



# CMS 2012 Tri-Regional PACE CONFERENCE

Programs of All-Inclusive Care for the Elderly

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## TRANSCRIPT

### Management of Nutritional Care with Chronic Care Diseases

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Good morning. I'm going to go ahead and get started because I do have quite a number of slides, as you see in your notebook. I do work with Kim, who gave a presentation a little bit earlier so you already saw the \INAUDIBLE\ PACE that I work at and it is in Virginia. And looking at this topic, it was like, whoo, that's a really big, broad topic. What am I going to present this morning? And so we are very goal orientated, and so my goal this morning was simply to give a pearl. And in giving a pearl, I thought of some of the goals to network and share information that is available on webinars, websites and printed information. Some with standards of care. I wanted to really promote interdisciplinary care and understanding of it because it takes a team. And quite often, as you all know, we overlap into other areas. And I wanted to define barriers to health in the elder PACE participant and provide some areas to sidestep that barrier.

Now, as I thought about this, I was actually reviewing my slides on the train coming up here, and I thought, this really – these aren't very good goals for a CMS presentation because they are not measurable. So I re-wrote my goal, and my goal is the attendee will learn one fact, technique or concept that she will find helpful as evidenced by utilization of this fact, technique or concept within 180 days. So if you learn something, send me an email of what you utilized to see if I met my goal.

My next slide, some of you will identify if you're a baby boomer. I'm a baby boomer. And I thought of this commercial from Virginia Slims, you've come a long way baby. And as I thought about what I was going to present, I thought how in my own mind I have changed the way I practice. When we're in school and dietetic internships we're looking at younger people, high acu – acuities to really make them wow. And I think geriatrics is quite different. And our approaches are different. And that is some of the things that I want to share with you today.

How do we practice in 2012? We practice – we do an evidence-based practice. And we really recognize that geriatrics is a specialty. And by saying that, you know, my questions are, do we really need tight glycemic control in relation to retinopathy, neuropathy, necropathy for someone who's a fall risk, and could break a hip, and land in the hospital? Another question, is a two gram sodium diet realistic for someone who cannot cook with a stove? For many of our participants who are living alone, we actually shut off the circuit breaker so they can't utilize their stove. We've a man who stores papers in his oven, and that's not real safe. So most of them have to rely on something that they could microwave or for some of our participants we have caregivers come in and microwave the food for them, and we don't want any knobs on the stove that they can turn on. Well, if you're a dietician and you know anything

about the two gram sodium diet, all the things that you microwave are really high in sodium. Your frozen dinners are, soups are. A lot of our people eat soups. Even your Healthy Choice soups are still around 500 milligrams. And then they also eat sandwiches. And sandwiches are deli meat, which are also high in sodium. And so, is it realistic to give them a two gram sodium diet?

And for someone with a fifth grade level of education, is a notebook of teaching material helpful? One of our participants had been in the hospital in April and May and we were reviewing her for coming into the PACE program in June. We do have electronic records and we are part of our hospital system, so I could look up the record on line, and I knew she had some teaching while she was in the hospital, and I would expect that because the whole reason she was in the hospital was for her diabetes that was very poorly controlled. So when I get started talking to her I say, did you get any teaching about diabetes when you were in the hospital? Well, yes. What did you do with the material? It's – it's at home. Well where is it? It's in a drawer. Have you looked at it since you came back from the hospital? No. And that is the great beauty of a PACE program, because this lady does not have a lot – a good cognitive function, and she can't learn a lot anyway, much less a bunch of material at one time. So the beauty of PACE is I can teach her one or two things, come back, reinforce it, and keep building on that.

One of the things that I wanted to do as my goals is to give you some good resources, and one is the Pioneer Network that I've given you a web address here. And what it is is I also, for over 30 years I've done work in long-term care, nursing home, rehab work. I continue to carry two of the accounts in addition to being a PACE dietician, so I have to keep up to date on what are our expectations there. And some key words in the past five years is culture change there. They want – CMS wants the staff at long-term care and rehab units to adapt to the participant, and not the participant adapt to the institution. And I'll give an example of that. My – my grandma was in a nursing home, and I went to visit her, and she said, well, I've got to be getting ready for bed, I have to get up at 5:30. I'm like, 5:30? Why do you have to get up at 5:30? Oh, Monday, Wednesday and Friday is my bath day and my bath is scheduled at 5:30. And I just thought, I hope I don't have to get up at 5:30 when I'm old for a bath. And that was a facility that did not really look at what is culture change. And what culture change does, it has some – it's a culture and some of the key words is they are dedicated to life affirming, satisfying, humane and meaningful life. And I think those same things are something that we in PACE want a culture for our participants. I would really encourage you to download this site. There are 66 pages of evidence-based practice here. And there's a lot of good information that the team can utilize as you go through some of the risks with our people. Because I know as a team sometimes we look, well, it's really not safe to take them on. We have one – one participant who has really, really bad dementia, and, yeah, it's not safe. But he's happy living in his own home. And he has functioned this long. And can we keep him functioning, because that is where his life is satisfying. That is where it is meaningful. He would – he would absolutely be so unhappy in a nursing home. And so we sort of – we have to balance everything as we work with our participants.

I'm going to use a few slides that I borrowed with permission from Dr. Driscoll (sp) and so the next few slides are from him. He did a one hour presentation for all of us at PACE on evidence-based practice. And I'm just sharing – I don't have time to go into the scientific evidence to be able to practice the way I am, but I wanted to share that I consider this as I do my work at PACE. And this was his little slide that I had to share with you. And here, what he did, he – he's – his whole seminar was around Barbie because he – this was given last year, and he said, did you know Barbie is 50 – 50 years ago Barbie came out? And if Barbie was 20 when she came out, she's now 70 years old. And so he went through all the different systems that had changed for Barbie as she aged, and one was blood. And I'm just going to use a few of his slides there. But, you know, this one is evidence-based practice. He went through Cochrane

Literature Review to find the strong studies that were high quality that support some of the facts by which he has taught the residency program in Lynchburg to treat as they treat their elderly people. And this slide is just about blood pressure, there's no evidence from randomized trials to support a strategy of lowering systolic blood pressure below 140.

This one is on blood sugar. And note it says both low and high mean hemoglobin A1Cs are associated with increased all cause mortality and cardiac events. So I get very concerned when I see hemoglobin A1Cs of 9 and 10. I get equally concerned when some of ours who are fall risks are like a 6.1. So we have to look at the total picture, and here he says that a U-shaped relationship of 7.5 is probably one of the safest areas.

With cholesterol, I like what he wrote on his slide. He said, Do I need to take this statin-thingy? Isn't that real professional? But he went on that the use of cholesterol-lowering drugs in people 70 or older should be limited to patients with very high cholesterol levels. And he explained this in relation to what it does to the liver, what it does with muscle weakness.

So, if we're not tightly controlling blood pressure and blood sugar, how do we practice? When I started with PACE, my – our center manager gave me the PACE guidelines, and that is really where I start out. And this is actually a copy I just put on my desk and I took a quick snapshot in preparing for this seminar, but if you note some of the things are highlighted. And I highlighted all the things that were pertinent to the RD. And one of the first things that I do when I write my goals is I look to see what Dr. Sellers has noted, if her goal for them in longevity, functional or palliative. We have an electronic record so I can look that up. And then I try to be very realistic. I really – I use the guidelines, but I have to consider the participant and I have to consider what their wishes were. We have an elderly gentleman who came in, and I, you know, I'm asking him, do you have a nutritional goal or something related to your health, and he said, I just want to come here and I want to eat a good meal like I did today. And that was his good. And food, and quality of food, and a liberalized diet was going to be very, very important to him because he enjoyed eating and at home he didn't have that full, hot meal like he did at PACE. So I had to keep in mind his wishes as we moved along.

So if we're – we're looking at liberalizing things, do we let this happen to Barbie. And this is, again, one of Dr. Driscoll's slides, that we let her sit in bed and get fat. And I want to say no, because I just look at that slide of her, and I'm thinking what's happening to her blood sugar. Her weight's going up. What does that have to do with her cardiovascular health? Look at those little knees with all that weight to support. Every pound of body weight is like four pounds on your knee when you walk, so she's going to need a knee replacement if she stays there. And then I look at her and I think she's not getting any flexibility, she's going to be a falls risk because she's in that bed all the day. She could develop a wound laying on her buttocks like that all day. And she's not going to have endurance as she has COPD because she's not getting up and moving at all. So no, we do not let this happen to Barbie.

This is another slide that I liked, and I just wanted to include it. It was a slide that I actually used – I did a weight presentation to our staff at the beginning of the year after all the holiday eating. But it really sends a message, you know, if we eat, sit, and watch TV, what's going to – what does the Grim Reaper represent?

So, we have goals to maintain or improve health. And as a dietician, when I started some of our \INAUDIBLE\ people, you know, the nurse would say, oh, you've got to get weight of them, and I, nope, no way, not a realistic goal. And often for my really obese people, my goal is simply that they don't gain

weight. And one of the reasons is, I have just said to her, you look at how many of our staff are overweight, and they're active. And I said, you look at our participants, they're inactive, food is one of the few pleasures. It is very difficult for them to lose weight. I actually come from a background with a lot of work in long-term care, and I know how many calories some of our tube feeders have lived years on. I have people maintaining on a thousand calories and they're not losing weight, on a tube feeding. And it – and metabolism and everything slows down, they're not using those muscles. So taking weight off, unless I have a – because we do individualize care – if I have someone extremely motivated, I can help them. But usually I just try to prevent weight gain.

I went to a seminar a couple of years ago in Washington, D.C. The whole seminar was on obesity, and it was all specialists in obesity and there was a lot of networking about obesity. And one of the things that a number of the seminars were on were on hormones in response to obesity. Incidentally, this seminar that probably had 500 people in, we had the little rating system, like we're doing here for evaluations, only they could show the results immediately on the screen. So we sat down, the very first thing they said, you had to hit one if you were in a normal BMI and two if your BMI was greater than 25. Twenty-five percent of professionals who were teaching weight control at the seminar had a BMI greater than 25%. And that just shows how hard it is to take off weight. And when they went into some of the pharmaceutical approaches that has – that they're trying – that they were trying to get FDA to approve, it has to do with hormones like Ritalin and Leptin, and they went through a lot of the response of your body, and in essence it's just very hard to take weight off and keep it off. And many people can take it off, but to keep it off, and it's because of these influence – the influence of these hormones and the signals that they send that we're hungry. So it's not a real realistic goal to get weight off.

Also it's difficult in our PACE population because they are not highly educated. They have a lack of movement. Many are in scooters, walkers. And they don't have the motivation of most of us in this room. And I even think, you know, right now I'm trying to take off a couple pounds before I go to the beach in June. But they're not going to the beach in June. They don't have that extra motivation that many of us have.

Some challenges to care, and as I look at this, this may not apply so much to some of the urban communities as us in Virginia. We have a Dollar Store, and all of our people love to go to the Dollar Store. That's just a big outing. Why do they like the Dollar Store? One thing is it has really cheap food. As I look at it as a dietician, it has very limited vegetables or fruit. And another thing for them is it's a small place to shop. And in Lynchburg our grocery stores – I mean a lot of people shop at Wal-Mart, and I once – I had a knee replacement a couple years ago, and when I first started driving I was – I drove home from work and I was going to run into Wal-Mart, and I realized I couldn't physically do it because it was just too long of a walk to get in there and across the store. And that's why our people like to go to the Dollar Store. Quick in. Small area. They can buy what they want. Now I realize that may be very different in some of the cities because you have a lot more smaller stores and you have the Trader Joe's, but those are also expensive. But this is what we face in Virginia.

We also face ministry boxes where people donate food, and they love to donate the high calorie white flour, white sugar things. We have a bakery that donates at a church, and they give breads, cakes, pies that are out of date, and one of my diabetic participants who has no impulse control loves to get food from this church, and he'll eat a whole loaf of bread or a whole cake at a time, so his son tells me.

Another challenge to care is healthy nutrition. We tell people shop the perimeter of a store. If you go around the perimeter, that's where your whole grains are, that's where your milks are, that's where

your meat is and that's where your fruit and vegetables. The perimeter of the store. It's a long ways to walk when you're not walking well.

Another challenge to care is limited dentition to chew. We do a Christmas buffet at our PACE every year where we invite the participants and family. I always make sure we have the raw vegetables and dip, but most of our participants don't choose them because they can't chew them. And that is what I tell people as far as modifying behavior. At buffets, fill your plate half up with vegetables, but they really can't.

There are cultural preferences. There is the inability to do scratch cooking because of the cognitive organization and everything that you have to do for scratch cooking. And it's almost scratch cooking that you need when you're going to get your diet really low in sodium, lower in fat, that type of thing. They have limited finances. One day I was doing a cooking class, so I ran into – I have a Wal-Mart I pass when I go to work, so I ran into Wal-Mart, go through the express lane, get my apple. A dollar for the apple. And it hit me. This is why one of our participants likes Little Debbie snack cakes. For a dollar he can have ten Little Debbie snack cakes or one apple. And we don't live in their world with the finances. And to try to understand that concept.

We have a decline in cognitive functioning, as I mentioned, and we have a lot of depression. And there is increased risk for depression, especially if you're diabetic. And some people if they're depressed go to overeating with comfort food, I would say a lot do. Some will not eat as much. But more will go towards comfort food.

So the challenge is great, and how do we do it? When I was preparing for this, to speak to you, I Googled mountain climbing to see what little pictures I could draw up for it, and I thought both of these really emphasize what we do. The hiker who's going up with the stick, she has AIDS to climb her mountain. She's also going by one step at a time. And that's what it takes as I teach health to the participants at PACE, one step at a time. Let's form one principle, let's make one simple dietary change, and then we'll take another step.

Another thing you see here is one mountain climber helping another. And I always let our participants know, sometimes when I counsel them, I just give them their numbers, and I explain what it is, and I say to them, if you'd like to lose some weight, I'll help you with this. Just let me know when you're ready. You know where I live. And I do have them come up to my desk. But I'm there to help them and to give them some literature and training and talk with them to achieve goals that they want.

I spend a fair amount of time in what I call marketing nutrition. When you think of commercials, why do they do all these commercials and pay all this money? It's called marketing. And I think it's just as essential as a dietician to market good nutrition to our participants. And so I – and it gives you group teaching, which is time saving. It gives an activity, which helps our activity department. And many of our participants love to learn. This actually – these are picture last year, I did a real focus for Go Red Day, which is by the American Heart Association. They were gracious enough to give all of our participants little red heart pins that we gave the last day. But each day during the week I did a half hour segment on something about cardiovascular health, a game or word search or something. And then we ended on Friday with Go Red Day, and we told all of our participants to wear red. And then I also asked staff to do a fashion show for me. And it took work on my part, because starting in January I had to keep talking it up and I kept – think about what you're going to wear on Go Red Day. And at first I had three people who were going to participate. But I kept talking, and it grew, and people started,

well, I have a red cocktail dress I could borrow from so and so. And different ones came up – our pharmacist came with a red sweater, and she brought her dog to work with a red tutu that she found at Goodwill. And here is Leslie, our pharmacist. She is taking her dog out for a walk in her red. And so I made up little stories for each one of them, and they told me what they were going to wear. I made up the story. And driving to work I'm writing down notes because this took some thinking on my part. But here you'll see one of our transportation drivers in the red prom dress. She had planned – it was originally her day off. She had planned to come in and her – she never wears makeup, never has her hair done. And she was going to curl her hair and do makeup and everything, and someone called out in transportation that day and she had to work. So we had to get her in as soon as she had a little bit of a break in transportation. She slipped on her dress, came through with no makeup and stuff, but they loved seeing her in a prom dress. The other person here is Dr. Sellers, our medical director. So we had a great time with this, and I was focusing on cardiovascular health. And I was marketing health. I'm speaking from a positive, rather than, don't do this, saying, let's do this. And one thing I really push is a lot of fruits and vegetables in the diet.

So in marketing nutrition I do a variety of things from cooking classes to tasting to National Nutrition Month to games that we play. In cooking classes last fall I made a butternut squash soup, and I chopped all these vegetables and I pureed it in front of them and it took over an hour. And what I do is I have other things along that I can talk about as things are cooking or so. I brought in all my knives. And I showed this is a French knife, and we use this for chopping. And this is a paring knife. And this is a peeling knife. And this is a knife for – for bread because they're learning. And they love that. They really love to learn. And so I'm cooking and I'm talking along the way. And that's how I do my cooking classes.

We do tasting. I did a – a sort of a cooking class and a tasting with oatmeal last month. I wanted something short and easy. We did instant oatmeal versus five minute oatmeal versus steel oats versus some cold cereals that were oatmeal. And I took them in and I taught them about a little bit, you know, this is fiber, and you have the instant ones, they have more salt. One of the principles I'm always teaching is the more processed it is, the more salt is in it. So whole foods have less sodium. So instead of using instant oatmeal, if you use a five-minute oatmeal it doesn't take long to cook, it is lower in sodium, and it's low cost. And so that's a lot how I teach. And then I also, because the steel cut oats are something new, I like to introduce them to new things, so they had some of the steel cut oats. I passed around some of the oatmeal squares that Quaker makes. I took Cheerios in. They tasted oats in different forms that day. And with the oatmeal squares, I just said, think about eating this as a bedtime snack. You get some fiber, you get some whole grain, instead of something sweet. And it did have a sweet taste. And they really liked it. And one lady afterwards couldn't find it in her store, so she asked me to buy it for her, which I did, and she paid me for it, because she really wanted to do that. I let them taste. In Virginia we have a lot of southern cooking. That's called fried chicken and greens with bacon fat. And I try to get them to taste new things. When Kroger had Asian apples, last fall, on sale for 99 cents, I sent our driver out to get some. And after lunch we just did a taste where I took several Asian apples and cut them in pieces, and I said, this is another type of fruit you may not have tasted. And it's really good and it's on sale right now, so – and I was teaching them a concept with them. I was teaching them that good food can taste good, and I was teaching them watch and buy sale items.

So I do a variety of things. I also recently introduced humus to them with raw carrots. And it's like, wow, this doesn't really taste too bad. And that is a really foreign taste to our southern population.

Again, this overlaps into activities. I try to do creative ways. I try to give the activities director a break. This is National Nutrition Month. I actually did this last week. I wrote – I contact USA – USDA via the computer to see what I could get free from them. They sent me a new Choose My Plate poster, and they sent me some handouts, full-color handouts. That was all free. So I put My Plate on a poster presentation board, and I took it out, and we covered the various groups. And then I put out pieces of paper on a round table. I put red and green and orange and purple and blue. And then I carried in my laundry basket full of food, things from home. My husband laughs at me sometimes. Of my canned salmon, my brown rice, and they had to fit the food to the group. And it was an activity for them. And they had fun with it. And as they're putting rice in the grains group, I say, nope, this is brown rice. Whole grain is healthier for you than white. And so I'm trying to teach them concepts as we move along.

Another thing that I did, and this was for cardiovascular week last year, I actually made a Tic Tac Toe board on a piece of Styrofoam poster board. I mounted it – I drew my form with it and mounted it with some magnetic tape. And then we had a red heart team and a pink heart team. And I would ask them questions, just like you have your X and Os with – with Tic Tac Toe, we had the red hearts versus the pink heart team, and if they answered it correctly they got a heart and they could put it up, and they played Tic Tac Toe in that manner.

So I'm marketing to our participants because I understand the stages of change for them. The stages of change are pre-contemplation, contemplation, preparation, action, maintenance and relapse. And when I went to this obesity seminar, they went through these stages change over and over. Because before someone can lose weight, they really have to go through the first three stages. Then there's going to be action. Then you work on maintenance, and you always expect relapse. And they really taught that to us. And to expect it, and then you have to go through the whole cycle again. And that gave me a great understanding how I teach, because I really view myself as a teacher for our participants.

So I'm going to give you an example of my teaching. I had a man I'm going to identify as Mr. G. Mr. G drinks two to four cans of beer every day. He's getting mental health counseling for that. Occasionally he has a little binge on a weekend. Three-day weekends are bad. We know that, and we try to prepare for it in advance. He also likes Pepsi. He drinks two liters of Pepsi a day. And I found that out at my initial interview with him. Mr. G did not want to really make any changes. I knew his diet was very deficient because when you're consuming that many calories in Pepsi and beer, you're not getting the nutritious foods that you need. Initially I counseled him on a little bit more nutritious feed to try to eat. But I didn't do a lot with him because our mental health counselor was working with the beer issue, and I felt like that was a priority.

Then one day I get his labs with triglycerides, and they are really high. And I don't remember the exact value, but I sort of did a double take. So I said to him, Mr. G, let's come and talk to me a bit. And I actually have my little arteries, and I don't know if you've seen – you've probably seen the arteries that show the beginning plaque stages, and then as it advances. And one thing that was brought out yesterday was the health illiteracy with our people, and we so often forget that. And I will never forget the time my father-in-law said to my husband, I think something's wrong with my liver. And my husband said, why do you think that, Dad, and he said, well, it really hurts down here – and that's not where your liver is, and it just shows the level of physiology and understanding the body that these people have. So what I did with Mr. G is I just took my little arteries, and I said, this is plaque development, and as it gets larger and larger in your artery, eventually there's just a small area for the

blood to flow. And if a clot goes through and it gets stuck, if it's in your heart, you have a heart attack, if it's in your brain, you have a stroke. And that's why we're concerned about your triglycerides. And his response to me was, well, I signed that Do Not Resuscitate paper, but I'm not ready to die. And for the first time I got him to make a change. He quit drinking Pepsi and he switched to diet Pepsi. And I encouraged him to include more tuna in his diet for Omega 3 fatty acids. But that's how I teach and I build on things, one step at a time.

I also try to remember one size does not fit all. This is one of my favorite handouts that I use in teaching, and I will give you the website – it's – it's in your packet – for this. And what I really like about this, this is actually what Tufts University put together for geriatric people, taking off the new My Plate that the USDA did. And if you look in the corner, grains are a quarter, and – of the diet, and they focus on all whole grains. And if you could see this – and you can download this page from the web – and I just downloaded like 20 of them, and I use it routinely in teaching. And I just put it in the participant's hand, and, you know, a fourth of our plate it's showing as grains, what kind of whole grains do you see, and, you know, we're looking at brown, not white. I teach the same principles over and over. What are some whole grains that you like? And then we go into protein. These are all lean protein. Your body needs protein for muscle. What are some things in that that you like? If they're overweight, there's fried chicken. Is fried chicken a good healthy food? Well, there's protein, but a lot of calories. Could you take off the skin and the breading? And that's how I approach care.

This is just – if you could see this graphic, and you can download it, it is a wonderful visual because it uses the canned tomatoes are low sodium, it uses frozen and fresh vegetables, frozen and fresh fruits and fruit in light syrup. And then what I like, we talked yesterday a little bit about UTIs and dehydration. In that corner, it's not just milk, and they're really \INAUDIBLE\ fluids, so I can talk to them about fluids. What are some of the ways that you can get fluid? Milk, coffee, tea, soups are in that group.

And then as far as cross training up in the corner you will see, we discuss this too, because we take a team approach to care. So those two people are walking. What are they walking with? Well, a cane, you know, so I encourage them, use your assistance device. You see the two people washing hand – dishes. I talk about sanitation in the home. I am really afraid of food-borne illness for some of our dementia people who live alone. There is a great – Iowa State University has a really great PowerPoint on food-borne illness, and I use that sometimes to – to train people that I think are at high risk. I've used it for some of the personal attendants in training so they look out in the home, how long has this food been in the refrigerator and this type of thing.

You'll see a man there lifting weights. I talk to them, please participate in our activities where we get in a circle and we do group exercise. And then you just see the socialization and bonding, and I talk how good it is to come to PACE and be able to meet friends and socialize. So I try to give them a lot of positive reinforcement when I teach them.

This is an example of one of our participants. She was greater than 40, with a BMI, very poorly controlled diabetic. She goes to the cardiologist. Dr. Sellers comes back and says to me, she went to the cardiologist and he wants her to achieve weight loss. She – the cardiologist recommends you enroll her in a program with Weight Watchers or bariatric surgery. Well, I just sort of looked at her and I said, Weight Watchers, she could never comprehend. Bariatric surgery is a very intense diet. I can't get her to stop drinking regular Pepsi. I can't get her to eat three meals a day. It was not a realistic goal for her. and I was preparing this seminar and I looked at this, I also got out some of my information that I keep in files, and there is – and I'll give you – I'll give you the location of where your dietician can get it. The



Practice Group for Diabetic – for Diabetes within the American Dietetic Association, now referred to as AND – has – she can, for \$25.00, join that practice group and get this paper, and it is a 33-page paper on treating diabetes in the elderly, and it is all evidence-based practice, with all the research right there for it. And I was looking at the slide, I reviewed it, and it just – it talked about with diabetes about the frontal lobe and the decreased cognitive skills involving organization. In fact, the cognitive dysfunction of the frontal lobe includes problems with problem solving, planning, organizing, insight, reasoning and attention. And that described her to a T. And I want to put her down, like she won't stop drinking Pepsi. But she has real disabilities with this. We would like to put her into assisted living. I'll cover that at the end of the – at the end of the presentation of why she's not in assisted living.

We have another diabetic, Mrs. U, BMI greater than 40. Gained 30 pounds in the past year. She recently fractured her hip. She went into a long-term care facility with three full meals a day. And I know long-term care facilities, typically their diets are 2,000 to 2,400 calories, far more than what she needed. She's very high functioning. She knows a lot about portion control, weight, label reading. She could be teaching the class with what she knows about diabetes. While she was in long-term care, her dog died. How's a dietician to handle – she was going home, and I was getting ready for my assessment, and looking at the goals for going home. So I brought her over to my little cubicle, showed her what her weights have done the past year. Said, you've gained 30 pounds, how do you feel about this? What do you think you need to do? Asked her a bunch of questions. She knows what to do. I just had to bring this to her attention. I did say to her, I know your dog died, and I know it's going to be really hard to go home without your dog. Do you think depression is going to be an issue? And the reason I asked that is if depression's going to be an issue, I want to point that out to Dr. Sellers so that she is aware of it in case we have to treat depression.

And again, I didn't give her a lot of literature. She needs to go through the stages of changes. I brought her up to contemplation, hey, you've gained 30 pounds, what are you going to do about it? But she's not ready to take action yet, so I'm going to let that happen in her timing.

A very useful tool for me has also been a book called diabetic mapping, and I actually reduced my slides in sending them in and I realize that I didn't have the address for this. The beginning is my address at work, and you can email me and I'll send you the address. This book was actually approved by the American Diabetes Association. It's put out by Merck. It's called Diabetic Mapping, and it's a little game that you take five, six or your participants. And you take – I bring a little Hot Wheels car, and it's like the game of Life. You go from one place to another and you drive around all day, and you ask questions. And these are some of the type of questions. We get to an area on the map where it's high or low blood glucose, and we draw a card, just like you're playing a game. Okay. If you have a late or skipped meal, is that going to be high or low blood glucose? And we get a lot of training – you get all this material free but you have to go to the training because we are facilitators and we are facilitating conversation. So, you know, what will a skipped meal do? If you're – if you're going to have a late meal, what could you do to prevent low blood sugar? And then you talk about eating something extra. It is a tremendous teaching tool. And I'm limited on time, so I can't go into more depth, but another one is just an area of myth or fact. Fruit is a healthy food, therefore it's okay to eat as much as you wish, is that a myth or a fact? And then we discuss that.

So key – three keys to success as I work with our participants with – and obesity is a big issue because it affects everything else – is nutrition, exercise and behavioral therapy. I always encourage what therapy does. We really try to complement each other. A great book on behavioral therapy, something that I've really enjoyed, is reading Dr. Beck's books on The Complete Beck Diet for Life. It's cognitive behavioral

therapy, and I know I can't – I can't do cognitive behavioral therapy because it's beyond my scope of practice, but I can take little tidbits that she uses and incorporate in for our participants. And I use some of her cognitive behavior therapy for me all the time, because the very reason I got into dietetics is I was an overweight teenager. And one of my favorite little cards that she has is, I can eat what I want whenever I want or I can be thin, but I can't have it both ways. And running that through my mind over and over, helps me stay away from the crescents.

Motivational interviewing is another thing. Here is a great website for some continuing education on it. I do individualized care. One of our men, Mr. P, was having really high blood sugars. Got together with his wife. Found out he was drinking a lot because he was thirty all the time. Well, that goes with the high blood sugars. What was he drinking? Fruit juices. I simply changed him to Crystal Light, and then we talked about what they did at breakfast. They eat at home with just eggs and bacon, there's no carb. Lunch they eat at PACE, there's some carb. Night meal is Meals On Wheels, standard amount of carb. What happens on weekends? Well, we get takeout food. So we discussed – they go to Chinese takeout food. We discussed less rice, more vegetable dishes that were not fried.

Likewise, his wife was fearful of hypoglycemia, she had fallen and broken her hip. She – her last review her hemoglobin A1C was less than 10.0. She was on Lantus only. She didn't want a regular insulin. She was so afraid of it. She gets very anxious. She did not want low blood sugar. Took her diet pattern. I knew most of the carbohydrate she got in for the day was at noon, so I go back to our pharmacist and doctor and said, I think we need to put some regular insulin right before lunch. She's here five days a week, so we can assure her we're there to watch, and that's where her most carb is coming, so that's what we chose to go.

Some – Tool chest. Great teaching material that your doctors can get free from American College of Physicians. Standards of Practice for new dining standards are on the Pioneer website. These are some of my other resources that I love but I don't have time to go into but give you that My Plate. I also didn't have time to speak on wounds, but there's a great white paper for nutritional interventions. A tool chest that I recommend for dieticians is right here, and the Diabetic Care and Information Group, I have got so much information from. Very worthwhile.

And some final thoughts in my 15 seconds is, in all of this, remember the trump card is the participant rights, to honor informed choices, to recognize interventions that have a potential to help or harm the elder, and as a team, support decisions and mitigate risk. I thank you for your time.