Nutrition in Primary Health

Delphi Questionnaire 1

Interdisciplinary Nutrition Services in Family Health Networks / Primary Care Models

ID Number

Please return completed questionnaire by email, post or FAX by (date) to:

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Process to Create Current Options

After the meeting in June 2005 the results from each group were combined. The options are organized under the topics discussed at the meeting, with the exception of two added headings at the beginning of the questionnaire. These are:

A. Issues Across Topics and Groups These options were mentioned by several groups under different topics. These options have been put into a separate section at the beginning to decrease repetition.

B. Overall counseling services. The options for overall counseling for nutrition services were created from the discussion of health promotion and disease prevention. All options include the services of a Registered Dietitian in some capacity. Options were grouped according to models that emerged from the notes: a referral only model, an integrated non-referral model with all health tem members providing nutrition counseling and various forms of mixed models.

Assumptions and working definitions have been provided to clarify concepts (page 2 and 3).

Working Definitions (adapted from the *Enhancing Interdisciplinary Collaboration Project*)

BEST PRACTICES: Technique or methodology that, through experience and research is thought by expert opinion and some evidence to reliably lead to a desired result. [Interchangeable with "Better Practices" and "Good Practices"]

COLLABORATION IN PRIMARY HEALTH CARE: Two or more primary health care providers working together with the patient and/or caregiver for purposes of improving health outcomes that involves joint information sharing, goal setting and decision making.

COLLABORATIVE PARTNERSHIP: A mutually-beneficial arrangement, agreement or understanding whereby two or more parties work jointly toward a common end.

DISEASE PREVENTION:
1. Primary prevention: Services to enhance and maintain a state of wellness by changing the environment and community, as well as individual and family lifestyles and behaviours. Primary prevention is usually applied to a specific type of problem or condition, such as diabetes, but is sometimes used interchangeably with health promotion.
2. Secondary prevention: Services to prevent specific diseases or conditions directed to groups or individuals known to be at risk or who have known risk factors for the conditions.
3. Tertiary prevention: Services to treat and prevent further problems or worsening of disease in individuals who already have the condition.

EVIDENCE BASED DECISION MAKING: The systematic evaluation of best available and reliable research and information combined with clinical expertise.

HEALTH PROMOTION: Services to promote the general health of communities or individuals, without consideration of specific diseases or conditions. Health promotion services are generally aimed at the total population in its environment, and frequently use multiple strategies.

INTERDISCIPLINARY: A range of collaborative activities undertaken by a team of two (2) or more individuals from varying disciplines applying the methods and approaches of their respective disciplines.

PATIENT: A recipient of health services and related support care to meet the individual's needs in any setting. [Interchangeable terms include "consumer", "user" and "client"]

PATIENT-CENTRED: Care that is respectful of and responsive to individual patient preferences, needs and values, ensuring that patient values guide all clinical decisions.

PRIMARY HEALTH CARE: An individual's first contact with the health system characterized by a spectrum of comprehensive, coordinated and continuous health care services such as health promotion, diagnosis, treatment and chronic disease management.

Primary health care is delivered in many settings such as the workplace, home, schools, health care institutions, the family physician's office, homes for the aged, nursing homes, day-care centers and community clinics. It is also available by telephone, from health information services and the Internet.

TEAM: A defined group of individuals with complementary and sometimes overlapping skills who are mutually accountable for achieving a common purpose using a common approach.

TEAMWORK: Joint, concurrent or sequential actions that are carried out by a team which has clearly defined roles and responsibilities, and a clearly defined decision-making process in a way that fosters mutual respect and trust, constructive communications and a breadth of perspectives

Additional Working Definitions

DIET or NUTRITION ADVICE: general, non-prescriptive reinforcement of basic or general "prudent" dietary guidelines, usually given in a brief period (5 minutes or less). Advice may be directed to any of health promotion, disease prevention and/or disease treatment issues.[1]

NUTRITION COUNSELING: Targeted dietary intervention wherein counseling has clear goals which are understood to have prescribed nutritive content and a timetable.[1] *This involves in-depth assessment, health edcuation and behavioural counseling to develop skills and motivation to undertake the specific diet and exercise changes with follow-up and evaluation, usually over several encounters. Counseling is usually directed to individuals and may be directed to any of health promotion, disease prevention and/or disease treatment issues.*

FAMILY HEALTH NETWORK (FHN): is an organization of five or more family physicians and other health care professionals who provide 24/7 access to primary health care services, offer the opportunity to roster to all of their patients, and are funded in a blended funding model. The FHN is an entity that undertakes to complete a task, without specifying a specific person or group within the organization.

PROVIDERS: secretaries, nurses, registered dietitians, nurse practitioners, physicians, counsellors, social workers, psychologists, pharmacists, chiropodists, chiropractors, physiotherapists, occupational therapists, midwives, lactation consultants, massage therapists, fitness instructors, outpatient clinics (hospital), diabetes education centre, recreation departments, schools, public health and others as deemed providers by the FHN or primary health care model used in the community.

CAPITATION: Capitation is a system of populations-based funding of health care services.

[1] Adapted from: Toronto Working Group on Cholesterol Policy. Chapter 7. Cholesterol-lowering programs: Recent policy statements. In: Asymptomatic hypercholesterolemia: a clinical policy review. J Clin Epidemiol 1990; 43: 1021-1122.

Working Assumptions

- The Registered Dietitian will be the leader of the nutrition program; which includes managing nutrition services, providing leadership to the team for development of the team's basic nutrition knowledge and nutrition messages for patients
- All providers act within their own scope of practice for nutrition services

Statement: What options do you prefer in addressing each of the following issues in FHNs. Please put an 'x' beside the number that best describes your opinion.	Not Important/ Not Appropriate			Somewhat Important			Essential / Highly Appropriate		
A. Issues Across Topics and Groups									
1. Each FHN will have an electronic health record (EHR)	1	2	3	4	5	6	7	8	9
2. All disciplines will have access to the patient record and will document their actions in the chart or EHR	1	2	3	4	5	6	7	8	9
3. Regular team meetings will be established to create a collaborative team approach to patient care	1	2	3	4	5	6	7	8	9
4. A funded coordinator role will be established to facilitate the interdisciplinary model, including regular communication, goal setting and evaluation (what was effective, what was not, what needs to be changed).	1	2	3	4	5	6	7	8	9
5. The FHN will develop common nutrition messages specific for each discipline to be used by the team within the FHN and in the community	1	2	3	4	5	6	7	8	9
6. Registered Dietitian(s) will meet or form a group with other Registered Dietitians in the community (e.g. partnering with other public health & community Registered Dietitians) to coordinate nutrition services and partner on other initiatives	1	2	3	4	5	6	7	8	9
7. A role will be developed for a dietetic technician in FHNs	1	2	3	4	5	6	7	8	9
B. Overall Counseling Services Models									
8. Interdisciplinary nutrition services offered through FHNs will serve only rostered patients	1	2	3	4	5	6	7	8	9
9. Interdisciplinary nutrition services offered through FHNs will serve rostered and unrostered patients	1	2	3	4	5	6	7	8	9
Referral Model									
10. All Providers will refer patients to the Registered Dietitian for both nutrition advice and nutrition counseling (see definitions)	1	2	3	4	5	6	7	8	9
Fully Integrated Models									
11. All Providers will provide basic nutrition advice and counseling, motivate the patient and will be responsible for affecting change (i.e. there are no individual roles).	1	2	3	4	5	6	7	8	9
12. The Registered Dietitian will act as a nutrition resource to various practitioners (including web-based or written) and will not provide direct nutrition counseling to patients	1	2	3	4	5	6	7	8	9
13. The patient can self-refer to any FHN Provider in order to obtain nutrition services	1	2	3	4	5	6	7	8	9
Mixed Models									
14. All Providers will have a foundation of basic nutrition	1	2	3	4	5	6	7	8	9

Statement: What options do you prefer in addressing each of the following issues in FHNs. Please put an 'x' beside the number that best describes your opinion.	Not Important/ Not Appropriate			Somewhat Important			Essential / Highly Appropriate		
knowledge, and will provide consistent nutrition advice to patients									
15. All Providers will identify target populations for nutrition counseling (e.g. motivated patients)	1	2	3	4	5	6	7	8	9
16. All Providers will refer to the Registered Dietitian for nutrition counseling	1	2	3	4	5	6	7	8	9
17. All Providers will refer patients to outside agencies, as available, for nutrition issues (e.g. diabetes clinic, public health) as agreed upon in the FHN	1	2	3	4	5	6	7	8	9
18. The Registered Dietitian will refer patients to outside agencies, as available, for nutrition issues (e.g. diabetes clinic, public health) as agreed upon in the FHN	1	2	3	4	5	6	7	8	9
Mixed Models – Provider Variations									
19. The Physician will screen for nutrition-related problems and will make referrals to a Registered Dietitian as appropriate	1	2	3	4	5	6	7	8	9
20. The Physician will reinforce messages resulting from nutrition counseling									
21. The Physician will provide basic nutrition counseling advice to within the context of individual patient appointments	1	2	3	4	5	6	7	8	9
22. The Pharmacist will help patients/customers with product selection (e.g. supplements).	1	2	3	4	5	6	7	8	9
23. The Pharmacist will advise customers on possible drug-nutrient interactions	1	2	3	4	5	6	7	8	9
24. The Pharmacist will provide basic nutrition information related to vitamin / medication usage	1	2	3	4	5	6	7	8	9
25. The Pharmacist will provide nutrition counseling specific to disease states	1	2	3	4	5	6	7	8	9
26. The Pharmacist will refer customers to a Registered Dietitian for nutrition counseling	1	2	3	4	5	6	7	8	9
27. The Nurse Practitioner will screen for and recognize nutrition-related problems	1	2	3	4	5	6	7	8	9
28. The Nurse Practitioner will make referrals to a Registered Dietitian for nutrition counseling for specific disease states	1	2	3	4	5	6	7	8	9
29. The Nurse Practitioner will provide nutrition counseling for specific disease states	1	2	3	4	5	6	7	8	9
30. The Nurse Practitioner will provide nutrition-counseling within the context of individual patient appointments	1	2	3	4	5	6	7	8	9
31. The Nurse Practitioner will reinforce the messages from nutrition counseling	1	2	3	4	5	6	7	8	9

Statement: What options do you prefer in addressing each of the following issues in FHNs. Please put an 'x' beside the number that best describes your opinion.	Not Important/ Not Appropriate			Somewhat Important			Essential / Highly Appropriate		
32. The Nurse will screen for and recognize nutrition-related problems	1	2	3	4	5	6	7	8	9
33. The Nurse will make referrals to a Registered Dietitian for nutrition counseling,	1	2	3	4	5	6	7	8	9
34. The Nurse will provide nutrition counseling for specific disease states	1	2	3	4	5	6	7	8	9
35. The Nurse will provide nutrition counseling within the context of individual patient appointments	1	2	3	4	5	6	7	8	9
36. The Nurse will reinforce the messages from nutrition counseling	1	2	3	4	5	6	7	8	9
37. The Registered Practical Nurse will screen for and recognize nutrition-related problems	1	2	3	4	5	6	7	8	9
38. The Registered Practical Nurse will make referrals to a Registered Dietitian for nutrition counseling, as appropriate	1	2	3	4	5	6	7	8	9
39. The Registered Practical Nurse will provide nutrition counseling for specific disease states	1	2	3	4	5	6	7	8	9
40. The Registered Practical Nurse will provide nutrition-counseling within the context of individual patient appointments	1	2	3	4	5	6	7	8	9
41. The Registered Practical Nurse will reinforce the messages from nutrition counseling	1	2	3	4	5	6	7	8	9
42. The Social Worker will provide access to resources to ease food security issues	1	2	3	4	5	6	7	8	9
43. The Social Worker will identify patients with lifestyle and/or socio-economic issues that are pertinent for nutrition assessment (e.g., food preparation equipment / skills)	1	2	3	4	5	6	7	8	9
44. The Social Worker will identify and communicate with other providers on individual patient's strengths in order to facilitate treatment planning and improved outcomes	1	2	3	4	5	6	7	8	9
45. The Social Worker will provide nutrition counseling	1	2	3	4	5	6	7	8	9
46. The Social Worker will make a referral to a Registered Dietitian when a lifestyle or socio-economic issue related to nutritional status is identified.	1	2	3	4	5	6	7	8	9
47. The Registered Dietitian will be the custodian of nutrition resource material	1	2	3	4	5	6	7	8	9
48. The Registered Dietitian will act as a nutrition resource to various practitioners and will provide direct nutrition counseling to patients	1	2	3	4	5	6	7	8	9
49. The Registered Dietitian will be involved in practice-based research	1	2	3	4	5	6	7	8	9
50. Only Registered Dietitians will do diabetic nutrition	1	2	3	4	5	6	7	8	9

Statement: What options do you prefer in addressing each of the following issues in FHNs. Please put an 'x' beside the number that best describes your opinion.	Not Important/ Not Appropriate			Somewhat Important			Essential / Highly Appropriate		
counseling.									
C. Health Promotion/ Disease Prevention									
51. FHNs should participate in health promotion activities only	1	2	3	4	5	6	7	8	9
52. FHNs should participate in disease prevention activities only	1	2	3	4	5	6	7	8	9
53. FHNs should participate in both health promotion and disease prevention activities	1	2	3	4	5	6	7	8	9
Delivery of Prevention and Health Promotion (Note: Many different initiatives could be promoted. Prioritize the following by rating preferred options higher.) Prevention and /or health promotion activities will be delivered through…									
54. self-help resources (e.g. web-based, email, internet, intranet, web cam)	1	2	3	4	5	6	7	8	9
55. a needs assessment and plan to target at-risk groups	1	2	3	4	5	6	7	8	9
56. use of common screening tools	1	2	3	4	5	6	7	8	9
57. screening clinics (e.g. screening for hypertension, blood sugar)	1	2	3	4	5	6	7	8	9
58. group classes – identify specific topics	1	2	3	4	5	6	7	8	9
59. individual counseling	1	2	3	4	5	6	7	8	9
60. e-mail follow-up with patients	1	2	3	4	5	6	7	8	9
61. home visits when patient has limited access	1	2	3	4	5	6	7	8	9
62. providing incentives to FHN/FHT for health promotion activities	1	2	3	4	5	6	7	8	9
63. promoting healthy eating through the community media	1	2	3	4	5	6	7	8	9
64. attaching health promotion to other disease prevention initiatives e.g. flu shot programs	1	2	3	4	5	6	7	8	9
65. home, school and worksite health promotion programs	1	2	3	4	5	6	7	8	9
66. advocating for changes in legislation	1	2	3	4	5	6	7	8	9
67. establishment of an integrated care model for disease prevention	1	2	3	4	5	6	7	8	9
68. establishment of an integrated model for health promotion	1	2	3	4	5	6	7	8	9
69. encouraging self managed / self-directed care by patients / patients	1	2	3	4	5	6	7	8	9
70. Each FHN hosting a community health promotion conference to facilitate a community effort on health issues, goals, access and coordination of this access	1	2	3	4	5	6	7	8	9
D. Interdisciplinary Care									
Team Communication									
71. Referral guidelines will be established between all providers (depending on practice model)	1	2	3	4	5	6	7	8	9

Statement: What options do you prefer in addressing each of the following issues in FHNs. Please put an 'x' beside the number that best describes your opinion.	Not Important/ Not Appropriate			Somewhat Important			Essential / Highly Appropriate		
72. Resources will be allocated for collaboration / regular communication	1	2	3	4	5	6	7	8	9
73. Regular chart review by the "clinic manager" will occur to identify issues and to manage interdisciplinary care	1	2	3	4	5	6	7	8	9
Continuity & Access to Care									
74. All health care providers will be educated about interdisciplinary processes	1	2	3	4	5	6	7	8	9
75. The patient will be responsible for scheduling their next follow up appointment at the time of their visit	1	2	3	4	5	6	7	8	9
76. The FHN is responsible for scheduling the patient's next follow-up appointment	1	2	3	4	5	6	7	8	9
77. FHN providers will aim for efficiency of patient interactions by coordinating appointments with multiple providers on the same day	1	2	3	4	5	6	7	8	9
78. FHN providers will identify and attempt to solve problems of access (hours of FHN) that the patients may face	1	2	3	4	5	6	7	8	9
79. The FHNs will collaborate with Local Health Integration Networks (LHINs) to identify & resolve access to nutrition and other services through alternative delivery of care e.g. outreach	1	2	3	4	5	6	7	8	9
80. Patients will be provided with a summary of their individual care plan allowing sharing of the care plan with providers external to the FHN	1	2	3	4	5	6	7	8	9
81. The patient will have access to their health record and be able to document in the health record	1	2	3	4	5	6	7	8	9
82. Any health care team member can refer to any other health care team member	1	2	3	4	5	6	7	8	9
83. All referrals to Registered Dietitians will be made by Physicians	1	2	3	4	5	6	7	8	9
84. Patients can self-refer	1	2	3	4	5	6	7	8	9
85. All patients will be assessed, by the Provider making the referral, for their readiness to receive nutrition counseling	1	2	3	4	5	6	7	8	9
86. All patients will be screened or triaged for nutrition risk	1	2	3	4	5	6	7	8	9
Effective Team Functioning									
87. All health care providers will be co-located (i.e. located in one office)	1	2	3	4	5	6	7	8	9
88. Regular educational meetings will be scheduled for Providers	1	2	3	4	5	6	7	8	9
89. Each team member will know the roles of other team members	1	2	3	4	5	6	7	8	9

Statement: What options do you prefer in addressing each of the following issues in FHNs. Please put an 'x' beside the number that best describes your opinion.	Not Important/ Not Appropriate			Somewhat Important			Essential / Highly Appropriate		
Interdisciplinary Delivery of Nutrition Programs									
90. The FHN will determine what information is relevant for the EHR	1	2	3	4	5	6	7	8	9
91. Patient objectives / goals will be shared with appropriate team members through the health record	1	2	3	4	5	6	7	8	9
92. The FHN team will develop the nutrition program that fits the population's need	1	2	3	4	5	6	7	8	9
93. The FHN will offer programs that are co-facilitated e.g., NP/RD/Pharmacist when appropriate e.g. lipid clinic	1	2	3	4	5	6	7	8	9
94. The FHN will offer the Intranet for patient use; the FHN team establishes information to be posted	1	2	3	4	5	6	7	8	9
95. The FHN will join the Smart Systems for Health, whose mandate is to provide a secure internet pipeline for Ontario Health Care.	1	2	3	4	5	6	7	8	9
E. Medical Directives/Delegated Acts									
96. FHN management will use medical directives to allow Registered Dietitians to order blood work, if clinically indicated (e.g. haemoglobin A_{1c}, blood glucose, CBC, ferritin, lipid profile, albumin, creatinine, electrolytes) (as "clinically indicated" allows Registered Dietitians to use their judgement and discretion)	1	2	3	4	5	6	7	8	9
97. As per a delegation (medical directive), all competent Registered Dietitians (e.g. certified diabetes educator, or with demonstrated knowledge) will be able to adjust insulin and medication dosages	1	2	3	4	5	6	7	8	9
98. As per a delegation, all Registered Dietitians will be able to perform capillary blood glucose testing by finger pricking (below dermis).	1	2	3	4	5	6	7	8	9
99. The Registered Dietitian may communicate the results of a nutrition assessment to a patient without communicating a diagnosis	1	2	3	4	5	6	7	8	9
100. Registered Dietitians will be permitted to recommend and dispense over the counter (OTC) scheduled drug products (e.g. nutrition / vitamin supplements, calcium supplements)	1	2	3	4	5	6	7	8	9
F. Professional Development/Accountability									
Human & financial resource allocation required for education, networking and practice-based research of the Registered Dietitian									
101. The FHN will define interdisciplinary education and designate a leader within the FHN who will coordinate education	1	2	3	4	5	6	7	8	9
102. The FHN will support external bodies or organizations that promote or sustain interdisciplinary professional development, as they develop	1	2	3	4	5	6	7	8	9
103. The FHN will work with other PHC groups to	1	2	3	4	5	6	7	8	9

Statement: What options do you prefer in addressing each of the following issues in FHNs. Please put an 'x' beside the number that best describes your opinion.	Not Important/ Not Appropriate			Somewhat Important			Essential / Highly Appropriate		
develop and apply "primary health care" accreditation programs currently being developed. The range of possibilities might include "best practices" and "benchmarks"									
104. The FHN will develop benchmarks and best practices for use within the FHN	1	2	3	4	5	6	7	8	9
105. The FHN may take on trainees (look at undergraduate opportunities, dietetic internship, upgrading and Canadian dietetic training)	1	2	3	4	5	6	7	8	9
106. The FHN will participate in practice-based research (university affiliation for practice-based research will help people feel supported)	1	2	3	4	5	6	7	8	9
107. The FHN will participate in evaluation/research with other agencies	1	2	3	4	5	6	7	8	9
108. The Registered Dietitian will participate in continuing education activities & share within the FHN	1	2	3	4	5	6	7	8	9
Quality and cost effectiveness of nutrition services (Note: the role of the FHN is separated from the role of the Registered Dietitian; the same options are provided for both)									
109. The FHN will set achievable nutrition goals for their patients	1	2	3	4	5	6	7	8	9
110. The FHN will utilize evidence-based practice whenever possible	1	2	3	4	5	6	7	8	9
111. The FHN will develop an evaluation plan for interdisciplinary practice	1	2	3	4	5	6	7	8	9
112. The FHN will dedicate human resources and/or time to evaluation, recognizing both the potential and the limitations of current technology to achieve accountability goals	1	2	3	4	5	6	7	8	9
113. The FHN will undertake an evaluation of the FHN, such as participating in a provincial initiative, or the Quality in Family Practice Program (QIFP)	1	2	3	4	5	6	7	8	9
114. The FHN will share the results of an evaluation among other FHNs	1	2	3	4	5	6	7	8	9
115. The FHN will promote/participate in associations or organizations to support FHN communication & evaluation	1	2	3	4	5	6	7	8	9
116. The FHN will use participatory research methods/models (e.g. stories, images) to conduct an evaluation of nutrition services	1	2	3	4	5	6	7	8	9
117. The FHN will evaluate services using lessons learned from other agencies and programs	1	2	3	4	5	6	7	8	9
118. The FHN will consult with the College of Dietitians of Ontario (CDO) to achieve documentation standards required in a non-hospital setting	1	2	3	4	5	6	7	8	9
119. The FHN will communicate with CDO regarding	1	2	3	4	5	6	7	8	9

Statement: What options do you prefer in addressing each of the following issues in FHNs. Please put an 'x' beside the number that best describes your opinion.	Not Important/ Not Appropriate			Somewhat Important			Essential / Highly Appropriate		
changing practice									
120. The FHN will establish primary health outcomes of the rostered population	1	2	3	4	5	6	7	8	9
121. The FHN will undertake workload assessment to determine the amount of time required for individual counseling, group counseling and screening.	1	2	3	4	5	6	7	8	9
122. The Registered Dietitian will set achievable goals to the FHN	1	2	3	4	5	6	7	8	9
123. The Registered Dietitian will utilize evidence-based practice whenever possible	1	2	3	4	5	6	7	8	9
124. The Registered Dietitian will assess population needs in the FHN for nutrition services, especially gaps in services	1	2	3	4	5	6	7	8	9
125. The Registered Dietitian will conduct an evaluation of her nutrition services	1	2	3	4	5	6	7	8	9
126. The Registered Dietitian will conduct an evaluation of interdisciplinary nutrition services in the FHN	1	2	3	4	5	6	7	8	9
127. The Registered Dietitian will dedicate human resources and/or time to evaluation, recognizing both the potential and the limitations of current technology to achieve accountability goals	1	2	3	4	5	6	7	8	9
128. The Registered Dietitian will undertake an evaluation of the FHN, such as participating in a provincial initiative, or the QIFP (Quality in Family Practice Program)	1	2	3	4	5	6	7	8	9
129. The Registered Dietitian will share the results of an evaluation among other FHNs (and with the staff of the FHN)	1	2	3	4	5	6	7	8	9
130. The Registered Dietitian will promote/participate in associations or organizations to support Registered Dietitian communication & evaluation such as an association	1	2	3	4	5	6	7	8	9
131. The Registered Dietitian will use participatory research methods/models (e.g. stories, images) to conduct an evaluation of nutrition services	1	2	3	4	5	6	7	8	9
132. The Registered Dietitian will evaluate services using lessons learned from other agencies and programs	1	2	3	4	5	6	7	8	9
133. The Registered Dietitian will consult with the College of Registered Dietitians of Ontario (CDO) to achieve documentation standards required in a non-hospital setting	1	2	3	4	5	6	7	8	9
134. The Registered Dietitian will communicate with CDO regarding changing practice	1	2	3	4	5	6	7	8	9
135. The Registered Dietitian will establish primary health outcomes of the rostered patients	1	2	3	4	5	6	7	8	9

Statement: What options do you prefer in addressing each of the following issues in FHNs. Please put an 'x' beside the number that best describes your opinion.	Not Important/ Not Appropriate			Somewhat Important			Essential / Highly Appropriate		
136.The Registered Dietitian will undertake workload assessment to determine the amount of time required for individual counseling, group counseling and screening.	1	2	3	4	5	6	7	8	9
G. Compensation Mechanisms									
Options to pay for Registered Dietitian services from private sources include:									
137.Fee for services from individual patients	1	2	3	4	5	6	7	8	9
138.Private insurance companies	1	2	3	4	5	6	7	8	9
The other options to pay for Registered Dietitian services assume payment is coming directly or indirectly from government and include:									
139.Fee for services	1	2	3	4	5	6	7	8	9
140.Capitation (see definitions)	1	2	3	4	5	6	7	8	9
141.Blended payment - base payment and incentives for special care (e.g. 80% of the rostered patients with an elevated HbA1C receive an intervention from the Registered Dietitian, and similarly for BMI, health promotion (networking and partnering), research, presentation of abstracts, cardiovascular health, mental health, target populations for interventions (children, prenatal))	1	2	3	4	5	6	7	8	9
142.Salary with accountability.	1	2	3	4	5	6	7	8	9
143.Baseline with efficiency factors as defined by the FHN	1	2	3	4	5	6	7	8	9
Other Compensation Issues									
144.All FHN team members will work under the same payment system	1	2	3	4	5	6	7	8	9
145.The FHN has methods/mechanisms to ensure Registered Dietitian efficiency / cost effectiveness	1	2	3	4	5	6	7	8	9
146.The FHN employs other staff (e.g. dietetic technician, student) to increase efficiency of the Registered Dietitian	1	2	3	4	5	6	7	8	9
147.The FHN has administration staff to support interdisciplinary practice	1	2	3	4	5	6	7	8	9
Registered Dietitian Bnefits The following benefits could be provided to the Registered Dietitian:									
148. paid holidays / personal days	1	2	3	4	5	6	7	8	9
149. vacation	1	2	3	4	5	6	7	8	9
150. attendance at conferences	1	2	3	4	5	6	7	8	9
151. sick / health benefits	1	2	3	4	5	6	7	8	9
152. pension	1	2	3	4	5	6	7	8	9
153. mileage	1	2	3	4	5	6	7	8	9
154. parking	1	2	3	4	5	6	7	8	9
155. liability insurance	1	2	3	4	5	6	7	8	9
156. association fees	1	2	3	4	5	6	7	8	9

Statement: What options do you prefer in addressing each of the following issues in FHNs. Please put an 'x' beside the number that best describes your opinion.	Not Important/ Not Appropriate			Somewhat Important			Essential / Highly Appropriate		
157. continuing education time allowance	1	2	3	4	5	6	7	8	9
158. maternity top up / parental leave	1	2	3	4	5	6	7	8	9
159. flex-time	1	2	3	4	5	6	7	8	9
H. Employment Structure									
Administrative support for Registered Dietitian services *Work spaces:*									
160. All FHN team providers will use their own office space for counseling	1	2	3	4	5	6	7	8	9
161. All FHN team providers will use common encounter or examining rooms when not in use by other team members for nutrition counseling	1	2	3	4	5	6	7	8	9
162. All FHN team providers will use a common generic counseling area	1	2	3	4	5	6	7	8	9
163. FHNs will have a teaching room or classroom (big area) available for group counseling	1	2	3	4	5	6	7	8	9
164. The FHN will have a lunch room available for all FHN team members	1	2	3	4	5	6	7	8	9
165. The FHN will have a combined group room and lunch room	1	2	3	4	5	6	7	8	9
Resources:									
166. The FHN will have a budget for software, and hardware	1	2	3	4	5	6	7	8	9
167. The FHN will have a budget for nutrition teaching materials (e.g. Beyond the Basics meal planning guide, food models etc.)	1	2	3	4	5	6	7	8	9
Secretarial/Booking:									
168. The FHN will have a booking clerk for all team members	1	2	3	4	5	6	7	8	9
169. The FHN will designate someone to coordinate bookings, referrals etc. (someone who knows where patient needs to go)	1	2	3	4	5	6	7	8	9
170. The FHN will have a shared clerk for all team members, who can do multiple tasks such as input dietary/food records for patients into the computer	1	2	3	4	5	6	7	8	9
171. The FHN will use a common scheduler with access information from any site	1	2	3	4	5	6	7	8	9
172. The FHN will use the same software as other health care agencies in the community such as in other FHNs, and community health centres (CHC's) etc. for data collection, information sharing and for booking appointments.	1	2	3	4	5	6	7	8	9
173. FHN booking and record keeping will be adapted when not co-located	1	2	3	4	5	6	7	8	9
174. Diet records will be done on-line prior to the patient's	1	2	3	4	5	6	7	8	9

Statement: What options do you prefer in addressing each of the following issues in FHNs. Please put an 'x' beside the number that best describes your opinion.	Not Important/ Not Appropriate			Somewhat Important			Essential / Highly Appropriate		
visit									
Accountability, custody of patient records, policy making and conflict resolution									
Accountability:									
175. The FHN will have processes that are consistent with the payment method to hire and terminate FHN team members	1	2	3	4	5	6	7	8	9
176. Registered Dietitians will have independent professional judgment and are responsible/accountable to their regulatory body	1	2	3	4	5	6	7	8	9
177. The Registered Dietitian will be responsible to the person who hires them (e.g., lead MD)	1	2	3	4	5	6	7	8	9
178. The Registered Dietitian will not affect the remuneration of other FHN team members)	1	2	3	4	5	6	7	8	9
179. The Registered Dietitian will be accountable to each MD in the FHN whose patients they are seeing	1	2	3	4	5	6	7	8	9
180. The Registered Dietitian will be accountable to patients / patients	1	2	3	4	5	6	7	8	9
181. The FHN team will facilitate patient access to all available and necessary services (not an easy promise to keep)	1	2	3	4	5	6	7	8	9
182. The Registered Dietitian is responsible to other FHN team members (non MD) whose patients they are seeing	1	2	3	4	5	6	7	8	9
183. The FHN will have a method for mutual / reciprocal accountability among team members	1	2	3	4	5	6	7	8	9
Developing Policy:									
184. The FHN team members will all have input in developing FHN policy	1	2	3	4	5	6	7	8	9
185. The FHN will ensure that policies that are developed are consistent with the standards and regulations of each College	1	2	3	4	5	6	7	8	9
Patient Records:									
186. The FHN will have options for private records by some Providers (e.g. psychologists)	1	2	3	4	5	6	7	8	9
187. The EHR will be password protected so that private information is disclosed only to the relevant FHN team members (e.g. psychologists) and not all FHN team members	1	2	3	4	5	6	7	8	9
188. The FHN will have Nutrition forms in the EHR e.g. assessment, food intake analysis, templates for reports	1	2	3	4	5	6	7	8	9
189. EHR of nutrition counseling will be available to all FHN team members	1	2	3	4	5	6	7	8	9
Conflict management:									
190. The FHN will designate a team leader with Human	1	2	3	4	5	6	7	8	9

Statement: What options do you prefer in addressing each of the following issues in FHNs. Please put an 'x' beside the number that best describes your opinion.	Not Important/ Not Appropriate			Somewhat Important			Essential / Highly Appropriate		
Resources skills to ensure team accountability/smooth functioning.									
I. Referral/Case Load Management									
191. The FHN will purchase/develop/adapt electronic systems to allow easy update and review of data. This software will allow for evaluation / feedback and will be used to refine wait list / triage referral mechanisms	1	2	3	4	5	6	7	8	9
192. The FHN will participate in national / provincial associations of Health Care Professionals in Primary Health Care, as they develop	1	2	3	4	5	6	7	8	9
Management of wait times for nutrition services (Note: Assume that a wait time of one month for nutrition counseling is considered reasonable. A number of options could be used to manage wait times. Prioritize the following by rating preferred options higher.)									
193. The FHN will evaluate the need for additional nutrition staff	1	2	3	4	5	6	7	8	9
194. The FHN will develop clear referral guidelines for use by the Provider who will refer patients to the Registered Dietitian	1	2	3	4	5	6	7	8	9
195. The FHN will utilize already available nutrition services in the community for specific needs (e.g. diabetes education to diabetes education centre, prenatal education to Public Health Unit)	1	2	3	4	5	6	7	8	9
196. The FHN will develop a referral pathway(s) of the services offered in the community	1	2	3	4	5	6	7	8	9
197. The FHN will develop relationships between the FHN and other community services to coordinate and negotiate services	1	2	3	4	5	6	7	8	9
198. The Registered Dietitian will conduct group classes instead of individual counseling	1	2	3	4	5	6	7	8	9
199. The FHN will allow self-referral, as it may indicate greater readiness for change	1	2	3	4	5	6	7	8	9
200. The FHN team will provide basic education material to those on waiting lists for nutrition counseling	1	2	3	4	5	6	7	8	9
201. The FHN will use health care providers other than the Registered Dietitian to assist with group facilitation	1	2	3	4	5	6	7	8	9
202. The FHN will limit the number of visits (individual or group) based on existing practice guidelines for each condition	1	2	3	4	5	6	7	8	9
203. The FHN will limit the length of individual visits/appointments based on existing practice guidelines for each condition	1	2	3	4	5	6	7	8	9
204. The FHN will assign other FHN team members to complete food intake assessment to assist Registered Dietitian practice	1	2	3	4	5	6	7	8	9
205. The FHN will have patients use self management	1	2	3	4	5	6	7	8	9

Statement: What options do you prefer in addressing each of the following issues in FHNs. Please put an 'x' beside the number that best describes your opinion.	Not Important/ Not Appropriate			Somewhat Important			Essential / Highly Appropriate		
strategies for nutrition counseling									
206. The FHN will use a shared care model or "mini" clinic to deliver nutrition services, in which service to one patient / patient may be provided by more than one Registered Dietitian or other providers	1	2	3	4	5	6	7	8	9
207. The FHN will participate/ promote the training of more Registered Dietitians	1	2	3	4	5	6	7	8	9
208. The FHN will develop a range of nutrition intervention services (e.g. brochures, counseling video tapes, follow-up)	1	2	3	4	5	6	7	8	9
209. The FHN will develop ways of setting priorities for wait lists so those with urgent needs are seen faster	1	2	3	4	5	6	7	8	9
210. The FHN will determine if the service is still required if wait time are long	1	2	3	4	5	6	7	8	9
211. The FHN will inform the patient about expectations and services provided at the time of referral to the Registered Dietitian	1	2	3	4	5	6	7	8	9
212. The FHN will provide flexible hours for nutrition counseling services (e.g. mornings / evenings / weekends)	1	2	3	4	5	6	7	8	9
213. The FHN will develop online booking by the patient to increase patient accessibility	1	2	3	4	5	6	7	8	9
214. The FHN will consider and market other channels of interaction for nutrition services e.g. telephone, e-mail follow-up	1	2	3	4	5	6	7	8	9
215. The FHN will have other team members besides the Registered Dietitian provide basic nutrition counseling and will provide a means to support this	1	2	3	4	5	6	7	8	9
Triaging referrals for nutrition care or health promotion. (Note: A number of options could be used to triage access to services. Prioritize the following by rating preferred options higher. Some options are similar to those above for wait times.)									
216. The FHN will triage certain medical/nutritional conditions to group visits	1	2	3	4	5	6	7	8	9
217. The Registered Dietitian will see a variety of 'types' of patients to avoid burnout	1	2	3	4	5	6	7	8	9
218. The FHN Providers will share patient information between Providers, especially for more "difficult" cases	1	2	3	4	5	6	7	8	9
219. Patients will be screened to identify appropriate referrals to other community resources	1	2	3	4	5	6	7	8	9
220. The FHN will refer patients to other community resources as needed and as available	1	2	3	4	5	6	7	8	9
221. The FHN will develop support groups so that patients will act as mentors/coaches for other patients	1	2	3	4	5	6	7	8	9