APPENDIX B:

PUBLIC HEALTH NUTRITION

Public health nutrition is defined as "the nutrition program conducted by a state, county, city, or other governmental agency that has the responsibility for the health of persons living in the area over which it has jurisdiction."[1] Public health nutrition programs take place in the public or private sector including government-operated public health departments, neighborhoods, hospital ambulatory care clinics, managed care organizations, and home health agencies. Programs include both community-wide health promotion and disease prevention and nutritional care for individuals in primary and/or ambulatory health care.[2]

Responsibilities of a public health nutritionist may include:

- counseling the new mother of a low-birth-weight infant about high-calorie feedings;
- working to ensure that nutrition education is part of training programs on domestic abuse prevention;
- establishing a 5 A Day program within local family physician offices;
- working with the local school board to reduce the number of nutrient-poor foods available in school vending machines; and
- increasing the number of worksites offering lunches that meet the Dietary Guidelines for Americans.

The goals of nutrition in public health are to promote optimal nutritional status, maintain health, and prevent or control disease for all members of the population.[3]

This Appendix reviews the nutrition-related national health promotion goals for the year 2000, as well as the essential services for which public health nutrition is responsible, the federal funding sources for food and nutrition programs,

nutrition and health reports and healthy eating guides developed by the federal government, nutrition-related responsibilities of various health providers, and documentation of nutrition services and medical nutrition therapy.

PUBLIC HEALTH NUTRITION GOALS AND RESPONSIBILITIES

Healthy People 2000

A general overview of *Healthy People 2000* is in Appendix A. Of 332 priority health objectives in the health promotion category, 21 are nutrition objectives. Another 45 objectives elsewhere in *Healthy People 2000* are nutrition-related. Thus, 66, or 20 percent, of the nation's Year 2000 health objectives challenge policymakers and administrators to collaborate with nutritionists in national, state, and local coalitions to plan, manage, and evaluate health promotion and disease prevention campaigns.

Mid-Course Review

Preliminary analysis of the sentinel objectives, which indicate general progress of all objectives, show positive but small gains in the number of adults exercising regularly and eating less fatty diets. There is also an increase in the proportion of workplaces offering health promotion programs. However, there is still an increase in the proportion of overweight adults.[4] Two non-sentinel, nutrition objectives have exceeded their goal:

- Reduce growth retardation among low-income children aged five and younger to less than ten percent.[5]
- Increase to at least 5,000 brand items the availability of processed food products that are reduced in fat and saturated fat.[6]

In the health protection priorities, progress has been made in food safety as measured by the decline in salmonella outbreaks. In oral health, more older people are avoiding complete tooth loss, which can affect eating habits and food choices.[7]

The clinical preventive service priorities show significant progress in reducing cholesterol levels and controlling hypertension as measured by a steady decline in coronary heart disease deaths and a reduction in stroke deaths. Cancer death rates have shown slight improvement. Analysis also shows that more pregnant women are seeking prenatal care during

the first trimester.[8]

For progress on the three health goals of *Healthy People 2000* see Appendix A.

Essential Public Health Nutrition Services

Nutrition services are essential in addressing the mission of public health as defined by the Institute of Medicine, that is, "to fulfill society's interest in assuring conditions in which people can be healthy."

Essential public health nutrition services include:

- assessing the nutritional status of specific populations or geographic areas;
- identifying target populations that may be at nutritional risk;
- initiating and participating in nutrition data collection;
- providing leadership in the development of and planning for health and nutrition policies;
- recommending and providing specific training and programs to meet identified nutrition needs;
- raising awareness among key policy makers of the potential impact of nutrition and food regulations and budget decisions on the health of the community;
- acting as an advocate for target populations on food and nutrition issues;
- planning for nutrition services in conjunction with other health services, based on information obtained from an adequate and on-going data base focused on health outcomes;
- identifying or assisting in development of accurate, up-to-date nutrition education materials;
- ensuring the availability of quality nutrition services to target populations, including nutrition screening, assessment, education, counseling, and referral for food assistance and follow-up;
- participating in nutrition research, demonstration, and evaluation projects;
- providing expert nutrition consultation to the community;
- providing community health promotion and disease prevention activities that are population-based;
- providing quality assurance guidelines for practitioners dealing with food and nutrition issues;
- facilitating coordination with other providers of health and nutrition services within the community; and
- evaluating the impact of the health status of populations

who receive public health nutrition services.[9]

FEDERAL GOVERNMENT FOOD AND NUTRITION FUNDING

There are several sources of federal government financial support that should be explored for nutrition services. Some of the major sources are described below. For more information on any of these programs, contact a public health nutritionist at the state department of health. A listing of state public health nutritionists is available from the Association of State and Territorial Public Health Nutrition Directors in Washington, DC.

Nutrition Services

The **Head Start Program**, administered by the Administration for Children and Families of the U.S. Department of Health and Human Services (DHHS), provides health, food, and nutrition education for children and their parents.[10]

Maternal and Child Health Services (Title V, Social Security Act). DHHS provides money to state health agencies through Maternal and Child Health (MCH) Block Grants. The program, which in earlier forms dates back to the 1930s, supports health services for mothers and children, including children with special health care needs, and provides funding for technical training, teaching materials, professional training, special projects, and research.[11]

Medicare (Title XVIII, Social Security Act). This federal health insurance program covers the elderly and disabled and is not limited to low-income recipients. It is administered by the Health Care Financing Administration of DHHS. Program regulations cover nutrition services provided in participating hospitals, nursing homes, home health agencies, and hospices.[12]

Medicaid (Title XIX, Social Security Act). Financed jointly by state and federal governments, this program provides medical assistance to eligible low-income recipients. These include Aid to Families with Dependent Children (AFDC) recipients and individuals receiving benefits under the Supplemental Security Income (SSI) program. The Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) provides funding for comprehensive child health services which include nutrition treatment and counseling for growth retardation, iron deficiency anemia, and obesity.[13]

Preventive Health and Health Services Block Grant. This

block grant provides funds for state and local nutritionists to provide health promotion nutrition services. Not all states have a nutritionist or nutrition component as part of their health promotion program.[14]

Primary Care Block Grant. Funds from this block grant have been used for nutritionists in community health and migrant health centers. It can also pay for nutrition consultation from hospital dietitians, public health nutritionists, or private practice nutritionists.[15]

Food Assistance

Food Stamp Program. This program provides eligible low-income households with coupons to be used like cash at most grocery stores to purchase food or seeds and plants to grow food. It is administered at the federal level by USDA's Food and Consumer Service (FCS) and at the state and local levels by human services and welfare agencies. The program served 27 million individuals monthly in Fiscal Year 1995. In 1982, the Food Stamp Program in Puerto Rico and the Northern Marinas was replaced with a block grant program that provides participants with cash and coupons rather than food stamps or food distribution.[16]

Child Nutrition

The FCS administers a number of programs aimed at improving child nutrition.

National School Lunch Program provides cash reimbursements and commodity foods for meals served to children in nonprofit food services located in elementary and secondary schools and in residential child care facilities nationwide.[17]

School Breakfast Program reimburses states that provide low-income school children with daily breakfast free or at a reduced price.[18]

Summer Food Service Program reimburses local sponsoring organizations for meals served to low-income children during school vacations.[19]

Child and Adult Care Food Program provides cash reimbursement and commodity food for meals served to children and adults in child and adult day care centers and family and group day care homes for children.[20]

Special Milk Program provides half pints of milk to schools, summer camps, and child care facilities without

federal meal programs.[21]

Homeless Children Nutrition Program reimburses providers for meals served to homeless pre-school age children in emergency shelters.[22]

Supplemental Feeding. The FCS administers the Special Supplemental Nutrition Program for Women, Infants, and Children, known as WIC. The program provides supplemental foods, nutrition education, and health services to low-income pregnant, breastfeeding and non-breastfeeding postpartum women. It also provides supplemental food and health services to infants and to children up to five years of age and infant and child nutrition education to their families. Vouchers are provided for redemption at food stores for specific types of high-nutrition foods.[23] The WIC Farmers Market Nutrition Program provides WIC participants with coupons that can be used at authorized local farmers' markets to buy fresh fruits and vegetables.[24]

Food Distribution

FCS administers the following programs which distribute food to target populations:

The Emergency Food Assistance Program (TEFAP) provides funds to purchase commodities and distributes surplus commodities to needy households. This program was formerly know as the Temporary Emergency Food Assistance Program.[25]

The Food Distribution Program on Indian Reservations and the Trust Territories provides commodity foods to Pacific Islanders and to Native American families living on or near a reservation. This program is also known as the Needy Family Program and dates to the Great Depression.[26]

Commodity Supplemental Food Program distributes food to the elderly and to a population similar to that served by WIC.[27]

Commodity Distribution to Charitable Institutions and to Soup Kitchens and Food Banks provides USDA surplus commodities to charitable institutions, soup kitchens, and food banks to feed the needy, and it also provides funds to soup kitchens and food banks to purchase food for this population.[28]

Senior Nutrition Programs

DHHS and USDA pool funds and work together to provide nutritionally sound meals for people age 60 and older.

Congregate Meals Program and the Home-Delivered Meals Program, authorized by The Older Americans Act of 1965, are administered federally by DHHS, Administration on Aging. Federal funds are distributed to aging agencies in states that contract with local organizations to provide the meals.[29] USDA also provides money and/or commodity foods to these local organizations.[30]

Nutrition Education Programs

Administered by the USDA, the **Cooperative Extension System**, formerly the Cooperative Extension Service, was established in 1914 and administers a general food and nutrition education program, delivering research-based information to the public. The system is organized with specialists based at land grant universities who work with agents located in each county throughout the country. Although the county agents generally have training and experience in general home economics, more food and nutrition extension programs are focusing on health and wellness.[31]

Expanded Food and Nutrition Education Program (EFNEP), administered by the USDA, Cooperative Extension System, is designed to teach low-income families, especially those with small children, the skills needed to choose and prepare an adequate, varied, and balanced diet.[32] The Food Stamp Program and WIC are working more with EFNEP to deliver nutrition education to the recipients of these programs. EFNEP is successful, in part, due to its use of paraprofessionals who are usually peers of the EFNEP program recipients.

Nutrition Education and Training Program (NET). Federally funded, NET is administered primarily through state departments of education to teach children about food and health; train food service personnel in child nutrition and food service system management; guide teachers about nutrition instruction; and develop classroom nutrition curricula.

Food Label Education Program. The FDA developed this program to coordinate public and private sector efforts to educate the public about the new food label. Elements of the program include brochures and pamphlets as well as the video, "The Food Label and You," which provides tips on how to use the new label to select healthy foods. The video package includes a teaching guide. The program is meant to promote healthy food choices and to be used in conjunction with other nutrition education programs such as the Dietary

Guidelines for Americans and the Food Guide Pyramid.

GOVERNMENT REPORTS AND GUIDES ON NUTRITION AND HEALTH

Government Reports

Two major government reports, *The Surgeon General's Report on Nutrition and Health*[33] *(SGR on Nutrition and Health)* and *Diet and Health: Implications for Reducing Chronic Disease Risk*[34] *(Diet and Health)*, published in 1988 and 1989 respectively, confirmed the link between nutrition and health. The conclusions drawn, the dietary recommendations, and the information in these two reports provide the scientific basis for nutrition intervention in health programs. The significance of the S*GR on Nutrition and Health* is its review of the scientific literature and the conclusions drawn on controversial health-related issues. *Diet and Health* provides an in-depth analysis of the overall relationship between diet and the full spectrum of major chronic diseases. Together, these authoritative reviews underscore the spectrum of dietary modifications needed to reduce the risk of diet-related chronic diseases.[35]

Surgeon General's Report on Nutrition and Health

The SGR on Nutrition and Health informs Americans about scientific developments that have widespread implications for human health. The *SGR on Nutrition and Health* addressed some of the controversy and misunderstandings regarding the link between diet and health. The report found that diet plays a prominent role in five of the ten leading causes of death for Americans: coronary heart disease; some types of cancer; stroke; diabetes mellitus; and atherosclerosis. The conclusion was "that overconsumption of certain dietary components is now a major concern for Americans."[36]

Diet and Health: Implications for Reducing Chronic Disease Risk

Diet and Health is a scientifically independent, comprehensive review of nutrition intake, food intake, and dietary patterns and their link to the development of chronic disease. The report includes nine recommendations for maintaining health which have been established by the biomedical scientific community.

1. Reduce total fat intake to 30 percent or less of calories. Reduce saturated fatty acid intake to less than ten percent of calories and the intake of cholesterol to less than 300 mg daily.

2. Eat five or more servings of a combination of vegetables and fruits every day, especially green and yellow vegetables and citrus fruits. Also, increase the intake of starches and other complex carbohydrates by eating six or more daily servings of a combination of breads, cereals, and legumes.

3. Maintain protein intake at moderate levels.

4. Balance food intake and physical activity to maintain appropriate body weight.

5. Alcohol consumption is not recommended. For those who drink alcoholic beverages, consumption should be limited to the equivalent of less than one ounce of pure alcohol in a single day. This is equal to two cans of beer, two small glasses of wine, or two average cocktails. Pregnant women should avoid alcoholic beverages.

6. Limit total daily intake of salt (sodium chloride) to six grams or less.

7. Maintain adequate calcium intake.

8. Avoid taking dietary supplements in excess of the Recommended Dietary Allowance (RDA).

9. Maintain an optimal intake of fluoride, particularly during the years of primary and secondary tooth formation and growth.[37]

Government Guides on Nutrition and Health

Dietary Guidelines

The Dietary Guidelines for Americans, developed by USDA and DHHS, provide advice on what healthy Americans ages two and over should eat to stay healthy. The guidelines reflect recommendations by nutrition authorities who agree that enough is known about diet's effect on health to encourage certain dietary practices by Americans.[38]

Food Guide Pyramid

The Food Guide Pyramid illustrates the research-based food guidance system developed by USDA and supported by DHHS. The Pyramid considers what foods Americans eat, what nutrients are in these foods, and how to make the best food choices. The Pyramid helps put dietary guidelines into action.[39]

Food Labels

Food labeling is the largest public health campaign by the federal government. The "new" food label introduced in 1994 provided more complete, useful, and accurate nutrition information than ever before. It's purpose was to clear up the confusion that had prevailed on supermarket shelves for years and to help consumers choose more healthful diets. It was also intended to offer food companies an incentive to improve the nutritional qualities of their products.[40]

These three guides are the most visible federal government efforts to improve America's health by encouraging better eating habits. Divisions within the two large agencies, USDA and DHHS, have developed numerous materials, for direct use by citizens or for use by professionals working with citizens, intended to improve the nutritional status of Americans. For example, the Maternal and Child Health Bureau of Health Resources and Services Administration in DHHS sponsored the development of *National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs,*[41] which provides specific guidelines on preparing and serving healthy and safe food to children in child care programs; the Food and Consumer Service of USDA has developed several materials to help school food service workers prepare meals that meet the Dietary Guidelines for Americans; and the National Heart, Lung, and Blood Institute of the National Institutes of Health in DHHS has several client education handouts and booklets such as *Eating Right to Help Lower Your High Blood Pressure.*[42] Federal agencies that have food and nutrition materials are listed in Appendix D.

NUTRITION SERVICE PROVIDERS

A variety of professionals are involved in delivering nutrition services to a client or a community of millions. This handbook contains a review of the responsibilities and boundaries of some of the service providers who deliver nutrition services.

Administrator

The health agency director, administrator, or health planner who is convinced that nutrition is an essential component of the comprehensive health promotion and disease prevention initiatives of the agency interprets the need for well-qualified nutrition personnel to legislators, policymakers, and those who allocate funding. The agency director provides administrative support for the public health nutritionist to define the nature and extent of nutrition problems within the context of the community health needs assessment, budgets funds to

establish nutrition services, recruits well qualified nutrition personnel, and maintains support for a strong, creative nutrition program. In most settings, the chief public health nutritionist should be a member of the health management team, administratively responsible to the agency director.

Public Health Nutritionist

The chief public health nutritionist on the agency staff plans, organizes, manages, and evaluates nutrition services. The nutritionist collaborates with the administrator and other management team members, establishes policies, standards, and criteria for health and nutrition services, and assesses the nature and magnitude of problems. The chief public health nutritionist recruits, trains, and supervises professional and technical nutrition personnel, and coordinates with community resources needed to augment and reinforce nutrition services of the health agency. The nutritionist staff provides nutrition consultation and in-service education to personnel in the agency and in other health and human service agencies and institutions in the community and provides diet counseling and nutrition education to agency clients in the community and through the mass media. *Personnel in Public Health Nutrition for the 1990's, A Comprehensive Guide* provides detailed information on the function, responsibilities, and qualifications of the various series and classes of public health nutrition personnel.[43]

Other Allied Health Professionals

Physicians provide medical direction and work with nutrition personnel in establishing policies, standards, protocols, and criteria for nutrition services. They direct the clinical and biochemical aspects of nutritional assessment, diagnose nutrition-related health problems and refer clients to nutrition personnel for diet counseling. As the leader of the health team, physicians must reinforce the diet counseling and encourage client and family compliance. **Nursing personnel** assist with nutritional screening and can educate low-risk clients with training and consultation from the nutritionist. **Social workers** mobilize community resources, particularly food and financial assistance, and assistance with social, emotional or educational problems that create barriers to client and family ability to cope with dietary advice. **Physical, occupational or speech therapists**, and **dentists** and **dental hygienists** support counseling and assist clients who have conditions that interfere with adequate nutrition such as impairments affecting self-feeding, chewing, or swallowing.

Since **health educators** in many agencies direct the planning of community health promotion and disease prevention interventions as well as serving as the agency spokespersons with the media, they are the liaison to assure that nutritionists participate in these programs.

Nutritionists must guide and prepare the members of the community health team to perform their roles in nutrition services through in-service training, consultation and technical support.

Other Nutrition Staffing Options

When the administrator cannot obtain the funding to employ a full-time, qualified public health nutritionist some alternative strategies can be utilized to provide for limited input of professional nutrition personnel.

These include:

- employing qualified nutrition personnel on a part-time basis;
- contracting with a private practice nutritionist for a stipulated number of hours of specified consultation, technical assistance, and/or staff in-service education;
- contracting for specified services of nutrition personnel employed by another community health agency, institution, or university; or
- arranging with a federal or state health agency for a time-limited assignment of a qualified nutritionist on a demonstration basis.

Few agencies can support the number of qualified nutrition personnel they need to meet assessed needs and the demands of their communities and develop new health promotion and disease prevention initiatives. Creative problem solving with others in the agency and in other community organizations may suggest ways of extending resources to expand services without new funding. Internal and external interdisciplinary health care teams can brainstorm ways of pooling resources, such as sharing information, space, staff, and equipment within the agency and with other health agencies. For example, the nutrition personnel working with maternal and child health services, family planning, and WIC Programs can cut unnecessary duplication by pooling their staff, equipment, nutrition education programs, and materials, medical records, and client assessment data within program confidentiality

requirements.

Exchanging resources is another strategy. For example, the health agency nutritionist may teach a course at the local university. In exchange a faculty member might train staff through planned in-service education. Offering student field experiences can be bartered for a fee waiver for staff to participate in credit or non-credit university courses needed for continuing education or career advancement.

Volunteers can also extend nutrition services. Retired professional nutritionists or dietitians may donate their professional expertise and assist in nutrition education. Other volunteers can be trained as peer counselors or as nutrition or clerical assistants. Motivated clients may be trained to present nutrition information to their peers in a breastfeeding support group or a weight management program.

DOCUMENTATION OF MEDICAL NUTRITION THERAPY

Essential to on-going health care is the careful recording of data obtained through interview and observation, as well as objective data from laboratory findings and anthropometric measurements. Record keeping by nutritionists and others involved in providing nutrition services will facilitate the monitoring of patient's progress, communication of information about the patient's needs to the health care team, and assessment of the quality of patient care. The method of recording selected by the nutrition service must be keyed to the clinical system. Concise information about dietary intake, food habits, nutritional status, recommendations, adherence, and follow-up should be recorded chronologically in the client's medical record.[44]

Clinical settings use a variety of methods to record medical intervention. The problem-oriented medical record (POMR) and the source-oriented record (SOR) are two examples. In a problem-oriented record, the nutritionist addresses one problem at a time, using the "SOAP" note to record the medical nutrition therapy. The SOAP note is comprised of four elements:

"S" — Subjective data. Statements by the patient obtained by taking a history. It relates how the patient feels, his or her concerns, and his/her description of status, including interim dietary intake and food habits.

"O" — Objective data. A summary of physical observations and findings, results of laboratory tests, and other parameters being followed (height, weight, hematocrit/hemoglobin, skin folds).

"A" — Assessment. Includes two elements: diagnosis and severity or degree. This is the nutritionist's view of the problem considering the subjective and objective data. Little needs to be said if the subjective and objective data are consistent.

"P" — Plan. Describes the recommended action as a logical result of the assessment. Includes counseling, anticipatory guidance, referrals, and future appointments for follow-up.

In contrast, the traditional medical record, the so-called "source-oriented record" (SOR), groups data for several different problems together. The progress note begins with the patient's complaints and continues with relevant historical data, a physical examination, a diagnostic impression, and the therapy. All the historical data or physical findings are grouped together, rather than separated out problem-by-problem.

Regardless of format, patient records should contain sufficient data to be used in peer review and to assess standards of care. The records should also contain data on selected indices of nutritional status to be used in nutrition surveillance of the population served.

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