better understand those with IDD. The federal government does not require an RDN to be part of the group home interdisciplinary care team. However, California is one of 11 states that does require an RDN consultant in group homes in order to maintain licensure.[6]

The RDN plays a key role in the interdisciplinary care team to ensure the quality and effectiveness of nutrition services in group homes. Dietitians ensure dietary standards are being met according to the guidelines set forth by the group home funding agencies, for example adhering to the USDA dietary guidelines if federally funded, as well as ensuring that dietary intake is appropriate and individualized.[7] This is especially important because individuals with IDD may have additional risk factors that make them more susceptible to weight gain, such as the use of appetite-altering psychotropic medications, syndromes that may increase risk for weight gain, physical limitations, and disordered eating habits.[8] Conversely, individuals with IDD may also be more susceptible to unwanted weight loss and underweight due to feeding and swallowing difficulties, conditions affecting metabolism and nutrient absorption, reduced muscle mass, poor eating habits, and caregiver knowledge deficit.[9]

Among their responsibilities, RDNs recommend foods to meet special dietary needs as well as individual preferences, develop individualized meal and snack plans, create appropriate menus, recommend diet orders with individualized portion sizes to meet a resident's needs, and conduct assessments and evaluations. Dietitians also provide nutrition education and training for group home staff in order to promote practical improvements in nutrition knowledge and to encourage positive changes in food choices.[10] These factors all contribute to better nourishment of individuals with IDD living in group homes, improving their health and well-being, as well as improving feeding of malnourished individuals, preventing chronic disease, and reducing obesity risk. Therefore, the purpose of this study is to evaluate the impact of the services provided by an RDN consultant across group homes throughout Southern California, and to expand the limited existing knowledge on the benefits that RDNs serve for this vulnerable population with special healthcare needs.

### Methods

#### Setting and Participants

All data for this retrospective cohort study was collected by RDN consultants from January 2013 to January 2021. These RDNs serve as the dietitian consultants for each of these group homes, and collect annual heights and monthly weights for all residents. Height and weight data from 459 individuals residing in 86 group homes across 4 counties in Southern California was de-identified prior to being delivered to the research team. These individuals were aged 20 to 82 years, with an average age of 49. Three individuals were excluded from the dataset due to age (<20 years at the endpoint). Their length of stay ranged from 1 month to 8 years, with an average length of stay being 4 years and 8 months. These individuals had all been diagnosed with at least one intellectual or developmental disability and all consumed an oral diet, meaning that none were reported to be on enteral or parenteral nutrition support.

#### Statistical Analysis

This data was de-identified by way of a coding system prior to being sent to the researcher team. Each home was assigned a number and the individuals within each home were assigned a letter (A-F). For each individual, biological sex (M/F) and year of birth was also provided. Data was transferred into a spreadsheet and frequencies and percentages were reported for categorical variables. Means and standard deviations were reported for continuous variables, and medians and interquartile ranges were reported for variables that were not normally distributed. A Wilcoxon signed-rank test was used to examine overall changes in BMI for males and females and for the full length of stay. A chi-square analysis was conducted to examine how time in the group home influenced BMI categories.

### Results

There were a total of 459 adults who resided in the 86 group homes, in which they had access to an RDN for the entirety of their time in the group home, which ranged from 1 month to 8 years. Individuals ranged in age from 20 years to 82 years at endpoint. The entry BMI ranged from 13 to 53, while the final BMI ranged from 15 to 50.

Although decreasing slightly, there were no significant changes in the median (IQR) entry BMI of 24.13 (6) compared to the final BMI of 23.95 (6); P = 0.19. Adults staying in the group homes 5 years or more versus 4 years or less were significantly less likely to be obese (42.9% vs. 57.1%), but were more likely to be overweight (72.9% vs. 27.1%) and within normal BMI range (64.3% vs. 35.7%); X2 (df) = 17.73 (3), P = 0.001.

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## The Role of the Registered Dietitian Nutritionist in California Group Homes for Weight Stabilization of Individuals with Intellectual and Developmental Disabilities

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Table 1. Demographic characteristics of adults in the sample of group homes served by a Registered Dietitian Nutritionist.

| Demographic Characteristic | Total Sample |
|---|---|
| | n (%) or Median (IQR) |
| Age | 49 (26) |
| Length of Stay in years | 5 (1) |
| **Biological Sex** | |
| Male | 281 (61.2) |
| Female | 178 (38.8) |
| **Entry BMI Categories** | |
| Underweight | 42 (9.2) |
| Normal | 226 (49.2) |
| Overweight | 130 (28.3) |
| Obesity | 61 (13.3) |
| **Final BMI Categories** | |
| Underweight | 21 (4.6) |
| Normal | 249 (54.2) |
| Overweight | 133 (29) |
| Obesity | 56 (12.2) |

| Length of Stay | Underweight (N=21) | Normal (N=249) | Overweight (N=133) | Obesity (N=56) | X2 (df) | P |
|---|---|---|---|---|---|---|
| | n (%) | n (%) | n (%) | n (%) | 17.73 (3) | .001* |
| 4 years or less | 11 (52.4) | 89 (35.7) | 36 (27.1) | 32 (57.1) | – | – |
| 5 years or more | 10 (47.6) | 160 (64.3) | 97 (72.9) | 24 (42.9) | – | – |

*P < 0.05

### Discussion

This is the first study, to our knowledge, to examine weight stabilization within group homes that utilize the services of an RDN consultant. There was no significant change in BMI from entry into the group home to the final BMI measurement. Furthermore, as the length of time that adults resided in the group home with the RDN increased, there appeared to be additional benefits in decreasing the likelihood of obesity, and increasing the likelihood of having a normal or overweight BMI. These results suggest that over time, the weights of individuals living in these group homes tended to normalize toward normal range and overweight, moving away from the extremes of underweight and obesity.

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## The Role of the Registered Dietitian Nutritionist in California Group Homes for Weight Stabilization of Individuals with Intellectual and Developmental Disabilities

*continued from page 20*

Overweight and obesity have been suggested to increase one's risk of developing multiple comorbidities, including serious chronic diseases. On the contrary, there is evidence suggesting that being overweight may serve as a protective factor for aging individuals, particularly those above the age of 60.[17] However, more research is needed in order to determine if this information is able to be generalized to all populations, namely those with IDD. The Centers for Disease Control and Prevention estimated in 2018 that close to 74% of the general U.S. population over the age of 20 was either overweight or obese.[13] According to 2018 National Core Indicators (NCI) survey data of all California Regional Centers, 62% of Californians with IDD are overweight or obese.[14]

In general among the population with IDD, the highest prevalence of obesity exists among women with IDD, those with Down syndrome, those with "mild" IDD, as well as those living independently or with family members as opposed to a more supervised environment in which dietary guidance is offered.[4,15] Although the overweight and obesity rates of individuals with IDD living in group homes in California as a whole are unknown, among this study sample, 41.2% of individuals were overweight or obese at endpoint.

On the opposite end of the spectrum, individuals with IDD may also be at a higher risk of malnutrition resulting in underweight, especially with conditions such as cerebral palsy, for example. The 2017-2018 National Health and Nutrition Examination Survey (NHANES) estimated that 1.6% of U.S. adults above the age of 20 are underweight.[16] 5% of Californians with IDD are underweight according to the NCI survey.[14] In this study sample, the prevalence of underweight was 4.6%, although no other data has been published on this specific population. On either end of the spectrum, individuals with IDD are likely at increased nutritional risk and are more susceptible to nutritionally-related risk factors that could negatively impact their health and well-being.[5]

RDN consultants can effectively create and implement nutritional programs within group homes that focus on providing individuals with adequate nutrition and staff members with food and nutrition education and resources. These programs, as suggested by the data presented in this study, can result in weight normalization within group homes. It could be possible that these individuals living in group homes do not fall into the same weight gain patterns as the average adult, of 0.7-1.8 pounds per year, as estimated by Chambers et al.[12] RDN consultants may also be able to address feeding issues and other challenges present among malnourished underweight individuals to prevent weight loss and encourage appropriate weight gain. If individuals can maintain their standard weight or approach what may be considered a more "normal" weight, they may be able to decrease their risk of developing multiple comorbidities, whether they are underweight, overweight, or obese.

### Limitations

Limited research has been published that evaluates nutrition adequacy of individuals with IDD residing in group homes in the United States. While this study provides insight on this topic, limitations must be discussed. BMI was the primary characteristic used to evaluate nutrition adequacy as it relates to weight and weight stabilization. Given the data available, BMI was considered to be the most measurable outcome for this study. However, there are few standards of practice when it comes to determining the most appropriate ways in which to measure health status among individuals with IDD, and BMI was not designed to assess the health status of an individual. There are many factors that influence both health status and weight of individuals with IDD who may have special healthcare needs, and weight alone may not be an accurate measurement or reflection of health status. This makes it all the more necessary to have a trained professional, such as an RDN, who is able to perform additional quantitative and qualitative assessments on those residing in group homes, given their knowledge of the eating behaviors, diet tolerance, changes in appetite, etc. of those with IDD.

Furthermore, the data de-identification process involved excluding all diagnostic information, therefore it was unknown to the research team whether any of the individuals had additional conditions or diagnoses that may have impacted their nutritional status or mobility, or whether their conditions may have worsened over time. It was clarified, however, that no patients were on parenteral or enteral nutrition support, and all consumed an oral diet. The lack of racioethnic data may serve as an additional limitation, and more research is warranted in order to explore the racioethnic disparities that exist among individuals with IDD, not only those living in group homes.

Given the nature of this retrospective cohort study, this sample was unable to be compared to a population composed of individuals living in group homes who did not have the oversight of an RDN consultant. While National Core Indicators survey data gives some insight into Regional Center as well as California statewide averages of BMI classifications, exercise patterns, and tobacco use, there are no further details helping to connect living arrangements and quality of care with health status. In order to draw more clear conclusions on the impact of RDNs in this setting, further research is needed that compares outcomes of individuals with IDD living in group homes served by RDN consultants with an organized nutrition program, versus those living in group homes that lack RDN supervision.

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## The Role of the Registered Dietitian Nutritionist in California Group Homes for Weight Stabilization of Individuals with Intellectual and Developmental Disabilities

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# From Our DHCC Delegate

Joanne Zacharias, MS, RD, LDN

**Joanne Zacharias, MS, RD, LDN**

It has been a busy year in the House of Delegates this year! Gone are the days when the house met twice a year in the Fall and in the Spring! We have focused on making the House of Delegates more relative and productive to the profession. Virtual meetings have allowed much more frequent "contact" and the ability to move issues forward in a timelier manner.

Over the last few years, each HOD member has been assigned to a "POD" (Power of Delegate Support) group. The PODS are smaller work groups, typically 9-10 members, that usually meet on a monthly basis to discuss current issues. Members are made up of a mix of delegate types, and new or returning delegates. The purpose of the POD program is to provide all delegates with a support group of fellow delegates who are available to answer questions, provide direction, and offer a social contact.

The HOD met in the fall, winter, and spring of this past year. In addition to these meetings, town hall meetings and updates have been provided frequently throughout the year.

The year started off with the proposal for an Academy bylaws change which would result in a transition of governance of the academy eliminating the existence of the House of Delegates. This became a hotly contested issue and was eventually voted down.

The fall 2021 HOD meeting focused on transformation of the HOD to best meet the future needs of Academy members and the profession. A task force has been convened and has been hard at work this year on transforming the House of Delegates - addressing how the house will function in the future.

In January 2022 the HOD meeting focused on Collaborative Ready Practice: "How do we develop collaborative-ready practitioners across all practice areas?" A motion is currently before the house on the actions recommended to address this issue.

The Spring meeting which was held in the end of April addressed two separate issues:

- **COVID-19:** What are the short and long-term implications of COVID-19 on nutrition and dietetics practitioners, nutrition and dietetics practice, and the profession? What actions might the Academy take to effectively address them?
- **Volunteerism:** How might the Academy evolve its member leadership model to meet the needs of current and future volunteers to ensure a robust pool of engaged leaders?

Each year, we as Delegates send out surveys to our constituents. At the close of the survey period, we receive a summary of all survey responses. We also can view those responses that are from our constituents. The responses received from constituents provide much appreciated and helpful guidance in representing the interests of our practice group. I would encourage all members to try to respond to these surveys. They are typically brief, and your input is valuable!

In closing, as I am finishing up my second term as your representative to the House of Delegates, I want to thank our members for the opportunity to represent you these past six years! It has been an awesome opportunity that I am grateful to have had. I wish Cora Martin well, as she will be stepping into this role, and I know she will be a fantastic representative for DHCC!

# Correctional Dietitian Spotlight: Michelle Tatman, RDN, LDN

Jessie Silverman, MSPH, RD – Corrections Sub-Unit Chair

Michelle Tatman, RDN, LDN

This year, each issue of the newsletter has featured a correctional dietitian to shed light on this little-known area of our profession. This time, I interviewed Michelle Tatman, who is currently Dietary Operations Manager for the Ohio Department of Rehabilitation and Correction. This interview has been edited for length and clarity.

**JS: Tell me about your career path and how you got to where you are today.**

**MT:** I completed my undergraduate at the Ohio State University in Columbus and my dietetic internship at the Christ Hospital in Cincinnati. During my internship, I had a rotation with a contract nutrition company. After my internship, I told the company to give me a call if they had any jobs come up. Lo and behold, they called and told me they had a temporary contract with the Ohio prison system and asked if I was interested. I said yes. Then I was hired on as a permanent contractor, and I provided clinical nutrition services to the prison's medical facilities. Eventually I got promoted to the role that I'm currently in as the Dietary Operations Manager for the Ohio Department of Rehabilitation and Corrections. We're the largest state agency in Ohio with about 12,000 employees and 44,000 incarcerated people across 28 facilities. I am the only state-employed dietitian, but we have several contracted dietitians and diet techs in the facilities whom I work with very closely. I've been in this job for about eight years. I started in corrections because I needed a job, but I've continued to grow in this field because I have a passion for working with this underserved population.

**JS: What are you responsible for and what does a typical day of work look like for you?**

**MT:** Every day is different, and that's one of the things that I love about my job. I typically am in the facilities two to three days a week and have office days the remaining time. I'll complete both announced and unannounced audits of facility food services as well as clinical nutrition staff. I collaborate with our contracted food service provider on developing the master menus and our religious services administrator to develop our religious accommodation menus. Every single item that we put on the menu, we taste test first. We get feedback from staff from an operational perspective and from the incarcerated individuals on palatability.

On a day-to-day basis, I'm in our electronic medical record, monitoring nutrition services, making sure there are no delays in care. If an incarcerated individual's family member, or an outside agency, or anybody contacts our department with any sort of nutrition-related item, I'll respond to it on behalf of our agency. I do a lot of policy and procedure development, both developing them and keeping them up to date. I'll provide training for medical, nutrition, and food service staff. Finally, I monitor menu substitutions across all 28 facilities.

**JS: Are there any special projects you are currently working on that you would like to highlight?**

**MT:** The special projects are the best part of my job. Currently what I'm working on is developing a statewide recipe contest for our incarcerated population. The plan is to publish a cookbook with all the submitted recipes. We're trying to feature healthy recipes that can be prepared in the correctional environment utilizing commissary foods, so I think that'll be a lot of fun. Another project I'm working on is in collaboration with our private food service provider, and that's a dietetic internship. It's entirely corrections-based and the first intern is going to start in August of 2022.

One of the projects I'm most proud of is the work I've done with our Ohio Reformatory for Women (ORW) Achieving Baby Cares Success Program. The program allows incarcerated mothers who are pregnant at the time of incarceration to keep their babies with them in a specialized unit while they serve their sentence. There are stringent criteria for this program, but if they do qualify, the mothers and babies are able to stay together and they both leave together. In 2016 I was brought in, because at that time legislation changed the maximum age of children in the program from 18 months to three years. Since the nutritional needs of an 18-month-old or a baby is different from a three year-old, we had to review and adjust all of the services we provide to the children. We put together a comprehensive menu guide; all of the recipes we developed incorporated foods they could get through WIC (all of the children in the program are enrolled in WIC) and could be made with the minimal cooking equipment available in the nursery.

**JS: What are the most rewarding parts of your job? The most challenging?**

**MT:** One of the rewarding parts of my job is that you use everything you learned in school—clinical, community, public health, food service, all of it. And every single health condition you have in the community, you also have in prison, and then some. I re-

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## Correctional Dietitian Spotlight: Michelle Tatman, RDN, LDN

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ally enjoy the diversity of work and the freedom and creativity I have in my job. I also know my work has a direct impact on the daily lives of the incarcerated individuals within our care. I take pride in providing quality, nutritious, and filling meals.

It's also very challenging, because everything that we do, must fit within the correctional environment. I learned very early on that we cannot serve grapes or raisins, which can easily be made into homemade wine. That's a very simple example, but there are a lot of barriers in this area of work. Another challenging aspect of my job testifying on behalf of our agency, sometimes in federal court in front of a judge and jury, and that can be very nerve-wracking.

**JS: What advice would you have for RDs or students who are interested in the correctional setting?**

**MT:** Just know that you must know a little bit about everything. Also, don't be afraid to take a job just because it might not be the perfect fit for you right now because it could lead to something that is the perfect fit. Corrections is not for everybody, and that's ok. I would recommend volunteering at a local facility. Get inside the facility and see how you feel, because not everybody is going to feel comfortable within a prison environment. Some of the best advice that I received was to do it afraid. Even if you do not feel totally comfortable taking on a challenge, do it anyway, because that's what makes you grow.

# Celebrating our 50-year Members!

## DHCC celebrates our 2021-22 members with 50 years of Academy membership:

Salma M. Alikhan, RD
Mana Brown, RD
Nancy M. Chopchitz, RD, LDN
Ann M. Ditzler, MBA, MS, RD, LD
Gail C. Frank, DRPH, RD, CHES
Charlette R. Gallagher-Allred, PhD, LDN
Grace A. Gehlhausenm, MA, RD, LDN
Carol J. Gilmore, MS, RD, LD, FADA, FAND
Barbara J. King, LD
Janette L. Kochis, RDN, LD
Guylene Maurer
Lucy M. McProud, PhD, RD
Marsha E. Piacun, MBA, RD
Karen M. Ritchie, MS, BS, RD
Margaret E. Russell, RD


Learn more about one of our members, Gail C. Frank, DrPH, MPH, RD, CHES, as she shares her story. Dr. Frank is a Professor of Nutrition & Dietetic Internship Director at California State University Long Beach.

During my ongoing career, my membership in the DHCC DPG has provided continuing education especially on timely issues and membership has given me contact with many colleagues in organizations that I link with during my research and community involvement. My professional life would have been limited if I had not had the knowledge gained and friendships made by DPG involvement.

It all began during my Dietetic Internship at Touro Infirmary, New Orleans in 1971, when I was exposed to public health and community nutrition training at the Louisiana State Health Department under the direction of Judith Sylvester, RD. I spent training time with 'Home Health of Louisiana' and accompanied nurses on home visits. This seeded my interest in pursuing an MPH degree in Public Health Nutrition at Tulane University which I began about 2 weeks after I completed my Internship. My master's thesis linked me with the Nutrition Section of the Florida Department of Health under the supervision of Mildred Kaufman (author of the first textbook in Public Health Nutrition). Years later Mildred recommended me as author of the second textbook, published in a 1st and 2nd edition: ***Community Nutrition – Applying Epidemiology to Contemporary Practice.*** Chapters reflect essential role of healthcare facilities and staff in the prevention and treatment of disease across the lifecycle.

After focusing on cardiovascular programs in Florida, I stepped into my first position which spanned 16 years at LSU Medical Center where I designed and implemented the dietary studies of the Bogalusa Heart Study. In this capacity I linked with several local health facilities in Louisiana and joined several dietetic practice groups connecting me with colleagues in many health care communities. In addition, I began consulting to two nursing homes in nutrition and was invited to speak to the Advisory Board

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## Celebrating our 50-year Members!

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for the then 'Gerontological Nutrition DPG' when it met in New Orleans. This led to working with the Louisiana Council on Aging and servicing Plaquemines Parish for over 5 years. I became actively involved with the New Orleans Chapter of the American Diabetes Association, elected to Vice-President, but moving to California the year before I took office. Success in my career meant having a positive working relationship with multiple health organization.

Jumping forward to 1989, I moved my family to California and as a Professor at California State University Long Beach, I began the Dietetic Internship providing school nutrition as a rotation in 1991. I became involved with the then American Association of School Nutrition and the Academy's School Nutrition DPG receiving their first grant of $3,000 to incorporate training of Interns into school nutrition in 1991. This led to working with local schools, school nurses and their associations, in addition to working with RDNs who directed school nutrition programs and with pediatricians and school nurses in the Orange County Chapter of the Academy of Pediatrics (writing two articles for their state publication about the role of nutrition).

During my ongoing 33 years as a Professor at California State University Long Beach, I was active in the Long Beach chapters of the American Diabetes Association, the American Cancer Society (ACS) and the American Heart Association (AHA) serving on the AHA Board and was Chairman of the Board of AHA in the '90's. ***(See photo of Interns discussing food-related risks for colorectal cancer at a health fair planned by the ACS.)*** These are vital healthcare non-profit organizations open to RD involvement.

My most recent outreach into community health facilities involved a 5-year USDA community-based participatory research study that I have co-directed. With our development and implementation of an educational intervention for Latino families with children at risk for obesity, ***'Sanos y Fuertes' (2011-2016),*** continuous collaboration with health care communities (clinics, hospitals, private practices in the greater Orange and LA Counties) for recruitment and intervention has been essential while incorporating the training of the CSULB Dietetic Interns into these facilities.

Thank you for asking me to share my perspective on the role of DHCC membership in my 50+ - year career. It should be evident that my career would have been limited had I not partnered my DPG membership with the realities I was living.

# Dietetics in Health Care Communities (DHCC) Executive Committee 2021-2022

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