Key Informant Interviews: Dietitian Service Programs (2005)

Nutrition in Primary Health

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Abstract

Objective

This key informant survey was undertaken to obtain information on primary health care nutrition services, including organization and team membership, types of clients served, health promotion activities, and innovations among primary health care programs across Canada.

Methods

The interview guide was adapted from previous surveys. Professionals were contacted to request a telephone interview. Interviews were taped and transcribed. The interviewees reviewed the questions and transcripts. Transcripts underwent content analysis.

Findings

Fourteen of the 21 people contacted, representing 12 programs, were interviewed. One program was a national program with a disease focus, three were regional programs that included both in-patient and primary care, two were wellness or chronic disease management programs, and six were community health centres (CHC) or family health group (FHG) practices. The clientele varied with the program focus, and the mix of professionals varied considerably. The Registered Dietitians (RDs) in the programs were all salaried employees or hired under contract. Most of the RDs were developing health promotion activities but it was not a large part of their jobs due to the demands of treating patients. Health promotion and disease prevention activities varied considerably. Numerous innovations were mentioned and included various combinations of enhanced information technology support, enhanced collaboration among team members, improved follow-up of clients, and specific initiatives to reach clients.

Conclusion

The organization and delivery of primary health care varies across the country. There are some interesting innovations that are occurring in programs that should be shared and may be adapted to other primary health care settings across the country.

Introduction

The Primary Health Care Transition Fund (PHCTF) enabled groups across Canada to develop and test new interdisciplinary, multidisciplinary and collaborative models of primary health services, including the addition of the specialist nutrition services of Registered Dietitians (RDs). While RDs do work in community health centres, primary health care clinics and consulting/private practice, documentation of and evidence for "best practices" in the organization of such services has not been established. Therefore, this key informant survey was undertaken as part of the evidence base to support development of a Practice Management Guide for Ontario Family Health Networks (FHNs) and similar models of primary health care services (1). Specific information on nutrition services being offered in various primary health care models across Canada has not been gathered previously.

Methods

Questionnaire Development

The draft interview questions, based on two previous surveys of dietetic practice (2,3), were developed to address core planning issues, the types of clients served, the nutrition services offered, the organization of the services, and to elicit advice on planning of new services. The questions were reviewed for face validity, clarity and feasibility by the project's steering committee, by members of the Dietitians of Canada Primary Health Care Action Group, and by a survey methodologist from the Survey Research Centre at the University of Waterloo. Questions were revised at each stage. (See Questions in Appendix A).

Sample

Possible key informants were identified from listings of the PHCTF projects and from conference proceedings of two national primary health care conferences (Winnipeg and Toronto 2004). Individuals affiliated with projects that included RD services were identified. Snowball sampling, whereby interviewees recommend other potential people to interview, was subsequently also used to identify as many key informants as possible.

Data Collection and Analysis

Potential participants were contacted by e-mail to solicit participation in the study. A mutually agreeable time was set for the telephone interview after a signed consent form was received from the interviewee. Respondents received a copy of the questions by e-mail prior to the interview. The interviewer, with the knowledge of the interviewee, taped the interviews, had them transcribed, and sent the transcript to the respondent for review and revision. These reviewed transcripts underwent descriptive content analysis by the first author to identify key results and any innovative programs. Results were summarized in paragraph format. Another investigator checked for the accuracy of key information.

The Research Ethics Board of the University of Guelph approved the study protocol.

Results

The key informant surveys were conducted from February 1 to April 27, 2005. Twenty-one individuals were contacted, and 14 (66 per cent) completed the data collection process. Nine respondents were RDs. Twelve programs were represented: one was a national program with a disease focus, three were regional programs that included both in-patient and primary care, two were wellness or chronic disease management programs, and six were community health centres or family physician group practices. The provinces represented in the

interviews were Newfoundland & Labrador, Ontario, Saskatchewan, Alberta and British Columbia. In total, five of the interviewees represented either nationally- or provincially-funded PHCTF projects. The following is a summary of the key learning from the interviews. (Summaries of each interview are given in Appendix B.)

The 12 respondents from 11 programs who manage or deliver direct services felt they provide health care services according to the World Health Organization (WHO) definition: “Primary Health Care is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element in a continuing care process (WHO, 1978).”

The client populations served by the projects varied, with six of 11 programs located in urban/suburban areas. Six of the 11 programs dealt with clients of all ages, and the proportion of female patients ranged from 50 to 80 per cent.

The types and numbers of providers in each program varied considerably, as shown in Table 1. It was not possible to determine the full time equivalent number of providers for most of the programs. The number of hours the RDs worked for their primary care program ranged from 15 hours to 195 hours per month.

All clinical conditions were taken care of by RDs with the majority being diabetes, heart health and obesity related. Most patients were seen for one-on-one counselling, but a couple of programs emphasized group counselling and provided limited one-on-one counselling. In one program, the nurse practitioner provided the nutrition counselling as there was not a RD on staff.

All respondents involved in direct delivery of services said they are or would like to be involved in disease prevention or health promotion activities. The time spent on health promotion ranged from as little as one per cent of the time to about 20 per cent of the time, with one dietitian spending 60 per cent of her time on health promotion. One respondent was not involved in health promotion, as her mandate was chronic disease management. Many felt they had inadequate staffing to focus on health promotion.

Eight RDs mentioned specific disease prevention and health promotion activities that they have already undertaken or planned. One respondent was focusing her efforts on educating fellow staff members on health promotion activities. She ran a staff wellness program to improve the staff’s nutrition knowledge. Each of the activities was mentioned only once except for grocery store tours.

The specific disease prevention activities for clients that were mentioned were:

- a multidisciplinary wellness clinic, with general nutrition information;
- programs for seniors in remote areas focusing on the primary prevention of diabetes;
- a community kitchen for mental health/low income patients;
- a child obesity program with an exercise specialist;
- senior wellness checks with a nurse practitioner;
- general nutrition and general heart health classes for referred patients; and
- diabetes and obesity prevention classes with a city recreation department.

Health promotion activities for clients or the public were:

- a school nutrition program (foods served at schools, student education, parent education focusing on importance of breakfast and lunches);
- a Canada Day walk with community posters advertising the walk;
- a fun and food camp for kids during the summer;
- grocery store tours (2 respondents);

• low-cost cooking groups;
• baby food workshops in Chinese;
• a “feeding toddlers” workshop;
• promotion of heart health during the month of February;
• the development of a directory of food resources in the community (food security is a problem);
• the development of a community garden policy; and
• advocacy for a change in the provincial diet allowance for a diabetic on income assistance.

With respect to administrative issues, all dietitians were salaried employees on either a permanent or contract basis. The organizational reporting mechanisms varied. All reported to a manager, director or coordinator. Most programs (n=6) had clerical support for booking appointments and in the other five programs the counsellor had to book their own patients.

They all had an office or space in which to work, but not all of them had a private area for an office. If they did not have a private office, they were provided a private space for counselling. They were all provided with at least the basic equipment: computer, desk, chair, filing cabinet and resource materials. In all except one program the employer provided liability insurance. The RD working as a contractor purchased her own liability insurance through Dietitians of Canada.

Numerous innovations were mentioned and included various combinations of enhanced information technology support, enhanced collaboration among team members, improved follow-up of clients, and specific initiatives to reach clients. Examples of innovations included:

Information technology support

• In Newfoundland, a regional Meditech system enables the dietitian and other health professionals to have access to the lab data results.

Enhanced collaboration

• RDs partner with other health professionals to provide the best care possible (for example, with an exercise specialist from a city recreation department).
• An RD and MD collaborate on diabetes care: evaluating how they practice diabetes care, improving the clinical outcomes and improving the flow through of patients.
• A healthy lifestyles initiative combined the resources from all of the chronic disease management teams to increase efficiency and, as a result, has expanded throughout the community.
• Diabetes, lipid and lifestyles education provided under one roof has created better communication between practitioners and improved care for the patients.
• A directory of food resources in the community was updated for all health practitioners to use.
• A community garden policy was created and a position paper developed advocating an increase the provincial diet allowance for a person with diabetes.
• Physicians attend the last five minutes of the initial appointment between RD and patient to learn about the nutrition care plan and to reinforce it with the patient.

Enhanced follow-up

• Follow-up care planned so, rather than waiting for patients to come in for a check up, all patients are booked for a follow-up in three months and some are on standing orders to make sure their lab work i completed on time.
• A trial of regular telephone follow-ups.

Other specific initiatives

• The PHCTF program in Newfoundland has the RD accepting public and self referrals.

• Instead of teaching patients with diabetes the foods they should avoid, they are provided with blood glucose monitors so they can self-monitor the effect certain foods and exercise have on their blood sugars. Sixty per cent of the patients with impaired glucose tolerance (IGT) have reverted to normal blood glucose levels within six weeks and HbA1Cs have dropped 12 to 13 per cent in individuals with diabetes mellitus.

Unmet needs were quite varied. They included lacking standard protocols for when to refer to a RD; limited communication between RD and physician; how to adequately address obesity and inactivity in the community; appropriate "training" for health professionals at the primary health care level; and the limitations of a fee-for-service payment structure.

Discussion/Conclusions

The results of this survey need to be interpreted in the context of the methodology used to identify key informants. These individuals were identified as offering nutrition services and had attended a primary health care conference or participated in a PHCTF project. While efforts were made to identify additional key informants through snowball sampling, knowledge of other programs was limited. Thus, the results cannot be considered representative of nutrition services being offered in primary health care, but do provide some interesting insights into nutrition services being offered in the programs reviewed.

A key observation was that primary health care services varied substantially across the country in terms of populations served, the organization and composition of interdisciplinary teams, and the types of health promotion and disease prevention activities undertaken. There were some interesting innovations in programs that should be evaluated and shared with other primary health care programs. These innovations included strategies to improve outcomes for chronic disease management, improving efficiencies by consolidating chronic disease programs, and working with interdisciplinary colleagues to provide lifestyle modification programs to the public.

There is a need to develop the knowledge base for nutrition services in primary health care, using a variety of approaches, including more comprehensive and representative surveys of current practices, evaluation of innovative interventions and programs, and development of recommendations and guidelines for practice. This key informant survey provided some useful baseline information.

Table 1. Numbers and Types of Providers in the Programs as Reported by Interviewees

Program	1	2	3	4	5	6	7	8	9	10	11	12
	NF	NF	ON	ON	ON	SK	AB	BC	BC	BC	BC	BC
Provide PHC services directly	No	Yes Regional care & staff*	Yes Regional care &staff*	Yes CHC	Yes CHC	Yes FHG	Yes CHC	Yes Region	Yes CHC	Yes CHC	Yes Wellness Centre	Yes Chronic disease program
Registered RD		1	1	2	0.1	0	1	1	Yes***	1	2	2
Family physicians		5	7	6	4.75	5	6	6	Yes	6	11 and 190 refer	4
Specialist physicians			2		0.2			3			4	4
Family medicine residents						8						
Registered nurses (other than nurse practitioners)		13	36	12	4.5	4	3	1.5	Yes		1	4
Nurse practitioners		1	3	6	3.5	1	1	1		1		
Other nurses (e.g. licensed practical nurses)		18	42					2				
Psychologists						0.3			3			
Social worker		3	4	4	2.5	1	2	0.5	Yes			
Occupational therapists					1				Yes			
Physiotherapists		1	1	1		1		1.2	Yes		1	
Pharmacists												
Massage therapist								2				
Recreation worker		1										
Laboratory and x-ray staff		3				Yes***						
Physiotherapy aide			1									
Acupuncturist				1								
Art therapist					0.5							
Community advocate					0.7							
Psychiatrist/nurse specialist team						1						
Exercise specialist						1					Yes	
Optometrist						1						
Personal care attendants								8				
Chiropractors								2				
Respiratory therapist									Yes		1	
Pharmacist										1		

* Regional organization that provides both acute care and primary health care services. Cannot separate out primary health care services.
** Reported by FTE
*** Number unspecified

Appendix A

Telephone Interview Questions
Thank you for taking the time to contribute to the knowledge we hope to gain on nutrition services in primary care settings. Do you have any questions or need for clarification before we proceed with the interview?

1. Do you provide health care services according to the following definition?
    - ☐ Yes
    - ☐ No

"Primary Health Care is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element in a continuing care process (WHO, 1978)." If yes, please continue – if no, thank you for your time.

2. Please describe your main service delivery organization, using one of the following categories.
Please check ONE only.
    - ☐ Group family physician practice, several office locations (e.g. Family Health Network, Health Service Organization)
    - ☐ Group family physician practice, one location or private office / clinic (excluding free standing walk-in clinics)
    - ☐ Single physician practice
    - ☐ Hospital out-patient unit
    - ☐ Community clinic / Community Health Centre
    - ☐ Academic family medicine teaching unit
    - ☐ Free-standing walk-in clinic
    - ☐ Nurse led station or clinic, not affiliated with a medical practice
    - ☐ Physician or nurses travel to various locations to provide services and are employed by Health Service Organization
    - ☐ Workplace wellness centre
    - ☐ Private wellness/health centre
    - ☐ Other Please specify:

3. Please describe the population that make up more than 50% of your practice. Please check ONE only.
    - ☐ Inner city
    - ☐ Rural
    - ☐ Urban / Suburban
    - ☐ Geographically isolated / Remote
    - ☐ Small town i.e. (<15,000)
    - ☐ Other Please specify:

4. Which of the following age groups do you generally serve in your organization? Please check all that apply.
    - ☐ Children (0-12 years)
    - ☐ Adults (19-64 years)
    - ☐ Adolescents (13-18 years)
    - ☐ Seniors (65+ years)

5. Approximately what proportion of your patients is female?
    _________ per cent

6. Please indicate the NUMBER of each type of health care provider in your MAIN practice setting. Please count yourself.

_____Family physicians
_____Specialist physicians
_____Registered nurses (other than nurse practitioners)
_____Nurse practitioners
_____Other nurses (e.g. licensed practical nurses)
_____Psychologists
_____Social worker
_____Occupational therapists
_____Physiotherapists
_____Pharmacists
_____Massage therapist
_____Other Please specify:

7. Does your organization have one or more registered dietitians directly involved in providing services to your clients?

- Yes – go to Question 8
- No - thank you for completing the interview

8. How many hours per week or month do one or more dietitians work for the organization?

_________ hours per week OR ___________ hours per month

9. From the following list, for what clinical conditions or issues does the dietitian provide advice or services?

- Diabetes mellitus
- Heart health e.g. high blood cholesterol, high blood pressure, stroke
- Other chronic diseases e.g. cancers, renal diseases
- Maternal & child health e.g. pregnancy care, low birth weight infants
- Growth failure and weight control in children
- Gastrointestinal problems e.g. diarrhea, digestive diseases
- Unexplained weight loss in the elderly
- Obesity in adults and children
- Anemia
- Other Please specify:

In the following questions, please take “the dietitian” to mean “the one or more dietitians” associated with the practice.

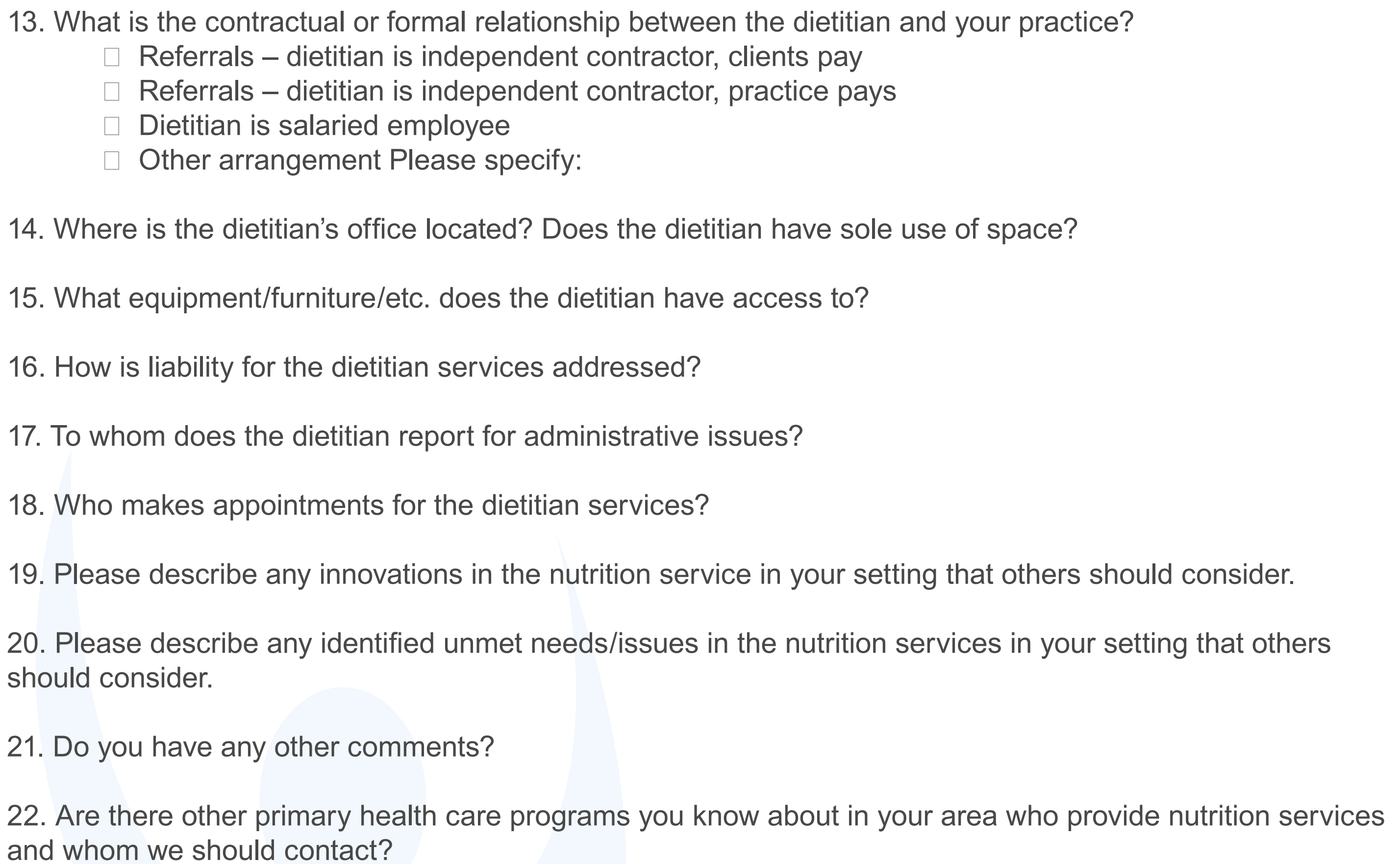
10. Does the dietitian engage in health promotion /disease prevention activities?

- Yes
- No

11. If, yes, estimate the percentage of the total dietitian time spent on health promotion activities?

___________ per cent

12. What health promotion issues are being addressed by the dietitian and how? Please provide examples.



13. What is the contractual or formal relationship between the dietitian and your practice?
    - ☐ Referrals – dietitian is independent contractor, clients pay
    - ☐ Referrals – dietitian is independent contractor, practice pays
    - ☐ Dietitian is salaried employee
    - ☐ Other arrangement Please specify:

14. Where is the dietitian's office located? Does the dietitian have sole use of space?

15. What equipment/furniture/etc. does the dietitian have access to?

16. How is liability for the dietitian services addressed?

17. To whom does the dietitian report for administrative issues?

18. Who makes appointments for the dietitian services?

19. Please describe any innovations in the nutrition service in your setting that others should consider.

20. Please describe any identified unmet needs/issues in the nutrition services in your setting that others should consider.

21. Do you have any other comments?

22. Are there other primary health care programs you know about in your area who provide nutrition services and whom we should contact?

Thanks

Appendix B

Individual interview summaries from national programs are described first, followed by summaries from programs by east to west location.

National Project

Program 1 (Interview #3) – Ontario Coordinator for Getting a Grip on Arthritis Project
This project was funded by the national envelope of the PHCTF. The project is to provide a program aimed at increasing the capacity of primary health care providers to manage the burden of arthritis. The program will be educating primary health care providers around the management of arthritis through a workshop format. Healthy eating is part of the program. This project does not provide primary health care; its intention is to influence it through education of multidisciplinary teams in Family Health Networks and Primary Care Networks.

Newfoundland

Program 2 (Interview #2) – Primary Health Care Team Coordinator (Registered Dietitian) in Bonne Bay
The Bonne Bay area received a national PHCTF grant to initiate a primary health care project in the region. The coordinator started the role in September 2004 and the funding lasts until March 2006.

This project includes a combination of a small town health centre and in-patient care, which includes long-term care, acute care, emergency and an outpatient clinic. They also have community health staff such as social workers and public health nurses working for the project. The in-patient component is included in primary health care to reduce duplication of services and to coordinate services better. The focus is on team development to facilitate appropriate referrals from hospital care to the community health staff.

This is a regional project that comprises about six towns and some of them are quite remote. All age groups are followed in this project and about 50 per cent of the population is female. Total population is about 5,000 people.

There are five family physicians, 13 registered nurses, one nurse practitioner, 18 other nursing personnel, three social workers, one physiotherapist, one recreation worker, one dietitian and three lab/x-ray technicians. The dietitian works 15 hours per week. As they move toward health promotion activities, the coordinator foresees that the dietitian's hours will increase. Currently the dietitian sees patients mainly for diabetes and heart health but she will see any patient that needs diet/nutrition counselling. She receives referrals from the physicians, other health care professionals and self-referrals.

Currently the dietitian is not involved in health promotion but because this is one purpose of this funding she will be involved as strategies are rolled out. Some of the ideas for health promotion include: school nutrition (foods served at schools, student education, parent education focusing on importance of breakfast and lunches); a multidisciplinary wellness clinic, which will include general nutrition information; seniors in remote areas – primary prevention of diabetes is a target – examining risk factors and educating the seniors.

The dietitian is a salaried employee of the hospital board, which could explain the lack of health promotion activities in the past. She has an office in the health centre and she has sole use of it even though she is only part-time. She has all the required office equipment, including a laptop computer. The employer covers liability insurance and she reports to a Director of Nutrition Services with support from the coordinator of the project. The dietitian has to book her own appointments.

Innovations include public self-referrals and access to the regional lab technicians. Regardless of who orders the blood work and where in the province the lab work is completed, the data is entered into the regional database and is accessible by all health care professionals in the region. Unmet needs include no

standard protocol for when other professionals should refer to the dietitian. This project is looking at this issue, particularly for diabetes management. The other unmet need is around communication, i.e. how to communicate information about the care provided back to the physician and how to communicate information about the dietitian's services to the general public.

Program 3 (Interview #10) – Regional Dietitian for the Central East Health Care Institutions Board
This dietitian serves rural/small town areas in the province and spends part of her time working on the same PHCTF project as the previous interview, but in a different area. She sees all age groups and approximately 60 per cent of the patients are female. She is responsible for long term care, acute care, as well as primary health care. She books her own appointments but is struggling to keep up with the list.

The regional team is also comprised of seven physicians (there should be nine), two visiting specialist physicians, 36 Registered Nurses (RNs), three nurse practitioners (NPs), 42 licensed practical nurses (LPNs), four social workers, a visiting physiotherapist and one physiotherapy aid. The dietitian works about 90 hours per month for the primary health care project. She sees patients for all clinical conditions. She does not have time to do health promotion activities but on her own time she runs a healthy eating class from time to time.

Health promotion activities include a Canada Day walk with community posters advertising the walk. Also, a "Fun and Food" camp is held for kids during the summer.

An unmet need is that there are not enough dietitians to work on health promotion and prevention activities. The dietitian has ideas for health promotion but generally cannot act upon them, as there are not enough dietitians to service patients with chronic diseases as well as work on preventing the chronic diseases.

Ontario

Program 4 (Interview #12) – Registered Dietitian with Somerset West Community Health Centre in Ottawa
This community health centre services the inner city: the patients are mainly adults and 80 percent are female. The centre employs six family physicians (not all FTEs), 12 RNs, six NPs, four social workers, one physiotherapist, two dietitians and one acupuncturist. The two dietitians work 40 hours per week in total. (one FTE = 35 hours.) The interviewee provides primarily group counselling whereas the other dietitian provides primarily one-on-one counselling. They see patients for all clinical conditions. About 60 per cent of the time is spent in health promotion activities and that entails grocery store tours, low-cost cooking groups, baby food workshops in Chinese, a feeding toddlers workshop and a community kitchen for mental health/low income patients. Medical secretaries book all of the appointments.

She could not think of any innovations.

The interviewee says an unmet need is that there is never enough time to do all the work requested. The week before the interview, the dietitian was asked to start a "Good Food Box" program, and a cooking group for people living in a rooming house with one burner and no refrigeration.

Program 5 (Interview #1) – Senior Health Planner with the Thames Valley District Health Council in London
The interviewee's specialty was strategic planning and primary health care. She did not provide primary health care services but she planned services for the London Inter-Community Health Centre (LICH). She suggested that the Executive Director of the Community Health Centre be interviewed (see Interview # 7 below). The innovative component of the program is the special population (Aboriginal and Latin American) that they serve. The LIHC collaborated with the university and with family medicine practitioners to serve these two populations.

Program 5 (Interview #7) – Executive Director of the London Inter-Community Health Centre in London
This community health centre provides care to an inner city population of all age groups, with particular emphasis on Latin American and Aboriginal populations. About 50 per cent of the clientele is female.

The staffing quotient at LIHC is 4.75 FTE family physicians, 0.2 FTE specialist physician, 4.5 FTE RNs, 3.5 FTE NPs, 0.3 FTE psychologist, 2.5 FTE social workers, one FTE occupational therapist, 0.5 FTE art therapist and 0.8 FTE dietitian. At the moment, only 10 hours per month (0.10 FTE) goes to a RD and the balance of funds are spent employing a community advocate. The dietitian takes care of patients with diabetes and heart health problems. She spends 60 percent of her time on health promotion. This entails talking about how to consume a healthy diet on a fixed income (i.e., very limited means). The dietitian will also help patients with diabetes learn how to monitor their post-meal blood glucose levels and make the best decisions from that information.

The dietitian is an employee of a local hospital, and the LIHC purchases the services of the dietitian from the hospital. If the dietitian requires privacy for counselling, the community health centre provides a room for the counselling session. The biggest innovation is having moved away from teaching patients with diabetes about the foods they should avoid, and instead providing them with blood glucose monitors so they can self-monitor the effect certain foods and exercise have on their blood sugars. Sixty per cent of the patients with IGT have reverted to normal blood glucose levels within six weeks. HbA1Cs have dropped 12 to 13 per cent in individuals with diabetes mellitus. An unmet need is the dietitians need to learn more about the different foods eaten by the different cultures in order to better understand the resulting dietary concerns. For example, typical foods from African countries are very different than the foods typically eaten in Central and South America.

Program 6 (Interview #4) – Nurse Practitioner from the Byron Family Medical Centre in London
This academic teaching centre and Family Health Group has an NP focusing on chronic care management (e.g., diabetes and smoking cessation counselling), health promotion and lifestyle counselling. She serves all age groups with about 65 per cent of the patients being female. There are five family physicians, eight family medicine residents, four RNs, one NP and one social worker. A physiotherapist and mental health team (psychiatrist and clinical nurse specialist) provide part-time service. There are no dietitians on staff; the NP provides all nutrition counselling. She motivates the patients with Type 1 diabetes before they are referred to a specialist clinic and a dietitian. She reviews carbohydrate counting with patients with diabetes. She deals with osteoporosis and prevention. Nutrition is part of the whole systems review.

The NP's role in health promotion is largely promoting positive lifestyle changes to people with chronic diseases such as diabetes. She also provides a few group sessions, including a weight loss program (the patients refer themselves to the program), "diabetes tune ups," cholesterol management and hypertension (for the PRIISM project).

She is an employee of the London Health Sciences Centre but the Ministry of Health funds her salary and overhead expenses.

The NP feels that the system does not support referrals to dietitians — patients would have to pay for this service since this family medicine centre does not collaborate with a dietitian. She would prefer to work as a team with a dietitian rather than have the patients referred out because she does not know the other dietitian and does not necessarily have the same values about nutrition and diet.

Saskatchewan

Program 7 (Interview #8) – Registered Dietitian with the Regina Community Clinic in Regina
This community health clinic serves mainly adults in an urban/suburban area and 75 per cent of the patients are female. There are six family physicians, three RNs, one NP, two social workers, one dietitian (who works 29

hours per week), one exercise specialist, one optometrist and lab and x-ray services.

The dietitian sees patients for all types of medical problems. She believes she spends about 13 per cent of her time in health promotion activities, such as running a child obesity program with the exercise specialist. She also does monthly grocery tours, and senior wellness checks with the NP.

The dietitian is an employee of Saskatchewan Health and the employer covers her liability insurance.

Innovations include running multidisciplinary groups as mentioned previously. An unmet need for the dietitian is that she feels isolated being the only dietitian and she does not have access to up-to-date resources, such as journals and a medical library.

Alberta

Program 8 (Interview #6) – A family physician who works for the Taber Health Project in Taber

Taber, Alberta has six family physicians for a rostered (enrolled) population of 7,000 in the town and about 16,000 people in the surrounding area. The project also includes two General Practitioner (GP) surgeons, one GP anesthetist, 1.5 RNs, one NP, two LPNs and eight personal care attendants. All other health care practitioners are available to the project but they are regional employees rather than clinical employees. The regional employees accessible to the project include three psychologists, 0.5 social worker, 1.2 physiotherapists, several pharmacists (both hospital and retail based), two massage therapists, two chiropractors and one dietitian. See Interview 9.

The dietitian has a role in the diabetes, lipid and obesity clinics. She plays a role in the care of other chronic diseases as well, particularly vascular protection. She spends two half-days on the Building Healthy Lifestyle Initiative as part of her mandate in health promotion, which includes healthy eating and exercise (people with chronic diseases, such as diabetes, participate in the healthy lifestyles initiative). The dietitian is a salaried employee of the region.

Innovations include the development of the healthy lifestyles program. It was set up to eliminate providing separate resources to different chronic disease management teams. It has taken off and moved into the community. There are lots of volunteers involved with the program. Also, now that the chronic disease team is under one roof, there are more hallway consultations and overall much better communication about the care provided. The use of family physicians as part of the team increased and there were fewer referrals to specialists.

An unmet need is an adequate means of dealing with obesity and inactivity. The team is trying to approach this problem as best as it can.

Program 8 (Interview #9) – Director of Nutrition Services with the Chinook Health Region in Lethbridge

The Director is responsible for some areas that provide primary health care services, and the one she referred to in the interview was the Taber Health Project (THP). She became involved with the THP when the project wanted to bring a dietitian into a new initiative referred to as Building Healthy Lifestyles, where previously no dietitian had been involved.

The dietitian works at the THP two days per week (0.4 FTE) and the majority of the dietitian's time is spent on diabetes and heart health. Health promotion activities are undertaken but they are not the focus of the dietitian's job. The activities include promotional heart health during the month of February. She does some general nutrition, and general heart health classes, for referred patients, not for the general public.

The program has a common referral form that goes to a central triage location. The referral is assessed and booked by a booking clerk. Sometimes the physician will have a patient in his/her office that, if possible, could be seen by the dietitian at that time as well.

The Building Healthy initiative is a new innovation, described in interview #6. An unmet need is the limited time a hospital dietitian can spend with patients, compared to a dietitian in a primary health care setting. The other gap is the lack of information technology, particularly the absence of electronic medical record.

British Columbia

Program 9 (Interview #11) – Registered Dietitian with Raven Song Community Health Centre in Vancouver

At this community health centre, the dietitian serves adults and seniors and 50 to 60 per cent of the patients are female. She works 36 hours every two weeks (0.5 FTE). She does mainly home visits, but she also participates as member of the team in ambulatory care clinics where patients are coming into the community health centre. Since she works on different teams for the home visits and clinics, it was not possible to determine how many other providers she works with, but they include physicians, nurses, speech language pathologists, occupational therapists, physiotherapists, a respiratory therapist and social workers. (Another dietitian takes care of children and youth and the interviewee was not sure how much time the other dietitian is budgeted at Raven Song. They are both employees of the region and the employer covers their liability insurance.)

The interviewee books most of her own appointments. She spends five to 10 per cent of her time on health promotion activities to develop a staff wellness program that will improve nutrition knowledge. She does not spend time on health promotion for patients or the public.

There isn’t enough time to come up with innovations. An unmet need is the lack of nutrition services to other health care teams, such as mental health.

Program 10 (Interview #13) – Registered Dietitian with the Mid-Main Community Health Centre in Vancouver

This community health centre has been in existence since 1988. It received funding through the provincial envelope of the PHCTF to hire a full time dietitian to develop the chronic disease management component of their programming; she also spends one day per week doing one-on-one nutrition counselling. The other staff members include six physicians, one NP and one pharmacist. They service an urban/suburban area and mainly adult patients. Approximately 75 per cent of the patients are female.

The dietitian’s main role is to develop programs and initiatives that focus on chronic disease. For example, she plans and organizes the diabetes initiatives and she evaluates the chronic disease care in relation to their outcomes. She is working with the team to strategize on how best to meet the targeted outcomes. She also focuses on other chronic diseases, such as heart disease, congestive heart failure, hypertension and obesity. She is not involved in health promotion because she is dealing with chronic disease management.
The dietitian’s salary is paid by the grant and she purchased her own liability insurance through Dietitians of Canada.

One innovation is the development of the clinic’s chronic disease management initiative. They are “proactively” managing patient care, which means that instead of waiting for a patient to come in for a check-up, the patients are called in every three months. Some are on standing orders for lab work to ensure it gets done, with very good outcomes. No unmet needs were identified.

Program 11 (Interview #5) – Coordinator (Registered Dietitian) of the Wellness Centre Project in Richmond
This project is funded by the provincial envelope of the PHCTF.

The Wellness Centre is similar to a community clinic in an urban/suburban area that serves mainly adults. The coordinator believes the gender split of the patients seen is 50/50. It is a collaborative project with 11 family physicians directly involved and 190 family physicians who refer patients to the centre. Four diabetes medical specialists, one RN, a physiotherapist, a respiratory therapist, two dietitians (1.3 FTE) and exercise leaders also work at the centre.

The dietitians see patients for diabetes, heart health, renal disease, maternal and child health, gastrointestinal problems and adult obesity. Health promotion activities include diabetes and obesity prevention. Both diabetes and obesity prevention entail spending about one day per week working with city recreation staff in terms of nutrition and exercise and also providing glucose tolerance curriculum and classes.

The dietitian is paid a salary by the provincial government. The time spent on obesity is cost recovery because weight loss is not covered under insured services. The employer provides liability insurance.

One innovation is the partnership of the dietitian with the exercise leader from the city recreation department. The program is promoted through the city recreation guide. Another innovation is the relationship with the family physician groups, which includes evaluating how they practice diabetes care in order to improve clinical outcomes and the flow-through of patients.

An unmet need is the gap between what usual care ideally should be and what it actually is. There are thousands of people out there who have diabetes and dyslipidemia who are not being served.

Program 12 (Interview #14) – Registered Dietitian with the Vancouver Island Health Authority, Saanich
The national envelope of the PHCTF funds the Chronic Disease Initiative project.

There are 60 physicians, four specialist physicians, four nurses and two dietitians (1.7 FTE) involved with the project. The area covers Victoria (urban) and Sooke (rural). The team sees adults and seniors and about 60 per cent of patients are female. The dietitians see patients for diabetes, heart health, and other chronic diseases, such as renal, obesity and depression. The three main patient problems are depression, diabetes and congestive heart failure. The dietitians only see patients who are enrolled in the project. The dietitians have their own office in a medical building but they travel to the physicians' offices to see the patients.

The dietitians have been encouraged to be involved in health promotion activities (accounting for about 20 per cent of their time). The health promotion activities include developing a directory of food resources in the community (food security is a problem), developing a community garden policy, and advocating for a change in the provincial diet allowance for a person with diabetes on income assistance.

Innovations include testing the effectiveness of regular telephone follow-ups and having physicians attend each new referral for at least five minutes at the end of the appointment. In this way the physician learns about the plan of care and reinforces the teaching and the next steps. Patients seem to value this approach. The nurses started this before the dietitians were hired and the dietitians have continued it.

An issue for this project is the fact that the physicians are fee-for-service and not reimbursed for interdisciplinary care (i.e., they cannot bill for the five minutes with the RD and the patient). Also, there is a lack of office space and the RDs have to use the office of an absent physician.

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