

PENINSULA COMMUNITY HEALTH SERVICE

NUTRITION SERVICE

This document includes:

Reorientation of Nutrition Service Delivery Policy, January 2003

Evaluation of Service Delivery Policy, October 2004

Nutrition Service Evaluation Review, December 2005

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REORIENTATION OF NUTRITION SERVICE DELIVERY POLICY

Endorsed by PCHS Management and CEO, 21 January 2003

Executive Summary

The nutrition service at Peninsula Community Health Service (PCHS) has seen much change during its 15 years of representation within PCHS, growing from 1.0 EFT and one position to 2.0 EFT and three positions, one at each of the three sites. During this time, government direction and community comparative need, has specified that the dietitians undertake all aspects of community nutrition from individual nutrition intervention and counselling to community development and health promotion work. At times the allocation of resources has been focussed on one or other of these types of interventions, with present funding agreements being based on individual and group services and specific target groups. Health promotion within the organisation is seen as central to all service providers' work that provides ongoing challenges to the dietitians. Making time for developmental health promotion and public health nutrition work is often replaced by the demands for individual and group services.

The Mornington Peninsula has great nutrition needs specifically in relation to non-communicable diseases or 'lifestyle' diseases¹. Evidence suggests that individual and group nutrition education on lifestyle modification has limited outcomes and recommends that lifestyle modifications are best addressed through public health interventions.

The purpose of this model of service delivery is to create a more public health oriented nutrition service at PCHS using existing resources. In this model, public health nutrition is defined as population or community-wide activities that focus on the underlying causes to nutritional health problems. Strategies for public health nutrition includes health promotion or any other process that aims to achieve change in broader social systems using partnership approaches, critical thinking, reflective practice and respects community beliefs and values². The aim of this change in service delivery is to make healthy choices, easy choices for the people of the Mornington Peninsula. This model will initially look at building capacity for public health nutrition and will have outcomes for PCHS, the dietitians and the Mornington Peninsula community.

¹Magnus, A. and Bensberg, M. September (2000) Southern Metropolitan Burden of Disease Study: Mortality and Morbidity. Department of Human Services.

Background

Current Nutrition Service Delivery by PCHS

The nutrition service commenced at PCHS in November 1987 with 1.0EFT community health funded allocated to service the whole Mornington Peninsula region including Mornington, Hastings and Rosebud local government areas from the Mornington site of Peninsula Community Health Service (PCHS). Like Australia, in the Southern Metropolitan Region of Victoria, cardiovascular disease and cancer (particularly lung, bowel and breast cancers) contribute to the greatest burden of disease¹. In addition, the Peninsula has the highest rates of admission to hospital for complications of diabetes and heart disease in the Southern metropolitan area². These diseases are strongly linked to nutrition and lifestyle. The Mornington Peninsula's burden of disease is similar to the state average, however unlike other metropolitan areas, the Mornington Peninsula population has less access to health services because of issues such as transport and lack of knowledge of services. The Mornington Peninsula is also one of the most socio-economically disadvantaged and unequal regions in Victoria^{1,3}. Health services on the Mornington Peninsula are limited with PCHS three bases being the only low cost community health service available. Rosebud hospital has no outpatient service and Frankston Hospital, although outside the Mornington Peninsula catchment area has an outpatient nutrition service, which is only available for individuals who have been inpatients of Frankston hospital. Private health services at two private hospitals and a small range of private clinics are available. All of these private services offer nutrition services at a much greater expense to the client.

The initial dietitian position of PCHS was based on community education, which contributed 50% of the workload focusing on establishing partnerships with other workers, volunteers, teachers and other community health dietitians to promote nutrition awareness in the community. Individual clinical work, professional development and community development (a somewhat undefined term then) accounted for 20% of time each (Karen Ridgway, personal communication April 2002). There was also the provision in the job description for "ongoing review of the dietitians work roles" to improve the service delivery. In October 1992 the Liberal government was appointed in Victoria and community health centres were directed to base their services on primary care. Great demands were placed on the dietitians to meet service directives and despite resistance, demands for individual clinical services continued to increase. The networking that had previously formed part of the job roles only put further demands on the clinical service. Ongoing political pressures continue to play a large part in influencing the nutrition service delivery and funding round targets are already predetermined before being made available for community health services. For example, current trends are towards chronic disease management and prevention of hospital admission in community health services. These service directives limit PCHS capacity to be flexible and develop services or programs that truly reflect the needs of the local community.

Since the commencement of the original nutrition service an additional 1.0 EFT of community health and home and community care (HACC) funding, has been allocated to the nutrition service that has been spread across the three sites – Hastings 0.5EFT, Rosebud 0.9 EFT, Mornington 0.6 EFT. Despite the change in state government, the nutrition service continues to battle on a day-to-day basis to meet the demands and service targets for individual and group

² Department of Human Services. (2001) Health Outcomes Section. Public Health Division. Victorian Ambulatory Care Sensitive Conditions Study. Preliminary Analyses

³ McCaffer, J. (2002) Health and Well-Being Study. Mornington Peninsula Shire Council.

work and make time for health promotion projects and organisation based work. These time restrictions prevent the PCHS dietitians from working on any public health nutrition. Priority continues to be given to individual clinical and group work to meet service agreements defined by government. In addition, although strong nutrition policy in Australia exists, (National Food and Nutrition Policy (1994)⁴, the Australian Dietary Guidelines (1992)⁵ and more recently 'Eat Well Australia' (2000)⁶), the community nutrition services in Victoria have not made attempts to work towards any of the priority areas outlined in these policies due to limited resources and support.

Capacity for Health Promotion and Public Health at PCHS

In 1999 PCHS appointed a Health Promotion Coordinator who worked to establish health promotion infrastructure within PCHS, which included development and implementation of a Health Promotion Policy. This policy states that “the principles of health promotion underpin and are an integral component of all service delivery at PCHS ... services (are required to) allocate 15 to 35 percent of their community health budget to health promotion.”⁷ In addition, the recent community health framework also expects a commitment to health promotion and prevention by community health service providers⁸. These policies provide challenges to all workers at PCHS including dietitians.

The nutrition service has supported the PCHS health promotion policy and Department of Human Services (DHS) draft health promotion guidelines⁹ as a model and has tried to work within a health promotion framework within all aspects of the nutrition service. To date most health promotion work has been on an individual and group level through screening, information and education and through supporting organisational development via establishment and membership on various organisational committees. Some community focussed programs, such as the 'Body Image Project' have attempted a wider focus to planning and implementation through involvement of the community and a prevention focus. This project involved partnerships with a university, which provided the capacity for a broader approach but with a lack of focus on PCHS strategic directions and state wide public health nutrition policy, the project integration was limited.

The health promotion policy and draft health promotion guidelines expect that all staff, including dietitians, will work proficiently across all areas of the health promotion continuum. The nutrition position descriptions include as a desirable criterion “a demonstrated ability to plan implement and evaluate programs and activities” and “experience in, and commitment to, health promotion and early intervention” but have “experience and skills in a range of dietetic specialties including diabetes, cardiac and nutrition risk screening/assessment” as an essential selection criteria. In addition the nutrition and dietetics training in Victoria focuses on clinical nutrition and has limited public health nutrition content (Malcolm Riley, personal

⁴ DHHCS (1994) Food and Nutrition Policy. Commonwealth Department of Health, Housing and Community Services, Canberra

⁵ NHMRC (1992) Dietary Guidelines for Australians. National Health and Medical Research Council, Canberra.

⁶ National Public Health Partnership. (2000) Eat Well Australia: An agenda for action in public health nutrition 2000-2010. SIGNAL.

⁷ Peninsula Community Health Service Health Promotion Policy. 12 September 2002.

⁸ Department of Human Services (2002) Community Health Unit. Towards and Community Health Policy Framework: Discussion Paper.

⁹ Department of Human Services. (2000) Draft Health Promotion Guidelines.

communication, 2002). As identified by the capacity building committee of PCHS, staff involved in recruiting within PCHS may not have an intricate understanding of health promotion or public health nutrition and focus less on this aspect of a dietitian's application. As such, nutrition staff may lack the interest or skills in health promotion and public health nutrition and easily succumb to the demands for clinical work and spend the majority of their work time in this area. In addition public health nutrition projects require a great investment of time that is not currently available with the existing service structure, and support for public health nutrition activities is limited due to the lack of public health nutrition workforce in Victoria¹³. Although working with communities is often more difficult, this should not be an excuse to move away from a population focus in community health.

In Victoria there has been recent interest and commitment to public health nutrition with the appointment of a statewide public health nutritionist and the commencement of projects aimed to build public health nutrition infrastructure in Victoria, such as the development of nutrition monitoring and surveillance program and public health nutrition workforce development project. The Dietitians Association of Australia (DAA) has identified a small number of public health nutrition experts that are made available to members. The nutrition workforce project indicates that no community nutrition service in Victoria is providing adequate public health nutrition and includes recommending greater support for community health service dietitians to work on public health and health promotion¹⁰. Directives from the Department of Human Service (DHS) in relation to these recommendations are pending.

Public health nutrition is vital to make a significant impact on the nutritional health of communities. Evidence suggests that a clinical/treatment approach to health problems only make small improvements in health¹¹. An example of this is the increasing prevalence of overweight and obesity in Australia despite the concurrent increase in knowledge, awareness and education about obesity, nutrition and exercise¹². In addition with the majority of morbidity and mortality in Australia from non-communicable diseases, the focus for management and prevention should be on lifestyle modifications (eg. stressful living, tobacco smoking, nutrition, lack of exercise and environmental factors). Lifestyle modifications, including nutrition, are better addressed through public health interventions as it is well known that educational interventions fail to achieve intended results^{13, 14}.

¹⁰ Hughes, R. and Woods, J. (2002) Workforce Development Project. (Unpublished).

¹¹ Palmer and Short. (2000) Health Care and Public Policy: An Australian Analysis.

¹² Eggar, G. and Swinburn, B. (1997). An "ecological" approach to the obesity pandemic. *BMJ* 315; 477-80.

¹³ Syme, S.L. (1998) Individual vs. community interventions in public health practice: Some thoughts about a new approach. *Health Promotion Matters* 2; 2-9.

¹⁴ Eggar, G, Spark, R, Lawson, J. and Donovan, R. (1999) Health Promotion Strategies and Methods. McGraw-Hill Book Company. Australia Pty Ltd.

Purpose of the Model

The model of service delivery intent is to direct the PCHS nutrition service to ensure that within the three nutrition positions, expertise in public health nutrition and health promotion in addition to nutrition-related disease expertise with individuals and groups is available for the people of the Mornington Peninsula. The aim of this change in service delivery is build capacity to assist in making healthy choices easy choices for the people of the Mornington Peninsula.

The outcomes of implementing this model of service delivery are many. Communities of the Mornington Peninsula will continue to have access to individual and group nutrition services but in addition, the knowledge gained from these interventions will be supported by the ability to make the recommended choices easier. In addition, communities that have not accessed PCHS will be exposed to healthy eating interventions in the wider community. This new model will lead the field in community health as the first community health service to adopt a commitment to public health nutrition and meets an unmet need of providing capacity for public health nutrition services to the Mornington Peninsula. PCHS will benefit from this model as it will be seen as the leader in community health in this area and PCHS will also see a more efficient intake system for the nutrition services. The PCHS dietitians will be greater supported in their roles to undertake interventions across the health promotion continuum and will offer a wider array of expertise to PCHS and each other.

Policy Framework Proposed Direction

Nutrition Service Model - Peninsula Community Health Service – Example of distribution of EFT

This example allocates the public health nutrition role to the Mornington position. At the time of development a greater number of alternative clinical nutrition services were available in Mornington compared to Hastings and Rosebud and thus reduced demand on individual services.

Community Health (CH) total = 1.0EFT HACC total = 1.0 EFT (38 hours) (includes 3 hours per week contracting to MI health program)

Key: **Blue = Position 1 (currently Mornington site)** **Green = Position 2 (currently Rosebud site)** **Pink = Position 3 (currently Hastings site)**

SCREENING, INDIVIDUAL RISK ASSESSMENT	HEALTH INFORMATION	HEALTH ED, COUNSELLING & SKILL DEV.	SOCIAL MARKETING	ORGANISATIONAL DEVELOPMENT	COMMUNITY ACTION	ECONOMIC & REGULATORY ACTIVITIES
<p><i>(Recognise that this may be a small part of all positions when conducting individual and group services)</i></p> <p><i>Supported by PCHS intake system.</i></p>	<p><i>A small component of brief nutrition intervention/info provided on all nutrition related complications by all positions. Dietitians will recognise the ineffectiveness of ‘one-off’ information sessions unless accompanied by a broader support structure.</i></p>	<p><i>Individual</i> 0.2 EFT 0.1 EFT 0.05 EFT (Includes vulnerable groups under MI health allied health model) General nutrition issues* excluding type 2 diabetes.</p> <p><i>Group</i> 0.3 EFT 0.2 EFT 0.05 EFT Includes; Diabetes ‘first steps’ Diabetes 4-week group program Diabetes 6 month review Other sessions as part of structured groups eg. ‘Stay on Your Feet’</p>	<p><i>Opportunistic involvement with state-wide nutrition and lifestyle promotions.</i></p>	<p>0.1 EFT - staff meetings - (one other)</p> <p>0.1 EFT - staff meetings - (one other)</p> <p>0.2 EFT - staff meetings - PPAC (essential membership) - Food & nutrition policy development - Review nutrition service every 2 yrs (review of outcomes of the public health nutrition service vs clinical nutrition service)</p>	<p>0.3 EFT</p> <p>0.1 EFT</p> <p>0.2 EFT</p> <p>Capacity Building eg. training of self-help group members in nutrition.</p> <p>Respond to requests support community groups eg. Community gardens.</p> <p>Public Health Nutrition Projects</p> <p>Health Promotion</p>	<p>0.1 EFT</p> <p>- Member of <i>Eat Well Australia</i> and Victorian Public Health Nutrition expert advisory group.</p> <p>- Build Capacity for Public Health Nutrition on the Mornington Peninsula eg. Contribution to Municipal Public Health Plan.</p>
Minimal EFT	Minimal EFT	20% EFT individuals 20% EFT groups	Minimal EFT	20% EFT	30% EFT	10% EFT

* General nutrition issues include, body image, cardiovascular conditions (eg. hyperlipidaemia, hypertension), cancer, constipation, uncomplicated gastrointestinal disorders (eg. irritable bowel syndrome), gout, healthy eating, general paediatric or adolescent eating issues (eg. fussy eating), osteoporosis, overweight/obesity, underweight, vegetarian, and iron deficiency anaemia.

Note: Health promotion activities also include those that are not nutrition related.

Nutrition Service Model

This model assumes that skills in public health nutrition are essential to at least one dietitians job description in order to make the model sustainable to support the other positions to undertake this type of work. Therefore, PCHS Dietitian job descriptions have been modified so that “Demonstrated knowledge and experience in planning, implementing and evaluating health promotion and public health nutrition programs and activities” is an essential criterion in all job descriptions. The PCHS management team will monitor this skill within the nutrition team. All positions will continue to have opportunities to work across the health promotion continuum and will support public health nutrition and health promotion activities. The dietitian who takes the lead role in public health nutrition will also be supported by the health promotion team through regular communication and attendance at their discipline meetings when appropriate.

The model also describes the importance of equity of access, a PCHS policy, to a clinical service at all bases, allows flexibility for clients not suitable for groups to be seen individually and will ensure government service targets and current political directions are met. It ensures that individuals and groups accessing PCHS are provided with nutrition intervention from appropriately skilled professionals. There are some nutrition-related diseases that are more complex in nature and may require more specialised intervention. These include, food allergy/intolerance, eating disorders, coeliac disease, type 1 diabetes, crohns disease, ulcerative colitis, other complicated gastrointestinal disorders (eg. short gut syndrome, complicated liver disease), sports nutrition, nutrition support (eg. nasogastric/gastrostomy feeding (refer to Home Enteral Nutrition Position Statement¹⁵), texture modification). Referral will be made to specialist nutrition service providers either at first point of contact with PCHS via the Access intake system or after minimal intervention with the dietitian after which time the dietitian will refer on if appropriate.

The intake system will function more effectively as part of this model. The intake worker will have greater access to alternative sources for individual nutritional intervention for clients and greater support will be offered in relation to nutrition information and resources. Specialist clinical services at Frankston hospital outpatients and private hospitals on the Peninsula will be utilized more frequently and the option of private consultation also made available if affordable to the client. In addition a model of management of overweight/obesity by the dietitians will be adopted due to the observed limited outcomes with this client group. This includes a contractual arrangement with the client specifying, the role of dietitian and the number of times of service.

Initially the model will focus on building capacity for public health nutrition including forming partnerships, training staff and obtaining community nutrition baseline data. Evaluation of this new model of service delivery after a one-year pilot including reviewing outcomes of the individual nutrition service at PCHS will be conducted.

Sustaining an appropriately skilled dietitian in the public health nutrition position may be difficult considering the lack of public health nutrition skills in Victoria. Other allied health disciplines have trouble filling positions on the Mornington Peninsula, however recruiting to nutrition positions has never been a problem. Professional development opportunities and links with the public health nutrition workforce (for example the DAA experts group) must be made available to the person in the public health nutrition position, regardless of their experience in public health. Recruiting with an essential selection criteria as being ‘demonstrated knowledge and experience in planning, implementing and evaluating health promotion and public health nutrition programs and activities’ will ensure applicants either have the necessary skills or a great interest in public health nutrition

¹⁵ Peninsula Community Health Service/Frankston Community Health Service. (2002) Position Statement: Home Enteral Nutrition (HEN).

and thus a commitment to develop their skills further. Ongoing support from the health promotion coordinator will assist in strengthening public health nutrition action.

This model also recognises that effective public health nutrition and health promotion takes time and resources. Presently PCHS has limited additional funding allocated for health promotion and this may prove a barrier to effective public health nutrition or health promotion programs. Initially interventions that can be accomplished with minimal resources, such as capacity building, will be the preference. This model will provide a mechanism for assisting in obtaining additional funding to support public health nutrition and health promotion action for PCHS in the future so hopefully the capacity to undertake public health nutrition is increased.

Implementation Plan

Objective 1: Increase the capacity for public health nutrition at PCHS.

Strategies	Activities	Evaluation (Process/Impact)	Timeline
1. Liaise with members of nutrition and health promotion team to develop model.	1.1 Present idea verbally and then written to nutrition and health promotion teams. 1.2 Workshop aspects and implementation plan for model	- Obtain feedback amend model (process).	April 2002
2. Liaise with PCHS management regarding model.	2.1 Discussions with CEO and some management team members during development. 2.2 Presentation to management team meeting.	- Changes to model (process). - Feedback from meeting/changes to model (process).	June 2002 Oct 2002
3. Discuss model to public health nutrition experts in Victoria.	3.1 Identify public health nutritionists in Victoria. 3.2 Present initial idea verbally and written model to experts ^{##} and obtain feedback. 3.3 Present model during workforce development project implementation.	- List of experts (impact). - Feedback loop comments (process).	
4. Liaise with health promotion team to assist in planning capacity building activities for staff to increase skills in public health and health promotion.	4.1 Organise one public health professional development activity each year in partnership with health promotion team.	- Feedback from facilitators regarding success of meeting (impact). - Satisfaction and knowledge questionnaire with workshop (process).	July 2003
5. Advocate model in wider community.	5.1 Present model to Mornington Peninsula Shire Council groups and consumer groups. 5.2 Present model to other Victorian community health service dietitians eg. At Community and Public Health Nutrition DAA Vic Interest Group Meeting.	- Nutrition contribution to Mornington Peninsula Municipal Public Health Plan (impact). - Feedback from consultation (process). - Pre and Post implementation interviews with PCHS dietitians (impact).	Dec 2002 Oct 2003 Dec 2003

Objective 2: Increase PCHS dietitians involvement public health nutrition activities on the Mornington Peninsula and in Victoria.

Strategies	Activities	Evaluation	Timeline
1. Identify potential public health nutrition partners.	1.1 Contact organisations and engage.	- Partnerships formed (process). - Process documented (process).	Dec 2002
2. Work with partners to commence public health nutrition.	2.1 Work on projects identified. Eg. Municipal Public Health Plan.	- Public health nutrition documented on the agenda. (impact) - Pre and Post interviews with PCHS dietitians (impact)	Dec 2003

[#] Victorian State-wide Public Health Nutritionist, Department of Human Services
Public Health Nutrition Academics, Deakin and Monash University
Other experienced and committed Public Health Nutritionists in Victoria (eg. DAA identified experts).

EVALUATION OF NUTRITION SERVICE DELIVERY POLICY

October 2004

1. Background

The nutrition service at Peninsula Community Health Service (PCHS) has seen much change during its 15 years of representation within PCHS. There is an expectation that nutrition experts employed by PCHS provide a range of nutrition services from individual nutrition assessment and education, to group education, health promotion and community nutrition projects. Group education, nutrition information and individual nutrition services have predominated the roles of the nutrition experts at PCHS in the past. To ensure all these service areas were addressed adequately and that PCHS were attempting to make a difference to the nutritional health of the people of the Mornington Peninsula, the nutrition team developed the 'Reorienting Nutrition Service Delivery' model, which was endorsed by PCHS management in January 2003. The purpose of this model was to create a more public health oriented nutrition service at PCHS using existing resources to increase the scope of the nutrition service across the peninsula.

In this model, public health nutrition is defined as "organised efforts to promote well-being and prevent diet related diseases in populations"¹⁶ and communities. The aim of this change in service delivery was to make healthy choices, easy choices for the people of the Mornington Peninsula and make better use of the limited nutrition resources. The model initially focused on building capacity for public health nutrition and was proposed to have outcomes for PCHS, the dietitians and the Mornington Peninsula community.

The main evaluation strategies used in this report are qualitative and include observation and feedback from PCHS staff members, other service providers and organizations and the community. This was collected through a questionnaire and diary of feedback. Some quantitative data was collected in relation to the distribution of EFT across all nutrition service delivery areas and this was collected from SWITCH. The evaluation was conducted for management of PCHS to review its nutrition service. The report is also expected to be accessed by the Dietitians Association of Australia (DAA) Victorian Community Nutrition and Public Health Nutrition Interest Group (CN & PHN IG) and provide recommendations for the future nutrition service at PCHS.

¹⁶ Hughes, R. and Woods, J. (unpublished/unreleased report). Report One: A review of issues and intelligence for Public Health Nutrition Workforce Development. Victorian Public Health Nutrition Workforce Development Initiative. Griffith University, Monash University. 2003

2. Results of Evaluation

2.1 Support for the Model

The model of reorienting nutrition services towards a public health approach was supported strongly by the health promotion team of PCHS. This model of work complements the role of health promotion in organisations where similar skills and knowledge are required to initiate and support preventative health projects. Supporting the nutrition experts to work in this way increased the capacity for health promotion in the organisation.

Reorienting the nutrition service has created mixed emotions amongst the nutrition experts. There is much belief among the community health sector dietitians that community dietitians have a role in providing individual and group nutrition services. This has been the traditional role of community health service Dietitians in Victoria for many years which varies significantly from the role of community nutrition experts in other states of Australia. The nutrition experts at PCHS response to working in a more health promoting way were varied and included a lack of confidence in working in a public health nutrition/health promotion framework. There was also a perception that preventative nutrition projects are not a major role of community health and needed to be supported by a public health nutrition workforce. Despite these feelings the nutrition team generally supported most aspects of the model.

PCHS management team also supported documenting the nutrition service. One of the underlying principles of PCHS is supporting staff to balance their work across the health promotion continuum. The management team supported the dietitians working within their community health funded time on health promotion projects but at the same time ensuring targets for direct care, both community health and home and community care funded time was accounted for. Despite some time lapse between submission of the model and approval by management, the model became accepted to be trialled in January 2003.

One of the strategies outlined in the model was to gain support from nutrition experts on the model. The DHS public health nutritionists were the main stakeholders in this consultation however public health nutritionists at Deakin and Monash University were also consulted. Support and encouragement for the model was gained from all of these groups. The model was also subject to peer review by the DAA CN & PHN IG in June 2003 where its development and principles were presented to 17 Victorian community health service dietitians. From this consultation the model has been used to help shape the services of four other community health service nutrition services¹⁷. The dietitians from these services report that the model was useful in allowing them to spend more time on public health nutrition projects and provided an evidence base for this practice. However, they faced and still face multiple barriers in implementing the model due to management and service agreements.

¹⁷ Western Region Health Centre, Bayside Community Health Service, Caulfield Community Health Service, Monashlink.

2.2 Capacity for Public Health Nutrition

The nutrition team has increased its capacity to undertake public health nutrition since the implementation of the model. Two of the three staff have participated in the DHS and Monash University Public Health Nutrition Mentoring Program and one of those staff members has completed a Master of Public Health. An increase in public health nutrition knowledge and skills has not been observed for PCHS as an organisation as the nutrition team have not been involved in planning the capacity building activities of PCHS. PCHS capacity building activities for 2003/2004 have centred on community development with the Jaques Boulet mentoring program, and behaviour change, through internally provided workshops.

Another main outcome of the model has been the development of a working partnership with Mornington Peninsula Shire Council through the Social Planner. PCHS nutrition service have been recognised as a key partner in implementing priority area two in the Health and Well Being Action Plan (2003), 'Healthy Lifestyle Choices'¹⁸. This partnership has been developed through joint work on food security which was recently showcased in a joint forum "Food for Thought: Food Insecurity on the Mornington Peninsula". Prior to the development of the model no nutrition specific relationship existed between PCHS nutrition experts and Mornington Peninsula Shire Council.

Since the endorsement of the model the nutrition team reported a small increase in the amount of public health nutrition work they were undertaking. At the time of development of the model the nutrition team were undertaking one public health nutrition project "Body Image Participatory Action Research Project". Since the implementation of the model that project has evolved into two separate projects, "Growing Healthy Kids" and "Good Nutrition in Primary Schools", which have two separate target populations, pre school aged children (0-5 years) and their families and school aged children (5-12 years) and their families. Both projects are being based on best practice evidence in these areas of public health nutrition using a multi strategy approach in line with the Ottawa Charter (1986). In addition in mid 2003 with support of an external grant of ten thousand dollars, the "Food Security and Social Connections" project was initiated in the Mornington area. Just recently the southern peninsula and western port areas have undertaken preliminary work to commence food insecurity prevention strategies. Despite this increase SWITCH data analysis from January to December 2003 has shown that direct care nutrition services continue to outweigh public health nutrition action despite the commitment of the model to allocate 50% of the total EFT to work on public health nutrition projects. The table below shows that on average health promotion contributes approximately 30% of the nutrition teams time. It must be noted that not all this time is nutrition related projects as all three nutrition staff members are involved in their base health promotion projects which do not have a nutrition focus. In total the nutrition service is meeting 133% of its service reporting targets which provides grounding for allowing the ongoing focus on public health nutrition activities.

¹⁸ Mornington Peninsula Shire (2003). Health and Well Being Action Plan. Health Hope and Happiness. Action Plan 2003-2006.

Table 1: Recommended versus actual EFT allocated across the Health Promotion Continuum. Per annum. Expressed as a percentage of total accounted time.

	Direct Care (Group & Individual)	HACC	Health Promotion
RECOMMENDED	20%	30% (incl MIH)	50%
ACTUAL (AVERAGE)	54% Mton 38% Rosebud 52% Hastings 73%	13% Mton 22% (incl MIH) Rosebud 16% Hastings 1%	32% Mton 39% Rosebud 32% Hastings 25%

This SWITCH data analysis is limited in that it does not show the internal committee commitments of the nutrition team. It must be noted that the nutrition team members contribute a significant proportion of time to PCHS committees, including Quality Improvement, Medical Records and Project Program Advisory Committee. As stated in the PCHS Health Promotion Policy (2002) “All health professional staff, unless otherwise indicated, are to participate in a multi-disciplinary activity, ie a health promotion project or committee or an organisational committee”. The nutrition team significantly contribute to the organisation in this way by participating in additional three committees/projects outside the requirement stated in the policy. In addition one of the nutrition team members is the support staff member on the schools sexual health education program. Again this exposes the amount of nutrition time allocated to other non nutrition activities. This is of particular concern considering that the nutrition team represents the lowest EFT of all health disciplines employed by the organisation.

The capacity of PCHS to undertake public health nutrition has also increased through the development of partnerships. Prior to the implementation of the model, the nutrition projects involved very few partners, approximately three. Currently the nutrition team are involved with over eight difference service providers and organisations in their public health nutrition projects. This is a 60% increase in the number of external partnerships.

The nutrition team overall reported an increase in skills and knowledge in the area of public health nutrition since the implementation of the model. The major barriers to achieving more in the area of public health nutrition were reported to be a lack of resources, including staff and supporting budgets and a lack of strategic direction from within PCHS and with local and state governments to have nutrition as a priority. One other major barrier to providing a public health nutrition service to the communities of the Mornington Peninsula is the lack of nutrition EFT at PCHS. Currently the nutrition EFT is 2.1. Since the implementation of the model the EFT has increased by 0.3, 0.2 of community health funded time through the Hospitals Admissions Reduction Program (HARP) allocated to Rosebud, and 0.1 to Home and Community Care (HACC) in the Mobile Integrated (MI) health program in Hastings. The 0.1EFT will be removed in October 2004 after a recent review of the MI health service in Hastings.

Responses gained from the questionnaires indicated the difficulty in working across all areas from individual to group and project work. The nutrition team recognised that the different skills,

knowledge and personal qualities required to undertaken each of these roles are vastly different. “I have other demands on my time and cannot put enough time into providing an adequate public health service on my own”. Due to the more flexible nature of the public health work this if often what is left out over more structured individual and group education services and committees.

Despite the commitment in the model to not undertake one-off nutrition information and education sessions, the nutrition team have still undertaken these activities. It is estimated from SWITCH data analysis that 11 sessions were conducted over the period from January to December 2003. The evidence to indicate the ineffectiveness of these sessions is well documented however the nutrition team have obviously succumbed to community pressure. There is a need for organisational policy to support all PCHS staff including the nutrition team to discontinuing these activities.

3. Conclusion

The evaluation of ‘Reorienting Nutrition Service Delivery’ has shown that with an endorsed document direction the capacity to undertake public health nutrition in a community health service has increased. The support of PCHS management and health promotion team have been fundamental to allowing the nutrition team to increase their skills in public health nutrition and also the amount of project work conducted in this area. Due to the limited EFT and the ongoing requirements to meet individual and group services there has been a limit to what has been achieved.

The Department of Human Services has set a policy direction that all community health services in Victoria commit 20% of its community health budget to health promotion. This has been a fantastic achievement. It must be noted however that this budget is for health promotion not public health nutrition, therefore if a community health service does not identify nutrition as a priority area in their health promotion plan, work in nutrition in a health promotion framework cannot be undertaken. Fortunately although not a key priority area of PCHS health promotion plan nutrition is listed as a broader determinant of each of PCHS key priorities in the plan, thus providing justification to work in public health nutrition projects. A further barrier to undertaken public health nutrition in community health services in Victoria is the recently released Victorian Community Health Policy (2003) which provides a disease treatment focussed approach to the work at community health services, which would see dietitians in community health working in tertiary prevention nutrition education.

It is well documented that a health promotion and public health framework for health provides better and longer lasting benefits overall¹⁹. There is much evidence to prove that the provision of nutrition information and teaching of skills are not very effective in bringing about lifestyle change. Improving the dietary behaviour of individuals and communities requires a long term commitment with multiple strategies. This approach to nutrition programs is the most effective to progress individuals and communities through the various stages of behaviour change.²⁰

To provide a more effective nutrition service to the communities of Victoria, including the Mornington Peninsula, a coordinated approach to the orientation of nutrition services needs to be taken. Nutrition experts providing services to individuals and groups need to be seen as separate to nutrition experts working on public health nutrition and health promotion program and projects.

¹⁹ Rose, G. The Prevention Paradox.

²⁰ Contento, I, Balch, G.I, Bronner, Y. L, Maloney, S.K. Journal of Nutrition Education. 1995: 27(6): 275.

These different key roles require different sets of skills and competencies²¹. And the community health sector needs to better define the role of their employed nutrition experts.

Recommendations

Poor nutrition is a well established risk factor for development of chronic and life threatening diseases¹ and is a recognised priority area in the PCHS strategic plan and Mornington peninsula Health and Well Being Strategy. This report demonstrates the need to continue to build capacity for public health nutrition services across the Mornington Peninsula. The following list of recommendations will assist in providing a better public health nutrition service to the communities of the peninsula.

Action	Performance Indicator	Timeline
PCHS nutrition team to reorient its service and position descriptions to ensure all position have a focus on as a public health/community nutrition skills and competencies.	Job descriptions altered to require public health and/or community nutrition competencies.	December 2004
Nutrition service (2.0 EFT) to discuss balance of work to meet service agreement targets with a focus on nutrition specific health promotion projects.	Consultation with dietitians, site managers and health promotion coordinator conducted and consensus gained.	October 2004
Liaise with Peninsula Health nutrition departments to improve the nutrition service provided to the population of the Mornington Peninsula. This will include a review of current services provided by community versus acute health and feasibility of restructuring these services to ensure more time is available for public health nutrition activities across the peninsula.	Mapping of nutrition services completed.	August 2005
Feasibility of conducting 'first steps' program at Hastings investigated.	Report submitted.	December 2005
Support the development of an organisational policy direction for one-off information sessions.	Policy endorsed.	March 2005
Improve the efficiency of individual nutrition services provided by PCHS - development of 'healthy eating/weight management' group education program targeting individual with one risk factor for chronic illness (secondary prevention strategy)	Rosebud and Mornington group programs developed and piloted. Reduction in number of individual dietetic consultations.	August 2005
Seek funding at an organisational level to support nutritional management of lifestyle diseases and chronic illness through HARP or HACC funding.	Dietitian employed	June 2005

²¹ Hughes, R. (2004). Employers expectations of core functions, credentials and competencies of the community and public health nutrition workforce in Australia. *Nutrition and Dietetics. The Journal of the Dietitians Association of Australia.* 62 (2): 105-111

NUTRITION SERVICE EVALUATION REVIEW

December 2005

1. INTRODUCTION

The nutrition and dietetics service at Peninsula Community Health Service (PCHS) has been part of the service mix in the organisation for 15 years. Currently the nutrition service is provided by permanent 1.95EFT dietitians from a mix of community health and home and community care funding. The dietitians employed by PCHS provide a range of nutrition services from individual nutrition assessment, counselling and education, to group education, health promotion and community and public health nutrition projects. Prior to 2001 the workload consisted of group education, nutrition information and individual nutrition services and allowed little scope for primary prevention. The development of 'Reorienting Nutrition Service Delivery' (2003) and 'PCHS Nutrition Strategic Framework' (2003) together with the organisations health promotion policy provided a platform for the nutrition service to focus more on primary prevention of nutrition related disease.

The 'Reorienting Nutrition Service Delivery' provided a framework from which to delivery nutrition services to the community of the Mornington Peninsula. This document discussed reorienting nutrition services away from a focus on individual behaviour modification, towards creating environments supportive of healthy eating. The evidence for the development of this model was based on community demographics and need, and cost effectiveness of outcomes. In addition, the direction towards health promotion in community health by the Department of Human Services supported PCHS to undertake more health promotion. A commitment was made by each individual Dietitian to work in a health promoting way with communities rather than simply focusing on individuals. The document provided a policy framework to support this, including the development of the *Home Enteral Nutrition Position Statement* and support to refer complicated and specialised nutrition issues, including allergy/intolerance, eating disorders, gastrointestinal disease, type 1 diabetes and complicated paediatric issues to specialist nutrition services. The model recommended that 40% of the dietetics EFT be dedicated to nutrition focused health promotion initiatives and 40% to direct care services, including group and individual nutrition education, and 20% to organisational activities.

The 'PCHS Nutrition Strategic Framework' 2003-2008, identifies the priority nutrition areas for action on the Mornington Peninsula. The framework suggests a plan for PCHS nutrition service to address these issues within the 40% EFT allocated to nutrition focused health promotion initiatives. The document was developed based on PCHS strategic and health promotion plan and Eat Well Australia, the national public health nutrition policy document. 'Lifestyle related disease', 'food security' and nutrition in 'early life' were identified as the priority areas. Each issue was analysed for direct and indirect determinants and goals and objectives developed for each area. The three main goals related to each risk factor include,

- To assist in the reduction of overweight and obesity in people of low-socioeconomic status.
- To assist access to an affordable, nutritious and safe food supply for people of low-socioeconomic status
- To ensure all children 0-12 years consume fruit and vegetables in line with core food group recommendations.

Objectives and strategies with a five year timeline were suggested based on best evidence available for public health approaches to the issues. This document will evaluate the progress of 'Reorienting Nutrition Service Delivery' and 'PCHS Nutrition Strategic Framework' and the current nutrition service at PCHS providing recommendations for future directions and development.

2. EVALUATION PROGRESS REPORT 2001-2005

2.a. Summary of Nutrition Service

The nutrition service has significantly increased and improved its profile of community and public health nutrition activities while at the same time continuing direct care services. The following table describes the nutrition service provision in more detail.

	Service Type	Target Population	Type of Service
I N D I V I D U A L ↓	Individual nutrition counselling / education	Adults	Weight management Type 2 diabetes Hyperlipidaemia Undernutrition/Underweight Nutritional Assessment
		Children	Weight management Fussy eating Nutritional Assessment
B E H A V I O U R A L	Group nutrition education	Adults	Type 2 diabetes - <i>Diabetes education program (5 week, first steps)</i> - <i>Diabetes self help / support groups</i> - <i>Supermarket tours</i> Weight management & healthy eating - <i>Pathways to health</i> - <i>Stay on Your Feet</i> - <i>Healthy food shopping bus trips</i> Cardiovascular disease - <i>Cardiac Rehab</i>
↓ E N V I R O N M E N T A L	Health Promotion Early Life Food Security Overweight / Obesity	<i>Kids 4 Fruit & Veg</i> Children 5-12 years and their families, in primary school settings <i>Growing Healthy Kids/Smiles 4 Miles</i> Children 0-5 years and their families, particularly in preschool and Maternal and child health settings. <i>Start Right Eat Right</i> Children 0-5 years in long day care settings <i>Food Security Projects (network, gardens, kitchens, shopping trips)</i> Vulnerable groups – adults & families	Prevention of childhood obesity and nutrition deficiencies Prevention of childhood obesity & dental decay Prevention of childhood obesity & nutrition deficiencies Prevention of nutrition deficiencies and obesity

The dietitians at PCHS are also involved in organisational activities including, project/program planning and evaluation, Quality Improvement Committee (QIC) and Client Records Committee and also support the implementation of the services food safety plan and policy. The nutrition service also supports the PCHS sexual Health program and have been involved in the sexual health education program and has been involved in base specific community development health promotion projects (Tanti Park, Hastings Caravan Park). Supervision of final year nutrition and dietetics students from Deakin and Monash University is also core business. These student projects significantly increase the capacity of the nutrition team to respond to community nutrition issues.

2.b. Analysis of Nutrition Service

The dietitians have continued to meet demands for individual nutrition education through improving the efficiency of services. This has been achieved by facilitating access to group education where appropriate and providing brief intervention and referral of specialist nutrition issues for more appropriate management. Opportunities for quality improvement have occurred with the review of the diabetes education program from a four-week to a five-week education program with a nutrition specific week as well as the introduction to diabetes group education (first steps) at the Hastings site. The *pathways to health group* has also been piloted. Outcome evaluation data collected from the diabetes education groups has shown a significant reduction in the HbA1c of participants.

The individual and group education direct care services of the dietitians are replicated across the three sites of PCHS which creates inefficiency. This model of delivery creates an expectation that all dietitians have specialist nutrition knowledge and skills in a wide variety of areas which is impractical, particularly for professional development. This service delivery requires review, using creative ways to meet the diverse community needs while responding efficiently using best practice.

To further improve the quality of PCHS nutrition services, the nutrition and dietetics department of Peninsula Health was consulted. Clarity on service provision and improved service coordination was discussed and the beginning of a working relationship established with a view to improve continuity of care particularly in the development of the chronic disease framework. To strengthen the nutrition related health promotion activities, collaboration with Frankston community health service has also been achieved with regular and ongoing communications including nutrition health promotion activities, for example development of Community Kitchens.

The health promotion activities of the PCHS nutrition team are significant and increasing with funds obtained recently to continue to support activity. The key to the success of these activities has been through the formation of partnerships between agencies and communities on the Mornington Peninsula.

The “early life” priority area is being well addressed with the current project activity. Partnerships have been formed with Mornington Peninsula Shire, Maternal and Child Health, Primary schools, Pre-schools and Dental Health Services Victoria. Central to the development of these partnerships has been strengthening the nutrition capacity of these stakeholders. The gaps in this area include the family day care and playgroup settings and the promotion of breastfeeding as well as continuing the roll-out of the current nutrition related health promotion activities across the whole peninsula.

“Food security” has been well addressed by the current capacity of PCHS and is now also a priority for the Mornington Peninsula Shire as part of the municipal public health plan. Getting local government on board this priority was a key objective and important for future success. For example, the *Food for Thought* report (2005). PCHS is the lead agency for the Mornington Peninsula Food Security Network, whose members include Mornington Peninsula Shire, Good

Shepard, Anglicare, Southern Peninsula/Mornington/Western Port Community Information and Support Centres, Peninsula Youth and Family Services and Brotherhood of St Lawrence. Future development around the food security priority area includes, identifying key activities / strategies that can be sustained by the community and supported by local government.

“Overweight and Obesity” has been addressed through the “early life” and “food security” priority areas of the strategic framework. Interventions that address the social determinants of health need to be further developed to better support physical activity in the community. Improved secondary prevention activities through collaborative partnerships with General Practice, promoting healthy choices with local businesses and community awareness activities would address this priority.

3. RECOMMENDATIONS BASED ON CURRENT EFT

The following recommendations are based on the additional dietetics hours (0.2EFT) for a total of 2.15 EFT dietetics to best meet community need and the new directions outlined in the nutrition strategic framework document.

Aged and Complex Program 1.1 EFT

This service would include direct care service and health promotion activities across the organisation focused on the aged and other vulnerable groups. Direct care service would include for example, diabetes education programs, cardiac rehabilitation, diabetes support groups, stay on your feet, better health self-management, individual clients from both community health and HACC funding sources. Health promotion activities for example would be the coordination of the food security project and related activities including, shopping bus trips, community kitchens and community gardens. It is envisaged that this program would support organisational policy for example Food Safety Program as this relates to the services of this program.

Children and Family Program 1.0 EFT

This service would focus on health promotion activities but also include direct care services across the organisation focused on the children and families. Health promotion activities for example would include, Growing Healthy Kids and Kids 4 Fruit and Veg projects. Direct care service would include for example, sexual health in schools program and individual clients in this target population. The current externally funded projects including Smiles 4 Miles (Dental Health Services Victoria), Start Right Eat Right (Lady Gowrie Child Care Centre/Kids Go for Your Life) would sit under this program area.

Infrastructure 0.05 EFT

The nutrition service supports the Quality Improvement Committee and Client Records Committee in the organisation. This support could be incorporated into either program area.

4. FUTURE DEVELOPMENT

There is a need for the nutrition service at PCHS to develop to improve its capacity to meet the growing demands for the community. There are gaps in current activities but the service mix described above has the capacity to further develop current initiatives by either expanding to other areas or refining current activities. For example, “early life” could develop a number of new initiatives, for example, interventions to increase breastfeeding or preschool settings based health promotion could be expanded to other areas. In addition nutrition related health promotion can be supported by seeking additional external funding. Being recognised as a key partner in the Municipal Public Health Plan together with funding opportunities to support additional projects had increased the demand and profile of PCHS nutrition services. The current nutrition capacity cannot meet the growing demands for chronic illness early intervention and management. Nutrition is a key component of any management in the area of lifestyle related disease. For PCHS to improve the nutritional health of people on the Mornington Peninsula with or at risk of a lifestyle related disease, additional nutrition services across the river of health including primary, secondary and tertiary prevention are required.