



# Review of Home and Community Care (HACC) Program Food Services

## Final Report



HDG Consulting Group

2004

# EXECUTIVE SUMMARY

The HACC Food Services Review is a partnership project between the Department of Human Services and the Municipal Association of Victoria.

HACC Food Services play a critical role in supporting those people at nutritional risk, in home and in their communities. Evidence and trends have shown that the community's use of food services and options is changing. Like all programs, HACC Food Services must respond to and reflect these changing needs within society.

Commonwealth and State government funding, administered by the Department of Human Services, subsidised 4,400,452 units (meals) in the 2002/2003 year. These were distributed through 103 HACC food service providers across Victoria, to 29,737 HACC eligible clients. HACC Minimum Data Set reports indicate that 4.8% of the total Victorian population aged 70 years and over, utilise HACC Food Services. Due to demographic changes, the population increase in this age group is estimated to be 9.1% by 2006.

Victorian communities will best be served by a long-term approach to HACC Food Services based on cost-effective models that most appropriately support those individuals at nutritional risk.

## Recommendations

### Short term impact: operational and service delivery related recommendations

1. Annual consideration of the inclusion of training in nutritional risk screening for HACC Assessment Officers, Food Service Coordinators, HACC Social Support Coordinators and relevant others, delivered by an appropriate dietitian, as part of the coordination of HACC regional annual training calendars.
2. A DHS policy of assessment by trained Assessment Officers using the Service Coordination Tools, to identify needs for all clients using HACC food services (delivered meals).
3. A DHS policy of promotion of integration of HACC Food Services with other HACC services and increased liaison by HACC Food Services with assessment teams.
4. Consideration by DHS of service provider access, for secondary consultation, to HACC dietetics across all local government areas, through an appropriate funding mechanism.
5. Sharing and encouraging innovative practice through organisations such as Meals Victoria.

### Medium term impact: research and evidence based recommendations

6. With the support of DHS regional offices and input from a range of service providers, the development of Food Service Plans for rural areas identifying both short and longer term strategies.
7. A review of the recommended servings guidelines listed in the Victorian HACC Program Manual, and the development of core standards in relation to food quality, in consultation with the sector (producers, contractors, providers).
8. Planning and conduct of a small scale trial of the market segmentation 5 level framework and/or the food provision/social contact/monitoring matrix, encompassing assessment, monitoring, health promotion, service response and resource use.
9. Planning and conduct of a small evidence-based study to determine the impact of HACC Food Services on the nutritional and health status of individuals across segments (including CALD) and across metropolitan and rural cohorts.

### Longer term impact: systemic recommendations

10. Hosting of high level discussions or forums with the broader industry players (manufacturers, buyers, retailers, distributors) to build relationships and share information.
11. Development of a long term blue print (including employment, volunteer retention, capital works, assessment, service delivery, monitoring) with the HACC Food Services sector for structural reform, as a component of the whole HACC program in Victoria.

## TABLE OF CONTENTS

1	INTRODUCTION .....	1
2	HACC FOOD SERVICES – A VICTORIAN OVERVIEW .....	2
3	A PROFILE OF HACC FOOD SERVICES.....	4
4	SERVICE DELIVERY MODELS .....	5
5	LITERATURE.....	8
6	DISCUSSION .....	9
7	CONCLUSION AND RECOMMENDATIONS .....	13

Project Consultants: HDG Consulting Group  
Contact: Dr Ro Saxon 03 9421 4601 [ro.saxon@hdgconsulting.com.au](mailto:ro.saxon@hdgconsulting.com.au)

# 1 INTRODUCTION

## Background

The Victorian Review of Home and Community Care (HACC) Food Services was announced by the then Minister for Health, John Thwaites, in August 2002, in conjunction with a \$12.5 million increase in prices for key local government HACC activities.

The HACC Food Services Review is a partnership project between the Department of Human Services and the Municipal Association of Victoria. The key focus of the review is on revisiting the objectives of the HACC program in relation to nutrition, support and the provision of food services, and scoping potential food services models to meet changing needs, that providers may wish to implement.

HACC Food Services plays a critical role in supporting those people at nutritional risk, in home and in their communities. Evidence and trends have shown that the community's use of food services and options, is changing. Like all programs, HACC Food Services must respond to and reflect these changing needs within society.

Commonwealth and State government funding, administered by the Department of Human Services, subsidised 4.4 million units (meals) in the 2002/2003 year. These were distributed through 103 HACC food service providers across Victoria to 29,737 HACC eligible clients.

Victorian communities will best be served by a long-term approach to HACC Food Services based on cost-effective models that most appropriately support those individuals at nutritional risk.

## Ageing Population

It is widely accepted that adequate nutrition plays a fundamental role in the maintenance of health, self-sufficiency and quality of life in older adults. As health care continues to shift from acute care to community and home-based programs, effective nutrition services will become especially important.

Based on population data and the HACC Minimum Data Set (MDS), 4.8% of all people aged over 70 years utilise HACC Food Services; and 71% of HACC Food Services recipients are aged 75 years and over. Generally speaking, older adults experience one or more long-term conditions and represent 33% of all hospital admissions and 50% of total bed occupancies. Furthermore, 46% of persons aged over 75 years are reported to consult a GP in a two-week period. Clearly, strategies that improve the health and well being of the older population are a high priority. The importance of optimising nutritional support in maintaining good health should not be underestimated.

## Review Aims

- Review the objectives of HACC Food Services and assess whether food services are achieving the overall objectives of the HACC program
- Build on the HACC Statewide Ethnic Meals Project findings and examine trends and issues
- Review the range of potential models local government and other food service providers may wish to implement
- Develop and recommend a number of viable, cost-effective long-term models of service provision to meet the needs of those people in the HACC target group at nutritional risk.

This final report provides a summary of the findings of the review and presents the final review recommendations. It summarises information presented in the review Discussion Paper (December 2003), and reflects validation by the sector of the recommendations as presented at the Great HACC Food Debate (May 2004).

## 2 HACC FOOD SERVICES – A VICTORIAN OVERVIEW

### Historical Context

The original 'Meals-on-Wheels' service commenced in the City of South Melbourne in 1952 and was subsequently taken up by a number of other local governments in Victoria, delivering a hot midday meal to people in their homes. The *Home and Community Care Act 1985* subsumed four previous Acts, including the *Delivered Meals Act 1970*, under which the Commonwealth government provided a small per meal subsidy to service providers.

Under the HACC Agreement, the Commonwealth no longer subsidises meals providers directly. The Victorian government administers the \$1.20<sup>1</sup> per meal subsidy and continues to subsidise local governments to the amount of \$2,060 per annum for each Senior Citizens Centre at which they provide communal meals.

### Aims and Objectives

The Victorian HACC Program Manual (February 2003) documents the aims and objectives of the HACC Program:

*The HACC Program provides care in home and community-based settings to frail aged people and younger people with disabilities and their carers. The overall objective of the HACC Program is to enhance the independence of people in these groups and to avoid their premature or inappropriate admission to long term residential care.*

More specifically, the purpose of HACC Food Services is described as:

*Delivered meals and centre based meals are provided to those consumers who are assessed as nutritionally at risk. The risk factors for poor nutritional status include: being underweight, unintentional weight loss, the presence of various acute or chronic conditions or diseases, poor dental health, inadequate or inappropriate food intake, poverty, dependency, the inability to shop, prepare food or feed oneself, or disability and chronic medication use.*

---

<sup>1</sup> Subsidy of \$1.20 in 2002/2003; subsidy indexed to \$1.23 in 2003/2004.

### Delivered Meals

In Victoria, the direct costs of delivered meals are paid for through the combination of three sources of revenue:

- Client fees: \$3.40 to \$6.00 per meal<sup>2</sup>
- Commonwealth and State government subsidy<sup>3</sup>: \$1.20 per meal subsidy administered by DHS
- Agency contributions.

It is estimated that total direct expenditure across the three sources of revenue amounts to in excess of \$33m annually.<sup>4</sup> (Direct costs incorporate the food, packaging and volunteer delivery, but do not include indirect costs such as client assessment, non-food service personnel, management salaries, paid delivery staff, capital equipment investment and maintenance, or contract management). Of this, approximately 16% is attributed to the subsidy, 66% to client fees, and 17% to agency contributions.

In addition to the \$1.20 HACC Program subsidy, additional sources of HACC Program funding include: Service Development Grants, funding for capital equipment grants and Flexible Service Response block funding.

In terms of government expenditure, the HACC Food Services program is highly cost efficient. For every \$1.20 of government subsidy, \$6.30 is garnered from other sources, effectively allowing a multiplier effect that enables seven times the level of delivered meals service that would be possible with the government subsidy alone. This would be even greater with the inclusion of indirect costs.

---

<sup>2</sup> CACPs client fees are higher and based on cost-recovery.

<sup>3</sup> The HACC Program is jointly funded by the Commonwealth (60%) and Victorian (40%) Governments

<sup>4</sup> It is anticipated that more detailed and precise financial information will be available through the MAV Meals Costing Project.

## Communal Meals at Senior Citizen Centres

Communal meals at Senior Citizens Centres are also funded through a tri-partite arrangement:

- Client fees: \$3.40 to \$8.00 per meal
- Commonwealth and State Government subsidy: \$1.20 per meal subsidy administered by DHS
- Agency contributions.

In addition to the per meal subsidy, DHS provides a \$2,060 per annum subsidy to local governments which are subsidised to provide communal meals at 328 Senior Citizens Centres.

## Trends and Distribution

When considered by subsidised units (meals), local government receives subsidy to provide 88% of delivered meals while non government organisations provide 7%, and health related organisations (community health services, multi-purpose services, bush nursing, health services) provide 4% of delivered meals.

The number of subsidised units (meals) has decreased over the past five years – from 5 million units in 1997/1998 to 4.4 million units in 2002/2003, equating to a 12% decrease. Suggested reasons for this decrease include:

- Increased choice for consumers through private providers
- Increased availability of convenience meals at supermarkets
- The movement of funds from delivered meals to other client support strategies, such as assisted shopping.

In contrast to the units trend, the subsidy trend in dollar terms has shown an increase in the 2002/2003 year, explained by the increase in subsidy from \$1.10 to \$1.20 per meal.

## Facts and Figures

- Total expenditure on direct costs of meals services is estimated at more than \$33m per annum in Victoria; indirect costs add substantially to this figure
- Service development grants and DHS grants for minor capital amounted to \$604,577 over the 1999/2000 – 2002/2003 period
- 97% of meals reported through HACC MDS data are delivered meals
- 88% of HACC meals are provided by local governments
- 45% of subsidised units are provided by inner metropolitan local governments
- The number of subsidised units has decreased over the past five years due to a range of factors
- 13% of all HACC clients receive meals (29,737 clients in 2002/2003)
- 71% of those receiving meals are aged over 75 years; this is equivalent to approximately 6.5% of the overall Victorian population aged over 75 years
- 6% of meals recipients are aged under 54 years
- A high proportion of HACC clients who live in private homes (whether owned or rented) receive meals
- The largest single category of user, accounting for 26% of all meals recipients, are short stay and low use; long stay clients of high or medium use account for another 26% of meals recipients (MDS).

### 3 A PROFILE OF HACC FOOD SERVICES

#### Survey Results<sup>5</sup>

- The majority (66%) of providers contract out the production of meals, primarily to health service providers in rural areas and private contractors in metropolitan areas, with a small percentage contracted to other councils
- Just over 25% of food services agencies cook their own meals
- Demand for delivered meals is reported as: increasing for half of providers, stable for one third of providers, and decreasing for a small proportion of providers
- The key reason given for increasing demand is simply more demand from consumers; in areas where demand remains constant, this tends to be because the number of new clients is balanced by the number of exiting clients
- Over half of all providers use volunteers to deliver meals, 14% use paid workers to deliver meals, and the remainder use a mix of paid workers and volunteers
- Most providers have a set price menu although a small proportion (10%) offer low cost/high cost options
- Almost half of all providers offer a choice of main course
- Over half of all consumers have a general assessment prior to commencing food services; another third have an assessment within 4 weeks
- The top barriers to good nutrition as subjectively reported by survey respondents are: confusion/forgetfulness equally with general frailty, and disability and/or mobility limitations
- In relation to the relative importance of the food and monitoring functions, providers subjectively reported that both the food and the contact were equally important for 60% of clients; that the food was more important than the contact for 22% of clients; and that the contact was more important than the food for 18% of clients.

There are a number of key differences between rural and metropolitan areas:

- Inner metropolitan providers are most likely to contract to a private provider or cook meals using their own facilities
- Rural areas, in particular large and small shires, are most likely to contract a Health Service to produce meals
- In inner metropolitan areas, demand is remaining stable or decreasing while in outer metropolitan areas it is more likely to be increasing
- Large shires, small shires, NGOs, Koori and CHS/MPS providers are more likely to report increasing demand than other areas
- Delivery by volunteers is most common in rural areas whereas providers in metropolitan areas use a higher proportion of paid workers
- Rural areas are more likely to include geographic isolation and small shires and NGOs are likely to include price/affordability of food as barriers to good nutrition.

Implications for service providers and the HACC program include consideration of:

- The development of resources to support the high proportion of HACC Food Services purchasing meals from contractors
- The development of appropriate strategies at a regional level to support those areas reporting high levels of growth/demand for food services
- Facilitation of shared learnings re operational matters
- Continued support for Volunteer Coordinators in areas with a high proportion of volunteer deliverers
- Cost-benefit analysis and service study regarding the use of paid drivers
- The need for ongoing training and resources relating to nutritional risk screening
- Strategies to address the barrier of distance and client ability to purchase food.

---

<sup>5</sup> Refer to Discussion Paper for description of survey and interpretation limitations

## 4 SERVICE DELIVERY MODELS

### Victoria

Across Victoria food services are provided through a complex structure with a diverse mix of service models, procurement, production and delivery systems. For example: some providers provide hot meals while others provide chilled meals and some provide a combination of both; some providers cook meals in stand-alone kitchens, while others purchase meals from not-for-profit contractors (eg: council or hospital) or private sector contractors; some providers use volunteer drivers, others use paid delivery staff, and some use a mix of both. Client fees also vary.

A number of providers have moved to cook-chill to comply more easily with food safety regulations. Some providers are employing a strategy of moving away from hot meals in order to be able to introduce broader delivery timeframes and greater flexibility, while others are remaining strong advocates of the hot delivered meal. As a general trend, the majority of food service providers are moving away from a hot delivered meal (with the exception of provision to some high risk clients) to chilled meals.

Some providers commented that for some recipients, HACC delivered meals can accidentally reinforce a sedentary lifestyle.

Supply Drivers
Type and philosophy of auspice agency
Size and capacity of kitchens
Availability of contractors
Delivery capacity
Capacity for financial contribution

Demand Drivers
Client targetting policies/practices
Consumer demand
Availability of other options
Meal cost (compared with other options)
Agency philosophy and innovation

### HACC Funded Dietitians

HACC Funded Dietitians play a crucial role in relation to the provision of advice regarding nutrition and dietary requirements for individual service users. The Dietitians Association of Australia has been instrumental in developing a number of resources to support the identification and provision of assistance to people who are at nutritional risk. These include the Nutritional Risk Screening project and a Resource Manual for dietitians working in HACC. The introduction of the nutrition risk screening tool and associated training served to elevate the importance of good nutrition to HACC assessment officers.

An estimated 18.4 EFT dietitians are employed in HACC programs across Victoria. This compares to 5.2 EFT in 1996, 9.9 EFT in 1998, and 15 EFT in 1999, demonstrating a gradual increase over this period. As indicated there is an uneven distribution of HACC funded dietitians across the state in comparison to the HACC target population.

DHS Region	EFT <sup>6</sup> 2003	HACC Target Population <sup>7</sup>
Barwon	0	53,265
Eastern	2.2	123,569
Gippsland	1.0	41,987
Grampians	0	32,554
Hume	3.7	37,192
Loddon Mallee	2.7	46,953
Northern	2.3	106,384
Southern	5.7	157,945
Western	0.8	80,911
Total	18.4	680,760

<sup>6</sup> Provided by Megan Murray on behalf of the Dietitians in Rehabilitation and Aged Care Group

<sup>7</sup> HACC Target population by region 2003/2004 calculated by the Regional Resource Equity Formula, DHS. The RREF base population includes persons aged 0-69 years with a profound, severe or moderate disability; all persons aged 70+; with deductions for persons in residential care and DVA eligibility. RREF figures are generated for planning and resource allocation purposes and do not necessarily correspond to the number of persons in need of/eligible for HACC services.

## **Recommended Food Servings for Meals**

The Nutrition Committee of the National Health and Medical Research Council has established Recommended Dietary Intakes (RDI) of nutrients, which are necessary for Australians to maintain good health.

A HACCC meal should provide two-thirds of the RDI for Vitamin C, one-half of the RDI for other vitamins, proteins and minerals and at least one-third of the RDI for energy. It is a condition of funding to service a Vitamin C supplement with each meal provided.

The recommended food servings, which would assist in achieving this nutritional standard, are listed in the Victorian HACCC Program Manual.

## **Volunteers**

The use of volunteers by food service providers varies. According to the survey results, the majority of agencies (58%) rely entirely on volunteers to deliver meals. Survey results indicated that 14% of survey respondents use paid drivers only; and an additional 28% use a mix of volunteers and paid workers for delivery. Compared to previous reports, these data indicate that the use of volunteers in delivery of meals is diminishing.

A number of services utilise strategies for targeting non-traditional sources of volunteers, such as local businesses, banks and secondary schools. These organisations undertake voluntary work as part of an organisational social charter or business and community partnership philosophy. Areas with paid volunteer coordinators were more likely to have systematic and ongoing volunteer recruitment and support strategies in place.

Cost/benefit analysis of the use of volunteers in delivered meals services has not been undertaken. However, some services utilising paid drivers estimate the cost of delivery at \$1-\$3 per meal; another HACCC service provider using paid delivery staff reports the cost of delivery to be \$6.09 per delivery occasion (for one or more meals).

## **Food Safety Regulations**

Food Safety Regulations have been implemented by the majority of providers with varying levels of sophistication and some variation in interpretation of standards by auditors reported by providers. The impact for some providers, of implementing these regulations has resulted in a move from delivering hot meals to delivering chilled meals; the inability to continue to provide senior citizen centre meals in some centres due to sub-standard kitchen facilities; and training for volunteers in temperature monitoring and delivery practices. The costs and additional administrative tasks borne by providers in implementing food safety regulations have been significant and have largely been funded through agency resources.

## **Ethnic Meals**

There are currently two specialist CALD providers of food services. Overall, 25% of survey respondents reported that they offer ethnic meals. Previous reports indicate that regional models are most viable for the specialist production of authentic ethnic meals, and that for many communities regional cuisine (eg: Mediterranean, Asian) utilising key ingredients is acceptable to a range of communities. Menu integration (rather than ethnic-only options) is reported as being the preferred model in terms of financial viability.

## **Koori Meals**

There are currently six Koori services funded to provide HACCC Food Services. These services tend to use a mix of service models including purchasing meals from other providers, using home care staff to cook meals, and providing meals in a group setting.

## Delivered Meals -Product and Price Comparison

While supermarket convenience meals and commercial home delivered meals offer greater choice than HACC delivered meals, the cost of purchasing a comparative 3 course meal plus orange juice is two to three times greater than a HACC delivered meal.

## Financial Issues

A significant issue currently facing, or about to face, those providers who use contractors to supply meals (67%) is that of contractors increasing their contract price. One metropolitan council reported that in recent retendering the delivered meals supply contract, there was a 20% increase in the cost to council. While in some metropolitan areas the competitive tendering process can assist to keep prices down, in rural areas there may only be one contract provider. The implication for food service providers is that they will either have to pass this cost increase on to clients by increasing client fees, or cover the increased costs through other revenue streams, where these are available.

## Summary: Strengths and Weakness

Strengths
Statewide program servicing the HACC target group at nutritional risk
Tri-partite funding arrangement
Increasing choice and quality of product
Implementation of food safety regulations
Tailoring of services to reflect local communities
History and dedication of volunteers
Increasing use of the Service Coordination Tools
Awareness of service in community
Some integration with other HACC services
Providers openness to innovation

Weaknesses
Reported difficulty in implementing the recommended food groups and servings listed in the Victorian HACC Program Manual
Financial capacity to meet both predicted future and current increasing demand in some areas
Opportunity cost of capital to maintain facilities
Limited access to HACC funded dietitians
Reliance on volunteer delivery in areas without volunteer coordinators
A lack of flexibility in delivery settings and services perceived as reinforcing isolation and stereotypes
Limited menu choice in some areas and some younger service users find serving sizes inadequate
Cost remains an issue for some client groups, including: homeless people, some people with disabilities, those with significant expenditure for chronic conditions
Capacity to meet special dietary requirements in some areas and for some segments
Capacity to provide transport to clients to participate in alternatives to home-delivered meals
Variability of price, choice, and access, partially dependent on location
Cost pressures arising from increasing contract prices

## 5 LITERATURE

Around the world, delivered meals are provided on the fundamental assumption that the provision of food will improve the quality of the recipient's diet, and contact with the meal deliverer or a group in a social setting might improve the recipient's quality of life, and thereby prevent early or inappropriate admission to residential care.

The hope is that better nutrition through the provision of nutrient-dense foods that provide a high amount of energy as well as vitamins, minerals and other nutrients in a small compact amount of food, is an investment in diminishing the risk of malnutrition and forestalling more costly hospital or nursing home care for older people.

Studies consistently comment on the high rate of undernutrition in older people in developed countries, even those living relatively independently. The emphasis on nutrition and addressing nutritional risk is a key feature of the HACC Food Services Program. This focus is appropriate given recognition of the high risk of poor nutrition in elderly populations; recognition that nutrition is one of the major modifiable risk factors for the prevention of chronic disease; the contribution of good nutrition to overall health and wellbeing in elderly persons and the opportunity provided for socialisation through community and group meal programs.

In Australia, limited studies have been conducted to assess the outcomes of delivered meals programs or the nutritional impact of the service. A South Australian study involving home care clients found that 38% were at risk of malnutrition and 5% were malnourished; and a Victorian Alfred Hospital study indicated that 35% of HACC delivered meals recipients were under-weight.

Literature indicates that consideration should be given to the following:

- Utilising a market segmentation approach to identify subgroups
- Developing a customer type/service response matrix to enable more precise provision of nutrition services
- Consideration of: the use of a liquid supplement to the healthy elderly; addressing gender issues; morning meals for those with dementia; meals reflecting the preferences of different age cohorts; the use of descriptive menus to counteract the decrease of dietary variety that comes with age; separation of the food provision and monitoring roles for some sub-groups
- Development of a utilisation benchmark to assess and minimise wastage
- Pursuing the use of monitoring technology
- Undertaking further research in relation to the role of HACC subsidised meals at senior citizens centres and the impact on the nutritional support of participants
- Promoting good screening and assessment
- Facilitating work with hospitals to address early nutritional risk screening and/or assessment of elderly inpatients
- Developing a research program to provide better evidence and evaluation
- Defining quality in food services.

### Defining Food Insecurity<sup>8</sup>

Definitions of food insecurity encompass food affordability, accessibility, and availability due to lack of resources. Wolfe et al (1996) defines food *insecurity* as 'the inability to acquire or consume an adequate quality or sufficient quantity of food in a socially acceptable way, or the uncertainty that one will be able to do so.' The American Institute of Nutrition defines food *security* as: 'access by all people at all times to enough food for an active, healthy life and includes at a minimum: a) the ready availability of nutritionally adequate and safe foods, and b) the assured ability to acquire acceptable foods in socially acceptable ways. Food insecurity exists wherever the availability of nutritionally adequate and safe foods or the ability to acquire acceptable foods in a socially acceptable ways is limited or uncertain.'

---

<sup>8</sup> Refer also Attachment 1: Glossary of Terms

## 6 DISCUSSION

### A Market Segmentation Approach

Service users are not a homogenous group - consumers of HACCC Food Services have a range of differing needs and/or wishes concerning their food preferences and how they wish to be treated. It is a false assumption to think that a provider can satisfy the needs of every potential consumer in a similar manner. There is no single service solution or one best way that will both optimise the nutritional support of consumers and/or address social and health monitoring needs.

Consumers can be classified into *segments* (groups) which are homogenous and which are sufficiently different from each other. Flexibility in product choice, services, settings and delivery is required to best meet the needs of individual segments. Consultation with key stakeholders, survey data, MDS data, and literature support this notion. Considering the 8 service user groups in relation to duration and intensity of use, identified from the MDS data, is one starting point for this segmentation; another is the food provision and social monitoring matrix; another is perceived reasons for using food services. Some providers undertake this type of segmentation through their priority of access guidelines.

HACCC, food service planners and providers may benefit from developing and utilising a market segmentation approach. This will enable them to segment their service user population and more closely tailor service provision to each service user cohort, maximising the nutritional support for each group.

In some cases delivered meals will be the most appropriate service response while for other service user cohorts, alternative models of nutritional support (eg: supported shopping, group meals) may be more appropriate.

### Maximising Resources

There are five main categories of HACCC food service providers: local government, non-government organisations, health services, Koori organisations and specific ethnic organisations. The type of auspice agency has significant impact on the structure, model, resources and operational decisions regarding the provision of food services.

Local councils are significant contributors to the food services operational budget from their rate base; resource management staff time for food service functions, such as planning, assessment and/or contract management; and can integrate food services with other HACCC activities to offer increased diversity of support (eg: assisted shopping/cooking, social support, community transport). Conversely, food services can be used as a means of offering a service to consumers when there may be waiting lists for access to other HACCC service types.

NGO providers may or may not have the capacity to supplement the food services operational expenditure from other revenue sources. For those who do not have this capacity, the food service must be managed to achieve financial break-even to ensure expenditure does not exceed revenue, placing significant pressure on services, particularly those experiencing increasing demand. NGOs in rural areas are often heavily reliant on an ageing volunteer base to deliver meals as well as meet and maintain management and operational standards. Those located within a larger NGO agency, often have a staff member, partially funded through other sources, managing the food services program. Those in larger NGO agencies have some capacity to offer additional services to clients, available through other program areas to consumers of food services (eg: allied health, social support).

## Focusing on and Investing in Nutritional Support and Monitoring

The Victorian HACC Program Manual states:

*The HACC Delivered meals and Centre Based meals service provides a nutritious, appetising and culturally appropriate main meal delivered to the consumer's home, or to a community centre where meals are eaten in a social setting.*

The Manual acknowledges the requirement of meal deliverers to:

*Monitor the well-being and other circumstances of consumers ... in general this should not be the primary reason for a consumer to receive a delivered meal.*

*Funded agencies should ensure that consumers who require monitoring or social contact receive a more appropriate service, where possible.*

At present, the focus of food service providers is spread across the different dimensions of food procurement, meal production, monitoring and social contact to varying degrees. Providers need to be strategic in their thinking about determining where the investment of effort and resources should be.

Some providers have ageing buildings/kitchens/equipment infrastructure and will need to give careful consideration and undertake cost benefit analysis regarding future capital investment.

### Potential focus of providers

Focus	Related Mission	Strategy	Investment Focus
Production of meals	To be the best food producer for home delivered meals	State of the art commercial kitchen facilities, high volume, efficiencies, quality packaging	Capital facilities and equipment
Nutritional support	To significantly reduce the incidence of nutritional risk by guaranteeing nutritional support	A focus on food quality, safety, nutritional guarantee, menu planning, individual health (It doesn't matter who cooks or supplies the food provided it meets given standards and menus are specifically planned for the target group)	Expertise for planning and monitoring of food quality and safety
Monitoring of individuals	To be highly attuned and responsive to the changing health status of individual service users	A focus on monitoring consumers health and well being through a systematic approach using evidence based parameters	Expertise for monitoring of individual health status
Social contact	To reduce social isolation	A focus on providing opportunities for social interaction	Transport, coordination of social activities

## Integrating Food Services

Some food services reported feeling isolated from the HACC service system. For example, those located in stand-alone venues reporting minimal contact with HACC assessment officers. HACC Food Services and clients benefit from closer integration with other HACC services.

Food service providers benefit from detailed information in relation to individual consumer's nutritional needs and broader health profile.

Ideally, all food service clients should have the nutritional risk screening profile completed within one week of commencement.

HACC assessment officers benefit from ongoing access to training in relation to nutritional risk screening. HACC assessment officers and food service providers benefit from access to HACC funded dietitians for secondary consultation.

## **The Role of Dietitians in the HACC program**

Dietitians are funded by the HACC Program to provide professional advice to consumers and assess nutritional risk. If funded for Service System Resourcing dietitians also work at a systemic level. For example, by using their expertise to offer up-to-date nutritional information to HACC providers, training and resources. There is an uneven spread of dietitians across Victoria with some rural regions having no HACC funded dietitians. HACC funded dietitians play an important role in the provision of: nutritional assessment, advice to consumers and up to date nutritional information.

Catering management skills and contract management skills contribute to an effective food service.

### **Monitoring Clients at Risk**

The monitoring function can be distinguished from that of food provision in terms of the service offering. The current form of monitoring provided by the majority of volunteer delivery-based services is a brief observation and courtesy contact ('how are you today?') to appraise the person's well being. Clients may well be unaware that this monitoring is actually part of the food service program parameters and this may raise issues in relation to privacy and consent.

In food services, evidence of more formal monitoring is starting to emerge with some providers identifying those consumers who are considered at greater risk and monitoring them with paid workers. This has arisen as a result of food services concerns about individual clients and by virtue of food services having the most frequent contact with clients in comparison to other in-home services. For high needs people receiving more than one service, this monitoring is integrated into service delivery.

Clients at risk benefit from a systematic approach to monitoring and active intervention to minimise risk or prevent inappropriate admission to residential care.

## **Promoting Alternatives for Social Contact**

Data suggests that there is a service user cohort (segment) of clients for whom the social contact is considered more important than the meal itself. In essence, the primary and secondary goals of food services are reversed so that the monitoring role (social contact) is perceived as the core service, and the food is peripheral to this.

Local government Senior Citizens Centre meals programs, other group meals where the social activity is the key focus, and indeed some recipients of home-delivered meals may fall within this category. Some studies have questioned whether centre based meals effect the nutritional status of individuals and suggest that this redirects scarce funds away from at risk individuals. The courtesy contact offered by delivered meals programs may be inadequate for those clients whose main priority is social activities and community connection.

### **Strategies to Manage Growth**

There are a number of potential options for managing growth over the coming years. The desirability of which depends on a number of factors including the political situation, auspice philosophy and local circumstances. Strategies can be broadly categorised as growth strategies or efficiency strategies.

Potential growth management strategies include:

- Increasing government funding/subsidy
- Increasing agency contributions
- Increase in client fees
- Increases in third party contributions
- Introduction of a scaled approach to the government subsidy.

Potential efficiency management strategies include:

- Achieving production efficiencies to enable a greater number of meals
- Reducing the number of stand-alone kitchens and reinvesting these assets
- Implementing strategies to reduce meal wastage (by an estimated 5-10%)
- Development of client categories with allocation of services and costs tied to categories.

## **Moving Towards Evidence Based Outcomes**

Monitoring quality and client outcomes is important for all human services programs. Food service providers utilise a range of mechanisms to monitor food services quality and client outcomes. These include: the use of consumer reference groups to trial and recommend menu items; the use of feedback questions on menu sheets; the use of periodic customer satisfaction surveys; and informal feedback from deliverers and workers.

Chefs and menu planners consulted, proffer the view that it is difficult to meet the guidelines due to a mix of factors including: the size of containers; and the ability to get specific nutrients into each day's menu (which requires the use of quality ingredients to ensure nutrition-dense foods rather than convenience products such as powdered bases and boosters).

One provider with twice yearly independent meals nutrient analysis advises that meals are under on cereal, calcium and fruit, and acknowledges the dilemma of trying to address this through a single meal. Other providers comment anecdotally that meals nutrient requirements do not quite meet the guidelines.

## **Supporting and Promoting Innovation**

Innovative approaches identified by food service providers and literature are listed in Attachment 2. It should be noted that these are largely enhancements to existing models, not new models per se. Food Service providers are encouraged to continue introducing innovations at a local operational level to best suit their operating context and the needs of particular market segments.

Additional resources could be prepared for use by meals providers (eg: contract specifications, catering management, quality and monitoring mechanisms, contract management) to assist in the exchange of information.

## **Taking a Long Term View**

HACC Food Services are nearing maturity from an organisational life cycle perspective. Operational efficiency is becoming increasingly evident (eg: fewer stand-alone kitchens, high volume, multiple contracts) and there is increasing menu choice. This development at an individual provider level is likely to continue until the point at which providers experience a level of pressure that leads them to reposition or reconceptualise their service. The need to do this may be brought about by a number of pressures, some of which are already being experienced, such as supply/demand pressures, resource pressures, and capacity or facility status.

In conceptualising HACC Food Services as a service system, one future scenario is for the sector to continue to progress from its historical structure of multiple independent small providers to that of a regional or cross regional integrated network structure, providing services in a systematic efficient standardised manner across Victoria. This includes considering the benefits of:

- Using major bulk purchasing power to achieve significant economies of scale
- Purchasing from a mainstream commercial supplier in conjunction with a number of smaller specialist providers to focus on monitoring rather than production/distribution
- Continuing to streamline production through fewer larger scale operations with standardised technology
- Creating centrally located expertise in food service production and packaging
- Using technology based systems, for example, an area wide meal ordering system, or the use of monitoring technology.

HACC Food Services providers could consider moving towards a regional integrated network structure in the long term. Extensive discussion across the sector would be required, in which, Meals Victoria could take a lead role.

In doing so, it will be necessary to take into account the differences across metropolitan and rural areas. Particularly, in relation to transport/delivery and the role food services play in local rural economies.

## 7 CONCLUSION AND RECOMMENDATIONS

### **Are HACC Food Services achieving the overall objectives of the HACC program in relation to supporting people at home and in their communities?**

An emphasis on nutrition and addressing nutritional risk is a key feature of the HACC Food Services program. This focus is appropriate given:

- The high risk of poor nutrition in elderly populations
- Nutrition as one of the major modifiable risk factors for the prevention of chronic disease
- The important contribution of good nutrition to overall health and wellbeing in elderly persons.

It is clear that HACC Food Services plays a crucial role in supporting people at home and in their communities. This is evidenced by:

- The provision of 4.4 million subsidised units in 2002/2003 through 103 HACC food service providers to 29,737 HACC eligible clients (frail aged people, people with a disability and their carers) in Victoria
- HACC MDS data illustrates that HACC Food Services is utilised by 4.8% of all people aged over 70 years and 8.7% of all people aged over 80 years.

It is considered important that:

- Evidence based research is undertaken in relation to the effect of HACC Food Services on the nutritional status of service users across different cohorts to establish the groups with which the program has the greatest potential effectiveness
- Training in relation to nutritional risk screening is available
- Resources in relation to contract specification and contract management for HACC Food Services are developed or shared
- Resources (eg: menus, recipes, procedure manuals) for HACC Food Services providers who produce their own meals are shared

- In addition to the continuation of home delivered meals, providers consider alternative strategies where possible and practicable to minimise the potential isolation of individuals and support their links within the community
- Providers continue to work towards a commercial standard of product quality and presentation in relation to menu and product choice, delivery time and mechanisms.

### **What are the trends and issues across the range of food services?**

In Victoria, HACC Food Services is reaching maturity, as suggested by:

- The volume of service is stabilising with some providers reporting increasing demand and others reporting decreasing demand
- The product is increasingly differentiated with increasing menu choice and an increasing number of competitive products
- Service user segments are requiring specific service responses
- Quality is based on food safety standards and influenced by consumer acceptance in light of competitive products
- The strategic focus is increasingly moving towards greater productivity and efficiency; evident through larger multiple contract suppliers and a reducing number of smaller suppliers.

The implications of this for HACC Food Services includes the challenges of:

- Managing supply and demand tensions
- Ensuring services are targeted to those identified as priority segments
- Increasingly tailoring approaches to these segments and specialising (rather than mass market one-size-fits-all).

Making strategic organisational decisions about consolidation or growth. For example, does the organisation wish to: actively pursue growth and expansion strategies; consolidate services; or maintain the status quo?

Trend/Issue	Strategic Directions
A maturing market/industry with a significant number of stand-alone providers	<ul style="list-style-type: none"> <li>• Adopting a market segmentation approach</li> <li>• Supporting and promoting innovation</li> <li>• Considering an integrated network structure in the long term</li> </ul>
Limited access to additional resources for NGO stand-alone services; inequity in client fees; reliance on an ageing volunteer base	<ul style="list-style-type: none"> <li>• Maximising resources and increasing equity</li> <li>• Integrating food services</li> </ul>
Ageing building infrastructure; variance in the use of quality of food products which impacts on the ability to provide nutrient dense meals	<ul style="list-style-type: none"> <li>• Focusing on, and investing in, nutritional support and monitoring</li> </ul>
Emergence of more formal monitoring by paid workers	<ul style="list-style-type: none"> <li>• Monitoring of clients at risk</li> </ul>
Menu advice sought from dietitians	<ul style="list-style-type: none"> <li>• Understanding the role of dietitians in the HACCC program</li> </ul>
Growing demand pressures for some providers; decreasing demand for some providers.	<ul style="list-style-type: none"> <li>• Implementing strategies to manage growth</li> <li>• Promoting alternatives for social contact</li> </ul>
Increased contract purchasing	<ul style="list-style-type: none"> <li>• Moving towards evidence-based outcomes</li> </ul>

**What is the range of potential models local government and other food service providers may wish to implement? What are the recommended viable, cost-effective, long-term models of service provision to meet the needs of those people in the HACCC target group (including special needs groups) at nutritional risk?**

### Option 1

One proposed model (framework) of service provision to meet the needs of those people in the HACCC target group at nutritional risk, recognises the differing needs, preferences and behaviours of sub-groups in relation to both their nutritional needs and social contact/monitoring needs. The framework incorporates 6 layers (see below) that provide a continuum of services and can be used to reflect the sub groups identified through the HACCC MDS data. In practice, clients may move between layers as their needs change over time. Within this framework, it is suggested that the emphasis of HACCC Food Services should be on layers 1 to 4.

The framework<sup>9</sup> can be used by providers to ensure that services are being directed in accordance with the HACCC Guidelines to those at nutritional risk through a range of appropriate strategies. HACCC Food Services providers can consider the framework and map their client base and activities against the layers and allocate an indicative proportion of resources to priority levels.

<sup>9</sup> For additional information refer Attachment 3

### Option 2

The concept of market segmentation is based on breaking a group of people into smaller cohorts or sub-sets, based on factors they have in common. The key to market segmentation is in understanding the user group and being able to define a number of different variables or traits that can be used to describe the different sub-sets. For example, based on MDS data it is evident that:

- 13% of HACCC clients receive meals
- 51% of those who receive meals are aged 80 years and over; 6% of HACCC are aged under 54 years
- HACCC meals recipients can be divided into 8 groups based on their length of stay and intensity of meals use.

HACCC Food Services incorporates the elements of providing food for those at nutritional risk and providing a monitoring role. However, the degree to which each of these aspects is most paramount varies for different cohorts of service users and is influenced by the service delivery model, style, culture and ethos of provider. One way of conceptualising this tension is to apply a high/low importance scale for each of these elements, in the form of a matrix (see below). It should be noted that clients may move between cells over time as circumstances change.

By utilising this matrix approach, food service providers can assess their own current positioning in light of organisational priorities and take strategic decisions as to preferred future positioning, considering their population groups and the balance within and across cells.

### Option 1: Framework

	Service User Models	Focus	
1	Highest level nutrition program with flexible delivery to those at greatest risk	Interventionist, reduce hospital admissions, rehabilitative, may be short term in this category. Resources from HACC and other program areas.	↑ Increasing nutritional risk
2	Nutritional support and minimising risk through the provision of home-delivered meals and professional monitoring	Minimising risk	
3	Nutritional support through the provision of traditional home-delivered meals and courtesy contact	Maintaining independence in the community	
4	Alternatives to HACC home-delivered meals including group meals, use of mainstream providers, supermarket meals, food ordering assistance, etc	Maintaining independence in community and reducing social isolation	
5	Integrated social support and physical activity with secondary nutritional support	Preventative and health promotion. Resourcing this area impacts on the other levels. Resources for this level are typically broader than HACC.	
6	Community food security	Ability to readily and continuously access mainstream and community food supplies	

### Option 2: High/Low Food Provision and Social Contact/Monitoring Matrix

Importance: food provision	High	Service models designed to cater for those for whom the provision of food is rated as of high importance but the monitoring is rated as less important. For example, consumers experiencing poverty, chronic medical conditions, severe functional limitations, people with disabilities. Appropriate service models for this segment may include: delivery of more than a single day supply of food at once.	Service models designed to cater for those for whom the provision of food and monitoring are both rated as of high importance. For example, chronic food insecurity groups, people with a disability who are highly vulnerable nutritionally, homeless people. Appropriate service models for this segment may include: the use of paid drivers or home carers to deliver meals daily plus provide a skilled monitoring role; the provision of supplementary food.
	Low	Service models designed to cater for those for whom the provision of food and monitoring are both rated as of low importance. For example, those who tend to use food services primarily because of convenience. Appropriate service models for this segment may include: intermittent food delivery of grocery bag by volunteers, senior citizens centre meals, café/pub informal meals.	Service models designed to cater for those for whom the provision of food is rated as of low importance but the social monitoring is rated as of high importance. For example, those whose families encourage them to utilise food services because of the monitoring. Appropriate service models for this segment may include: mixture of group meals facilitated by a paid worker and delivered meals, an emphasis on monitoring by a paid worker, such as through assisted shopping or cooking.
		Low	High
		Importance: social contact/monitoring	

## Review Recommendations

### Short term impact: operational and service delivery related recommendations

1. Annual consideration of the inclusion of training in nutritional risk screening for HACC Assessment Officers, Food Service Coordinators, HACC Social Support Coordinators and relevant others, delivered by an appropriate dietitian, as part of the coordination of HACC regional annual training calendars.
2. A DHS policy of assessment by trained Assessment Officers using the Service Coordination Tools, to identify needs for all clients using HACC food services (delivered meals).
3. A DHS policy of promotion of integration of HACC Food Services with other HACC services and increased liaison by HACC Food Services with assessment teams.
4. Consideration by DHS of service provider access, for secondary consultation, to HACC dietetics across all local government areas, through an appropriate funding mechanism.
5. Sharing and encouraging innovative practice through organisations such as Meals Victoria.

### Medium term impact: research and evidence based recommendations

6. With the support of DHS regional offices and input from a range of service providers, the development of Food Service Plans for rural areas identifying both short and longer term strategies.
7. A review of the recommended servings guidelines listed in the Victorian HACC Program Manual, and the development of core standards in relation to food quality, in consultation with the sector (producers, contractors, providers).
8. Planning and conduct of a small scale trial of the market segmentation 5 level framework and/or the food provision/social contact/monitoring matrix, encompassing assessment, monitoring, health promotion, service response and resource use.
9. Planning and conduct of a small evidence-based study to determine the impact of HACC Food Services on the nutritional and health status of individuals across segments (including CALD) and across metropolitan and rural cohorts.

### Longer term impact: systemic recommendations

10. Hosting of high level discussions or forums with the broader industry players (manufacturers, buyers, retailers, distributors) to build relationships and share information.
11. Development of a long term blue print (including employment, volunteer retention, capital works, assessment, service delivery, monitoring) with the HACC Food Services sector for structural reform, as a component of the whole HACC program in Victoria.

## **Acknowledgements**

### **Advisory Group**

Clare Hargreaves	Municipal Association of Victoria (Chairperson)
Patsy Morrison and Calvin Graham	Department of Human Services
Adrian Murphy	City of Yarra
Anne Sommerville	VICAD
Belinda Greening	Central Gippsland Health Service
Betty Knight	COTA
Bev Wood	Dietitians Association
Derryn Wilson	Moreland City Council
Jean Brown	Ashburton Support Services
Jenny Semple	Ethnic Communities Council of Victoria
Jill Fraser	Hobsons Bay City Council
Laurie Reed	Department of Human Services, Eastern Metropolitan Region
Sue Milner	Department of Human Services, Disability Division
Will Hanrahan	Department of Human Services, Gippsland Region

### **Other Contributors**

Justin McDermott and Gwenda Blackwell, DHS for the provision of HACC MDS Data Survey respondents and other key stakeholders consulted during the review

### **Project Consultants**

HDG Consulting Group      Contact: Dr Ro Saxon 03 9421 4601  
Email: [ro.saxon@hdgconsulting.com.au](mailto:ro.saxon@hdgconsulting.com.au)  
Level 1, 487 Swan Street, Richmond VIC 3121  
Ph: 03 9421 4601

Cover photograph      Supplied by City of Port Phillip - Delivery of Meals in South Melbourne, June 1953

### **The Great HACC Food Debate, May 2004**

Debating team members: Bev Wood, Jill Fraser, Belinda Greening, Anne Lyon, Jan Martin, Adrian Murphy.

Attendees at the Great HACC Food Debate are thanked for their input and validation of the draft recommendations.

## Attachment 1: Glossary of Terms<sup>10</sup>

### Food and social exclusion

*'Food is itself a powerful marker of social exclusion, both for individuals and communities'* (McGlone et al, 1999). It means the inability to readily and continuously access mainstream food supplies.

### Food security

Food security is defined in its most basic form as 'access by all people at all times to the food needed for a healthy life. Achieving food security means ensuring that sufficient food is available, that supplies are relatively stable and those in need of food can obtain it'. (FAO/WHO, 1992). It includes community food security and local food access, and household and individual food security.

### Community food security and food access

'Food security can be defined as the state in which all persons obtain a nutritionally adequate, culturally acceptable diet at all times through local non-emergency sources. Food security broadens the traditional conception of hunger, embracing a systemic view of the causes of hunger and poor nutrition within a community while identifying the changes necessary to prevent their occurrence. Food security programs confront hunger and poverty' (Community Food Security Coalition, 1995)

'Access to the food supply is defined as access to quality food in local communities which is safe, affordable at competitive prices, culturally and environmentally acceptable and nutritious, with opportunity for healthy food choices, within walking distance or by readily available, frequent and affordable public transport.

A checklist follows:

Local areas provide clean (free) drinking water

Basic foods can be obtained at a safe walking distance-2.5km- from peoples homes

All people (including vulnerable people) can access the local food supply readily by local transport

Local food outlets provide real choice in food

The food supply is user-friendly in access to all

There is choice in food type, unit size, packaging, food quality, and food cost

The food items on sale are easily accessible, with good signage, and visibility

A choice of healthy cheap prepared meals/snacks is provided by local food outlets

The local food supply is adjacent to an amenity area including toilets, seats/, and weather protection

### Household and individual food security

'Access by all people at all times to enough food for an active, healthy life and includes at a minimum:

1) The ready availability of nutritionally adequate and safe foods; and

2) An assured ability to acquire foods in socially acceptable ways (for example, without resorting to emergency food supplies, scavenging, stealing, or other coping strategies)'

(Anderson, 1990)

A checklist follows:

- Ability to purchase or carry food and fluids

- Ability to walk and carry food regularly

- Independent ability to organise, prepare and feed self

---

<sup>10</sup> Provided by Bev Woods, member of Dietitians in Rehabilitation and Aged Care Group and the Advisory Group

## Attachment 2: Innovative Approaches

Innovative approaches as identified by food service providers and in literature.

Meal choice and food content	<ul style="list-style-type: none"> <li>• Provision of breakfast</li> <li>• Large menu choice</li> <li>• Full daily nutritional requirements, if required</li> <li>• More choice, light meals/snacks</li> <li>• Reduced reliance on soup (as it is not nutrient-dense, takes up stomach space, and acts as food deterrent)</li> <li>• Finger food for those with dementia or arthritis</li> <li>• Use of software that can do glycaemic index of food</li> <li>• Increased range of texture-modified diets</li> <li>• Standards across all providers for special diets such as gluten-free diets</li> </ul>
Improved packaging	<ul style="list-style-type: none"> <li>• More room in the containers so that foods and flavours remain separate</li> <li>• See-through lid</li> <li>• Improved labelling</li> <li>• List of ingredients</li> <li>• Heating instructions</li> </ul>
Meal venue - meals available from more sites	<ul style="list-style-type: none"> <li>• Café meal models, Meal mates</li> <li>• Home based, centre-based, community/café meals</li> <li>• Voucher system</li> <li>• More community-based options</li> <li>• Building up venues in the community where clients can gather for a meal (eg: Neighbourhood House) rather than developing own centres (eg: Senior Citizens Centres), recognising that this has an impact on costs</li> </ul>
Use of volunteers	<ul style="list-style-type: none"> <li>• Volunteers to assist with shopping, cooking, outings</li> <li>• Volunteers to share meals with client</li> <li>• Volunteer bank</li> </ul>
Monitoring	<ul style="list-style-type: none"> <li>• Monitoring by paid staff</li> <li>• Longer contact with some clients</li> <li>• Regular review for those on special diets</li> </ul>
Delivery	<ul style="list-style-type: none"> <li>• More drivers to reduce delivery time, paid drivers</li> <li>• Flexible delivery time</li> <li>• Combination of volunteers and paid drivers</li> <li>• Different/less frequent deliveries, multiple meals</li> <li>• Dedicated food transport vehicles with choice of food</li> <li>• Home delivery of staple food products</li> <li>• Delivery time moved to the afternoon and the evening meal provided (instead of lunch)</li> <li>• Reducing double handling (eg: some services deliver to one distribution point where meals are packed into refrigerators and then the meals are collected and delivered by volunteers)</li> </ul>
Assessment and meals options	<ul style="list-style-type: none"> <li>• Regular nutritional risk screening</li> <li>• Range of supports in response to assessment outcomes</li> <li>• Assessment focus on priority need (ie. Nutritional support, monitoring, social contact)</li> <li>• After 2-4 weeks of receiving delivered meals, recipients have full assessment of their needs and introduction to other support services that may be more appropriate</li> <li>• Establish program looking at alternatives to delivered meals (eg: what is in the supermarket? introduction to nutrition-dense foods, other sources of delivered or take away meals, social support options, cooking classes, advice from dietitian)</li> <li>• Directory of alternatives</li> <li>• Alternative delivered meals suppliers</li> </ul>
Increase use of home care staff, funding to assist with shopping/cook in home	<ul style="list-style-type: none"> <li>• Promoting on-line shopping or telephone shopping</li> <li>• Negotiating with accessible and supportive cafes</li> <li>• Temporary food support when leaving hospital</li> </ul>
Payment	<ul style="list-style-type: none"> <li>• Retaining cash collection for those clients who have difficulty managing their money</li> <li>• Introducing voucher-based systems</li> </ul>

## Attachment 3: Framework

### Layer 1

Description:	Highest level nutrition program with flexible delivery
Target group:	HACC target group, particularly special needs groups, frequent hospital admissions, those requiring more than 1/3 RDI, assessed at high risk and require professional monitoring
Market segments:	Frank malnutrition, hospital discharge, homeless, multiple disabilities, multiple chronic diseases, confusion/forgetfulness and general frailty
Financial implications:	Intensive input to prevent premature admission to residential care or avoidable hospital admission. This requires a higher resourcing level. eg: an increased meal subsidy for this group
Role of dietitians:	Critical to individual assessment and advice
Role of volunteers:	Minimal
Use of technology:	Potential for monitoring technology
Procurement:	Specialist responses eg: Full nutritional requirements, liquid supplements
Outcomes:	Preventing malnutrition and hospital admissions

### Layer 2

Description:	Nutritional support and minimising risk through the provision of delivered meals and professional monitoring
Target group:	HACC target group, those requiring professional monitoring
Market segments:	Homebound, severe mobility limitations, high risk, unstable health, multiple functional limitations, chronic diseases, confusion/forgetfulness and general frailty
Financial implications:	Monitoring by home care workers impacts on home care budget
Role of dietitians:	Critical; specialist diets
Role of volunteers:	Minimal
Use of technology:	High potential use of monitoring technology; microwave ovens for heating food
Procurement:	High volume, efficient meals production
Outcomes:	Minimising risk, preventing malnutrition and hospital admissions

### Layer 3

Description:	Nutritional support - traditional delivered meals and courtesy social contact
Target group:	HACC target group
Market segments:	Confusion/forgetfulness with general frailty
Financial implications:	Status quo
Role of dietitians:	Important; general advice
Role of volunteers:	Delivering meals and courtesy contact
Use of technology:	Potential for use of monitoring technology; use of microwave ovens to heat food
Procurement:	High volume, efficient meals production
Outcomes:	Maintaining independence in the community

### Layer 4

Description:	Alternatives to HACC delivered meals – group meals, use of mainstream providers, supermarket meals, assisted shopping/cooking
Target group:	HACC target group, those who can be supported to access alternatives to delivered meals
Market segments:	Those with fewer functional limitations
Financial implications:	Flexible use of government subsidy
Role of dietitians:	Information
Role of volunteers:	Assisted shopping, transport, assisted ordering of supermarket meals
Use of technology:	Ordering of supermarket produce
Procurement:	Assisted shop/cook; provision by supermarket; by private providers
Outcomes:	Preventing clients becoming isolated and dependent on HACC delivered meals

## Layer 5

Description:	Integrated social support/physical activity/health promotion with nutrition support programs eg: Senior Citizens Centres
Target group:	HACC target group for whom social support is a priority
Market segments:	Those for whom nutritional support is secondary to social support eg: some communal meals
Financial implications:	Use of funding from other activity types and program areas eg: Flexible Service Response, Volunteer Coordination, Health Promotion resources, service users fund food provision, Community Health Services
Role of dietitians:	Educational
Role of volunteers:	Transport
Outcomes:	Health promotion and general well-being

## Layer 6

Description:	Activities that support broader community food security (not HACC responsibility)
Target group:	Broad community
Outcomes:	HACC Food Services input in broader planning functions in relation to community food security