RAINMAKER THINKING®

About Bruce Tulgan
Founder and Chairman, RainmakerThinking, Inc.

Bruce Tulgan is internationally recognized as the leading expert on young people in the workplace and one of the leading experts on leadership and management. Bruce is a best-selling author, an adviser to business leaders all over the world, and a sought-after keynote speaker and management trainer.

Since 1995, Bruce has worked with tens of thousands of leaders and managers in hundreds of organizations ranging from Aetna to Wal-Mart; from the Army to the YMCA. In recent years, Bruce was named by Management Today as one of the few contemporary figures to stand out as a "management guru" and he was named to the 2009 Thinkers 50 rising star list. On August 13, 2009, Bruce was honored to accept Toastmasters International's most prestigious honor, the Golden Gavel. This honor is annually presented to a single person who represents excellence in the fields of communication and leadership. Past winners have included Stephen Covey, Zig Ziglar, Deepak Chopra, Tony Robbins, Ken Blanchard, Tom Peters, Art Linkletter, Dr. Joyce Brothers, and Walter Cronkite.

Bruce's most recent books include the updated and expanded edition of *Not Everyone Gets a Trophy: How to Manage the Millennials* (Wiley/Jossey-Bass: Revised Updated 2016; originally published 2009) and *Bridging the Soft Skills Gap: How to Teach the Missing Basics to Today's Young Talent* (Wiley/Jossey-Bass, 2015). He is also the author of *The 27 Challenges Managers Face* (Wiley/Jossey-Bass, 2014), and the best-selling *It's Okay to Be the Boss* (HarperCollins: Revised Updated 2014 ; originally published 2007), and *Managing Generation X* (W.W. Norton, 2000). Bruce's other books include *Winning the Talent* Wars (W.W. Norton, 2001), which received widespread acclaim from Fortune 500 CEOs and business journalists; the best-seller *Fast Feedback* (HRD Press,1998); *Managing the Generation Mix* (HRD Press, 2006) and *It's Okay to Manage Your Boss*
(Jossey-Bass, 2010). Many of Bruce's works have been published around the world in foreign editions.

Bruce lectures at the Yale Graduate School of Management, as well as other academic institutions, and his writing appears regularly in human resources, staffing and management journals, including a regular column in TRAINING magazine called 'Sticky Notes' and a regular column in the Huffington Post. His writing has also appeared in dozens of magazines and newspapers such as the Harvard Business Review, BusinessWeek, HR Magazine, the New York Times, the Los Angeles Times, and USA Today. As well, his work has been the subject of thousands of news stories around the world.

Before founding RainmakerThinking in 1993, Bruce practiced law at the Wall Street firm of Carter, Ledyard & Milburn. He graduated with high honors from Amherst College, received his law degree from the New York University School of Law, and is still a member of the Bar in Massachusetts and New York. Bruce continues his lifelong study of Okinawan Uechi Ryu Karate Do and holds a sixth degree black belt, making him a Renshi master of the style. He lives in New Haven, Connecticut with his wife Debby Applegate, Ph.D., who won the 2007 Pulitzer Prize for Biography for her book *The Most Famous Man in America: The Biography of Henry Ward Beecher* (Doubleday, 2006).

The Fundamentals of Highly-Engaged Management

The Eight Fundamentals of Engaged Management

1. Get in the habit of leading every day

2. Take it one person at a time

3. Learn to talk like a performance coach

4. Make accountability a real process

5. Tell people what to do and how to do it

6. Track performance every step of the way

7. Solve small problems before they become big problems

8. Do more for some people and less for others...based on what they deserve

The Seven Myths That Prevent Managers from Being Strong

1. The Myth of Empowerment

2. The Myth of Fairness

3. The Myth of the Nice Guy

4. The Myth of Difficult Conversations

5. The Myth of "Red Tape"

6. The Myth of the Natural Leader

7. The Myth of Time

Be the Manager...

...whose employees consistently deliver the highest productivity and quality;
... with high retention of high performers and high turnover among low performers;
... with the best business outcomes and high morale and team spirit.

www.rainmakerthinking.com bruce t@rainmakerthinking.com @BruceTulgan

RAINMAKER THINKING®

How to Be the Manager Your Employees Need

High-Structure, High-Substance Communication

Good Meeting Discipline

The right people, well prepared, on time, with a clear agenda for...

- Communicating the same information to the same people in the same way at the same time

- Brainstorming open questions with multiple constituents

- Planning interdependent work with multiple players

Regular One-on-Ones at Every Level

Scheduled at least weekly, with a clear agenda specific to every individual

- Talk about the work

- Coaching style dialogue: describe, describe, describe and always point to next steps

- Provide support, guidance, direction, troubleshooting, and help with resource planning

Make Accountability a Process

Get everyone in the habit of giving an account of their performance on a regular basis

- Clarify expectations every step of the way

- Solve small problems before they turn into big problems every step of the way

- Link rewards with performance whenever possible every step of the way

Bruce Tulgan is internationally recognized as the leading expert on young people in the workplace – and one of the foremost experts on leadership & management practices and supervisory relationships. He is an advisor to business leaders all over the world, and the author/coauthor of numerous books including the classic MANAGING GENERATION X (1995), the best-seller IT'S OKAY TO BE THE BOSS (Revised Updated 2014; originally published 2007), NOT EVERYONE GETS A TROPHY (Revised Updated 2016; originally published 2009), THE 27 CHALLENGES MANAGERS FACE (2014) and BRIDGING THE SOFT SKILLS GAP (2015). Since founding the management training firm RainmakerThinking, Inc. in 1993,he has been a sought-after keynote speaker and seminar leader.

@BruceTulgan /in/brucetulganRMT brucet@rainmakerthinking.com

RAINMAKER THINKING®

Not Everyone Gets a Trophy
How to Manage the Millennials

The Millennials

First Wave, born 1978-1989
Today*: 28% of the workforce
2020* : 27%

Second Wave, born 1990-2000
Today*: 14% of the workforce
2020* : 24%

*US, Canada, Germany, UK & Japan

"If you want high performance out of Millennials, you better commit to high-maintenance management." - Bruce Tulgan

9 Steps to Managing Millennials

1. **Get Them on Board Fast with the Right Messages**
   - Diversify your sourcing, and deliver a killer message.
2. **Get Them Up-to-Speed Quickly, and Turn Them Into Knowledge Workers**
   - Train and engage them from Day One.
3. **Practice In Loco Parentis Management**
   - Give them guidance, direction and support. Take a strong hand.
4. **Give Them the Gift of Context**
   - Help them understand where they fit in *your* picture
5. **Help Them to Care About Great Customer Service**
   - Use their customer mentality to commit them to good service
6. **Teach Them How to Manage Themselves**
   - Help them set priorities, take notes, and be good workplace citizens
7. **Teach Them How to Be Managed By You**
   - Meet regularly one-on-one, and set your ground rules
8. **Retain the Best of Them, One Day at a Time**
   - Use their needs for today and tomorrow as a way to retain the best
9. **Build the Next Generation of Leaders**
   - Teach them the basics of good management

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Top 14 Myths About Millennials

1. **Millennials are disloyal**

   Reality: They offer the kind of loyalty you get in a free market: transactional loyalty

2. **They won't do the grunt work**

   Reality: They won't do the grunt work if they fear no one is keeping track

3. **They don't know much and have short attention spans**

   Reality: They think, learn, and communicate in sync with today's information environment

4. **They want the top job on day one**

   Reality: They want to hit the ground running on day one

5. **They need work to be 'fun'**

   Reality: They want work to be engaging, to learn and be challenged

6. **They want to be left alone**

   Reality: If they care, they want a manager who is highly-engaged

7. **They want their managers to do the work for them**

   Reality: They want managers who will teach them how to do their work very well

8. **They don't care about climbing the career ladder**

   Reality: Their career path will be eclectic, progressive, and developmental

9. **Money and traditional benefits don't matter to them**

   Reality: Money and benefits are only a threshold issue

10. **Money is the *only* thing that matters to them**

    Reality: What they're really asking is, "What do I need to do to earn more?"

11. **They don't respect their elders**

    Reality: They do respect their elders, but they want respect too

12. **They want to learn only from computers**

    Reality: They need the human element to do their *best* learning

13. **It's impossible to turn them into long-term employees**

    Reality: You can turn them long-term, you just have to do it one day at a time

14. **They will never make good managers, they're too self-focused**

    Reality: They just have to learn good management basics, and practice

Michelle Mathura, RDN, LRD, CDE

Director, Nutrition Division – Success Coach
DM&A

Approaching 8 years as a DM&A Success Coach and the Director of the Nutrition Division, Michelle continues to passionately work with her team and hospitals across the country to provide the best coaching and education to improve patient care.

Michelle leads the DM&A Nutrition Division team to provide education, coaching and support to dietitians, Clinical Nutrition Managers, Food Service Directors, physicians, and other members of the patient care team. She is a national presenter and has spoken for the Academy of Nutrition and Dietetics Clinical Nutrition Management and Food Service Management DPG, Florida Association for Parenteral and Enteral Nutrition, North Dakota Board of Pharmacy, University of North Dakota Physician Residency Program among others.

In December 2015, Michelle co-authored *"Implementation of Malnutrition Coding: A Success Story"* in the Academy of Nutrition and Dietetics Support Line Journal and also was quoted in the Nutrition-Focused Physical Exam article in the February 2016 Issue of Today's Dietitian.

Michelle holds a B.S. in Food and Nutrition/Dietetics with a minor in Chemistry from North Dakota State University. She is a Registered Dietitian and a Certified Diabetes Educator but most importantly she is a wife to Randall and a mother to their daughter Lilyanne.

"Finding a perfect rhythm and balance every day between the joy of being at home with my family and the excitement and passion for the work I do is a gift. Being part of an incredible team and leading the charge to serve others and improve patient care is the best reward. The old saying goes, if you love what you do you will never work a day in your life. I've never worked a day in my life."

Ron Stewart

Success Coach
DM&A

Ron is a graduate of the University of Nevada-Las Vegas, where he completed a Bachelor of Science in Hotel Administration that launched him into a highly successful career spanning over thirty years in food services, hospitality, healthcare, project management, and finance—a career defined by passion, innovation, and excellence. Throughout his career, Ron has managed teams of hundreds of employees, overseen budgets up to $30M, and solved complex operational challenges for organizations large and small.

Ron's efforts have been rewarded with the Dr. Frist Humanitarian Award, and two separate awards for innovation in healthcare, but his greatest rewards continue to come from building consensus and helping leaders and team members reach their fullest potential by fostering a culture of trust, teamwork, and growth using state-of-the-art tools. Ron's father, his first and greatest coach, taught him that any challenge can be overcome, if you focus your mind and hands to the task while remaining open to grow personally. Of course, by doing you learn life's most important lessons.

Today, Ron uses passion and tenacity as he coaches his clients and helps them engage in the Destination 10® process, discover their assets, overcome liabilities, and use the DM&A tools to create success in the face of complex difficulties which previously prevented them from reaching their best. Ron is also responsible for the DM&A Room Service Implementation Project Managers. With Ron's support and leadership, the DM&A room service process has truly become "World Class" helping to revolutionize hospital food forever.

Ina Miller, MA, RD, LD, CHES

Room Service and Clinical Nutrition Manager
Midland Memorial Hospital

Ina earned her Master of Arts in Health Studies & Health Promotion from the University of Alabama, and her Bachelor of Science in Nutrition and Dietetics from Samford University in Birmingham, Alabama. In 2012, Ina joined Midland Memorial Hospital as a Clinical Dietitian. In 2015, she began serving as the Clinical Nutrition Manager. Since 2016, she now serves as both the Room Service and Clinical Nutrition Manager.

At Midland Memorial, Ina completed the Leadership Development Program in 2014 and currently serves as a Leadership Development Program Committee Team Member. Ina also served as the District President for the West Texas Academy of Nutrition and Dietetics in 2015-2016. She enjoys the challenge of being in a leadership role where she is continuously learning and using opportunities to execute her focus and determination in improving patient care.

Ina ran competitively in college and continues to enjoying running as a hobby. She participated in the 2016 Boston Marathon and will participate again April 2017. Ina met her husband in 2015 and recently tied the knot last fall in Nashville, Tennessee.

State of the Union:
Caring for Adult and Pediatric Malnutrition

GOOD TO BEST

DM&A

Today's Presenters

Michelle Mathura RDN, LRD, CDE
Director, Nutrition Division, DM&A

Ron Stewart
Senior Project Manager, DM&A

Ina D. Miller, MA, RD, LD, CHES
Room Service Manager/Clinical Nutrition Manager
Midland Memorial Hospital

GOOD TO BEST

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Global Prevalence of Malnutrition

- 25 to 50% of patients admitted to hospitals each year are malnourished in emerging and developed nations.
- An estimated 20 million children under the age of 5 worldwide are severely undernourished.

Sources: *Clinical and economic outcomes of nutrition interventions across the continuum of care.* Annals of the New York Academy of Sciences, 14 August 2014. Academy of Nutrition and Dietetics and the American Society of Parenteral and Enteral Nutrition Consensus Statement Pediatric Malnutrition http://www.andjrnl.org/article/S2212-2672(14)01339-8/abstract

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Global Prevalence of Malnutrition

- Undernutrition in developed countries generally occurs with acute or chronic illness.
- Undernutrition in the United States is most frequently seen in hospitalized acute and / or chronically ill children and those with special needs.

Source: Academy of Nutrition and Dietetics and the American Society of Parenteral and Enteral Nutrition Consensus Statement Pediatric Malnutrition http://www.andjrnl.org/article/S2212-2672(14)01359-8/abstract

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Malnutrition Global Consensus

- Malnutrition is common worldwide.
- Malnourished patients have poorer health related outcomes than non-malnourished counterparts.
- Nutrition intervention can make a difference.

Source: Alliance to Advance Patient Nutrition. Report details consensus from Global Malnutrition Conference 01 November 2014. www.malnutrition.com

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Protein Calorie Malnutrition Prevalence in the United States

AHRQ Agency for Healthcare Research and Quality

- 4.5% of all inpatient stays (2013)

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- 5.6% of all inpatient stays (2016)

Source: Characteristics of Hospital Stays Involving Malnutrition, 2013. Healthcare Cost and Utilization Project. Agency for Healthcare Research and Quality. 2016 September.

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Malnutrition Impact on Patients

- Patients diagnosed with malnutrition have a longer length of stay (LOS). *
- Malnourished patients are 2 times more likely to develop a pressure ulcer in the hospital.[2]
- Patients with malnutrition and weight loss have 3 times the risk for surgical site infection.[3]

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Malnutrition & Readmissions

- In 2013, 30 day readmission rate (all causes) for **patients with malnutrition** was **23.0 per 100**, compared with 14.9 per 100 for patients without malnutrition
- Average cost per readmission was $16,900 for patients with protein calorie malnutrition; **26-34% higher** than the readmission cost for those patients without malnutrition.

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Malnutrition in the Hospital

DM&A Programs

- Malnutrition is the only comorbidity in an estimated 10 – 15% of patients.
- The diagnosis of malnutrition is identified in various ways among health care providers.

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Malnutrition in the Hospital

Leads to…

- Increased complications during hospitalization
- Poor and decreased wound healing
- Increased length of stay and cost of hospitalization
- Increased risk for readmission

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Malnutrition ICD-10 Codes

ICD-10	ICD-10 Description
E43	**Unspecified severe protein-calorie malnutrition**
E44.0	**Moderate protein-calorie malnutrition**
E44.1	Mild protein-calorie malnutrition
E46	Unspecified protein-calorie malnutrition
E40	Kwashiorkor
E41	Marasmus
E42	Marasmus Kwashiorkor

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Severity of Illness (SOI) Risk of Mortality (ROM)

ICD-10-CM Codes	SOI	ROM
Mild Protein Calorie Malnutrition (E44.1)	2	1
Moderate Protein Calorie Malnutrition (E44.0)	**3**	**2**
Severe Protein Calorie Malnutrition, unspecified (E43)	**4**	**3**
Marasmic Kwashiorkor (E42)	4	3
Nutritional Marasmus (E41)	4	3
Kwashiorkor (E40)	4	3
Retarded development following protein calorie malnutrition (E45)	3	1
Sequelae of protein-calorie malnutrition (E64.0)	3	2

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GOOD TO BEST

Malnutrition Characteristics

	Acute Illness or Injury				Chronic Illness				Social or Environmental			
	Moderate Protein Calorie Malnutrition		Severe Protein Calorie Malnutrition		Moderate Protein Calorie Malnutrition		Severe Protein Calorie Malnutrition		Moderate Protein Calorie Malnutrition		Severe Protein Calorie Malnutrition	
Energy Intake	<75% of EER		≥ 50% of EER		<75% EER		≥75% of EER		<75% of EER		≥ 50% of EER	
	>7days		≥ 5 days		≥1 month		≥1 month		≥ 3 months		≥ 1 month	
Weight Loss												
	1-2%	1 week	>2%	1 week	5%	1 month	>5%	1 month	>5%	1 month	>5%	1 month
	5%	1 month	>5%	1 month	7.5%	3 months	>7.5%	3 months	>7.5%	3 months	>7.5%	3 months
	7.5%	3 months	>7.5%	3 months	10%	6 months	>10%	6 months	>10%	6 months	>10%	6 months
					20%	1 year	>20%	1 year	>20%	1 year	>20%	1 year
Body Fat Loss		Mild		Moderate		Mild		Severe		Mild		Severe
Muscle Mass Wasting		Mild		Moderate		Mild		Severe		Mild		Severe
Fluid (Edema)		Mild (+1)		Moderate (+2) to Severe (+3)		Mild (+1)		Moderate (+2) to Severe (+3)		Mild (+1)		Moderate (+2) to Severe (+3)
Hand Grip Strength		N/A		Measurably Reduced		N/A		Measurably Reduced		N/A		Measurably Reduced

2 Characteristics are required for a diagnosis of malnutrition.

Reference: Academy of Nutrition and Dietetics & American Society of Parenteral and Enteral Nutrition Clinical Characteristics Malnutrition 2011; DM&A (additional references available). Webinar version. Revised: 03/10/2015 DM&A Nutrition Division

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Malnutrition Characteristics (Pediatrics)

Indicator	Mild Protein Calorie Malnutrition	Moderate Protein Calorie Malnutrition	Severe Protein Calorie Malnutrition
Weight for height z score	-1 to -1.9 z score	-2 to -2.9 z score	-3 or greater z score
BMI* for age z score	-1 to -1.9 z score	-2 to -2.9 z score	-3 or greater z score
Length/height z score	No data	No data	-3 z score
Mid-upper arm circumference	Greater than or equal to -1 to -1.9 z score	Greater than or equal to -2 to -2.9 z score	Greater than or equal to -3 z score

Primary Indicators when a single data point is available for use as a criteria for identification and diagnosis of malnutrition related to undernutrition: Academy of Nutrition and Dietetics / American Society of Parenteral and Enteral Nutrition 2014 Consensus Statement

Malnutrition Characteristics (Pediatrics)

Indicator	Mild Protein Calorie Malnutrition	Moderate Protein Calorie Malnutrition	Severe Protein Calorie Malnutrition
Weight gain velocity (<2 years of age)	<75% of normal for expected weight gain	<50% of normal for expected weight gain	<25% of normal for expected weight gain
Weight loss (2 to 20 years of age)	5% usual body weight	7.5% usual body weight	10% usual body weight
Deceleration in weight for length/height z score	Decline of 1 z score	Decline of 2 z score	Decline of 3 z score
Inadequate nutrient intake	51% to 75% of estimated energy/protein needs	26% to 50% of estimated energy/protein needs	≤ 25% estimated of energy/protein needs

Primary Indicators when two or more data points are available for use as a criteria for identification and diagnosis of malnutrition related to undernutrition: Academy of Nutrition and Dietetics / American Society of Parenteral and Enteral Nutrition 2014 Consensus Statement

The Value & Purpose of a Malnutrition Program

- Provides training and tools to effectively implement evidenced based guidelines
- Elevates the role and function of the RDN in the healthcare setting
- Promotes collaboration and integration
  - CDI/Coding, Physicians, RN/PCT's, Administration, Information Systems, and more
- Demonstrates the value of the RDN to the healthcare organization

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Caring for Malnutrition

Demonstrate positive patient related outcomes!

- Length of Stay, readmissions, patient satisfaction, financial outcomes related to reimbursement

Challenge the dietitian to refine skills and practice.

- Promote job satisfaction, growth, and value as they demonstrate a positive impact to patient care and hospital initiatives

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Identifying & Caring Malnutrition

- **Dietitian lead initiative**
  - Closely working with physicians, providers, documentation specialists and coding
- Improving patient care & outcomes, documentation, intervention, and preventing admissions and readmissions
- Improvements in accurate documentation of severity of illness, risk of mortality, reimbursement, length of stay

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"It's really gratifying personally to be past the adoption phase and able to use our Clinical IT applications to help improve patient care and outcomes." - *Dr. William Peglow, Ridgeview Medical Center, Director of Provider Engagement. Waconia, MN*

MAKING A DIFFERENCE

Malnutrition in Adult Inpatients

Ina Miller MA, RD, LD, CHES
Midland Memorial Hospital
Midland, TX

Our expectations at MMH

- To be trained on nutrition focused physical assessment
- To improve overall patient care
- To increase awareness of best practice methods
- To increase reimbursement
- To enhance communication between MD and RD and other team members
- To increase confidence of dietitians
- To enhance current processes to make more efficient and effective

GOOD TO BEST

Changes Implemented at MMH

- Added Malnutrition Screening Tool to Nursing Health Screen
- Changed RD Patient Assessment Tool
- Became competent in nutrition focused physical assessment
- Utilized laptops, phones, and time spent up on patient floors
- Education with physicians, coding, and case management
- Developed additional reports and resources
- Updated competencies for dietitians

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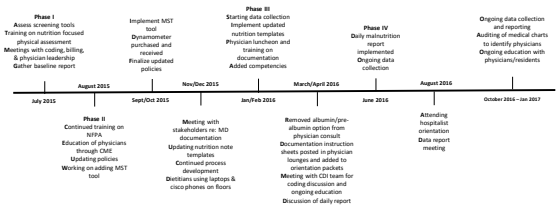
Key Milestones at Midland Memorial Hospital



Results of the Program

- Increased reimbursement *($382,250 in less than 1 year).*
- Enhanced relationship between dietitian, physicians, case management
- Increased severity of illness scores (7.4% to 13%)
- Increased case mix index and risk of mortality scores
- DRG moves (from 2.9% to 16%)
- Provided overall better patient care
- Increased skills of dietitians

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Why MMH partnered with DM&A

- **Malnutrition Documentation Program Support**
  - Education
  - Coaching
  - Hands on training
  - Resources
- **Without support**
  - Limited expert opinion to fine tune
  - Limited enhancement in our processes
  - Delayed learning of best practice
  - Delayed development of interdisciplinary teams

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Looking Ahead

- Continued education with physicians, residents, new dietitians, etc.
- Continued tracking of financial impact, physician scores, numbers on cases diagnosed
- Continued process improvement for interdisciplinary team
  - How to close the gap between discharge, at home, and follow up
  - Streamlining communication processes
- Continued training of pediatric malnutrition screening tool

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A few words from the MMH Team…

"Since we have started doing physical assessments on patients, I believe it helps me connect better with the patient and get an overall picture of how the patient is doing nutritionally."

–Alyssa Richardson MS, RD, LD

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A few words from the MMH Team…

"It provides more conversation that applies to the patient intake/deficits/and overall nutritional health. Explaining what I am looking for as I complete the assessment gives me topics to nutritionally intervene with patient care. It helps the patients understand what we are doing, and allows for additional subjective information that they might have not otherwise revealed."

–Rachel Murphy MS, RD, LD

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A few words from the MMH Team…

"The consults your staff completes provides us with useful information on nutritional recommendations that are easily implemented. Your team has done an excellent job of identifying our patient's with malnutrition, ***making the hospitalist aware of proper documentation, and implementing proper interventions****."*

–Dr. Allen Gibson, MD

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A few words from the MMH Team…

"The implementation of nutritional recommendations and physician engagement has ***enhanced the Clinical Documentation Specialist and Coders*** *ability to better paint the true picture of severity of illness and risk of mortality in our patients."*

–Cheryl Craig, RHIA, Director of Health Information Management

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A few words from the MMH Team…

"Since the introduction of the malnutrition program there has been a demonstrable improvement in the recognition, documentation, and treatment of nutritional disorders at Midland Memorial Hospital. ***The benefit is beyond the recognition of the specific disorder, but it has helped improve capturing comorbidities that influence risk and management decisions.***

Further, with my executive hat on, ***the measurable improvement in revenue is great too. Better quality care with improved patient experience in a cost effective fashion****. "*

–Dr. Larry Wilson, Vice President Medical Affairs/CMO

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Move Forward with Passion

- Push forward with objectives
- Break down the silos
- Move forward with proper education & training
- Follow Up! Follow Up! Follow Up!

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Questions?

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GOOD TO BEST

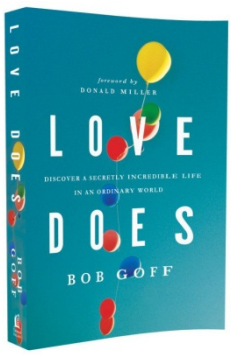
Bob Goff

Keynote Speaker, NY Times Best Selling Author

Bob Goff is the New York Times Best-Selling Author of *Love Does*, as well as an attorney who founded Restore International, a nonprofit human rights organization operating in Uganda, India, and Somalia. Bob is a sought after speaker for leadership, church and university events, inspiring current and future influencers to get to the "do" part of life. Choosing to live audaciously, Bob connects to audiences in a powerfully inspirational, yet down to earth manner.

Bob has pioneered the vision of Restore International to fight for freedom and human rights, working to improve education opportunities and to be helpful to those in need of a voice and friend. Restore has worked with Uganda's judiciary in bringing over 200 cases to trial, as well as pursuing justice, intervention and education for at risk women and children in Uganda, India and Somalia. Restore Leadership Academy in Northern Uganda educates over 300 students with a focus on character and leadership development. Because of Bob's vision and the work of Restore International, he serves as the Hon. Consul for the Republic of Uganda to the United States.

Bob has been a practicing attorney for over 25 years. He is also an adjunct professor at Pepperdine Law School where he teaches Nonprofit Law, and Point Loma Nazarene University, where he teaches Business Law.



Chef Jeff Groch, CDM, CFPP

Success Coach

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Jeff is a graduate of Northern Arizona University with a B.S. in Hotel and Restaurant Management. Prior to earning this degree he completed an apprenticeship program with the American Culinary Federation (ACF) in Culinary Arts Management while working as a Sous Chef at Skyline Country Club. He has been awarded numerous awards and medals in American Culinary Federation sanctioned culinary competitions. Jeff completed a year of practical training at a luxury resort in Bavaria, Germany.

While employed by a large corporation consisting of fifty convention center hotels, primarily represented by Marriott and Crowne Plaza, Jeff was trained and certified to Marriott management standards and quickly moved from Executive Chef and Assistant General Manager to developing corporate menus and convention service management for many of the company's flagship properties. Jeff transitioned to healthcare via contract management, once again working with a German based firm specializing in high-end managed care, hospitals, and retail outlets.

Jeff is experienced in all aspects of exceptional foodservice: healthcare, hotels, fine dining, and convention center venues. Jeff is extremely skilled at creating innovative diets and transitioning recipes, purchase specifications, and production to promote successful menu adaption. Whether it is managed healthcare, institutional foodservice, or fine dining, Jeff brings new energy and drive to operations. He possesses a high level of focus and dedication to food quality, presentation, and service. Jeff has a strong passion to teach others to achieve their very best, establish training standards, and develop leadership roles.

GOOD TO BEST

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HOW TO TAKE YOUR ROOM SERVICE CULINARY OPERATION TO THE NEXT LEVEL

Chef Jeffrey Groch, CDM, CFPP
Success Coach, DM&A

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DM&A = Operational Success

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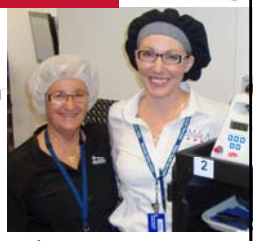
WHAT WE DO!
Design and implementation of "transformational" food models to take leadership, staff and food to the next level.



Note: It starts with developing/building strong teams!

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Desired Outcomes

Great service, food quality, menu selections, fresh, innovative, menu aligns with population

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Defining Quality Outcomes

Menu, presentation, order taking/delivery, professionalism

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Temperature Control

Heating systems, proper use of pellets, keeping items cold, temperature the leading indicator of food quality expectations

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Tray and Plating Presentation

Food items are no better than the canvas in which they are painted upon:
china vs disposable,
quality flatware,
napkins,
details, details, details.
Temperature control,
ease of access to
food items, service ware
durability/replacement
issues ruining success

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Recipes for Success

Recipes no matter how good have to be consistent, presented well and most importantly cooked properly.

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Recipe Standardization

Recipe guides have to be clear, large print and encompass illustrations in their content.

New concepts as well as enhancements to plating require clearly communicated “standards”

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Equipment Configuration

Proper equipment ensures

- flow of service
- just in time food cooking
- proper temperature control
- lean processes

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Food Batching/Holding

Food must be cooked as close to service as possible, held at temperature, not too high or low and in a moisture controlled environment.

Food service workers cook great food, but the after cooking process diminishes the end results.

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Food Waste "Save BIGGER"

Overproduction, limit pan sizes, preproduction worksheets, food waste analysis, how fresh is your food?

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Purchasing Practices

Defines best practice.

Does your facility have a system?

Food management starts with product acquisition, receiving, storage and ingredients.

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Summary

You have gone 90 yards, but can you score?

All about the details!

Processes must be in place from start to finish to assure consistent quality outcomes.

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Della Dunbar, MS, RDN

Director, Nutrition Informatics Division
DM&A

Della Dunbar is a Registered Dietitian with over 30 years' leadership experience in the healthcare foodservice industry. She has a Bachelor of Science in Dietetics from Loma Linda University and a Master of Science in Institutional Management from Kansas State University.

Della has a long history of commitment to healthcare foodservice excellence. She joined the DM&A team in January 2009 to use her special expertise and experience to help our clients go from, "Good to Best."

Prior to joining DM&A, Della has been the Food Service Director at several major healthcare facilities where she developed expertise in identifying ways of reducing costs and improving efficiency in the foodservice department. She spent several years coordinating the computer systems for 20 hospitals, becoming a specialist in healthcare information systems.

Della has always been active in dietetics, and is currently a member of The Academy of Nutrition and Dietetics Interoperability & Standards Committee.

In 2010 Della completed the Academy of Nutrition and Dietetics/AMIA 10x10 Healthcare Informatics Course and in 2016 completed the HL7 Fundamentals Course. She has used this knowledge to assist DM&A clients to successfully implement their food and nutrition software systems. These systems include ADT/Orders interfaces, room service, nutrition service software, foodservice management software (recipes, inventory, purchasing, production, menus), and point-of-sale systems.

Adam Johnson

Director of Business Development
Delegate Healthcare Solutions, LLC

Adam Johnson is the Director of Business Development of Delegate Healthcare Solutions LLC where he has worked for 10 years – 4 years in Vienna working with the Development team as a Business Analyst and 6 in Australia as the Managing Director.

Adam's background is in the hospitality industry in which he has worked for 16 years prior to moving to Delegate. He worked his way up from a Waiter, at the age of 16, to finally a General Manager, of a 200-bed hotel with conference facilities for up to 500 people. Adam then moved into the software industry working as an installer and trainer for MICROS Fidelio UK, the largest supplier of Hospitality hardware and software in the world.

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Stella

Think you can't afford a Menu Management Solution – Come Meet Stella!

Learn the benefits of a Menu Management System and how you can afford a system.

Della Dunbar, MS RDN – DM&A, Director, Nutrition Informatics Division
Adam Johnson – Delegate Healthcare Solutions, Director of Business Development

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Objectives

Stella

- Define Nutrition Informatics
- Benefits of a Menu Management System
- Why is Stella different from other systems
- Introduction to Stella
- Q&A

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Nutrition Informatics

Stella

"The effective retrieval, organization, storage, and optimum use of information, data, and knowledge for food and nutrition related problem solving and decision making. Informatics is supported by the use of information standards, information processes, and information technology."

(ADA Nutrition Informatics Work Group, 2007)
Adapted from the definition of biomedical informatics in Biomedical Informatics by Shortliffe & Cimino Springer Science & Media 2006

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"The intersection of information, nutrition, and technology."

(Academy Nutrition Informatics Committee, 2010)

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Nutrition Informatics Goals

- Optimize the use and application of nutrition informatics in all areas of practice within the profession of nutrition and dietetics
- Leverage nutrition informatics with external stakeholders to position the RD and DTR as key players to improve healthcare outcomes, improve operational efficiencies, and manage healthcare costs

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History of Informatics in Nutrition & Dietetic Profession

- 1962 – Article in the Journal titled "Computers in Dietary Studies
- First uses were:
  - Inventory Management
  - Nutrient Analyses
  - Nutrition Research
- 2009 – Passage of HITECH/ARRA
  - Meaningful Use and Interoperability requirements for hospitals and clinics
  - Requirement for Electronic Health Records & CPOE

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Meaningful Use & Interoperability Requirements

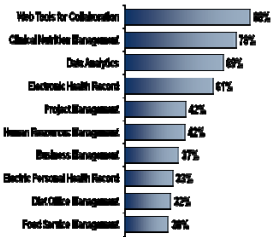
- 2011 CMS developed EHR Incentive Programs
- 2017 Modified Stage 2 or Stage 3 adoption
- 2018 Stage 3 adoption
- Academy Interoperability and Standards committee working with ONC to require Clinical Quality Measures for Nutrition in Stage 3

Meaningful Use in Food & Nutrition Services

- EHR calculates and displays BMI
- Patient specific education resources identified by EHR
- Future requirements
  - Documentation of food allergies
  - Nutrition Care Plan documentation
  - Nutrition Care Plan part of discharge and transfer of care records

Use of Technology by Academy Members

Question:
Please indicate which of the following technologies or computer applications you have used in the past six months to support your daily activities.



2011 Nutrition Informatics Survey-Academy/HIMSS Analytics

Benefits of Menu Management System

Management of Patient Information

- Interface – ADT, Diets and allergies
- Patients select meals from items allowed for diet and allergies
- Tallies based on patients menu selections
- Easy to read tray cards/ room service tickets

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Benefits of Menu Management System

Food Service Management Tools

- Inventory Control
- Scaled Recipes based on forecast
- Purchasing based on menu needs
- Nutritional Analysis of recipes & items
- Nutritional Analysis of Menus
- Floor Stock Ordering

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Benefits of Menu Management System

Reduce Waste = Reduce Costs

- Patients order what they want closer to meal time
- Likes/Dislikes modify non-select meal
- Fewer Late trays
- Only send trays for patients with diet orders
- Produce to forecast/tallies vs. guessing on production
- Less on-hand inventory

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Why Facilities don't have Software

- Cost of initial investment
- Lack of resources to build and maintain database

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Where did Stella come from?

DM&A saw need for another option based on:

- Cost of software was preventing clients from automating
- Clients who had systems were not realizing full benefits due to lack of staff resources to implement

Stella is the result of the collaboration between DM&A and Delegate Software Solutions

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Who is Stella?

Stella is Software as a Service (SaaS)

- Stella is hosted by DM&A
- Delegate software is 100% cloud based
- Database was developed by DM&A chefs and dietitians
- Database includes patient and retail recipes/menus
- Supports HL7 interface to Electronic Health Record
- Patient information stays on facility network to meet all HIPAA requirements
- Database is customized to meet clients' needs

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Why Stella?

- Lower initial investment
- Facility only needs one server to support system
- Stella Solution is licensed for a small fee per patient day
- DM&A maintains the database

What does Stella look like?

Q & A


Stella
For More Information Contact
DM&A
619-656-2100
info@destination10.com
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stellasolution.com

Steve McKenna, CDM
Director, Field Operations
DM&A

Steve brings a broad array of service skills to our team, with hospitality and management experience across a wide spectrum. Most recently he served for twelve years in corporate services for a major healthcare organization, where his portfolio included, not only food and nutrition services, but also environmental services and a number of other hospital disciplines, including, life safety, patient transportation, laundry services, television and telecommunication, and records management.

A former restaurateur, Steve has been a featured speaker at healthcare symposiums and has collaborated with the Culinary Institute of America, training students in healthcare foodservice. His collaborative approach to meal delivery has been featured in nursing periodicals and his dining programs have also been cited in published articles.

Previously, Steve has held regional management positions with several contract companies. In one role, he operated food and nutrition services for fifteen hospitals and long-term care communities throughout the northeast. In another, he oversaw over twenty business dining and catering accounts for well-known corporate clients. His expertise brings DM&A the opportunity to further expand our menu of services, as we continue to offer our clients a wide array of avenues in which to go from “Good to Best”. His roles include project manager for room service, as well as leading Destination 10® programs for both foodservice and EVS departments.

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HOW TO TAKE YOUR EVS OPERATION FROM GOOD TO BEST

STEVE MCKENNA
Director, Field Operations

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Organizations make these decisions for several reasons… good ones

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- Efficiency of reporting and cost savings
- Trust in YOU and your work history
- Opportunity for a leader to spread his/her wings…a job interview in slow motion
- Don't let the organization see it as an EASY BUTTON; these are complex services

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- Remember that organizational leaders may not have a full understanding of the inner working and complexity of service departments
- They may be so busy that they manage by the "my phone isn't ringing and the budget is met" school, so we need to be EDUCATORS also!
- So your job in each department is to demonstrate VALUE , and to show that the VALUE results from your leadership, not circumstances (new equipment, new building, single rooms, new café) or random chance
- VALUE in service departments can be defined in a number of ways, including:
- Changing the culture
- Changing the outcomes
- Raising revenue and lowering cost *and risk*

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What are some similarities between Food & Nutrition and Environmental Services departments?

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Both are "on stage" departments

- They have the opportunity to serve as ambassadors for the organization…speaking to care and concern as well as safety. We are in front of our customers ALL THE TIME
- Customers perceive that they know a lot about our products, and in fact they do. Everyone knows "clean", "looks and tastes good" and "I felt important". Not everyone knows how to read an X-ray.
- We bring good things…a meal, a safe environment. We never deliver a frightening medical diagnosis, we don't use sharp needles.
- Our on stage presence and key words can set the tone for the entire patient experience
- This reinforces our need to define ourselves as care-providers! We don't want to be seen as floor-moppers or Ethel the lunch lady, but it is our responsibility to grab hold of an elevated role, it won't necessarily be handed to us

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Both are "script driven"

- The use of key words prompts the customer to anticipate a certain kind of care experience
- (Knock), "good morning, my name is ____, I have your breakfast, may I come in? Where would you like the tray? Would you like some help with the coffee lid?"
- (Knock), good morning, my name is ____, I would like to clean your bathroom and empty the trash, it would take about 5 minutes, is this a good time? "
- "Did I miss anything?"
- "Is everything as you hoped?"
- "I will be back a bit later", for your tray, to sweep, etc.

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Both are standards-driven

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- Meals served per minute
- Meal delivery in 45 minutes max
- Cost per meal or day
- Area cleaned by square foot /FTE
- Occupied rooms cleaned in 15 minutes and cleaned CORRECTLY
- Discharge rooms cleaned in 45 minutes and cleaned CORRECTLY
- Food and refrigerator temperatures compliant
- Waste streams segregated and monitored (municipal trash; hazardous waste (red bag); acutely hazardous waste (chemo)
- Inspecting what you expect is critical to leaders in both areas: key words, taste tests (scored, please), visual room inspections (scored, please)

What are some differences?

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- The EVS business does not yet have a universal language comparable to "net cost per meal or day" (AHE is working on this project. Initial attempts in years past did not yield enough data to develop reliable conclusions)
- Many operators use 8000-10,000 net cleanable square feet per FTE, but that is an overly broad brush: how much is carpet? Do you clean the operating room suites? Do you have a number of off campus medical offices requiring a different metric?
- Cost avoidance has some commonalities, but EVS tends to have a higher risk, and compliance can be more readily measured. There are in-room measuring devices such as ATP systems which can objectively determine if a surface is adequately bug-free. Foodborne illnesses are trickier to identify and trace.
- Costs of a hospital-acquired infection can be in the tens of thousands of dollars
- Surfaces exposed to different pathogens require very different chemicals

If you are a F&N leader assigned to EVS, get to know some basics!

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- Use AHE (similar to AHF) website and list-serv groups to keep up
- Understand hot buttons, like…..
- UNITIZING: a term that is constantly in use but commonly misunderstood
- UNITIZING is a process by which EVS activities are time-measured. A common time standard is applied to a task, such as a discharge room cleaning. The number and size of common area items is assessed (sinks, tubs, furniture cleaning, etc.)
- The mathematical results are used to build a schedule objectively
- Who is "slow", who is "fast", who "takes a lot of breaks", who "likes the second floor"….none of these factors contribute to building an objective schedule

Is this a job?

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- I was asked to clean South 6, which has a census today of 24
- We know that the hallways, public bathrooms, and furniture in this area requires 1.5 hours per day
- I also got paged to do 4 discharge cleans
- LET'S do the math….
- 24 rooms at 15 minutes = 6 hours
- Add 1.5 hours for common space
- Add 4 discharges x 45 minutes = 3 hours
- Total is 10.5 hours, that is more than one 8-hour job!
- But If my census goes down to 12 patients, and I have no discharges, I should expect to be reassigned to another area for part of my day!

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So what kind of leader is needed for multi-departmental roles like this?

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The same kind of leader needed by any organization in any role, a catalytic leader…someone whose skill, energy and example leads to not only personal success but to the success of others!

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How do I know if I am one, or becoming one?

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- I am willing and able to have the crucial conversation
- I lean toward YES rather than NO, which doesn't make me a miracle worker, but makes my internal and external customers see me as a problem-solver

I am visible!

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- I tour the building, but with a purpose, both greeting and assessing
- I inspect, I ask questions, I don't thin out the standards by thinking "close enough"

Kareen Turner, MPH, RD
Director, Food & Nutrition Services
Loma Linda University Medical Center - Murrieta

Kareen Turner made the move from technology to healthcare twelve years ago. That switch in career led her from Toronto, Canada to Loma Linda, California. Two years later, she graduated with a Master of Public Health degree from Loma Linda University and became a registered dietitian. After declaring that she would only work in clinical nutrition, her first job after graduating was as general manager of food operations and she fell in love. She currently works for Loma Linda University Medical Center – Murrieta, a faith-based institution, in Murrieta, CA as Director of Food & Nutrition Services where she is responsible for clinical nutrition and plant-based, from scratch food and retail operations. Kareen was part of the team that opened the hospital in 2011, at the time, the fastest built hospital in Southern California.

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Creating a Culture of Compassion through Accountability

Kareen Turner, MPH, RD

Compassion

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Compassion Defined

- Caring and empathy in action
- Suspending automatic judgement
- Building mutual understanding

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Compassion Is Not…

- Sympathy
- Leniency
- Turning a blind eye

Keystones for Employee Engagement

- Stability
- Trust
- Compassion
- Hope

Accountability

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Accountability Defined

- Punitive
  - *Inflicting or intended as punishment*
- Accountability
  - *OWNERSHIP, ENGAGEMENT, INVOLVEMENT*
  - *An active choice to move beyond assigned responsibility*

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I should be safe here…

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Celebrate Wins!

- Celebrate the mundane
- Praise publicly
- Coach privately

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Simon Says...

If you create an environment in which people feel safe amongst their own...the natural human result to those conditions is trust and cooperation.... Likewise if you create an environment of fear the natural response is paranoia, mistrust, cynicism and self-interest.

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Accountability

- Set boundaries
- Address issues in the moment
- Be consistent
- Encourage creativity

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Accountability

- What will happen if I do nothing?
- Are you choosing certainly of silence over the risk of speaking up?
- Am I downplaying the cost of not speaking up?

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Techniques and Principles

- Plan
- Do
- Check
- Act

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Techniques and Principles

- Be Transparent (Plan)
- Re-establish Expectations (Plan)
- Monitor (Do & Check)
- Act

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References

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- *Leading With Compassion: A Guide to Successful Leadership by Building Trust and Gaining Commitment* by Katharine Parks
- *Resonant Leadership: Renewing Yourself and Connecting with Others Through Mindfulness, Hope, and Compassion* by Richard Boyatzis & Annie McKee

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Chef Mary Locke, CEC, CCA

Corporate Chef
Nestle Professional

Chef Mary Locke has worked in the foodservice industry for more than 30 years, perfecting her craft as executive chef with a variety of restaurant concepts. Her career blossomed at Aramark, where she oversaw foodservice operations for 18 units and was promoted to Associate District Manager. Residing on one of upstate New York's renowned Finger Lakes, Chef Mary is passionate about scratch-made cooking and bringing the benefits of farm-to-table mainstream.

EDUCATION/TRAINING:
Monroe Community College

FOCUS:
Operator efficiency

MAJOR ACHIEVEMENTS/AWARDS:
ACE Regional Gold Medalist

WORK HISTORY:
Advantage Waypoint – Non-Commercial Specialist
Aramark – Associate District Manager, Director of Operations, Resident District Chef
Private Restaurants

CONTACT:
Mary.Locke@us.nestle.com

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When Flavor Means Business
+
"Made for Me" Options
=
Success in Retail Operations

Good To Best
February 25, 2017
Chef Mary P. Locke CEC CCA

Nestlé PROFESSIONAL
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Quick intro....

Todays topic

- Flavor
- Taste
- Trends
- Made for Me
- Todays consumer

What is flavor?

How do we describe flavors?

How we describe flavors

Flavors	Spices	Bad Qualities	Good Qualities	General	Intensity
Asian	5 Spice	Artificial	Aromatic	Acidic/Tart	Concentrated
BBQ	Anise (Star)	Artificial	Comforting	Alkaline	Dull
Beany	Basil	Astringent	Cooling	Bitter	Energizing
Butter	Chili	Burnt	Exotic	Blended	Exceptional
Cajun	Cinnamon	Chemical	Familiar	Briny	Flat
Caribbean	Clove	Conflicting	Floral	Creamy	Harsh
Char Grilled	Cocoa	Dissonant	Flowery	Doughy	Heavy
Cheesey	Coffee	Krauty	Fragrant	Fermented	Hot
Chlorophyll	Cumin	Medicinal	Fresh	Fruity	Intense
Citrus	Curry	Mediocre	Lingering	Meaty	Medium
Clammy	Dill	Metallic	Pleasant	Nutty	Mild
Creole	Fennel	Moldy	Pleasing	Raw	Muted
Fishy	Garlic	Muddled	Refreshing	Roasted	Pungent
Fishy	Ginger	Musty	Relaxing	Salty	Quick Release
Flame Broiled	Italian	Perfumey	Reminiscent	Smokey	Robust
Lemon	Jerk	Rancid	Satisfying	Sweet	Sharp
Meaty	Licorice	Rotten	Savory	Syrupy	Shocking
Mexican	Mint	Skunky	Unique	Umami	Spicy
Milky	Pepper/Black	Sour	Warming	Winey	Strong
Onion	Pepper/Hot	Spoiled		Yeasty	Subdued
Sauteed	Poultry	Sulphury			Wild
Southern	Rosemary	Unfamiliar			
Southwest	Taragon				
Sweet & Sour	Thyme				
Tropical	Vanilla				
Vinegary					

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How do we taste flavor?

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The Jelly Bean Experiment

- **Step 1** - Look at provided jelly bean. What flavor sensations would you expect based solely on its appearance?
- **Step 2** - Holding nose tightly, place jellybean in mouth and chew for ten seconds. What flavor sensations do you perceive?
- **Step 3** - Release nose and continue chewing. What flavor sensations do you perceive?

Did the flavor meet your expectations based on its appearance?

What happens when you let go of your nose?

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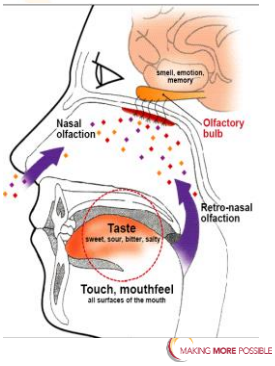
Aromas and Aromatics

- Aromas are external and enter though the Nasal passage
- Aromatics enter though the mouth and volatize



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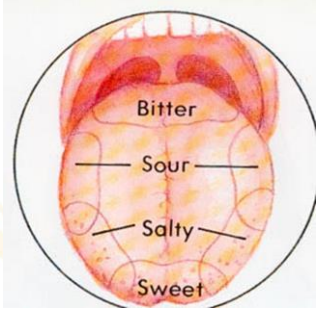
The Tongue Map



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The 5 Basic Tastes

Innate preference/ rejection of basic tastes ensures survival:

Sweet:	Liking (Carbohydrates = energy)
Salty:	Liking (minerals/electrolytes)
Umami:	Liking (Proteins)
Sour:	Dislike (unripe / spoiled food) Liking (Vitamins)
Bitter:	Dislike (toxic plants)

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Umami?

- A bullshirt invited flavor that tv chefs pretend to be able to recognize, but can never define. Due to peer pressure they regurgitate keywords to make it appear that they know what it is, but in reality none of them have a clue.
- "Dude I just saw Andrew Zimmern describe some butter as having an umami flavor. Last episode it was mushrooms. I'm pretty sure they are making this stuff up as they go."

Really....

- **Umami-** is a pleasant savory taste imparted by glutamate, a type of amino acid, and ribonucleotides, including inosinate and guanylate, which occur naturally in many foods including meat, fish, vegetables and dairy products.
- **Umami-** itself is subtle and blends well with other tastes to expand and round out flavors.
- **Umami-** which means "delicious" or "yummy" in Japanese.

Umami Rich Foods

- Kombu Seaweed
- Parmesan Cheese
- Ripe Tomatoes
- Beef
- Dried Shiitake Mushrooms
- Truffles
- Cured Meats
- Green Tea
- Soy Sauce
- Anchovies

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What is "yummy" ?

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So we covered flavor and taste, now trends

1 Hyper-local sourcing
2 Chef-driven fast-casual concepts
3 Natural ingredients/clean menus
4 Environmental sustainability
5 Locally sourced produce
6 Locally sourced meat and seafood
7 Food waste reduction
8 Meal kits
9 Simplicity/back to basics
10 Nutrition

National Restaurant Association | Restaurant.org/FoodTrends

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91% of U.S. consumers believe food and beverage options with recognizable ingredients are healthier.

Source Innova Market Insights

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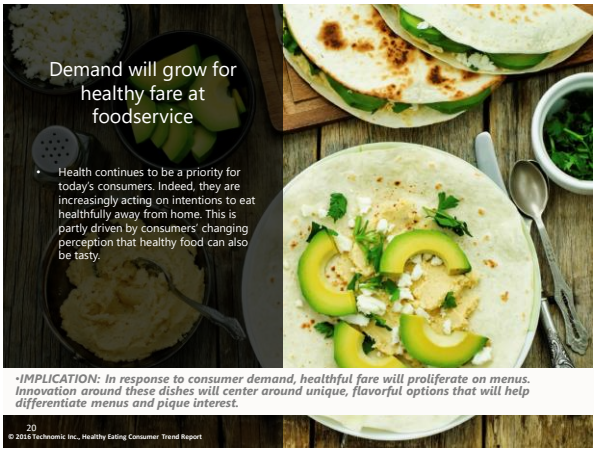

•IMPLICATION: In response to consumer demand, healthful fare will proliferate on menus. Innovation around these dishes will center around unique, flavorful options that will help differentiate menus and pique interest.

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Consumers are more likely to eat healthy at home, and indulge away from home

- As consumers become increasingly reliant on foodservice and foodservice occasions become more common, consumers will likely seek healthier foods at foodservice to balance their indulgence
- Consistent with secondary research,* upper and upper-middle-class consumers report healthier eating behavior than their counterparts

At-home vs. away-from-home healthy eating behavior

Those who selected 7–10, on a 1–10 scale where 10 = extremely healthy

Base: 1,500 aged 18+

Q: On a scale of 1–10 where 1 = not healthy at all and 10 = extremely healthy, how would you describe your __?

*Alternate Healthy Eating Index

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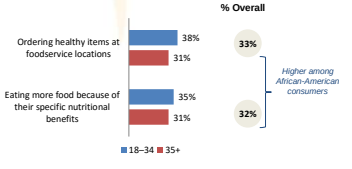
Some diners note improved healthy eating behavior when dining away from home

Improvements in healthy eating behavior

I'm ____ more than I was two years ago:



Base: Approx. 825 aged 18+

Q: How much do you agree or disagree with the following statements? Agree & agree completely

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Key areas of opportunity

- **Build trust through transparency**
- A majority of consumers say they want to see greater menu transparency as natural, organic and clean claims become stronger purchase drivers
- Be upfront about ingredients and, if possible, highlight local and animal welfare claims in order to appeal to today's savvy, health-conscious consumers

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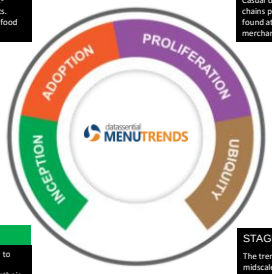
MENU ADOPTION CYCLE

Food trends follow a predictable life cycle. The MAC helps you determine a trend's current life stage, as well as its potential for future advancement.

STAGE 2 ADOPTION
Trend is picked up by food trucks, fast-casual, and casual dining independents. Specialty grocery stores and gourmet food retailers play here too.

STAGE 3 PROLIFERATION
Casual dining chains and eventually QSR chains pick up the trend. It's now also found at mainline grocery stores, mass merchandisers, and club stores.



STAGE 1 INCEPTION
Earliest stage trends, limited primarily to ethnic independent and fine dining restaurants, as well as neighborhood ethnic markets.

STAGE 4 UBIQUITY
The trend is now everywhere, including midscale restaurants, corporate dining, and K-12 schools. It's common even in the frozen foods aisle of the grocery store.

Adoption: Healthy Fast Casual | Operator Quotables

How could you see your operation leveraging this trend?

- *"**Healthy is the future**. This country has been trending that way and is finally hitting stride with healthier options."*
- *" "We already provide a **full salad bar** with very healthy prepared salads and salad ingredient options, including the latest trendy foods (quinoa, freekah, alternative proteins, kale, etc.)"*
- *"…**build your own concepts** like Chipotle offer a good format example…"*
- *"…we could **adopt the best parts and trends** of these fast casual concepts. We're always looking to add more value to our products and customers."*
- *"Many of our customers are trying to eat better and be more health conscious. A major part of this is us trying to **introduce them to healthier options that not only taste great, but are also lower in fats and sugars**. I want them to understand that eating healthy is a conscious choice, no matter where you are."*

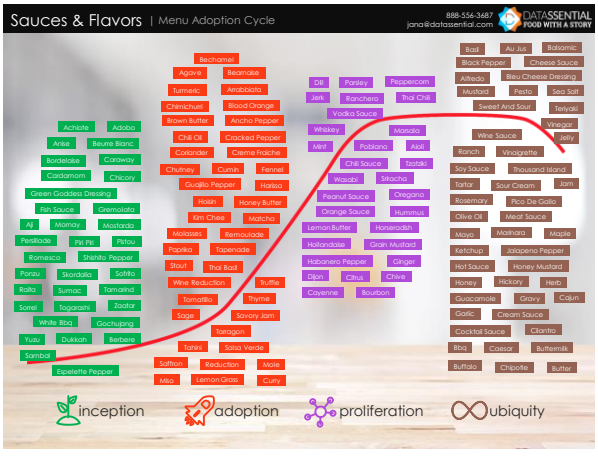
MAKING MORE POSSIBLE

Sriracha Mayo	+921%
Bacon Jam	+784%
Calabrian Chili Pepper	+613%
Sriracha	+531%
Kale	+374%
Quinoa	+369%
Chicken And Waffles	+305%
Banh Mi	+295%
Greek Yogurt	+256%
Buttermilk Chicken	+254%
Burrata	+204%
Pork Belly	+184%
Tomato Jam	+177%
Shrimp And Grits	+154%
Korean BBQ	+154%
Crudo	+153%
Kim Chee	+149%

fastest growing
foods & flavors

GOOD TO BEST

MAKING MORE POSSIBLE



Other trendy flavors

Island flavors

Umami notes are also prevalent in Filipino dishes, in which fish sauce, adobo and fermented items are common ingredients. These flavors also play well with the trend of street foods such as lumpia, taco mashups and more. The island flavors of Hawaii are also going mainstream as poke becomes widespread. The raw fish dish is typically served with Asian-inspired sauces such as togarashi, white soy and ponzu with lime.

GOOD TO BEST

MAKING MORE POSSIBLE

Global spice blends

Novel spice mixtures from India, Africa and the Middle East will make their way onto menus in 2017. Upgrade traditional curry powder with trending sweet-smoky vadouvan blend. Menu mentions of vadouvan are up 50% year-over-year, according to Technomic's MenuMonitor data. Or, add zip to dishes with dukka, an Egyptian blend of toasted nuts and seeds that's a popular flatbread topping. Also trending is za'atar, an aromatic Middle Eastern spice blend of sesame seeds, dried thyme, dried marjoram and sumac used on meats and vegetables.

GOOD TO BEST

MAKING MORE POSSIBLE

Spicy breakfast flavors

Move over muffins: Consumers are hot for shakshuka, a spicy Israeli breakfast dish that can also be served for brunch, lunch or dinner. Eggs are baked in a spice-infused tomato-red pepper sauce, flavored with cumin, paprika and cayenne. The dish's popularity signals that diners are open to global and non-traditional flavors for the day's first meal.

GOOD TO BEST

MAKING MORE POSSIBLE

Ethnic Trends

54%

of consumers prefer spicy sauces, dips or condiments.[1]

FAST GROWING:

An appealing selection of condiments & sauces is one of the fastest growing reasons consumers give for why they choose a place to eat and what menu items they order.[2]

82% of Americans are open to trying new flavors.[3]

60% of operators want to have more ethnic soup offerings.[3]

25% of consumers say they are satisfied with the availability of ethnic foods at restaurants.[4]

77% of Millennials say they enjoy eating a variety of ethnic foods.[5]

1. Technomic 2013, Flavor Consumer Trend Report 2. Datassential, 2014 Proprietary 3. Mintel Group Ltd., 2014 Innovation on the Menu Flavor Trends
4. Source: Millenial Behaviors & Demographics, by Richard Sweeney, University Librarian, New Jersey Institute of Technology
5. American Millennials: Deciphering the Enigma Generation," Barkley, Services Management Group and The Boston Consulting Group, 2013

MAKING MORE POSSIBLE

GOOD TO BEST

Flavor expanded

- Great taste is the **#1 criteria** consumers use when choosing a restaurant
- **Creative condiments** entice customers – the "selection of condiments/sauces to use" is one of the fastest growing criteria for diners deciding where to go and what to order when away from home.

Source: Datassential Consumer Planning Program, 2015

MAKING MORE POSSIBLE

Why Made For Me?

Food Experience
- Great variety, international and customizable

Variety
- Satisfies diverse tastes with a variety of international-inspired offerings.

Health Conscious
- Caters to dietary needs including low fat, gluten free, low sodium, vegetarian & more

Convenience
- Stations are easy to maintain and keeping menus fresh simply requires changing out ingredients.

Flexibility and Efficiency
- Provides the perfect opportunity to use on-hand ingredients.

Sustainable
- Highlight local produce and proteins

GOOD TO BEST

MAKING MORE POSSIBLE

Why Action?

1. The C&U, Healthcare and Lodging channels are **$22.7 Billion** projected at **2% real growth**
2. These operators are **seeking ideas** that will…
   - Keep diners/patrons dining onsite
   - Fit health & wellness expectations & provide variety
   - Provide food which is the perfect harmony between chef and dietitian.
   - Keep diners interested and enthused about their food
3. Consumer **trends** impacting this channel:
   - **Set meal periods disappearing** and **customization** is key as diners want flexibility *("I want it how I want it when I want it")*
   - Vegetarian, vegan and organic foods in high demand, but **comfort foods** (with a twist) are still popular
   - More **demand for world flavors,** especially Asian tastes
   - **Display cooking is popular** which flaunts freshness & customizability

MAKING MORE POSSIBLE

GOOD TO BEST

Exploration with Customization

- Variety
- Convenience
- Flexibility & Efficiency
- Health Conscious
- Profitable
- On Trend

GOOD TO BEST

MAKING MORE POSSIBLE

Why Street Food?

- Leverage success of International Soup & Noodle Bar
- Taps into the Food Truck phenomena
- Food trucks represent $804 Mio of foodservice revenue annually[1]
- Nearly 100 colleges have their own university-run food trucks, compared with 12 five years ago[2]

[1] IBISWorld
[2] National Association of College and University Food Services

MAKING MORE POSSIBLE

Why Street Food?

- 77% of millennials want ethnic[1]
- Top 3 dining trends for next decade are Asian, Mediterranean and Indian (Mexican was #1 for previous decade)[2]
- "Hot & Spicy" 3rd most requested flavor across all demographics[1]
- Globalization of flavors– particularly Asian, Indian and Mexican influences[3]

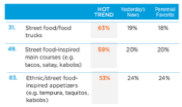
Banh Mi Station

[1] "American Millennials: Deciphering the Enigma Generation", Barkley Services Management Group and the Boston Consulting Group, 2013
[2] Datassentials
[3] Monin Flavor Trends, January 2015

MAKING MORE POSSIBLE

Why Street Food?

- Among the top 100 food trends (those which at least 50% of chefs identified as a hot trend), street food/authentic ethnic placed prominently throughout the list:
  - #16 Ethnic-inspired breakfast items
  - #31 Street food/food trucks
  - #42 Ethnic cheeses
  - #47 Ethnic condiments
  - #49 Street food-inspired main courses (e.g. tacos, kabobs, satay)
  - #61 Ethnic fusion cuisine
  - #70 Ethnic-inspired kids' dishes
  - #71 Authentic ethnic cuisine
  - #75 Regional ethnic cuisine
  - #83 Ethnic/street food-inspired appetizers (e.g. tempura, taquitos, kabobs)
  - #116 Ethnic dips (e.g. hummus, baba ganoush, tzatziki, dukkah)



ETHNIC FLAVORS AND CUISINES

1. Ethnic fusion cuisine
2. Authentic ethnic cuisine
3. Regional ethnic cuisine
4. Peruvian cuisine
5. Southeast Asian cuisine

Source: National Restaurant Association 2015 Culinary Forecast

MAKING MORE POSSIBLE

Why Salad Stations?

- NHW is a rising concern for consumers and key initiative for operators
- 30-40% of diners seek out vegetarian meals though only 3% identify themselves as Vegetarian/Vegan*
- Hits on 'super foods' trend
  - The menu incident rate of Kale has increased 480% over the last 4 years
- Dove-tails into the Wellness Bar

flexitarian

"All American" Grilled Romaine Salad

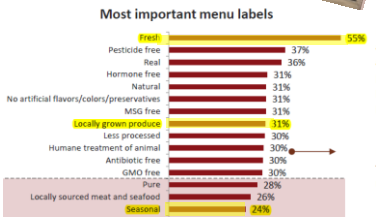
PALEO

Sources: Vegetarian Resource Group

MAKING MORE POSSIBLE

Why Salad Stations?

- Diners regard 'Fresh' as the ultimate symbol of food quality
- 'Locally Grown' and "Seasonal" also among top 10 menu descriptors diners are seeking out
- Salad Station is inclusive of locally sourced items (seasonal produce guide), allowing operators to market themselves to this motivational driver

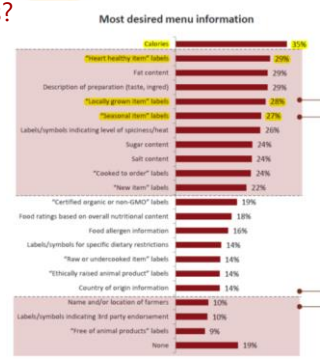


Source: Hartman Group 2015 Diner's Challenging Behaviors

MAKING MORE POSSIBLE

Why Salad Stations?

- 'Locally Grown' and 'Seasonal' descriptors now almost as salient as 'calorie' and 'fat' information on menus
- Not just looking for specific nutrient or ingredient info. Just that the food they order is truly fresh and will taste great.



Source: Hartman Group 2015 Diner's Challenging Behaviors

MAKING MORE POSSIBLE

Why Ancient Grains?

- Capitalizes on both 'healthy' and "ethnic" positioning
- Also taps into Gluten Free and non-GMO dining preferences
- Interest in grain-based salads:
  - 42% of Super Heavy Salad users and Women Under 25*
  - 36% of Men 25-34 y/o (2nd highest group)*

Wheat Berry Chopped Shaker Salad

Source: Technomic Left Side of the Menu: Soup & Salad Consumer Trend Report 2014

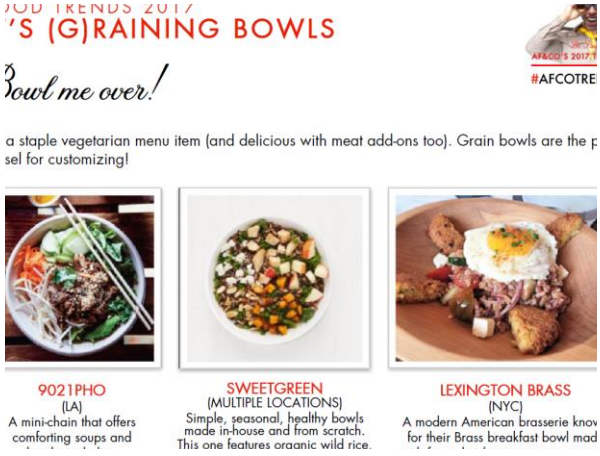
MAKING MORE POSSIBLE

Why Ancient Grains?

- Among the top 100 food trends (those which at least 50% of chefs identified as a hot trend), whole grains placed prominently throughout the list:
  - #11 Non-wheat noodles/pasta
  - #12 Gluten-free cuisine
  - #13 Ancient grains
  - #26 Non-wheat flour (e.g. millet, barley, rice)
  - #27 Simplicity/back to basics
  - #34 Quinoa
  - #39 Ethnic Flour (e.g. teff)
  - #46 Black/forbidden rice
  - #80 Farro
  - #94 Asian noodles (e.g. soba)

Source: National Restaurant Association 2015 Culinary Forecast

MAKING MORE POSSIBLE

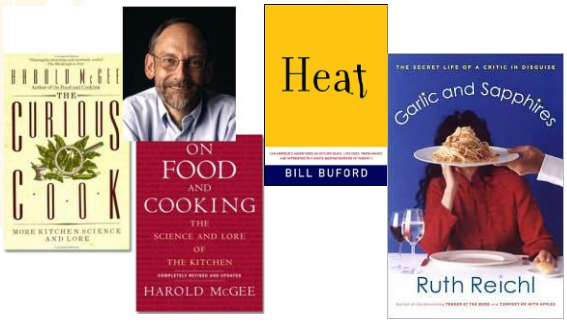


Retail Success in 2017 and Beyond

- Healthy
- Tasty
- Organization's Expectations
- Consumer Satisfaction
- Supplier & Consultant Resources
- Facility Implementation and Success

GOOD TO BEST

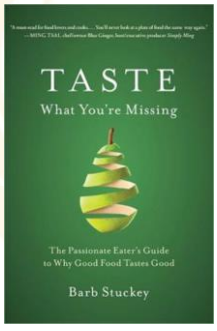
Food people that like to read…



GOOD TO BEST

MAKING MORE POSSIBLE

Highly Recommended Read



http://www.amazon.com/Taste-What-Youre-Missing-Passionate/dp/1439190739

MAKING MORE POSSIBLE

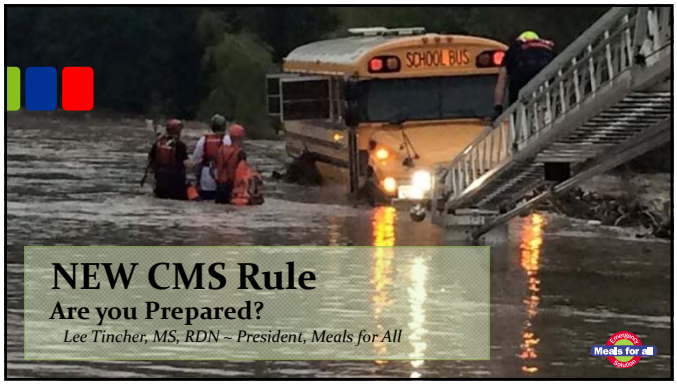
MAKING MORE POSSIBLE

LEE TINCHER, MS, RD

President
Meals for All, Inc.

Lee Tincher is the dynamic, problem solving leader and President of Meals for All emergency solution, one of the sponsors of Good to Best. Previously, Lee was President of Nutricopia, the largest California provider of Registered Dietitian services to hundreds of California facilities. Lee's food service career started washing dishes in a LTC facility as a teen. After completing her education at Loma Linda University and Masters' in Administration at University of La Verne, Lee returned to the LTC facilities as a consultant dietitian. During her career Lee has provided professional services to over 500 hospitals and facilities in California at one time or another. Lee wrote her first emergency menu plan way back "last century." However, real disasters from fires and earthquakes in California to Hurricane Katrina convinced Lee to focus on emergency preparedness for health care facilities to ensure nutritional needs are met. Lee has served in leadership roles in several professional organizations, but is particularly connected to and involved with Federal and State regulations living in the state capital. We invited Lee to speak at Good to Best to share her regulatory knowledge and passion for emergency preparedness in your healthcare communities.

GOOD TO BEST



NEW CMS Rule

Are you Prepared?

Lee Tincher, MS, RDN ~ President, Meals for All

Are You Ready for an Emergency?

"We live in a crazy world & we must think hard about possible disasters that will affect feeding in our facilities and institutions. "

Laurie Maurino, RD

Departmental Food Administrator

President, Association of Correctional Food Service Affiliates

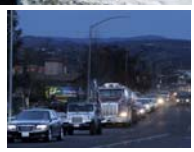
California Department of Corrections and Rehabilitation

Oroville Dam

Spillway damage and overflowing dam.

Immediate evacuation; dam likely to fail within the next hour --- "this is not a drill."

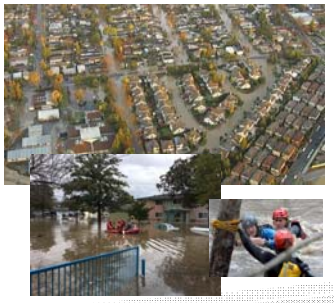
200,000 people evacuated Sunday, Feb. 12, 2017



San Jose, CA flooding

Anderson Reservoir overflows so Coyote Creek rises with floodwaters forcing 50,000 to evacuate.

The floodwater is highly contaminated with raw sewage and mixture of gasoline and oil.



California experiencing widespread flooding, mudslides, evacuations from storms after 5 years of drought and fires

Types of Disasters

- Fire or smoke
- Severe weather
- Loss of power
- Earthquake
- Explosion
- Bomb threats
- Armed individuals
- Gas leak
- Loss of heat
- Missing resident
- Loss of normal water supply

You never know where you'll be when disaster strikes...

FEMA

Department of Homeland Security

Plan --- Prepare --- Mitigate

Before --- During --- After

FEMA

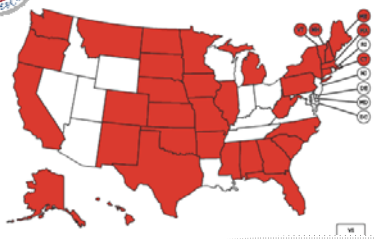
- 2005 = 155
- 2006 = 143
- 2007 = 136
- 2008 = 143
- 2009 = 115
- 2010 = 108
- 2011 = 242
- 2012 = 112
- 2013 = 95
- 2014 = 84
- 2015 = 79
- 2016 = 103
- 2017 = 12

Major Disaster Declarations

Meals for all

FEMA

34 Highlighted States
Have an Active Disaster



As of Wednesday
September 17th,
2014

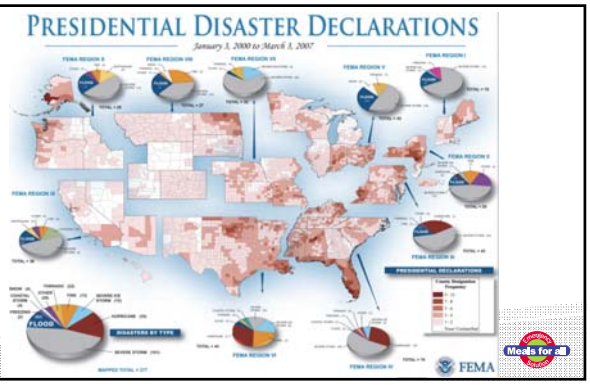
Meals for all

FEMA

Disaster Declaration Data

By State
By Year
By Type of disaster
By Damages

Meals for all



Meet The Regulations

- NEW CMS Rule

Are you Prepared? CMS Preparedness Rule

- Hurricane Katrina August 30, 2005 New Orleans
- Hurricane Rita, September 18, 2005 South Texas

- FEMA & OIG assessment of healthcare readiness 2006
  - 94% met Federal standards; 80% sufficient emergency training
  - 100% experienced complications from disasters
- Department Homeland Security
  - ESF 4: Health Care
  - ESF 8: Mass Care and Shelter

Are you Prepared? Why we need this Rule

- Safeguard Human Resources
- Ensure Business Continuity
- Protect Physical Resources

Are you Prepared? CMS Develops Rule

- CMS Draft Rule published in Federal Register Dec 21, 2013
- CMS Final Rule published September 15, 2016
- Some requirements were enforceable immediately
- Surveyed beginning November 15, 2017
  - No waivers or extensions!
- Some requirements have an additional year for full implementation

Are you Prepared? Regulations before Rule

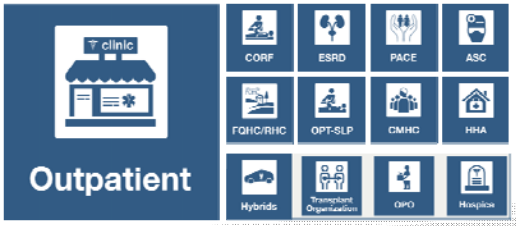
- CMS
  - Hospital A-Tags
  - SNF F-Tags
- State Regulations
  - CA Title 22
  - Specific state requirements vary widely
- Accreditation Standards
  - JCAHO
  - Others

Are you Prepared? CMS Preparedness Rule

- 651 pages
- 17 Levels of healthcare facilities included
- Are any facilities exempted?

Rule Applies to 6 Inpatient Providers

Rule Applies to 12 Outpatient Providers



Are you Prepared? CMS Preparedness Rule

- COP = Conditions of Participation
- Medicare and Medicaid funding to healthcare providers
- Substantial compliance is required

Are you Prepared? Core Elements

- Four Core Elements
- Apply to all provider types
- Best Practices --- Now Required

#1 Emergency Plan

- Perform a risk assessment
- Develop an emergency plan using an:
  - **all-hazards approach**
  - capacities and capabilities
  - full spectrum of emergencies
  - geographic-specific disasters

Types of Disasters

Use an ***All Hazards Approach***

- Fire or smoke
- Severe weather
- Loss of power
- Earthquake
- Explosion
- Bomb threats
- Loss of water
- Armed individuals
- Gas leak
- Loss of heat
- Missing resident
- Loss of normal water supply
- Proximity to waterways, airport, freeway, hazardous materials

CMS Preparedness Rule Subsistence Requirement

- The final rule will require all inpatient providers to meet the subsistence needs of staff and patients, whether they evacuate or shelter-in-place, including but not limited to food, water and supplies."
  - CMS Press Release September 8, 2016.

CMS Preparedness Rule Subsistence Requirement

- "Furthermore, we expect that most providers have agreements with their vendors to receive supplies within 24 to 48 hours in the event of an emergency, as well as arrangements with back-up vendors in the event that the disaster affects the primary vendor… We believe that a provider should have the flexibility to determine what is adequate based on the location & individual characteristics of the facility.
  - CMS Rule September 15, 2016.

CMS Preparedness Rule Subsistence Requirement

- We expect that when inpatient providers determine their supply needs, they will consider the possibility that volunteers, visitors, and individuals from the community may arrive at the facility to offer assistance or seek shelter.
  - CMS Rule September 15, 2016.

#2 Policies & Procedures

- Develop policies and procedures
- Implement policies and procedures
  - Based on the plan and risk assessment
  - Systems and chains
  - Multi-level campus

#3 Communication Plan

- Maintain a communication plan
  - Comply with both federal and state law
  - Patient care must be well-coordinated
    - Within the facility
    - Across healthcare providers
    - With state and local public health departments
    - Emergency systems

You are only as prepared as your community

- Is your facility prepared for a disaster?
- Is your neighbor prepared?
- Is your community prepared?
- Do you have a joint plan?
- What does it take to be prepared?
- What type of resources are available to you in YOUR community?

These are all the questions you need to ask BEFORE an emergency strikes.

You are only as prepared as your community

- Healthcare Coalitions
- Dept. Homeland Security
- 5 Year Funding Cycle $850M 2017-8
- Are you connected with your local coalition?
- How can you help your community?

#4 Training & Testing E-plans

- Training is Required
  - Conducted initially
  - Annual training
  - Training saves lives!
- Drills to test YOUR emergency plan
  - Table Top Exercise to Full Scale
  - Multi-disciplinary/agency/department

Core Elements of CMS Rule

- Risk Assessment
- Policies & Procedures
- Communication Plan
- Training & Testing Plan
- Alternate Sources of Energy to maintain temperatures, safe storage of supplies, lighting, fire detection/extinguishing/alarms; sewage & waste disposal

Are you Prepared? Rule Enforcement

- Who Conducts Surveys
  - SA = Survey and Accreditation Process for CMS by State DPH
  - AO = Accrediting Organization offering "deemed status"
  - RO = Regional CMS Offices support & enforcement
- What is missing????
  - Interpretive Guidelines
  - State Operations Manual
  - Specifies minimum compliance standards

Are You Prepared for a NEW Survey from.....

EMERGENCY Meal Plan Solutions

- HELP

...is on the way!

EMERGENCY Meal Plan Solutions

How to choose?

- Ask the important questions!

Asking the Right Questions

Nutrients & Menus

- Menu suitable for healthcare
- DRIs and all age groups
- Macro/Micro nutrients known
- Mirrors usual meal plan
- Texture modified diets
- Nutrient retention
- Allergies identified

Asking the Right Questions

Therapeutic Diets

- Match YOUR facility diets
- Diabetic
- Renal
- Protein sources accepted
- Diets easily implemented
- Vegetarian diets
- Religious preference

Asking the Right Questions

- Volume feeding plan
- Centralized preparation
- De-centralized prep and/or serving
- Ease of serving

Preparation

- No trained foodservice staff
- No utilities or kitchen
- Equipment needed
- Easy preparation
- Storage space required
- Avoid toxic waste
- Volunteer friendly

Asking the Right Questions

Regulations

- Comprehensive P&P Manual
- HACCP & food safety
- Survey compliant with historical results
- Documentation included
- Training Resources

Asking the Right Questions

Funding

- Hidden cost of preparedness
- Eliminate rotation expense
- Proven shelf life
- Reduce management time
- Improve supply security
- Consider capitalizing expense
- ROI calculation – What is TCO
- Staff & community surge

Hidden Cost of Emergency Preparedness

- Direct Cost
  - Food Cost
  - Replacement of missing food items
  - Store room shelves, locking cage or racks
- Indirect Cost
  - Man hours to inventory monthly
  - Man hours to order & re-order
  - Man hours to rotate
  - Emergency preparedness training
- Potential Cost
  - Labor cost during emergency
  - Survey infractions
  - Public relations

Asking the Right Questions

Support

- Turn-key program
- In-Service & Training Videos
- Operations expertise
- Clinical expertise
- Survey expertise
- Dynamic P&P updates
- RDN created and supported

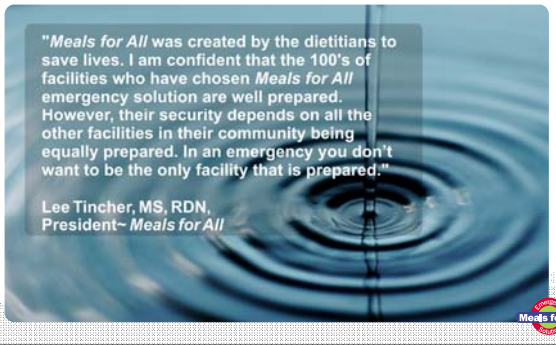
Asking the Right Questions

Other considerations

- Familiar comfort foods
- Delicious recipes
- USDA inspected meat
- Suitable for evacuations
- Lightweight cases
- Use food near end of shelf life
- Refuse plans needed

Meals for All Solution was Designed to Meet "Emergency" Challenges

- ✓Who will you be serving?
- ✓Where will you be serving?
- ✓Care quality
- ✓Passing survey
- ✓Storage space
- ✓Saving money
- ✓Meets therapeutic needs
- ✓Meets altered texture needs
- ✓Food safety
- ✓Enough for ALL – staff, visitors, surge, patients
- ✓ZERO DIRECT COST – No more Rotations!!!



Wayne Toczek

Success Coach
Senior Dining Division
DM&A

Wayne has 30 years of experience in the healthcare market including District Manager, Dining Services Director, and Consultant to senior living dining services programs. He has authored many books and articles on foodservice and innovative dining programs; and has been published in industry trade publications, notably, Provider Magazine, Food Service Edge, and Food Management. His books are approved for CEUs (dietitians, administrators, and dietary managers). Wayne has also created fun and interesting training videos, software for long term care, posters and cartoons for the foodservice industry. He has personally surveyed hundreds of food service operations over his career and has worked as District Manager for one of the largest contract food service management companies in the country. His experience as a Civil Money Penalty consultant for the state of Indiana provides him with a unique perspective on challenges in the food service industry. Wayne is a Sanitarian RDE. He is an instructor for ServSafe and Employee ServSafe, food safety education and certification programs from the National Restaurant Association Educational Foundation. Since 2016, Wayne has been working with DM&A's Senior Living Division.

GOOD TO BEST

BOTTOM LINE

GOOD TO BEST
FOR SUCCESS IN YOUR OPERATION

ARE YOU GOOD WITH YOUR BUDGET ?

- Good: You are able to discuss and articulate when you do not make budget and will try to avoid repeating in the future. If directed to, you can make improvements. You may not have seen it coming but your ready for it.
- You are ready to react to the needs and goals set forth.

GOOD TO BEST

CAN YOU BE BETTER ?

- Better: You are not only able to discuss plans for adjustment, but you are able and ready to follow direction to get it done.
- You knew this day would come and you're up for the challenge.

GOOD TO BEST

GOOD TO BEST

ARE YOU BEING THE BEST ?

- Best: You are always ready, looking ahead asking to lead and eager to implement. The plan has been done and you are ahead of the game.
- You do not have to react because you are proactive; you can say what people need to hear, not just what they want to hear.

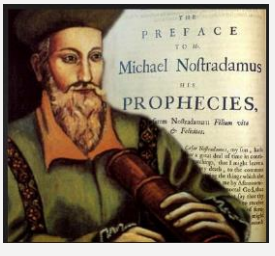
GOOD TO BEST

THE BEST HAVE…

- Fiscal responsibility and control.
- Systems and policies to support.
- Leadership to support staff.
- Work environment for all.
- Customer service to support service
- Compliance with regulatory agencies.

GOOD TO BEST

BEING AWARE OF THE FACTORS THAT HAVE AN EFFECT ON YOUR BUDGET AS WELL AS THE ONES THAT WILL IN THE FUTURE, CAN MAKE YOU THE BEST IN MEETING IT IN THE END



GOOD TO BEST

GOOD TO BEST

ZERO BASE

REVEALING THE UNKNOWN

FOOD -

- Patient or Resident food
- Revenue Generating Food: Café/Vending
- Non cash generating food: Transfers/Floor Supplies
- Internal Catering
- External Catering
- Other Food Provided

- Determine and predict what will be needed in terms of dollars by day, by week and annualize.
- Look at historical data and understand if the data is predictable and indicative of the future.
- Customer and Patient counts are critical.

GOOD TO BEST

PATIENT OR RESIDENT FOOD

- What is your operation preparing for facility wide?
- Are there any upcoming events to change the occupation such as renovation or conversion?
- What has happened historically by month.

GOOD TO BEST

GOOD TO BEST

BEST :PRODUCTION SYSTEM

-The system must be organized and maintained. It must include amounts to be made, room to record leftovers or shortages, reference to recipes, advanced prep and directions on pulling from the freezer.

- Use a computer to maximize your effectiveness.
- Keep records.
- Consider a recipe manager program, such as Master Cook.

.

GOOD TO BEST

RECIPES - BEST

- Accurate purchasing is impossible without the existence and use of standard recipes.
- Concerns require food service operators to know the exact ingredients and correct amount of nutrients in each serving of a menu item.
- Accuracy in menu laws requires that food service operators be able to tell guests about the type and amount of items in their recipes.
- Matching food used to cash sales is impossible without standard recipes.
- Accurate recipe costing and menu pricing is impossible without standard recipes.
- New employees can be trained faster and better with standard recipes.

GOOD TO BEST

REVENUE GENERATING FOOD: CAFÉ/VENDING

Forecasting includes predicting the total amount of revenue generated, guests served and the amount of money each guest will spend.

Advantages of Accurate Sales Forecasts:

- Accurate revenue estimates
- Improved ability to predict expenses
- Greater efficiency in scheduling needed workers
- Greater efficiency in menu item production schedules
- Better accuracy in food purchasing for immediate use
- Improved ability to maintain proper levels of perishable and nonperishable food inventories
- Improved budgeting ability
- Lower selling prices due to operational efficiencies
- Increased profit levels

GOOD TO BEST

INVENTORY TURNOVER

Inventory turnover refers to the number of times the total value of an operation's inventory has been purchased and replaced in an accounting period. Each time the cycle is completed, we are said to have "turned" the inventory.

$$\frac{\text{Cost of food consumed}}{\text{Average inventory value}} = \text{Food inventory turnover}$$

*High inventory turnovers accompanied by frequent product outages may indicate inventory levels are too low.

*Low inventory turnover rates and many slow moving inventory items may indicate the need to reduce inventory levels.

GOOD TO BEST

PURCHASING

- Are you part of a purchasing group ?
- Are you ordering products that have the negotiated pricing ?
- Are you meeting the volume incentive ?
- Is accounts payable meeting the payment terms ?
- Do you track your rebates and credit the department for them ?

GOOD TO BEST

WHEN YOU SHOP !

- Lose consistency.
- Waste time.
- Cannot be aware of price commitment from one week to the next.
- Create more checks and accounting work.
- Lose the method to the madness.
- Lose product familiarity.

GOOD TO BEST

GOOD TO BEST

ANALYSIS OF THE P&L STATEMENT

P & L analysis is a creative process and in general managers seeks to discover the following:

1. Sales/volume
2. Food expense
3. Beverage expense
4. Labor expense
5. Other controllable and non-controllable expense
6. Profits

GOOD TO BEST

REVENUE

- Explore your opportunities and set a goal.
- Set up automation for these opportunities such as pricing, menu and request form.
- Make sure you cover costs (the little things like spices, oil, chemicals, disposable).
- Make sure you understand if the opportunity is to make money or provide a subsidized service .

GOOD TO BEST

RETAIL

Is your retail set up for success?

- Impulse buying opportunities
- Pricing
- Are you setting up the special to compete against other menu items?
- Use of scales to control abuse
- Register/cash handling
- Tracking of peaks and valleys

GOOD TO BEST

GOOD TO BEST

SERVICES OFFERED

- Sometimes services offered are not realistic.

For example:

*Extend café hours.
*Additional choices.
*Free meals or food.
*Inappropriate costing.

GOOD TO BEST

THE BEST

WHEN LOOKING TO CUT COST, THE BEST CONSIDER HOW TO INCREASE REVENUE AND VALUE!!

LABOR

Controllable labor expense (sometimes referred to as productive time): Manager can schedule, add labor or cut labor. (This includes regular hours and overtime.)

Non-controllable labor expense (sometimes referred to as non-productive time): Taxes, benefits, etc. Note you have some control here, i.e. a safe work environment lowers workers compensation costs. (This includes vacation and sick time or PTO.)

GOOD TO BEST

FULL-TIME EQUIVALENT (FTE)

- FTE is determined by the amount of hours a full-time employee works. You can have 2 FTEs but 3 employees working it.
  - 700 hour/week scheduled
  - A workday is 8 hours x 5 days = 40 hours
  - To get the amount of FTE, divide 40 into 700, which equals 17.5 FTEs.
  - This refers to the full-time amount in hours, not in the amount of employees on your schedule.

GOOD TO BEST

BOTTOM LINE

- Know your hours daily and weekly.
- Find out what is in the weekly payroll number. Was holiday or vacation time driving it up ?
- Was this the month with 5 or 6 weeks of payroll ?
- Are high labor hours covered by special events or increased revenue ?

GOOD TO BEST

TURNOVER RATE

Number of employees separated = Employee turnover rate
Number of employees in the workforce

35 employees separated = 70% turnover rate
50 employees in the workforce

Number of employees involuntarily separated = Involuntary employee turnover rate
Number of employees in the workforce

Number of employees voluntarily separated = Voluntary employee turnover rate
Number of employees in the workforce

GOOD TO BEST

CONSIDER THIS…

Whether the separation is voluntary or involuntary, turnover rate is expensive. In both cases the organization will incur costs that are both actual and hidden.

- Actual costs: Vacancy advertising, training hours
- Hidden costs: Increased breakage, slow service, increased waste, poor customer service

GOOD TO BEST

PAPER/DISPOSABLES

- Are you using the right items for the correct application ?
- Does it have to be disposable or would it be better to buy something that will pay for itself over time ?

GOOD TO BEST

OTHER SUPPLIES, CHEMICALS AND SERVICES

- They are costs to you if not managed properly.

GOOD TO BEST

THE BEST

- Review your programs, make decisions if they are not working out or paying off.
- Revive them when you can, but be prepared to cut ties.
- Do your homework and justify the intentions !

GOOD TO BEST

BOTTOM LINE

ALWAYS CONSIDER LOSS PREVENTION A LIABILITY IF NOT MONITORED !

YOUR TIME IS MONEY !

- Use the technology out there.
- Computer program should save time.
- Everything should be done on computer.
- Calling a vendor to place an order is outdated.
- Use the internet.
- Network to solve problems.

GOOD TO BEST

YOUR TIME IS MONEY !

- Read trade magazines.
- Attend food shows with a goal in mind.
- Be aware of your surroundings [marketing and mechanizing of food].
- Try new things.
- Take what you like from this presentation and apply it !!!!!!!

GOOD TO BEST

Linda Handy, MS, RD

Handy Dietary Consulting
Retired Surveyor/Trainer – CA Dept. of Public Health

After working at Boston City Hospital and more than a decade as a Food Service Director at two of the largest multi-level continuing care campuses in San Diego, Linda accepted a position as a Specialty Dietitian Surveyor/Trainer for CA Dept. of Public Health, where she was extensively trained. She participated on the survey of many hundreds of CA hospitals and nursing homes. She also taught over a 1,000 surveyors how to inspect using state and federal regulations in "dietary services" in the New Surveyor Academy in Sacramento. She was loaned from CDPH to participate on the CMS Workgroup to revise the Surveyor Guidance for Sanitation and develop the first Investigative Protocol for Kitchen Observation (issued Sept 2008) which is still being used. Now retired, she uses that wealth of regulatory compliance knowledge in providing Mock surveys and consultation to hospitals and nursing homes as they develop Plans of Correction after difficult surveys. Her website at www.handydietaryconsulting.com lists her self-study training manuals, approved for continuing education for dietitians and dietary managers, and she is widely sought after for her dynamic presentations at healthcare conferences. She says, "I believe that most dietary leadership are hardworking, diligent folks, who would want to be compliant with all regulations, but often do not know what is required. And the federal requirements are becoming more challenging as CMS is demanding that surveyors hold hospitals and nursing homes more accountable. My passion has been to share my good fortune and experience."

Linda has a Bachelor's Degree in Nutrition from Brigham Young University, Provo, Utah and a Master's Degree in Food and Nutrition from Framingham State College, MA. Linda has taught at 5 different colleges, including full time for two years, and is currently Adjunct Instructor/Advisory Board in the Dietetic Division of Mesa College, San Diego. Recognized for her professional contributions "to many DPG (Dietetic Practice Group) meetings, publications, and committees," she received a Distinguished Member Award, at FNCE 2011 (Annual Conference of Academy of Nutrition and Dietetics, AND). She has contributed articles to many AND publications, participated on publication revisions, and was asked to be a member of the committee to develop the Scope of Practice/Scope of Professional Responsibility for Registered Dietitians in extended care (2010). She is also an advocate for the dining culture change in nursing homes to promote elder rights, choice, liberalizing of diets, and quality of life, and from 2010-2014 was asked to be on the CMS/Pioneernetwork Task Force for the development of the new Dining Practice Standards (issued Sept 2011) and "ToolKit" for its implementation (issue date April 2014).

Steve McKenna, CDM
Director, Field Operations
DM&A

Steve brings a broad array of service skills to our team, with hospitality and management experience across a wide spectrum. Most recently he served for twelve years in corporate services for a major healthcare organization, where his portfolio included, not only food and nutrition services, but also environmental services and a number of other hospital disciplines, including, life safety, patient transportation, laundry services, television and telecommunication, and records management.

A former restaurateur, Steve has been a featured speaker at healthcare symposiums and has collaborated with the Culinary Institute of America, training students in healthcare foodservice. His collaborative approach to meal delivery has been featured in nursing periodicals and his dining programs have also been cited in published articles.

Previously, Steve has held regional management positions with several contract companies. In one role, he operated food and nutrition services for fifteen hospitals and long-term care communities throughout the northeast. In another, he oversaw over twenty business dining and catering accounts for well-known corporate clients. His expertise brings DM&A the opportunity to further expand our menu of services, as we continue to offer our clients a wide array of avenues in which to go from “Good to Best”. His roles include project manager for room service, as well as leading Destination 10® programs for both foodservice and EVS departments.

GOOD TO BEST

DM&A

DEMYSTIFYING ROOM SERVICE IMPLEMENTATION

STEVE MCKENNA
Director, Field Operations

GOOD TO BEST

Agenda

DM&A

- Historical perspective
- Room service definitions
- Here to stay or just another fad?
- Benefits of room service
- The steps to room service
- Common mistakes
- Room service testimonials

GOOD TO BEST

Historical Perspective

DM&A

- **Hospital food** was the source of **jokes** until fairly recently
- **First** limited room service dates to US military **mid-70**'s
- **1980s** – First full room service appears in hospitals; lots of wrinkles; seen as an elite option
- **1990s** – Room service start ups continue
- **2003** – DM&A enters the RS arena
- **2011** – DM&A becomes largest independent room service installer in the US.
- **2017** – RS is by now the platinum standard, but there continues to be various ways to enhance dining (culinary upgrades, team training, better scripting)

GOOD TO BEST

GOOD TO BEST

Examples – Industry Challenges

- **2007** – 500-bed hospital. Started room service. 15 FTE's short to operate room service, with inevitable result. FSD terminated. We spend significant time planning the labor and recommend that you NOT enter the project without good numbers
- **2008** – Hospital in Oregon, prior to our involvement, ordered incorrect equipment, requiring additional costs and time
- **2010** – (Name withheld) Hospital, Illinois. Designer did poor job of designing and planning. Project stopped. Equipment was returned. Administration so frustrated that they called in (major contractor)
- **2010** – (Name withheld) California New Hospital project. Room service design not functional. DM&A re-designed

GOOD TO BEST

Room Service Definition

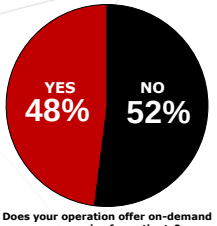
- **Customers order what they want when they want** it from a restaurant menu, between the hours of 7AM and 7 PM (approximately). It's a restaurant with nutrition screening and advice
- Most foods such as eggs/omelettes, chicken, fish, hamburgers, pizza are made fresh to order.
- Food savings may offset labor additions
- Certain "enhanced dining" models might serve as a bridge to full room service

GOOD TO BEST

Room Service – Here to Stay

FOODSERVICE DIRECTOR 2016 Healthcare Census:
Hospitals raise their game

✓ Room service continues to rise, with slightly more operators offering on-demand meals compared to last year. The larger the hospital, the more likely it is to offer room service – 67 percent of operators with F&B purchase of $5 million or more offer it, compared to 27 percent of hospitals with purchases less than $200,000.

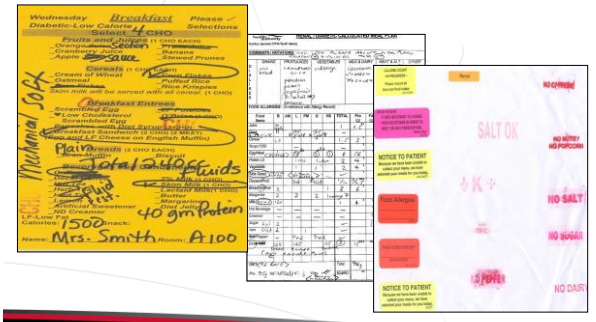


Does your operation offer on-demand room service for patients?

GOOD TO BEST

GOOD TO BEST

No more of this…



GOOD TO BEST

STICKER SHOCK

GOOD TO BEST

GOOD TO BEST

GOOD TO BEST


DM&A
GOOD TO BEST


DM&A
Uniforms by DM&A
Quality food &
Customer service
with a smile!
GOOD TO BEST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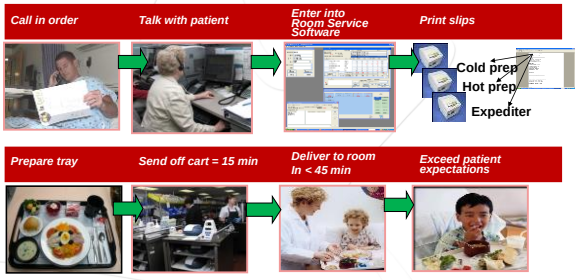
GOOD TO BEST

Room Service Steps



Benefits

- Increased patient satisfaction
- Fresher food transforms quality and sends a healthy message
- Reduced food waste –we will analyze this for you; generally 15-20%, often more
- Food service, nursing, and hospital staff are happier and proud of the product
  - More professional work environment
  - Easier to hire and retain staff
- Reduced risk of contract takeover

More Benefits!

- Dramatic reduction in wasted trays
- Patient consumption increases
- Floor stock is reduced
- Guest trays may provide added revenue
- Hospital image improves (C-suite is pleased!)
- More competitive in marketplace

Common Mistakes

DM&A

- Presuming that since you are an expert in food service, you must be an expert in room service
- Presuming that every designer and architect is a kitchen expert
- Presuming that if a peer claims something on a listserv or on the internet, it must be true
- Creating a Greek diner menu with 1,000 options
- Thinking that an automatic entree with 6 "every day choices" constitutes room service

GOOD TO BEST

Common Mistakes

DM&A

- Buying the wrong equipment or putting good equipment in the wrong place.
- Assuming that some sites can't have RS (big, small, specialty, high % diabetics)
- Making a mistake on projected staffing: this will sink your project and likely your job. It depends on building layout, staff skills, and other factors
- Not planning properly for database building
- Not having a committed departmental team to get through the project---lots of work!

GOOD TO BEST

Common Mistakes

DM&A

- Not allowing enough time to plan and implement room service. We won't tell you that this can be done in 3-4 months because it will rarely happen that fast. We'll give you a good estimate on our assessment visit once we get to know you
- Failing to obtain extensive support for start up.
- Assuming that every first day is a horror show. Proper planning makes first day manageable

GOOD TO BEST

GOOD TO BEST

Steps to Room Service

DM&A

Step 1 Call DM&A for a proposal for a *room service assessment.* Do this before administration asks you about room service so that you are well prepared with the facts

Step 2 Schedule DM&A for the on site room service assessment/study. In the study you will get data regarding:

- ✓ **Capital equipment needed**
- ✓ **Non-capital equipment needed**
- ✓ **Preliminary layout (concept design)**
- ✓ **Staffing required over and above present state**
- ✓ **Projected food savings**
- ✓ **10 year ROI to help justify room service financially**
- ✓ **Our fee to present a turnkey kitchen**

GOOD TO BEST

Steps to Room Service

DM&A

Step 3 During the same site visit we will host a debrief, and ask for 7-10 days to refine numbers and provide a written document

Step 4 If you contract with DM&A for implementation, we will begin service in 4-6 weeks from receipt of contract

Step 5 Go-Live: we use about 40-50% of our contracted coaching time for go-live week

Step 6 During the final 2-3 months especially, we expect conference calls on an increasing basis

GOOD TO BEST

Morris Hospital

DM&A

Room Service plays key role in increasing patient satisfaction scores

About

MORRIS HOSPITAL

Room Service 200—Gold Medal Winner

What Patients Like Best

The Champion Behind the Change

Shared Best Practices

Scores in the 99th Percentile!

GOOD TO BEST

Morris Hospital

"Room Service is phenomenal! Patients love it, and we have positive interaction with the patients."
- Nancy Stewart, FSD

Chef Don Miller and Client

Nancy Stewart, MS, RD
Morris Hospital - Morris, Illinois

GOOD TO BEST

For More Information

Please contact

DM&A
Steve McKenna
steve@destination10.com
619-656-2100
www.destination10.com

GOOD TO BEST

Sally McCray

Director of Nutrition and Dietetics
Mater Health, Brisbane

Sally McCray has been the Director of Nutrition and Dietetics at Mater Health, Brisbane since 2001. Mater Health includes adults, maternity and paediatric public and private hospitals across three Brisbane campuses. Sally has worked in a number of hospitals in Australia as well as in Canada over her 23 years as a Registered Dietitian. She has experience within a number of different healthcare foodservice models as well as in restaurant and hotel foodservice environments. She holds an Honorary Adjunct Assistant Professor position with the Faculty of Health Sciences and Medicine at Bond University, Queensland and is an Honorary Fellow at Mater Research Institute – The University of Queensland, Australia.

One of Sally's particular areas of interest is the development and implementation of innovative foodservice models to achieve optimal patient clinical outcomes, healthcare cost management and of course customer satisfaction. She is particularly interested in the clinical benefits of foodservice models as they relate to patients' nutritional intake and possibly as a tool to address the global issue of malnutrition risk in the healthcare setting. Her current research is focused on a "balanced scorecard model" in regards to measuring and documenting the benefits of room service and she is currently pursuing the question "Is room service a new treatment to help manage malnutrition?"

Do You Want To Provide Food or Do You Want Your Patients *to Eat*?

Room service improves nutritional intake in hospital

Sally McCray
Director Nutrition and Dietetics
Mater Health Brisbane
sally.mccray@mater.org.au

Mater
Exceptional People. Exceptional Care.

- 7 Hospitals
- Public and Private services
- Adults, Maternity and Paediatric facilities

Challenges/ Drivers?

Financial	Patient experience
• Cost containment/ budget restrictions • Manage to budget • Costs ($/ meal or OBD) • Rosters/ schedules	• Patient satisfaction • Patient engagement • Patient satisfaction • Quality/ temperature of food • Patient satisfaction
Systems and processes	**Clinical care**
• Mass food production • Traditional manual models – slow to embrace technology • Operational schedule ≠ clinical schedule	• Increasing clinical complexity • EBP/ research underpins care • National standards (NSQHS) • Increasing complexity of diets • Menu design and nutritional quality • Clinical schedule ≠ operational schedule • Malnutrition prevalence

"Mission Vs. Margin"
"Nutrition Vs. Foodservices"

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Malnutrition – The Clinical Issue

- Prevalence well recognised in the acute setting
  - 25-80% (higher in the elderly, cancer population, long stay units)
- Increased readmission rates *(Agarwal E et al. Clin Nutr, 2013; 32: 737-745)*
- Increased LOS; higher treatment costs *(Norman K et al. Clin Nutr, 2008; 27:5-15)*
- Increased pressure injury prevalence *(Banks M et al. Nutrition 2010; 26:896-901)*
- Risk of infection *(Fry DE et al. Arch Surg, 2010; 145-151)*
- Risk of falls *(Bauer JD et al. J Hum Nutr and Diet 2007; 20:558-564)*
- Independent risk factor - higher complications, increased mortality, LOS and costs *(Isabel M et al. Clin Nutr, 2003; 22: 235-239)*
- Poor hospitalisation outcome, increased costs *(Lim, SL et al. Clin Nutr, 2012; 31: 345-350)*

Nutritional Intake and Malnutrition
The Australasian Nutrition Care Day Survey, 2010

(Agarwal et al, **Clin Nutr**, 2013)

- 56 hospitals; 3122 patients; Australian and NZ

Prevalence

- 32% malnutrition prevalence

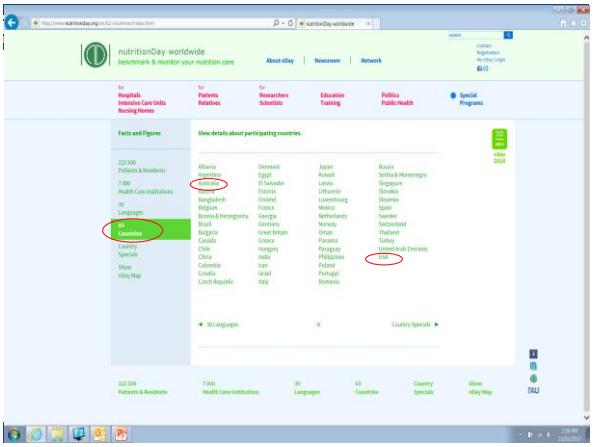
Outcome data

- Malnourished pts. 1.5 times more likely to die within hospital within 30 days
- 90 day outcome data, risk factor for death increases four times
- 50% longer LOS
- Greater readmission rates (36% vs. 30%)
- 1 of 3 malnourished pts. eat <25%; 1 of 5 well nourished pts. eat <25%
- Malnutrition and poor food intake are independently associated with in hospital mortality
- Cancer pts. 1.7 times more likely to be malnourished; prevalence of 50-80% *(Boltong A et al, Australian Health Review, 2013)*

NutritionDay Survey, Europe 2006

Hiesmayr et al. **Clin Nutr**, 2009

- 16,455 patients; 256 hospitals; 25 countries
- 60% patients did not eat full meal
- Progressive increase of 30 day mortality with decreased food intake
  - <1% eating full meals ***vs***. 6% < 25% intake ***vs***. 9% eating nothing
- ***Reasons:*** Not hungry (43%); normally eat less; don't like taste; don't want to eat; nausea
- ***Recommendations (UK NICE):*** fortified food, additional snacks/ sip feeds, enteral/ parenteral nutrition



Mater Health – Malnutrition Audits

- Prevalence is 24-27%
- Highest prevalence and numbers in oncology wards
- Highest prevalence in >65years; as age increases prevalence increases
- Highest prevalence in LOS >21 days; as LOS increases, prevalence increases
- Between 11-50% are on a restrictive diet, varies by facility*
- 28% of pressure injury pts. (n=18) were malnourished

- Intake is <60% requirements

Pre 2013….

Model	Issues
Fully manual, paper based menu; cook fresh	Manual system – inefficiencies/ paper waste
Manual recipes *(limited analysis)*	Poorly integrated menu – production load
Approx. 900 meals; 3 x day	Poor nutritional analysis of menu
Approx. 80 diet types + combinations *(low integration in menu)*	Significant wastage of supplements
Standard mid meals/ supplements/ fortification	High plate waste (30%) and kitchen waste
Meal order taken up to 24hrs in advance	Many late meal deliveries/ default meals
Low/ no interaction with patient meal ordering	Poor nutritional intake – approx. 60% requirements
Meals delivered at set meal times *(artificial)*	Patient feedback

Mater Private Hospital

- Adult private facility
- 323 patient beds
- 10 Operating theatres; 24 hour Emergency
- + 35 clinical services

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Room Service Choice on Demand ™

"The right meal to the right patient at the right time"

1. Significant shift from healthcare foodservice focus to a hotel foodservice focus
.....whilst still maintaining healthcare ***risk management*** and ***clinical acuity*** framework

2. Focus on patient driven care
- Shift to customer focused service vs hospital driven timetable
- Shift to greater patient engagement and participation

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Operationalizing Room Service

1. Redesign of kitchen
2. Redesign of menu - 1 hotel style a la carte menu (challenge to integrate diets)
3. Redesign of meal process - meal order and timing driven by the patient

- Implementation of electronic menu management system
- Strong customer focus – training, service delivery
- Integrated multidisciplinary team; focus on nutrition

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The Menu

- ✓ 1 'a la carte' restaurant style menu
- ✓ 97% diets integrated
- ✓ 0630-1900hrs service
- ✓ All day breakfast
- ✓ "Build your own" concept/ flexibility
- ✓ Educational symbols

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Room Service Choice on Demand

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Measuring Outcomes

Mater Food and Nutrition Balanced Scorecard

Financial performance ✓ - Reduced food costs - FTE neutral - Reduced waste ? ↓ *Financial sustainability*	Patient experience ✓ - Improved patient satisfaction (Press Ganey) - Consumer engagement *(Standard 2)* ↓ *Put the patient first*
System integration and change ? - Manual → electronic - Process efficiencies - Patient identification *(Standard 5)* ↓ *Be responsive*	**Clinical care and outcomes** ? - Reduction errors/ default meals - Increased nutritional intake *(Standard 12)* - Increased patient safety/ monitoring ↓ *Provide safe quality healthcare*

❖Australian National Hospital Accreditation Standards

Nutrition (standard 12); Consumer Engagement (standard 2); Patient identification (standard 5)

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Mater Food and Nutrition Balanced Scorecard

1. Financial Savings	2. Patient satisfaction
3. System integration and efficiencies	4. Clinical Outcomes

Mater Food and Nutrition Balanced Scorecard

1. Financial Savings • Reduced patient food costs (15-20%) • Improved stock control/ purchasing • FTE neutral • Reduced plate waste/ production waste • Nil incorrect/ default meals	

Mater Food and Nutrition Balanced Scorecard

1. Financial Savings • Reduced food costs – 15-20% • Improved stock control/ purchasing • FTE neutral • Reduced plate waste/ production waste • Nil incorrect/ default meals	2. Patient satisfaction • Improved Press Ganey scores • Better menu integration and choice/ flexibility • Greater patient interactions and engagement • Nil default meals

Mater Food and Nutrition Balanced Scorecard

1. Financial Savings • Reduced food costs – 15-20% • Improved stock control/ purchasing • FTE neutral • Reduced plate waste/ production waste • Nil incorrect/ default meals	2. Patient satisfaction • Improved Press Ganey scores • Better menu integration and choice/ flexibility • Greater patient interactions and engagement • Nil default meals
3. System integration and efficiencies • Manual → electronic • Integrated patient safety measures – compliance; identification; audit data • Evidence for national standards • Nutrition embedded into the MDT	

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National Accreditation Standards

12. Provision of Care

1. Assessment and care planning ensure that current and ongoing needs of the consumer / patient are identified.

2. The organisation ensures that the nutritional needs of consumers / patients are met.

3. Systems for ongoing care and discharge / transfer are coordinated and effective and meet the needs of the consumer / patient.

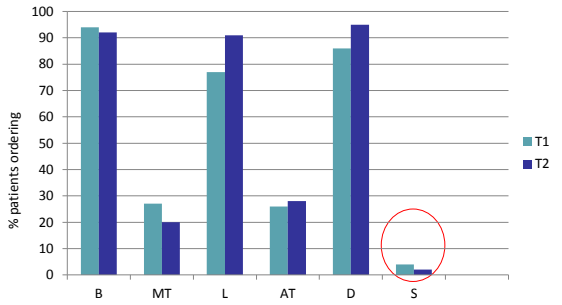
4. The care of dying and deceased consumers / patients is managed with dignity and comfort and family and carers are supported.

Mater Food and Nutrition Balanced Scorecard

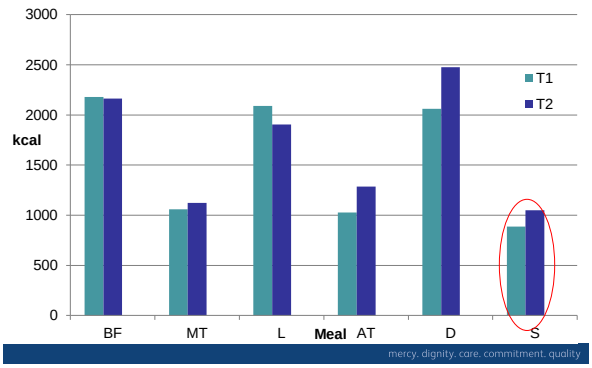
1. Financial Savings • Reduced food costs – 15-20% • Improved stock control/ purchasing • FTE neutral • Reduced plate waste/ production waste • Nil incorrect/ default meals	2. Patient satisfaction • Improved Press Ganey scores • Better menu integration and choice/ flexibility • Greater patient interactions and engagement • Nil default meals
3. System integration and efficiencies • Manual → electronic • Evidence for national standards • Integrated patient safety measures – compliance; identification; audit data • Nutrition embedded into the MDT	4. Clinical Outcomes • Nil default/wrong meals • Improved management allergies and intolerances • Patient satisfaction = nutritional intake? • Improved nutritional intake

mercy. dignity. care. commitment. quality

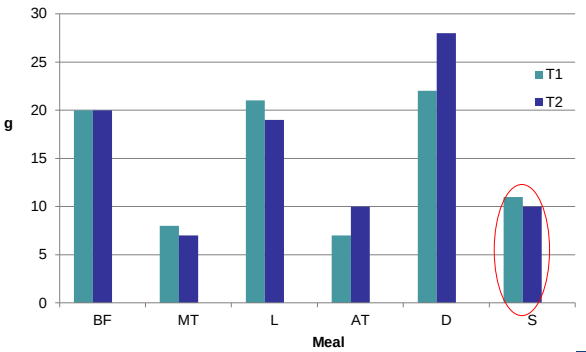
RS Meal Ordering Pattern



RS Energy Intake by Meal

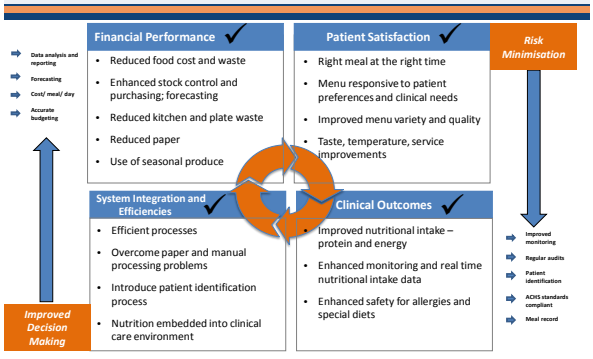


RS Protein Intake by Meal



Nutritional Intake Data Collection (Mobile Intake™ - *November 2016*)

- Document intake as trays collected
- Mobile tablet device/ ipads
- Nutritional intake : Plate waste
- Screen displays exact food served to patient
- % intake : waste & reasons
- Nutrient contribution by meal, day, series of days

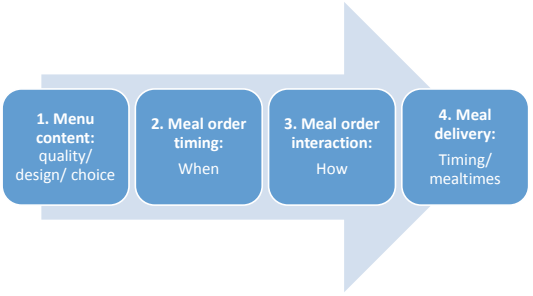


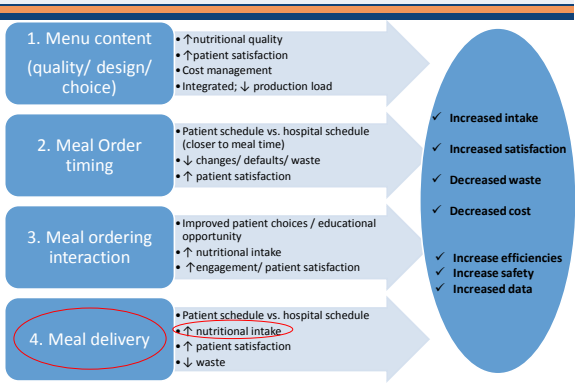
Mater Food and Nutrition Balanced Scorecard

Key Learnings

- Patients know what they want and when they want it
- Increasing role of consumers in their healthcare decisions ➔ participatory medicine
  - ➢ Our role is to provide a safe and clinically appropriate framework and environment to assist consumers to do this
- There are key points in the foodservice process that we can manipulate to enhance outcomes
- Use of electronic menu management system and process redesign allows ***integration of nutritional requirements and intake monitoring into daily clinical care***

The Patient Foodservice Process → the points to manipulate





Barriers to Nutritional Intake – *patient perspective*

(Hiesmayr et al. Clinical Nutrition 28, 2009, 484-491)

- ***Reasons:*** not hungry (43%); normally eat less; don't like taste; don't want to eat; nausea

(Mater Private Hospital Room service implementation, 2013)

- ***Reasons:*** satiated (53%), discomfort/nausea/unwell, taste/temp/dislike, poor appetite, default meal (no choice)

- "Keep calm and protect mealtimes: But what is the evidence? The findings of a systematic review and meta analyses" *Porter et al, AuSPEN 2016*
  - 150 studies retrieved; 7 met criteria; 3 original research papers
  - No stat significance; insufficient evidence for PM implementation
- "Evaluating an innovative foodservice approach to malnutrition in healthcare" *Collins et al, AuSPEN, 2016*
  - High energy menu; enhanced mid meal service (visual tools); greater patient interaction
  - Improved intake; no change patient satisfaction; study underpowered

The solution to poor nutritional intake?

- ***Reasons:*** Not hungry, feeling full, nausea, feeling unwell, poor appetite…..
- ***Recommendations:*** fortified food, additional snacks/ sip feeds, high energy menu, protected meal times?

OR……

- Provision of
  - a wide range of….
    - high quality foods…
      - at times that patients feel like it?

…….Room Service Choice on Demand!

Our Future?

- Room Service across public and private hospitals and a range of cohorts *(adult, maternity and paediatric)*
- Ensure routine outcome measurement
  - Mobile Intake™
  - Evidence based foodservice models
- Further research into solutions for improving nutritional intake ⇒ malnutrition risk and prevalence
- Foodservice models as a primary clinical treatment?

- *"In summary…… **malnutrition** might be one of the most important factors that interferes in health and disease in the hospital setting……*

*…….. The best decision is to treat the disease and **nourish the patient**…..*

*……..therefore it is fundamental to understand the **significant role that nutritional therapy plays** in improving the outcome of those who cannot or may not eat during their disease process, similar to what hemodialysis represents to patients with renal failure or ventilatory support to those with respiratory failure."*

Isabel, M et al. Clinical Nutrition, 2003 22(3): 235-239

Do You Want To Provide Food or Do You Want Your Patients *to Eat*?

Room Service……. A new clinical treatment for malnutrition risk?

Sally McCray
Director Nutrition and Dietetics
Mater Health Brisbane
sally.mccray@mater.org.au

Mater
Exceptional People. Exceptional Care.

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Thankyou

Sally McCray
Director Nutrition and Dietetics
Mater Health Brisbane
sally.mccray@mater.org.au

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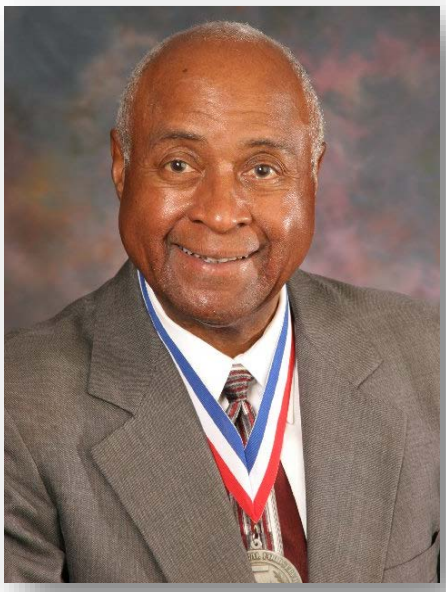

Carlton Green, Ph.D.

Silver Plate Winner

Success Coach, DM&A

Dr. Carlton Green is one of the most recognized and highly respected healthcare executives in North America. He holds a BS Degree in Nutrition Science, a Masters in Hotel and Restaurant Management and a Ph.D. in Business Administration.

Dr. Green's accomplishments in the healthcare industry over a 25-year period are well documented in the trade journals, to include many major cover stories.

Carlton is best known for orchestrating one of the most dramatic turnarounds in healthcare history at the UCLA Medical Center foodservice department. In just 12 months Carlton and his new team saved 12 million dollars per year, increased revenue by 1.2 million per year and increased Press Ganey customer satisfaction scores to the 98 percentile.

This team accomplishment led to Carlton winning the **Silver Plate award**—an award that goes to the industry's most outstanding operator during a particular year.

Carlton is now a Success Coach for DM&A, a company that specializes in helping healthcare teams go from "Good to Best".

Carlton is a proud husband of 50 years, father of 6, and grandfather of 6. He is also the proud author of a new book called, *What is the Purpose of a Banana?: Critical Success Factors for Effective Leadership.*