



PLENARY ABSTRACTS

Presented Friday May 28, 2004

Session Title: **Improving Patients' Satisfaction for Meals – Mission Possible.**
Speakers: **Mary Easaw-John, Mee Ling Thong**

Learning Objectives:

After the completion of this session, the audience will be able to:

1. Conduct customer (patient) survey regularly although it may be tedious.
2. Listen to the customers' needs and expectations.
3. Identify areas of concern and take appropriate actions in order to meet the standards of customers' requirement.
4. Use patients' satisfaction ratings to justify to the management, where required resources are critical to improve food services.

I. Introduction:

A hospital stay can generally be an anxious and fearful experience and under such circumstances, the only thing that the patient can look forward to, is the meal to break the monotony. Nourishing and tasty meals can help to prevent malnutrition among our patients. Presentation, appearance and taste of a meal are important in stimulating appetite. Portion size, meal temperature and using containers that are easy to open are other important considerations. However, in mass catering this is truly a challenge.

II. How did we arise to this challenge?

Food survey forms are important tools to assess what our patients' expect. Questionnaires were drawn up in order to survey our patients' expectation in meals. One to one interviews were conducted to identify areas requiring remedial actions and comply with patient's requirement and suggestions.

III. Findings from the food surveys

Analyses of the data from the questionnaires indicated that tasty meals, sufficient quantity, good presentation, accuracy in ordering therapeutic diet, choices menu and meals served warm were important attributes to improve ratings in satisfaction levels of customers' food services offered by the dietetics department of the National Heart Institute.

IV. How did we go about this change to meet patients' expectation?

1. **Taste** - All new recipes were test run and standardized to serve 50 to 100 paxs and tasted by other Department Managers to give constructive comments.
2. **Sufficient quantity** - Most of the respondents felt the breakfast portion was insufficient and changes were carried.
3. **Presentation** - The presentation of meal was inconsistent due to the decentralized system where the food was portioned at the kitchen in bulk and then sent to the

- wards via food trolleys and individually portioned out by the ward staff. With the introduction of the centralized system in 1998, food presentation score improved.
4. **Choice Menus** - A wider variety of meals including vegetarian and one meal dish were added to the choice menus.
 5. **Food served warm** – After centralization of meals, our patients' food surveys reported 5% of the meals were served cold, compared to the 12% earlier.

V. How did we challenge the foodservice staff?

1. Organizational Models – clear and simple communication

The catering executive reports to the chief dietitian, who manages the catering services. This is an advantage for building open communication and development of teamwork with opportunities to learn from one another. When faced with meal problems, they are easily addressed and solved by the team.

2. Recipes standardization - practice makes cooking perfect

All cooks were encouraged to search and test-run recipes. The modified recipes with healthy versions were then prepared and sampled.

3. Productivity and incentive driven

We used productivity as the ratio of input to output and quantified in terms of employee skills, levels and time required for work. When targets were met, the staff was rewarded in monetary forms.

VI. How did we further improve our services?

1. New format of questionnaire devised

As an ongoing improvement to our services, we devised a new format to look into attributes important to our patients such as to stimulate poor appetite and build up their nutritional status.

2. Develop good teamwork and network with ward staff.

These accomplishments were made possible because there was a positive interface and development of good relationship and teamwork that existed between the foodservice staff, the clinical dietitians and the ward staff. Perseverance and determination to work smart within our constraints put our team on the benchmark for other hospitals to follow our example.

VII. Conclusion

We found the importance in conducting patient satisfaction surveys and listening to our patients' needs and expectations, as a means to improve the ratings. Our findings in 1996 rated food services at a range of 65.6% to 74.4% on each of the six attributes; on taste, sufficient in quantity, presentation, accuracy in ordering therapeutic diet, choice menus and meals served warm. Surveys carried out in late 2002 showed an improved rating from 82.0% to 90.4%. This was an average increase of 16.4% to 17.6% on each attribute.

Surveys carried out since 1996 to the year 2002, has shown an increase in our ratings on the satisfaction levels in attributes deemed important to customers service in all areas of the hospital including dietetics. In the year 2000, The National Heart Institute was named the best organization in providing customer service by AD-MACS Corporate (Malaysia) Pte. Ltd. in the first nationwide survey on 40 selected organizations in 14 service industries. We scored 80.2 points against the average level of customer satisfaction of 67.8, which is now taken as the national benchmark.

Session Title: A Knowing Organization? Equality, Diversity, and Dietetics

Speakers: **Lucy Aphramor**

What would have to happen to stem the 'obesity epidemic'? Moving beyond traditional frameworks, this workshop will explore an inter-disciplinary, health promotive approach to re-visioning weight management; an approach which recognises, and responds to, diversities.

The workshop starts with an introduction to schema analysis, looking at the (often inappropriate) assumptions which underpin current dietetic practice. Applying this analysis to a case study, we will bring to light scientific, philosophical and therapeutic issues which are typically obscured by mainstream care pathways for overweight adults.

Expanding the insights gained from the case study, and illustrating my arguments using examples drawn mainly from contemporary British dietetics, I will demonstrate how an awareness of equality and inclusion is central to good practice. If it is to be a real player in tackling 'obesity', the global dietetic community must engage with other disciplines to address issues such as:

- **health risks of discrimination** - why 'closets are a health hazard'; the biochemistry of stress, racism and abdominal adiposity; size awareness
- **institutional invisibility in dietetics** – ethical imperatives; personal issues and professional ramifications; the way forward
- **the stages of change for dietetics** – where is our profession at?; limitations of reflective practice; developing research and student training agendas that encompass current findings from the new sciences
- **empowerment vs self-care** - a fresh look at promoting sustainable health behaviour change; when is 'obesity' a disability issue?
- **the art of dietetics** – a case for interdisciplinary learning?; narrative approaches; critical holism; media influences
- **social justice** – the long term sequelae of an unexamined weight management framework; are we mainstreaming indifference?; using socioeconomic evidence in dietetic/clinical practice guidelines
- **improving outcomes** – how do we measure up as a profession?; ideas to promote a paradigm shift; revisiting the biopsychosocial model; health at any size - enhancing salutogenic therapeutic alliances

Questioning organizational knowledge creation, this session will raise ethical and therapeutic issues with implications for policy guidelines, professional training programs, research, corporate partnerships, evaluation frameworks and professional credibility. In short, it will seed ideas for a 'critical dietetics' movement: a movement dedicated to critical thinking, hopeful realism, equity and activism.

Session Title: Poverty, Food Insecurity, and Obesity: A Paradox
Speakers: Marilyn S. Townsend, Manuel Pena, Margaret Haase

**Center for Food and Justice
Urban and Environmental Policy Institute
Occidental College
Los Angeles, California**

Local Food Environments: Strategies for Change

- I. Changing local food environments: opportunities and needs
 - A. Child nutrition programs and fresh food access: school meals, after school snack programs, summer feeding programs
 - B. Outlets for affordable quality food in neighborhoods: grocery stores and markets, farmers markets, community gardens
- II. Strategies for creating positive environmental change
 - A. Engaging and empowering local communities
 - 1. Community and school food assessments in low-income neighborhoods in Los Angeles: Project CAFÉ (Community Action for Food Environments)
 - a) Weaving food access issues into agendas of allied organizations
 - (1) Promotora (Health Promoter) programs
 - (2) Youth development programs
 - b) Engaging communities through community and school food assessments and collaborative development of action strategies
 - c) Incorporating community perspectives into research agendas
 - d) Evaluating community organizing as an environmental and behavioral change strategy
 - 2. Organizing for changes in school food policies - Healthy School Food Coalition
 - a) Approach to organizing
 - b) Recent policies implemented in LAUSD
 - c) Impacts of policies on the school food environment
 - B. Other regional and statewide coalitions working for policy changes
 - 1. Los Angeles Food Justice Network
 - 2. California Food and Justice Coalition
 - C. Farm to school programs: increasing access to health promoting foods and increasing school meal participation
 - 1. Scope of farm to school in California and the US
 - 2. Different models currently operating

3. Impacts:
 - a) Fiscal analysis of food services
 - b) Changes in fruit and vegetable consumption among children in participating schools
 - c) Changes in participation in school meal programs
- III. Challenges to a community-driven approach to changing local food environments
 - A. Coalition building
 - B. Defining issues and achieving consensus
 - C. Required skill sets: community and coalition organizing versus traditional programming and research

Session Title: Special Olympics Nutrition Programs for Healthy Athletes
Speakers: Alice Lenihan, Joan E. Medlen, Hilary Colgan

Nutrition Promotion at an International Event

Hilary Colgan, MSc. M.I.N.D.I.

Special Olympics World Summer Games were held in Dublin, Ireland in June 2003. Over 7,000 athletes and 3,000 coaches, representing 166 international delegations attended the Games with many of these individuals participating in the Health Promotion Nutrition Programme. This session will include a discussion on the role that the Irish Nutrition and Dietetic Institute played in organising this international programme and provide a closer overview of the nutrition promotion component of the programme. In addition to the nutrition assessment screening there were several nutrition education initiatives which will be outlined. These include interactive nutrition related games, food demonstration and computer - assisted nutrition education tools. Advice on how to coordinate activities for an international event will be presented. The practicalities of venue design, setup and management will be discussed in detail. The many challenges associated with volunteer recruitment, both local and international volunteers, will also be highlighted. Experiences from the Special Olympics 2003 World Summer Games held in Dublin Ireland will be shared. Lessons learnt will be discussed.

Session Title: Special Olympics Nutrition Programs for Healthy Athletes
Speakers: Alice Lenihan, Joan E. Medlen, Hilary Colgan

Healthy Athletes: Health Promotion Creating a Healthy Promotion Program in Special Olympics

1. Special Olympics Overview
2. Healthy Athletes Program
 - a. Clinical Screenings
 - b. Health Promotion Program components
 - i. Smoking Cessation
 - ii. Sun Safety
 - iii. Nutrition
3. Nutrition Programming
 - a. Issues of individuals with intellectual disabilities
 - b. Global nutrition issues
 - c. Nutrition assessment indices
 - i. Height-weight-BMI
 - ii. Bone density measurement
 - iii. Modified food frequency
4. Data Analysis
 - a. World Summer Games 2003
 - b. US State's games
5. Global Growth
 - a. Latin America, Caribbean Region, Asia, Europe, US
 - b. Dietitian's role
 - c. Recruitment
 - d. Resources
6. Questions

Session Title: Special Olympics Nutrition Programs for Healthy Athletes
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Designing Nutrition Education for People with Intellectual Disabilities

- 1. Introduction**
 - a. Choose your learning outcomes
 - b. Scaffold the instruction
- 2. Learning Methods**
 - a. Auditory
 - b. Visual
 - c. Hands-on learning
- 3. Design**
 - a. Keep it Simple
 - b. Choose fonts and layouts carefully
 - c. Make it FUN!!
- 4. Resources**

Questions

Session Title: **Cultivating Communities of Practice (Frances Fisher Lecture)**
Speakers: **Etienne Wenger, PhD**

Knowledge is a critical asset for the success of today's organizations, in the private, public, and non-profit sectors. Associations too need to focus more and more on the knowledge their members need in order to be successful as professionals. Traditional approaches have included courses and journals. These learning formats still have their role. But in today's fast-moving environment, increasing number of organizations in all sectors are recognizing that the best way to foster learning is to connect practitioners so they can learn directly from each other and develop their individual and collective expertise. These organizations have found that communities of practice are ideally suited for the task because they allow practitioners to engage in shared learning and manage their own knowledge. And through the experience of these pioneering organizations, we have learned a lot about the role these communities can play and what it takes to cultivate them.

The purpose of this session is to introduce the concept of communities of practice as a key element of an organization's knowledge or learning strategy. Through stories and examples, we will explore the value that these communities can create in organizations of various kinds. Finally, we will discuss some key insights and principles about the art of cultivating communities of practice.

During the plenary session, the audience will gain a better understanding of the following questions:

- What are communities of practice?
- What are their fundamental elements?
- How do they differ from other familiar organizational structures?
- What purpose do these communities fulfill in organizations?
- Why are so many leading organizations in the private and public sectors focusing on them today?
- Why should employees care?
- What are the main stages of development communities of practice go through and what does it takes to nurture their development?
- What are some critical success factors in cultivating them?

During the practice session, we will work together on the following questions:

- What are the learning issues we face?
- What role could communities of practice play in moving forward?
- What are the knowledge domains that communities could address?
- What will it take to get started?

The format for the practice session will be very interactive. We will engage in conversations and will work together on the issues faced by the organization, with the hope that this will be a first step toward a sustained initiative.

**Session Title: Regionalization of Healthcare Nutrition & Food Services:
Centralized Meal Assembly and Clinical Practice
Standardization-A Canadian Experience**

Speakers: Paul J. Brewer, Kathleen Richardson, Joanne Schweitzer

Rationalization and consolidation of healthcare services has become a reality in the past decade. This reality has not escaped the field of Dietetics and Dietitians across the globe are challenged to respond to the demands within their work environment. This session describes the evolution of a regional approach to coordinating Nutrition & Food Services across the healthcare continuum in Winnipeg, Manitoba, Canada. Although there are many opportunities and approaches to pursue consolidation, Winnipeg is unique in its shared food service system for providing meals to hospital patients and long-term care residents. Implementing a shared food service system disrupted an evolution of institutional independence and dietetics steeped in tradition.

The role of Allied Health Care professionals is continually evolving in healthcare systems worldwide. Looking at Canadian benchmarks the Winnipeg healthcare system has many opportunities to improve services. To achieve Canadian benchmarks the role of Allied Health Professionals, including the role of Dietitians, is being reviewed. There is a definite tension between traditionally institutional based resources and public access to these services. From a public health model the role and function of Dietitians needs to be addressed to meet needs across the continuum of care. Within a fixed financial resource base the challenge is how to implement a truly regional professional service with regional standards of practice that encompasses the entire continuum of care. Difficult decisions need to be made on how to redesign and align valuable resources from an institutional to a public health setting. The Winnipeg Regional Health Authority experience and dilemmas in restructuring professional Dietetic services will be shared in this session.

Winnipeg Regional Health Authority, Nutrition and Food Services is one of the largest shared food service systems in North America. There has been an increased popularity of centralized food services in national and international countries, due to cost-savings and labour efficiencies. This session will enhance ICDA members' knowledge of Winnipeg's healthcare Nutrition & Food service system and the opportunities it presents to establish standardization and best-practice across the continuum of care. The presenters will provide a Canadian perspective by sharing experiences; key lessons learned in building a common ground and identify areas of risk for nutritional professionals contemplating a centralized approach to managing professional dietetic and meal services.

The audience will be exposed to factors influencing a fully outsourced food production, preassembled meals, shared food services system including: patient/ resident satisfaction, advantages and challenges of shared food services, how to manage change through centralization, impact on food quality and high volume meal assembly, repetitive strain injury, tray accuracy, the ability to personalize client requests, cost effectiveness, HACCP for meal transportation, sourcing items for clinically challenging diets, the role of expert review group in the standardization of clinical nutritional practice, ability to customize food selections, clinical accuracy and responsiveness to dietitians' needs.

The Winnipeg Regional Health Authority's Nutrition and Food Services Program is one of Winnipeg's success stories; however, the road to success was a rocky one. Some of the bumps along the way included: labour unrest, political activism, negative public opinion, media sensationalism, management resistance, Provincial Auditor Investigation, and a governmental

mandated Operational Review, throughout the system has proved to be resilient to the strongest critics.

Session Title: Nutrition Education as Community Development: Building Community Food Security

Speakers: Kimberly R. Chung, Michael W. Hamm, Barbara Mutch

Session Overview and Goals

The goals of this session are to introduce dietitians to the defining characteristics, principles, and values of the community food security (CFS) movement and to provide examples of how dietitians might conduct nutrition education within a CFS context. Food-based responses are seen as part of (rather than the sole focus of) initiatives that seek to achieve food security for all while promoting community self-reliance, social justice and a sustainable food system. Furthermore, they are rooted in community-led initiatives that build common ground, often with partners uncommon to the field of dietetics. This approach involves partnering with people outside of the food and nutrition world and re-conceiving our roles as ‘nutrition educators’ and ‘health professionals.’ It also involves connecting to personally-held values and seeking ways to act on them in our professional and personal lives.

Session Outline

1. Overview (Hamm & Chung)

- What is community food security?
 - Essential components
 - Principles and values of the CFS movement
 - Building common ground
 - Brief examples of how it is practiced
- How does community development fit into community food security?
- Why should nutrition educators be involved in CFS projects?

2. Case Examples

2.1. Case Example 1: Improving Gleaning Activities at University Farms (Chung)

- Example of a CFS project
- Seeks to educate farming community (specifically University-based farms) on overcoming obstacles to donating gleaned produce to local emergency food network
- Role of partnerships
- Role of personal history, values in determining projects of interest
- Need to cross disciplinary boundaries and take risks

2.2 Case Example 2: Youth Farmstand Project (Hamm)

- Example of CFS project
- Creates links between farmers and urban communities while increasing access to fresh fruits and vegetables
- Creates small business experience for youth
- Variety of partners outside of nutrition and dietetics key to success
- Necessity of maintaining sensitivity to needs of various partners such that all could be successful

2.3. Case Example 3: The Saginaw Family Child Care Network and the Community Food System Network (Mutch)

- The role of nutrition-based education as part of a larger strategy to tackle the underlying causes of food insecurity and poverty.
- The role of partnerships with those *outside of nutrition and dietetics* to achieve goals which address the root causes of food insecurity.
- The importance of partnerships that are based on common values (CFS values).
- The need to be pioneering within one's home organization and to "go places that dietitians usually don't go"

3. Small Group Discussions (Mutch, Chung, & Hamm)

- Do the CFS values and principles resonate with me?
- Is this the kind of work that dietitians should do?
- How can I connect my own professional work as a dietitian to CFS work?
- Who is empowered by this process?
- Who is threatened by this process ?
- What partnerships are needed (within and outside my own organization)
- Can I connect it to my personal work (outside of work)?

2. Reflections and Feedback to the Large Group (Mutch, Chung & Hamm)

- What have we learned collectively?
- Are there things we can act on now personally or professionally?
- What things about CFS approaches are inspiring or troubling?

Session Title: Coaching to Accelerate Effectiveness

Speakers: **Carollyne Conlinn, Zoey Ryan**

Learning Objectives:

- Understand how coaching relates to dietetic practice.
- Experience practical applications of coaching in dietetics

Introduction

- Setting context
- Real life stories

Opening Partner Exercise

- What do you already know about coaching?
- What do you want to get from this session?

The Context for Coaching in Dietetic Practice

- What is coaching as distinct from counseling or consulting?
- Why coaching? Why now?
- Real life stories

Coaching Demo & Debrief

- Listen for the difference between what you hear and how you have learned to address the issue.

What is Excelerator Coaching?

- A framework that distills the best of professional coaching for use by subject matter experts like dietitians.
- Clients are: searching, stuck, soaring.
- Corresponding Excelerator Principles: enlighten, empower, excel.

Real Life Applications to Dietetic Practice: The Excelerator Coaching Game

- clinical
- administrative
- community
- private
- education

Play the game & de-brief

Review and Wrap-Up

- How can coaching accelerate your effectiveness?

Session Title: **The Nutrition Component of Substance Abuse Programs**
Speakers: **Lena Darrell, Jocelyn Rodrigues**

Substance abuse encompasses addictions to alcohol, tobacco and illicit drugs. Illicit drugs generally fall into three categories: Opiates (e.g. heroin), Stimulants (e.g. methamphetamine, cocaine), and cannabinoids (e.g. marijuana). From a nutritional perspective, illicit drugs and alcohol have a direct and negative impact on nutrition status during drug addiction and into the recovery process. While there are underweight issues in conjunction to insufficient nourishment, on the opposite spectrum, there are also obesity and eating disorder issues. The negative effects of illicit drugs and alcohol on nutritional status will be discussed for each drug category. A brief understanding of the therapeutic community model of substance abuse treatment will be presented as a model that includes nutritional services.

Given the high prevalence of infectious diseases like HIV/AIDS and Hepatitis C in the substance abuse population, these disease states will also be discussed as pertinent to the management of the abuser's nutritional needs. UNAIDS reports that HIV/AIDS infects 34-46 million people in the world. According to WHO, Hepatitis C (HCV) infects 170-240 million worldwide. While global figures are difficult to derive, it is estimated that 40% or more of all those infected with HIV are also co-infected with HCV. In the injection drug use population, the HIV/HCV co-infection rate is double, at 60% to 96% co-infection. While injection drug use is a major mode of HIV and HCV transmission, our research at Daytop has found that HIV-positive clients who report never using drugs intravenously also contract HCV. Hence, 25% or one in four clients at Daytop, receiving drug abuse treatment were sero-positive for HCV, compared to less than 5% who were sero-positive for HIV. Forty percent (40%) of drug abusers who were HIV-positive were co-infected with HCV at Daytop; this statistic mirrors the global HIV/HCV co-infection rate of 40%.

Dietitians should be aware that persons who receive medical nutritional care for drug abuse recovery, HIV/AIDS, or hepatitis may have a combination or all three conditions due to their high correlation as co-morbidities. In making a nutritional evaluation of these clients, there are the following considerations:

1. Physical exam and anthropometrics
2. Medical history and co-morbidities or multiple diagnoses
3. Social history (including available resources in the community)
4. Adjusted Basal Energy Expenditure rate and diet determination
5. Availability and use of pharmacological products
6. Determination of achievable goals

Socio-medical activism brought about a greater partnership between (1) the patient and doctor, (2) doctor and the allied health, forming a multi-disciplinary health team, and (3) the multi-disciplinary team and the patient. This paradigm extended to the creation of a supportive community with governmental resources allocated for the management of substance abuse, HIV/AIDS and its co-morbidities, which include Hepatitis C. This paradigm helps the medical community to address the socio-psycho-medico-nutritional

needs of chronic disease management. Dietitians therefore need to play an equal and active role in ensuring that clients receive the necessary nourishment and access to food resources and education in the community.

Building nutritional resources and education in the community requires understanding culture issues as well as health. This means social marketing of key nutritional concepts to the gatekeepers and clients in a format that utilizes as many sensory channels as possible. Dietitians should also be familiar with Prochaska et al's Transtheoretical Model of Change.

Nutrition counseling in nourishing the individual drug abuser is significant, but will not be adequate to sustain the education & nourishment, without the social support which clients need to move along a continuum of adopting a new behavior. While the dissemination of information through the media, posters, and television can increase the knowledge and attitude of diseases like HIV/HCV among target audiences, this strategy has had little affect on changing eating patterns. Changing behavior and providing social support rather than giving information must be the clear intention of a program if nutrition education is to be effective. In addition, people's concept and beliefs about feeding, health and growth are rooted in their traditions and language. Therefore, the conceptual framework for nutrition education needs to have meaning in each cultural context. The authors will share the success of Nutrition Group Education for HIV/HCV-positive recovering drug abusers at Daytop as an effective method to nourish, educate, and provide social support for substance abusers. The Transtheoretical of Change Model helps dietitians to understand and appreciate that clients are at different stages of change in adopting a new lifestyle. Behavior modification examines the influence of external environmental factors on an individual's behaviors and uses learning principles to understand and change undesirable behaviors. The following topics will be presented and discussed to provide dietitians with the tools to initiate similar programs for substance abusers:

1. Group Dynamics
2. Behavior Modification
3. Process of Change
4. Changing Eating Behaviors
5. Antecedents: Positive Stimuli/Cues
6. Behavior Response to group learning
7. Social Support