2ND EDITION

NUTRITION SUPPORTS FOR HEALTH CLINICS:

A toolkit of healthy eating policy, systems, and environmental change strategies encouraged by the national SNAP-Ed program for obesity prevention and addressing food insecurity

Acknowledgments and Disclaimers

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We recognize there might be strategies conducive to health clinics that are currently not included in this toolkit; resources we might have missed; and many stories we have yet to capture of health clinics that have implemented nutrition support strategies. If you have a strategy, resource, or story you would like to share to be added, please contact Carrie Draper at draper@mailbox.sc.edu.

SOUTH CAROLINA SNAP-Ed Supplemental Nutrition Assistance Program Education

SNAP Supplemental Nutrition Assistance Program

Arnold School Public Health

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Toolkit Purpose and Overview

The purpose of this toolkit is to ***encourage***, ***inspire***, and ***provide practical guidance*** to health clinics for implementing strategies to increase access to healthy eating opportunities among clinic patients and employees. This is the second version of the toolkit, first published in 2019. The following have been added or updated in this new version: Getting Started and Evaluation sections; resources listed for each strategy; and additional case studies.

The toolkit is divided into 5 sections:

1. **An Overview** of SNAP, SNAP-Ed, and policy, systems, and environmental change strategies for healthy eating.

2. **Getting Started:** a quick guide for how to assess readiness and ensure sustainability of strategies implemented.

3. **Strategies:** an explanation of each strategy, reasons a health clinic might want to implement the strategy, sample implementation steps, and links to additional resources.

4. **Evaluation:** an explanation of evaluation, different types of evaluation, why evaluation is important, and resources for sharing your story.

5. **Case Studies:** real life examples and experiences of health clinics that have implemented policy, systems, and environmental strategies for healthy eating and active living.

SECTION 1.

Introduction to SNAP, SNAP-Ed, and Policy, Systems, and Environmental (PSE) Strategies for Healthy Eating

What is SNAP?

The Supplemental Nutrition Assistance Program, or **SNAP**, is the federal nutrition assistance program previously known as food stamps. It is the largest program in the nation's domestic hunger safety net system, currently serving almost 42 million individuals.[1,2] The majority of people who receive SNAP are children, elderly, and people who have a disability.[3] Additionally, the majority of working-age adults who receive SNAP are employed, though, their employment is often unstable, in part due to the health conditions they face.[3] SNAP participating individuals and households receive money each month on an Electronic Benefits Transfer (EBT) card that can be used for food purchases at certified retailers, such as grocery stores or some farmers markets. These resources cannot be used to purchase hot prepared, ready to eat meals or non-food items.[1] A recent review of research found that financial incentives combined with nutrition education may be effective in improving dietary intake among SNAP participants.[4]

What is SNAP-Ed?

SNAP-Ed complements SNAP through providing nutrition education and obesity prevention support at locations where at least 50% of people served are of a low-income.[5] For health clinics, this means at least 50% of the patient population must make an annual income at or less than 185% of the federal poverty level – or, in other words, receive or be eligible to receive some form of public assistance such as SNAP, Medicaid, or Special Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC).[5]

SNAP-Ed strategies focus on both healthy eating and active living interventions, direct nutrition education, and social marketing campaigns. The goal of the program is to ensure low-income individuals and households are able to make healthy food choices within a limited budget, and to choose physically active lifestyles. SNAP-Ed strives to partner with and influence many types of entities and settings where people eat, learn, live, play, shop, and work.[5] Recent research shows demonstrates that participation in SNAP-Ed enhances participants' food resource management, and therefore, their diet quality.[6]

The healthy eating and active living aspects of SNAP-Ed are consistent with the current Dietary Guidelines for Americans, 2008 Physical Activity Guidelines for Americans, and MyPlate. Planning and implementation guidance to states is based on the Healthy, Hunger-Free Kids Act (HHFKA) of 2010 and 2016 grant program guidelines outlined in the SNAP: Nutrition Education and Obesity Prevention Grant Program Final Rule. The HHFKA established SNAP-Ed as the Nutrition Education and Obesity Prevention Grant Program and called for the program to include an emphasis on obesity prevention in addition to nutrition education.[5]

In Fiscal Year 2016, FNS authorized all 50 states and territories to provide nutrition education and obesity prevention services, using interventions that include direct education; social marketing; and policy, systems, and environmental (PSE) changes. While FNS encourages states to embrace a comprehensive approach, this toolkit focuses on PSE change strategies. Ideally, these strategies would be implemented in conjunction with: 1) providing nutrition education to clinic patients and employees (if a majority of employees at the clinic make a

low-income), 2) marketing and promotion of the strategy(ies) implemented, and 3) gaining and integrating the input of the patient population to ensure that strategies selected align with their priorities and needs.[5] An overview of PSE strategies is provided below, and section 3 presents individual PSE strategies for healthy eating conducive to the health clinic setting.

What are Policy, Systems, and Environmental (PSE) Change Strategies?

Education combined with PSE change strategies can be more effective than either strategy alone in preventing overweight and obesity. For example, if people are taught through nutrition education that half their plates should be fruits and vegetables, but they do not have access to affordable, quality produce in their community, then the goals of SNAP-Ed will never be realized without also the implementation of PSE strategies. Definitions and examples of PSE change strategies are described below:[5,7]

> ***Policy*** *changes are written statements of an organizational position, decision, or course of action. Ideally, policies describe actions, resources, implementation, evaluation, and enforcement. Policies are made in the public, non-profit, and business sectors. Policies help to guide behavioral changes for audiences served through SNAP-Ed programming.*
>
> > ***Example:*** *A health clinic that includes a majority of low-income employees writes a policy that states that healthy food options will be available at all employee meetings and events. The local SNAP-Ed provider can work with the health clinic to provide model policies and provide guidance on implementation steps.*
>
> ***Systems*** *changes are unwritten, ongoing, organizational decisions or changes that result in new activities reaching large proportions of people the organization serves. Systems changes alter how the organization or network of organizations conducts business. An organization may adopt a new intervention, reallocate resources, or in significant ways modify its direction to benefit low-income consumers in qualifying sites and communities. Systems changes may precede or follow a written policy.*
>
> > ***Example:*** *A health clinic has employees dedicated to assist patients at risk of experiencing food insecurity in getting linked to healthy food resources. The local SNAP-Ed provider can be instrumental in training the health clinic employees on how to start screening patients for food insecurity and available resources in the community for where to link them.*
>
> ***Environmental*** *changes include the built or physical environments that are visual/observable, but may include economic, social, normative or message environments. Modifications in settings where food is sold, served, or distributed may promote healthy food choices.*

> ***Example:*** *A health clinic hosts a farmers' market that accepts SNAP. A SNAP-Ed provider can provide consultation and technical assistance to the health clinic on how to start a market and how to get set up to accept SNAP.*

A set of specific healthy eating PSE strategies that could be implemented within the health clinic setting have been researched for this toolkit, although there may be other conducive strategies that are not included. Specific physical activity PSE strategies are not included in section 3, though, examples are included within section 5 to illustrate how some health clinics have used both healthy eating and physical activity strategies in tandem, which is an encouraged approach within the SNAP-Ed program.

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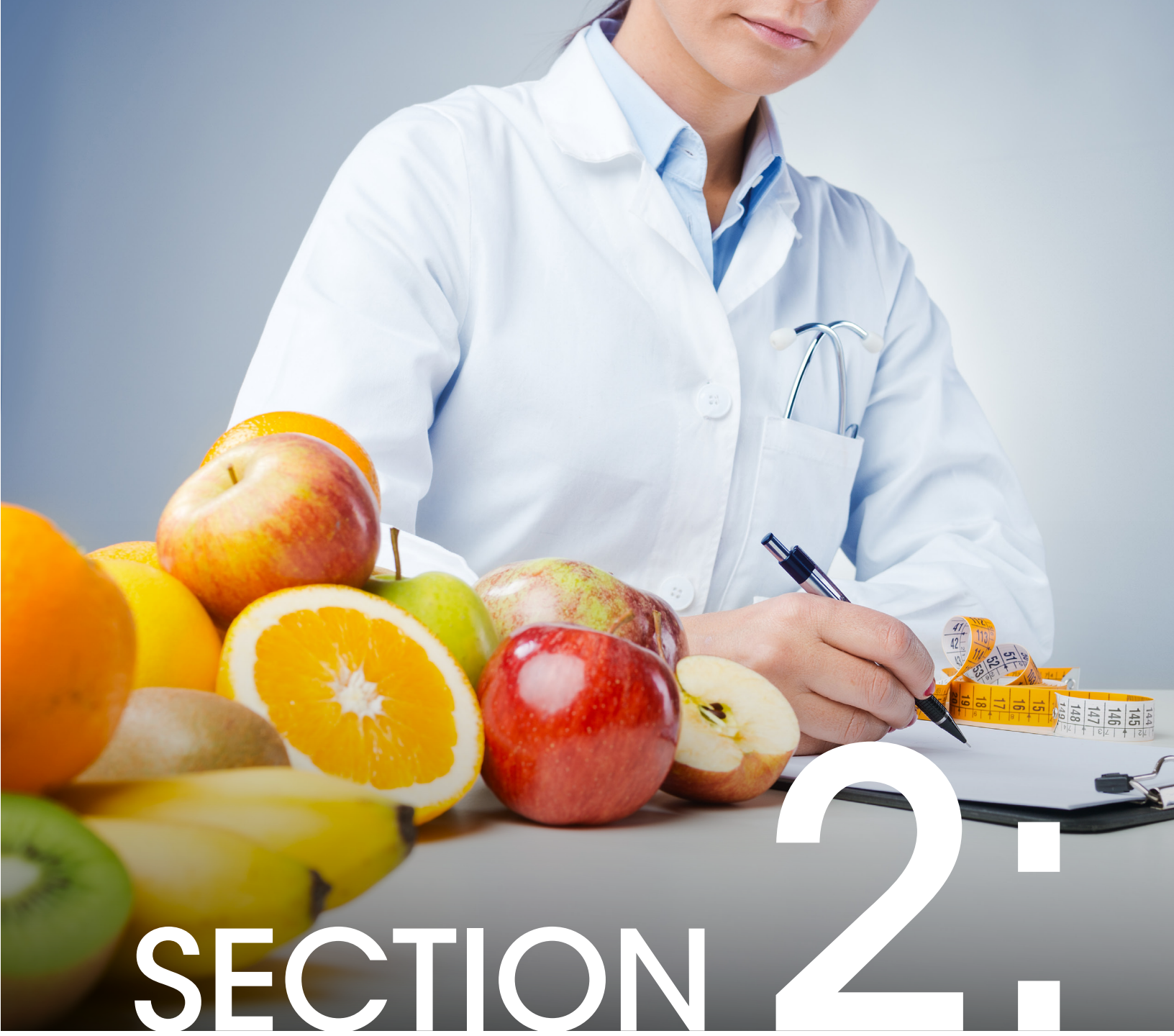

SECTION 2:

Getting Started Assessing Readiness and Sustainability

Assessing Readiness

Before implementing one of the healthy eating PSE strategies at your health clinic, it is important to consider readiness. Assessing readiness is encouraged as a short-term indicator in the SNAP-Ed Evaluation Framework (ST5: Need and Readiness).[1] What is motivating your health clinic and do you have the capacity to start and sustain the strategy or strategies of interest?[2] If a health clinic does not have all the capacity needed currently, what are capacity building needs that SNAP-Ed implementers can help address through providing guidance and technical assistance? The table below offers sample questions to consider before getting started.

Alignment	*How does working to increase access to healthy foods for your patients and/or staff align, if at all, with your clinic's current values, mission, and culture?*
	How does it differ?
	Which groups within the clinic's community are impacted by, invested in, or concerned with this strategy? (This could include staff, leadership, patients, and/or potentially others).
	Does this strategy directly address the needs and desires expressed by these groups?
	Was this strategy developed through partnership with and engagement of the intended population?
Purpose & Goals	*Why is your clinic interested in strategies to increase healthy food access?*
	What are the short-term goals you hope to achieve?
	What are the long-term goals you hope to achieve?
Capacity	*Are staff available to help support the strategy?*
	Can current funding be allocated to support the strategy? Do you need to identify additional funding?
	Are there partnerships with community members/organizations you could engage in?
Equity & Inclusion	*What adverse impacts or unintended consequences could result from the strategy?*
	Which inequities are addressed by the strategy?
	What factors are producing or perpetuating these inequities and does the strategy address them?
	Does this strategy support local leadership within marginalized communities?
	Are culturally and linguistically competent services planned for this strategy?
Further Considerations	*Does this strategy include a plan for ongoing engagement of stakeholders throughout implementation to support stakeholder-driven evaluation?*
	How can this strategy be maintained in the future?

Answering these questions as a part of selecting a strategy or strategies to implement will help identify current capacities and capacity building needs of your clinic, such as assets that can be leveraged and gaps that need to be filled in order to be successful.[3] For example, if you go through the list above and realize that you do not have agreed upon short- and long-term goals, then it would be helpful to develop these onsite to help guide your efforts and to gain buy-in among staff. Remember, even if you do not have readiness at the beginning of implementation, it can be built. In a study conducted with South Carolina health clinic staff to assess readiness to implement the strategies in this toolkit, the primary capacity building needs identified included: 1) identifying partnerships, 2) increasing knowledge of available community resources, 3) gaining patient interest and buy-in, and 4) increasing knowledge and understanding of the strategy of interest.[4] If your clinic identifies similar challenges, these are areas that many SNAP-Ed implementers are well equipped to provide technical assistance and consultation to help address.

Sustainability

In addition to assessing readiness before implementation, you will want to begin thinking about sustainability planning. Having a plan in place will help ensure that positive changes are not lost after implementation ends. Sustainability planning within SNAP-Ed sites where nutrition supports are adopted is encouraged as a long-term indicator in the SNAP-Ed Evaluation Framework (LT10: Planned Sustainability). The Centers for Disease Control and Prevention has a comprehensive guide that can help aid in the development, implementation, and evaluation of a sustainability plan. The guide includes examples of sustainability planning and more in-depth information about their ten-step guide for sustainability that includes the following:[3]

1) ***Create a shared understanding of sustainability***
2) ***Create a plan to work through the process***
3) ***Position efforts to increase the odds of sustainability***
4) ***Look at the current picture and pending items***
5) ***Develop criteria to help determine which efforts to continue***
6) ***Decide what to continue and prioritize***
7) ***Create options for maintaining priority efforts***
8) ***Develop a sustainability plan***
9) ***The sustainability plan***
10) ***Evaluate outcomes and revise as needed***

Another helpful framework for maintaining program effectiveness over time is the Program Sustainability Assessment Tool (PSAT) developed by researchers at Washington University in St. Louis.[5] This tool includes a framework, summarized in the table below, to help build capacity for sustaining a program. There are many resources available online as well as the full assessment tool, which can be accessed for free at https://sustaintool.org/psat/.

SUSTAINABILITY DOMAIN	DEFINITION
Environmental Support	Having a supportive internal and external climate for your program
Funding Stability	Establishing a consistent financial base for your program
Partnerships	Cultivating connections between your program and its stakeholders
Organizational Capacity	Having the internal support and resources needed to effectively manage your program and its activities
Program Evaluation	Assessing your program to inform planning and document results to answer
Program Adaptation	Taking actions that adapt your program to ensure its ongoing effectiveness
Communications	Strategic communication with stakeholders and the public about your program
Strategic Planning	Using processes that guide your program's direction, goals, and strategies

Program Sustainability Assessment Tool v2, copyright 2013, Washington University, St Louis, MO. All rights reserved.

Similar to the PSAT, a sustainability tool specific for clinical settings, the Clinical Sustainability Assessment Tool, CSAT, has also been developed by researchers at Washington University in St. Louis.[6] The framework domains with definitions are summarized in the table below. There are many resources available online as well as the full assessment tool, which can be accessed for free at https://sustaintool.org/csat/.

SUSTAINABILITY DOMAIN	DEFINITION
Engaged Staff & Leadership	Having supportive frontline staff and management within the organization
Engaged Stakeholders	Having external support and engagement for the clinical practice
Organizational Readiness	Having the internal support and resources needed to effectively manage the practice
Workflow Integration	Designing the practice to fit into existing processes, policies, and technologies
Implementation & Training	Promoting processes and learning that guide the direction, goals, and strategies of the practice
Monitoring & Evaluation	Assessing the practice to inform planning and document results
Outcomes & Effectiveness	Understanding and measuring practice outcomes and impact

Key Considerations for Community Partners Working with Health Clinics

Are you a SNAP-Ed Educator or other community partner working closely with a health clinic? Keeping in mind the following considerations can help your partnership be more successful:

- *Understand that confidentiality is of utmost importance to health clinics and help brainstorm ways to work together while respecting the Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines and other measures.*
- *Develop a shared language and consider differences in terms and acronyms to build trust and buy-in.*
- *Remember that decisions may be based on/limited to what can be reimbursed.*
- *Consider the type of health care organization and the capacity of each (e.g., Federally Qualified Health Center (FQHC), free clinic, or hospital system).*
- *Refer to the community health needs assessment.*
- *Explore how to connect to the health clinic's electronic health record system either through the system directly or explore compatible electronic referral systems.*
- *Consider the type of staffing present (e.g., Are they rotating volunteers or are they contracted employees tied to another organization?).*

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5. Program Sustainability Assessment Tool v2, copyright 2013, Washington University, St Louis, MO. All rights reserved.

6. Clinical Sustainability Assessment Tool, copyright 2019, Washington University, St. Louis, MO. All rights reserved.

Additional Resources

Readiness and Sustainability

SNAP-Ed Evaluation Framework - ST5: Need and Readiness
https://snapedtoolkit.org/framework/components/st5/
The SNAP-Ed Evaluation Framework provides a description, background, outcome measures, survey and data collection tools, as well as other information and resources for the Need and Readiness indicator.

SNAP-Ed Evaluation Framework - LT10: Planned Sustainability
https://snapedtoolkit.org/framework/components/lt10/
The SNAP-Ed Evaluation Framework provides a description, background, outcome measures, survey and data collection tools, as well as other information and resources for the Planned Sustainability indicator.

Sustainability Assessment Tools
https://sustaintool.org/
Researchers at the Washington University in St. Louis developed two tools, the Program Sustainability Assessment Tool and the Clinical Sustainability Assessment Tool, which provide a framework for guiding program sustainability. There are many resources available online as well as the full assessment tool, which can be accessed for free.

Organizational Readiness for Implementing Change (ORIC)
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3904699/bin/1748-5908-9-7-S1.doc
This 12-question instrument assesses a health care organization's readiness for implementing change.

CDC Criteria for Identifying Organizations that Can Support a Community-Clinical Linkage
https://www.cdc.gov/dhdsp/pubs/docs/ccl-practitioners-guide.pdf
The second resource of the toolkit includes questions that can help guide a readiness assessment for creating community-clinical linkages.

Health Equity and Cultural Competence

Assuring Healthcare Equity: A Healthcare Equity Blueprint
https://5536401f-20a1-4e61-a28e-914fb5dcef51.filesusr.com/ugd/888d39_e8585bda66b047178341de4a094a8b9f.pdf
This resource developed by the National Public Health and Hospital Institute is a helpful guide for addressing health equity in health care settings. It includes sections on creating partnerships with patients and the community as well developing culturally and linguistically appropriate resources, programs, and standards of care. The blueprint includes evidence-based best practices, tools, and additional resources.

The AMA's strategic plan to embed racial justice and advance health equity
https://www.ama-assn.org/about/leadership/ama-s-strategic-plan-embed-racial-justice-and-advance-health-equity
This American Medical Association's strategic plan is a roadmap for addressing and advancing health equity. The link includes the five strategic approaches of the roadmap as well as the opportunity to download the strategic plan in full.

Using a Health Equity Lens
https://www.cdc.gov/healthcommunication/Health_Equity_Lens.html
The Centers for Disease Control and Prevention outline key concepts to consider when addressing health equity.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
https://thinkculturalhealth.hhs.gov/clas
The culturally and linguistically appropriate services (CLAS) provides guidance for reducing health disparities and achieving health equity. The website includes a link to download the full guide as well as the National CLAS standards, education, and more resources.

SECTION 3:

Healthy Eating PSE Strategies

Healthy Eating PSE Strategies

1. Host a farmers' market
2. Establish a produce garden
3. Screen patients for food insecurity and make referrals to community or on-site resources for nutrition
4. Provide prescriptions for fruits and vegetables
5. Start a food pantry focused on wellness and nutrition
6. Support breastfeeding through space, policies, and practices
7. Offer healthy food and beverage options in vending machines
8. Improve free water access, taste, quality, smell, or temperature
9. Expand or improve transportation options to the health clinic
10. Establish worksite wellness policies and opportunities for health clinic employees
11. Provide an opportunity for health clinic employees to participate in a state or local food policy council
12. Provide an opportunity for health clinic employees to participate in a community coalition for addressing obesity

1. Host a Farmers' Market

Explanation of Strategy

This strategy involves either your health clinic partnering with a local farmers' market to come onsite, or your health clinic establishing its own farmers' market. Ensuring the market, as a whole, or individual vendors (those selling products) are set up to accept SNAP, SNAP healthy incentives, WIC and Senior Farmers' Market Nutrition Program coupons/vouchers will help ensure that SNAP-Ed eligible patients and employees are able to shop at the market. Thinking that space or employee capacity would prohibit hosting a full farmers market onsite? Partner with an individual farmer instead!

Why Implement this Strategy

Farmers' markets often provide access to affordable fresh, local, and in-season produce, and hosting one onsite helps make a clear and literal connection between healthy food and physical health. Studies of farmers' markets located at health care settings have shown an increase in the consumption of fruits and vegetables among shoppers.[1,2] Studies also show that market location matters, in part because transportation influences whether people do or do not shop at markets[3-6]; locating one at your health clinic can help mitigate transportation barriers for patients and employees. Markets can provide an opportunity for community partners to be involved and connect with shoppers through the sharing of resources or providing food demonstrations. For example, some markets provide a booth for SNAP outreach workers to sign shoppers up for SNAP, or they partner with dieticians or nutrition educators who set-up taste testing events or recipe demonstrations using foods sold at the market.

Possible Implementation Steps

Building Farmacies: A Guide for Implementing a Farmers' Market at a Community Health Center provides a setting specific guide for health clinics who are exploring starting an onsite farmers' market. (A link to the full guide is available here: https://wafarmersmarkets.org/resource-file/BuildingFarmacies_Bldg_FM_at_a_Comm_Hlth_Ctr_2013.pdf

They recommend the following key steps:

1) *Assess readiness to start a farmers' market (readiness tool included in the guide)*
2) *Hold a community visioning meeting*
3) *Recruit advisory council members*
4) *Determine market logistics (e.g., days and times of operation, months the market will be open)*
5) *Develop market regulations (e.g., what can and cannot be sold at the market, decide how much a farmer will pay to have a booth at the market)*

6) *Recruit farmers*
7) *Identify a market manager (also sometimes referred to as a "market master")*
8) *Secure start-up funding for operations and promotion*
9) *Get the market equipped to accept SNAP, if individual farmers do not already accept SNAP as a form of payment*

In order to get your market set up to accept SNAP, you need to become an FNS SNAP retailer and then secure the necessary equipment. Options now exist for you to be able to accept SNAP, credit, and debit transactions through one machine. An increasing number of markets now offer SNAP healthy incentives to shoppers (also known as "double bucks" or "double up" programs). These programs provide SNAP shoppers with an additional amount of money to go towards typically produce after an initiating purchase. Check to see if an agency or organization within your state is already operating a SNAP healthy incentives program that your market can participate in; if not, you should consider including this in your market budget. Individual farmers (not markets, as a whole) can get certified to be a vendor of the WIC and Senior Farmers' Market Nutrition Programs. Recruit farmers who are already certified to accept these vouchers to sell at your market and encourage those who are not to go through the process.

Finally, make sure to consult with your local health department and state department of agriculture to seek guidance on food safety and licensing rules. Many states also have a farmers' market association that could provide you with state specific guidance.

Additional Resources

Supplemental Nutrition Assistance Program (SNAP) at Farmers' Markets: A How-to Handbook
https://www.ams.usda.gov/sites/default/files/media/SNAPat%20Farmers%20Markets%20Handbook.pdf
Explains why farmers markets should accept SNAP; options for operating SNAP at markets; how to become a FNS SNAP retailer; equipment options; and ways to promote SNAP acceptance. Brief case studies are also included.

Supplemental Nutrition Assistance Program (SNAP) Application Instructions
https://www.fns.usda.gov/snap/retailer-apply
Provides steps for becoming authorized as a FNS SNAP retailer in order to be able to accept SNAP as a farmers' market and includes a link to the application.

WIC Farmers' Market Nutrition Program (FMNP)
https://www.fns.usda.gov/fmnp/wic-farmers-market-nutrition-program-fmnp
Provides a description of the program and participating state agency contact information.

Senior Farmers' Market Nutrition Program (SFMNP)
https://www.fns.usda.gov/sfmnp/senior-farmers-market-nutrition-program-sfmnp
Provides a description of the program and participating state agency contact information.

USDA Farmers Market Promotion Program
https://www.ams.usda.gov/services/grants/fmpp
Describes the USDA Farmers Market Promotion Program funding mechanism that currently accepts applications annually.

Gus Schumacher Nutrition Incentive Program
https://nifa.usda.gov/program/gus-schumacher-nutrition-incentive-grant-program
This website provides information on the Gus Schumacher Nutrition Incentive Program (GusNIP). It provides an overview of grant and project types (including produce prescription programs), eligibility, contact information, resources, and news.

State Farmers Market Associations
https://farmersmarketcoalition.org/state-map/
Provides a list of state farmers market associations with contact information.

Farmers Market Coalition Resources
https://farmersmarketcoalition.org/education/
Includes market manager FAQs, a resource library, webinars, a SNAP guide for farmers markets, and funding opportunities.

SNAP-Ed Connection: Farmers Markets/Local Foods
https://snaped.fns.usda.gov/seasonal-produce-guide/farmers-marketslocal-foods
Provides links to resources on teaching nutrition at farmers markets.

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2. Establish a Produce Garden

Explanation of Strategy

This strategy involves growing a fruit and vegetable garden at your health clinic. The purpose of the strategy is to educate people about fruits and vegetables, provide harvested fruits and vegetables to the community or patients, and establish partnerships with other nutrition-related groups or coalitions. Although gardens require regular maintenance, health clinic employees do not have to be responsible for all garden care. By engaging the community and creating partnerships, the garden can flourish with the help of volunteers.

There are several approaches to community gardening, so your health clinic can determine which strategy would be most appropriate based on clinic capacity, patient population, and purpose.

The top five most common gardening strategies:[1]

Plot Gardens—A larger plot divided into individual plots and maintained by the individual

Cooperative Gardens—One large garden is maintained by team of volunteers, patients, employees, etc.

Youth Gardens—Hands-on setting for learning and teaching skills in virtually every basic subject area

Entrepreneurial Market Gardens—Purpose is to sell produce

Therapeutic Gardens—Using plants to improve social, educational, psychological, and physical well-being

Why Implement this Strategy

Gardens provide an opportunity to encourage healthy eating, physical activity, and community engagement.

Specific benefits of establishing a garden include:[2,3]

- *Improving access to fruits and vegetables, especially for low-income patients and community residents*
- *Serving as an extension to patient education on health eating*
- *Improving social well-being through establishing and strengthening social connections*
- *Linking harvested produce with farmers markets, produce stands, or local food pantries*

These benefits may lead to positive health outcomes, including increased food security, reduced obesity rates, improved mental health and social connectedness, and improved sense of community and neighborhood safety.[4] A garden can also be a positive financial investment for the community. They are relatively inexpensive and allow several opportunities to provide or save income for local residents. For instance, volunteers who harvest and keep the garden's fruits and vegetables can spend less money on food. If the volunteers sell the harvested produce, it can serve as an extra source of income, especially for high yields, such as vertically-grown, fast growing crops like peppers and tomatoes.[4]

Gardens help to establish new partnerships within the community and enhance social interconnectedness. A garden can broaden a health clinic's partner base, which can ultimately help promote broader health or food policy agendas.[5] Gardens at health clinics are a tangible way to market healthy eating through an organized, community-centered activity. This sense of community can help your clinic form ties with other health-focused organizations, creating new professional partnerships. The partnerships can then assist your clinic in adopting other PSE strategies that can improve your patients' nutrition and physical activity.

Possible Implementation Steps

Engage patients and other members of the community from the beginning. While the idea of a garden can be very appealing in theory, the reality is that it generally takes a strong commitment from at least 3-5 individuals to build and sustain one. Also, gardens that are built by community "outsiders" are rarely maintained by community members.[6] Therefore, it is very important to engage community members from the initial planning stages and through the life of the garden. **Consider developing a planning committee**, including patients, employees, nearby residents, and potential partners. A committee can help determine the scope of the garden (what will be planted), budget, and make management decisions, such as whether there will be restrictions on pesticides and fertilizers.

Keep in mind that gardens can be seasonal, so **planning for an early trial run of a garden on a smaller scale**, spatially and time-wise – maybe a single summer garden or fall garden cycle – might help determine the level of sustained community involvement, before constructing a full-scale garden. It is also helpful to consider the climate and zone where you will be planting the garden. Become familiar with the planting seasons in your area and choose produce that grows best in your zone. Your local extension office can be a great resource; for a directory of the land-grant university system, visit https://nifa.usda.gov/land-grant-colleges-and-universities-partner-website-directory to find out who to contact in your area for planting guides or even possible volunteers.

Look for sponsorship. Many types of organizations sponsor community gardens and might also offer other resources, volunteers, or gardening specialists. Also, the purchase of seeds, plants, and small gardening tools and supplies for developing gardens are allowable expenses under SNAP-Ed.[7]

In speaking with various clinics with community gardening experience, the biggest barrier to success was actual maintenance of the garden, particularly in the longer-term. So, it may be important to include strong incentives (improved access to food, reduction in food costs,

ability to sell foods to outside markets, coupons/vouchers for farmers' markets, etc.) for community members to retain commitment to the garden.

Additional Resources

The South Carolina Garden Toolkit
https://scfarmtoschool.com/classroom/garden-toolkit/
This toolkit provides a how-to-guide for establishing a community garden, maintaining the garden, how to harvest, and other additional resources.

10 Steps to Starting a Community Garden
https://foodshare.net/custom/uploads/2015/11/10_Steps_to_Start_a_Community_Garden.pdf
Detailed information on each of the 10 steps to starting a community garden, from the American Community Gardening Association.

How to Organize a Community Garden
https://content.ces.ncsu.edu/how-to-organize-a-community-garden
Explains various types of gardens, steps for getting started, and modern examples of implementation. There are also links to many additional resources for getting started.

County Health Rankings and Roadmaps: Community Gardens
http://www.countyhealthrankings.org/policies/community-gardens
Provides several implementation examples, other implementation resources, and descriptions of both expected and potential beneficial outcomes of community gardens.

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3. Screen Patients for Food Insecurity and Make Referrals to Community or On-site Resources for Nutrition

Explanation of Strategy

This strategy involves screening all patients seeking services at the health clinic for food insecurity during each office visit. Food insecurity occurs when a household experiences diminished quality and quantity of foods because they cannot afford enough foods or enough of the right kinds of foods to maintain a healthy, active life. If a patient is found to be experiencing food insecurity, they should be linked to resources in the community or at the clinic to access healthy food.

Why Implement this Strategy

In the United States, 10.5 percent (13.8 million) of U.S. households are food insecure.[1] The COVID-10 pandemic has only exacerbated food insecurity across the country and has impacted families already food insecure or at risk of being food insecure, with racial disparities playing a significant role.[2,3] There is significant evidence that supports an association between food insecurity and poor health. More specifically, food insecurity is associated with hypertension, diabetes, and self-indicated poor health.[4–6] By screening and directing food insecure patients to food resources, the clinic can decrease their patients' risk for cardiovascular disease. Recognizing this, the Academy of Pediatrics recommends that pediatricians screen for food insecurity and make referrals to community resources, among other policy and practice-based strategies to address patient food insecurity. You can read the full statement here: http://pediatrics.aappublications.org/content/136/5/e1431 and find links to toolkits developed with the expertise of pediatricians and others in the next sections.

Possible Implementation Steps

Below is an adaptation of the Food Research and Action Center's Screen and Intervene Toolkit, which recommends:[7]

- *Educate and train employees on food insecurity and the importance of universal screening*
- *Schedule regular screenings of patients*
- *Create a workflow - Add screening to registration, intake procedures, and electronic health records*
- *Learn how to address food insecurity in a sensitive and non-stigmatizing manner*
- *Connect patients to known food resources*
- *Document and track screening and recommendations in patient medical records*
- *Support advocacy and educational efforts to end food insecurity*

Employee training

It is important to conduct employee training on the workflow that will be used. Educating staff about the prevalence of food insecurity, how to use the screening tool (including who, when, and where to ask the questions), documentation, and using sensitive communication techniques are key steps to ensure a streamlined process is adopted at your clinic. Employee training should include role playing to help staff practice feeling comfortable administering the screening tool and to give them opportunities to receive feedback. Training should also happen periodically and could include monitoring updates about how many patients have been screened and/or how many were connected to resources since the last training and any quality improvement needed.[8]

Screening tools

Multiple length food insecurity screening tools exist, ranging from 2 to 18 questions. Using longer versions could help better capture patients experiencing food insecurity, while using a shorter version could be more conducive to a clinic setting due to limited provider time required to administer the screener and patient response burden to answer the questions.

Validated 2 Question Food Insecurity Screening Tool[9]

1) "Within the past 12 months, we worried whether our food would run out before we got money to buy more."

   Was that often true, sometimes true, or never true for you/your household?

2) "Within the past 12 months, the food we bought just didn't last and we didn't have money to get more."

   Was that often true, sometimes true, or never true for you/your household?

Referral systems

Similarly, referral systems vary in type and resources needed to implement. Several examples include:

1) *Providing patients who screen positive for food insecurity with a list of area food pantries they can access or connecting them with an on-site food pantry if one exists.*
2) *Letting patients know about public nutrition assistance programs they or their children might be eligible for (e.g., SNAP, Commodity Supplemental Food Program, Summer Food Service Program sites) and how to apply for or access them. Some states have organizations that provide eligibility screenings for benefits and help people apply; if an organization like this exists, reach out to them and see if they have benefits counselors that could come on-site to provide this service to patients or offer the opportunity for clinic staff or partners to become trained.*
3) *Providing prescriptions for fruits and vegetables. (This strategy will be covered more in-depth next in the toolkit.)*

4) *Partnering with a local food-based organization, such as one that operates a bulk produce buying club, to get patients plugged in to participate. The FoodShare model is an example of a produce box program that has successfully partnered with clinics to provide food to patients that screen positive for food insecurity: https://snapedtoolkit.org/interventions/programs/foodshare/.*

Documentation

Food insecurity screenings and referrals should be documented as part of the patient medical record. Deciding who and where the documentation will take place should be part of the workflow planning process.[7] Ideally, the documentation should be part of the electronic health medical record. For more information on how to connect with information technology to set up a system and which codes can be used as part of the documentation process, refer to the additional resources section.

Additional Resources

Food Insecurity Screening Resources

Screen and Intervene: A Toolkit for Pediatricians to Address Food Insecurity

https://frac.org/aaptoolkit

This toolkit provides guidance on preparing to and screening for food insecurity and how to intervene and advocate in order to address food insecurity among patients.

Food Insecurity and Health: A Tool Kit for Physicians and Health Care Organizations

https://hungerandhealth.feedingamerica.org/wp-content/uploads/2017/11/Food-Insecurity-Toolkit.pdf

This toolkit provides guidance on how physicians and clinicians can help address food insecurity and how to measure outcomes and gauge success.

Community-Clinical Linkages for the Prevention and Control of Chronic Diseases: A Practitioner's Guide

https://www.cdc.gov/dhdsp/pubs/docs/ccl-practitioners-guide.pdf

This guide provides information on how to start, sustain, and evaluate community-clinical linkages.

Food Insecurity Screening in Houston and Harris County: A Guide for Healthcare Professionals

https://www.texaschildrens.org/sites/default/files/uploads/Food%20Insecurity%20Report%20Final.pdf

This toolkit is a guide for healthcare professionals on how to conduct food insecurity screenings among patients and connect those who are experiencing food insecurity to the appropriate resources. The toolkit also includes information on how to make food insecurity screenings and referrals part of the health care practice workflow as well as how to work with information technology to set up a system. Other key considerations such as staff training, sensitivity, evaluation, and sustainability are included.

PRAPARE Implementation and Action Toolkit
https://aapcho.org/wp-content/uploads/2021/02/NACHC_PRAPARE_ALL-Updated-8.24.20.pdf
The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a national effort to help health centers and other providers collect and apply the data they need to better understand their patients' social determinants of health, transform care to meet the needs of their patients, and ultimately improve health and reduce costs.

Launching Rx for CalFresh in San Diego: Integrating Food Security into Healthcare Settings
https://static1.squarespace.com/static/55130907e4b018f9300f3e63/t/5823d006f5e2312802b5fefc/1478742024280/Rx+for+CalFresh_FINAL-Oct+2016.pdf
This report, developed by the San Diego Hunger Coalition, is a resource for health care providers, policy makers, and anti-hunger advocates. The report includes in-depth information for five key prescription recommendations for CalFresh models, but the information and resources are transferable to any state looking to implement similar initiatives.

A Quick Guide to Food Insecurity Screening and Referral for Older Patients in Primary Care
http://www.aarp.org/content/dam/aarp/aarp_foundation/2016-pdfs/foodsecurityscreening_quickguide.pdf
This quick guide provides more information and a link to the "Implementing Food Security Screening and Referral for Older Patients in Primary Health Care: A Resource Guide and Toolkit." The guide is particularly helpful for getting started with food insecurity screenings and referrals among older patients.

U.S. Household Food Security Survey Module
https://www.ers.usda.gov/media/8271/hh2012.pdf
Here you will find the full 18-question food security survey module that includes household, adult, and child specific questions. It also explains how to score the results.

U.S. Household Food Security Survey Module: Six-Item Short Form
https://www.ers.usda.gov/media/8282/short2012.pdf
A guide to using the abbreviated 6 question food security module.

Coding Resources

An Overview of Food Insecurity Coding in Health Care Settings
https://childrenshealthwatch.org/wp-content/uploads/An-Overview-of-Coding_2.15.18_final.pdf
This resource provides an overview and links to other available resources for health care providers to learn more about how to document food insecurity screening, assessment, intervention, and billing using codes and language specific to standardized electronic health record medical vocabularies.

ICD-10-CM Official Guidelines for Coding and Reporting FY 2022
https://www.cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines.pdf
This listing is for the current guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).

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4. Provide Prescriptions for Fruits and Vegetables

Explanation of Strategy

This strategy involves prescribing the consumption of fruits and vegetables to patients if they are not meeting dietary guidelines and/or at risk of food insecurity. Ideally, in addition to writing a prescription, patients would also receive a coupon or voucher to redeem at an easily accessible food retail location. If the clinic hosts a farmers' market or farmer onsite, this strategy could be used in tandem to help encourage patients to shop at the market by physicians providing a prescription and coupon/voucher for purchasing and consuming produce from the market or farmer.

Why Implement this Strategy

Prescriptions for fruit and vegetable consumption (FVRx) can significantly improve the health of patients. It has been shown that suboptimal diets, low in fruits and vegetables, are associated with heart disease, stroke, and type 2 diabetes.[1] Writing a prescription for positive health behaviors helps communicate that fruit and vegetable consumption is legitimate medical advice, and patients might feel more inclined to follow "doctor's orders."[2] Recent studies have also indicated that these health behavior prescription programs have decreased patient body mass index, A1C levels, and blood pressure.[3–5] FVRx programs help develop patient understanding of the food/health connection and have been shown to significantly increase produce consumption.[3,5] Implementing a health behavior prescription program could reduce patient morbidity and mortality.[3,6]

Possible Implementation Steps

Many patients who do not meet the recommended amount of fruit and vegetable consumption often experience financial barriers to healthy eating. Therefore, it may be beneficial to partner with a local farmers' market, produce stand, 2 or produce box program. Once partnerships are established, the clinic and partners can determine patient eligibility for the prescriptions. Initiating clinic staff can then train physicians and employees on the new prescription system and begin to provide prescriptions to patients.

FVRx Components:[2]

A recommendation for fresh fruit and vegetable consumption

Coupons, if any, for fruits and vegetables

Map or address of where coupon can be redeemed or where fruits and vegetables are offered

Additional Resources

Gus Schumacher Nutrition Incentive Program

https://nifa.usda.gov/program/gus-schumacher-nutrition-incentive-grant-program

This website provides information on the Gus Schumacher Nutrition Incentive Program (GusNIP). It provides an overview of grant and project types (including produce prescription programs), eligibility, contact information, resources, and news.

Prescription for Health Program Implementation Guide Fruit and Vegetable Prescription Program Readiness Checklist

https://www.washtenaw.org/DocumentCenter/View/5270/Program-Implementation-Guide-PDF?bidId

https://www.washtenaw.org/DocumentCenter/View/5269/Fruit-and-Vegetable-Prescription-Program-Readiness-Checklist-PDF?bidId

This implementation guide was developed by Washtenaw County Health Department for the Prescription for Health program with funding in part by The Kresge Foundation. The checklist can help prepare your health center for a successful implementation of a fruit and vegetable prescription program.

Produce Prescriptions: A U.S. Policy Scan

https://www.healthlawlab.org/wp-content/uploads/2020/10/Produce-Prescriptions-A-U.S.-Policy-Scan-2020.pdf

This resource provides an overview of produce prescriptions, opportunities for produce prescription programs through health care and food systems, and ongoing gaps that must be addressed to create a policy environment that is supportive of funding and scaling-up produce prescription programs.

Wholesome Wave

https://www.wholesomewave.org/

The Wholesome Wave website has numerous resources, including the Produce Prescription Programs US Field Scan Report: 2010-2020 (https://static1.squarespace.com/static/5febb5b1df316630764c4dec/t/60d0e873a8100c7ed37499d5/1624303736319/produce_prescription_programs_us_field_scan_report__june_2021_final.pdf). Visit the website for more information and opportunities to get involved.

Fresh Produce: A new prescription for high blood pressure in Cuyahoga County, OH

https://nccd.cdc.gov/NCCDSuccessStories/TemplateThree.aspx?s=14529&ds=1

This success story is one example of a produce prescription for patients with high blood pressure.

South Central NY Fruit & Vegetable Prescription Program

https://foodandhealthnetwork.org/south-central-ny-fruit-vegetable-prescription-program/

The Food and Health Network of South Central New York has information, including a model, of a fruit and vegetable prescription program.

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5. Start a Food Pantry Focused on Wellness and Nutrition

Explanation of Strategy

This strategy involves offering an on-site food pantry at your health clinic and recommending patients to the pantry that are food insecure or suffering from diet-related chronic diseases. A pantry focused on health and wellness differs from traditional food pantries in that they prioritize providing nutritious foods (like fruits, vegetables, and whole grains), nutrition education, healthy eating tips, and healthy recipes in addition to distributing food to those in need.

Why Implement this Strategy

By offering nutritious foods at your clinic food pantry, it can significantly improve a patient's diet quality and overall health.

Starting a wellness food pantry:[1,2]

- Serves as an extension to medical nutrition advice
- Reduces the stigma of going to a traditional food bank or food pantry

Eliminates several barriers to a healthy diet, including:

- Transportation
- Income
- Limited access to healthy foods

Some individuals who are experiencing food insecurity also considered overweight or obese because healthy foods can be more costly than unhealthy foods.[3] By offering free nutritious food at your clinic food pantry, it can help address food insecurity and obesity simultaneously.

Possible Implementation Steps

1) *Assess readiness to start a food pantry*
2) *Establish partnership with local food bank, if available3*
3) *Determine food pantry logistics (e.g., day and times of operation, when to pick up pantry food supply)*
4) *Develop food pantry regulations (e.g., what types of food can be offered at the pantry, how much food patients can take, and how often patients can visit the pantry)*
5) *Develop a process for patients to access the food pantry (e.g., will the physician write "prescriptions" for food in pantry or recommend patients to food pantry) Identify a food pantry manager*

6) Secure start-up funding for transportation and storage, as needed

7) Obtain necessary shelving and refrigeration for the food pantry

The Supporting Wellness at Pantries (SWAP) system has also been developed and field tested – a nutrition rating system that uses green, yellow, and red promotional materials to mirror the lights on a stoplight to help clients determine the healthiest options to choose.[4] A simple guide to the process can be found here: http://site.foodshare.org/site/DocServer/SWAP_materials_for_SWAP_program_page.pdf?docID=9525

If a food bank is not available for partnership, you can also accept donations on your own either on-site or by identifying community entities to partner with such as a nearby church or school. In order to ensure you are able to provide nutritious foods to patients, make sure to provide guidelines and examples of which kinds of foods you will accept from donors.

Community Fridge Implementation

Aside from adding a pantry, you could add a community fridge. Community fridges are a safe way to reduce food waste and connect the local community to healthy foods. Every year, millions of pounds of food go to waste in the United States.[5] A community fridge can help increase access to healthy foods while also reducing food waste. Keep in mind food donations are often protected by the Good Samaritan Act,[6] which is a law that provides legal protection to people who donate food. Community fridges are often located outside, in a publicly accessible place.

Helpful Tips

There are different examples of community fridge models and you can decide what works best for your clinic. Before getting started, gather a team together and have a plan in place for sourcing and managing the food items and promoting the community fridge to patients and eligible clinic employees. The Community Fridge of Rock Hill, South Carolina put together a detailed starting pack with guidelines to consider from recruiting volunteers, to stocking the fridge, backstocking, and spreading the word. There are other helpful organizations cited under Additional Resources.

Additional Resources

Healthy Pantry Resources

Assessing Readiness and Creating Value Through Food Bank-Health Care Partnerships

https://hungerandhealth.feedingamerica.org/wp-content/uploads/2017/01/Assessing-Readiness-and-Creating-Value-Through-Food-Bank-Partnerships_.pdf

This resource provides guidance to assess four levels of readiness for health care entities to partner with food banks and gives next steps to take to forge the partnership based on readiness level.

Healthy Pantry Initiative: Strategies for Encouraging Healthy Choices at Food Pantries

http://hungerandhealth.feedingamerica.org/wp-content/uploads/legacy/mp/files/tool_and_resources/files/healthy-pantry-initiative.pdf

This brief guide provides information on strategies, best practices, and an assessment tool from the Oregon Food Bank.

Feed the Hungry: Shifa Clinic

https://www.icnarelief.org/shifaclinics/hunger-prevention-programs/

This link provides an overview of the current hunger prevention programs with a health clinic in South Carolina.

Hunger + Health. Feeding America: A Food Bank Clinic Partnership to Support Senior Health

https://hungerandhealth.feedingamerica.org/2017/10/food-bank-clinic-partnership-support-senior-health/

This link provides a case example of a food bank partnering with a health clinic in Indiana.

Food Banks as Partners in Health Promotion: Creating Connections for Client & Community Health

http://www.chlpi.org/wp-content/uploads/2013/12/Food-Banks-as-Partners-May-2016.pdf

A comprehensive guide for how food banks and health care entities can partner within the changing health care system landscape.

Healthy Food Pantry Assessment Toolkit

https://extension.wsu.edu/pierce/nutrition/healthy-food-pantry-assessment-toolkit/

An assessment tool, instructions for using the tool, and a resource guide can be found at this link developed by a Regional Nutrition Education and Obesity Prevention Center of Excellence.

Community Fridge Resources

Protecting our Food Partners

https://www.feedingamerica.org/ways-to-give/corporate-and-foundations/product-partner/bill-emerson

This resource has more information about the Bill Emerson Good Samaritan Food Donation Act, how it encourages food donations, and how it protects the donor.

Community Fridge Starter Pack

https://drive.google.com/file/d/1bKWjjYAH3phiCjH87CHl6la5Zn2WD6ze/view

The Rock Hill Community Fridge created an easy-to-read starter pack to help you get started with choosing a community fridge.

Free99Fridge

https://free99fridge.com/

Free99Fridge is a mutual aid model of community fridges in the Atlanta area. Their website includes information about the model as well as donation guidelines.

Wellness Pantry

https://lowcountryfoodbank.org/about-us/partner-agencies/training/

The Lowcountry Food Bank of South Carolina's video on how to start a wellness pantry is a helpful resource when looking to get started.

What is Freedge?

https://freedge.org/

Freedge is an international network that promotes and supports community fridges and also includes information such as how to get started and finding grants.

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6. Support Breastfeeding through Space, Policies, and Practices

****Note on SNAP-Ed rules related to this strategy*

All SNAP-Ed activities that address breastfeeding must be planned and implemented in collaboration with the State WIC agency and State Breastfeeding Coordinator. The WIC Program should have the lead and primary role in all breastfeeding activities with SNAP-Ed supplementing existing WIC activities. Please see the FY 2023 SNAP-Ed Plan Guidance for more information: https://snaped.fns.usda.gov/sites/default/files/documents/FY2023_SNAPEd_PlanGuidance_FV.pdf

Explanation of Strategy

This strategy focuses on providing a safe, sanitary, and private room for lactating mothers and their infants, and implementing other policies and practices that support breastfeeding. This strategy can support both patients and employees within a clinic setting.

Why Implement this Strategy

Exclusive breastfeeding for the first six months and complimentary breastfeeding from 6 months to the child's first birthday provides several health benefits for baby, child, and mother including:[1]

- *Providing optimal infant nutrition*
- *Lowering obesity prevalence in children*
- *Lowering risk of infectious disease throughout childhood*
- *Shaping long-term health, as breast milk contains hormones and biological factors that may help inform physiological processes involved in energy balance from food and nutrition sources.*
- *Decreasing the risk for infant morbidity and mortality as well as maternal morbidity*

Although breastfeeding rates continue to rise in the United States, many mothers still encounter barriers to exclusive breastfeeding for the first six months as recommended by the World Health Organization.[1] One of the most significant barriers to breastfeeding is the lack of private, sanitary locations to breastfeed or express breastmilk.[2] To support mothers and their infants, clinics should strive to eliminate this barrier and make breastfeeding as easy as possible. By dedicating a clinic room to breastfeeding, it demonstrates support for breastfeeding, provides a space for education and discussion, and serves as a model for other public and private entities that wish to adopt a breastfeeding-friendly environment.

Possible Implementation Steps

Once a space is made available, steps to implementation, as recommended by the California Department of Public Health (2015), might include:[3]

Establishing written procedures and a quality assurance plan that ensures a breastfeeding-friendly clinic environment. Elements of the plan may include:

- Setting up clinic design and comfortable furniture for breastfeeding mothers
- Allowing appropriate media and educational material, and prohibiting use of media that markets breast milk substitutes or other formula supplies

Communicating the quality assurance plan and making it available as a reference to all employees, including to:

- Define employee roles and responsibilities and incorporate employee duties into job descriptions and daily activity logs
- Train and designate employees to preview and evaluate educational materials for the clinic environment
- Avoid formula marketing techniques and materials
- Develop a support system to allow breastfeeding mothers to continue feeding uninterrupted in the designated area

Even if the clinic currently has informal systems in place to accommodate breastfeeding mothers, having a written policy to formalize these systems and actively promoting the availability of breastfeeding supports to patients and employees is recommended. An example policy can be found here: https://www.secured-site7.com/washingtoncounty/www/uploads/docs/SampleClinicBFPolicy.pdf.

Additional Resources

The Breastfeeding-Friendly Pediatric Office Practice
http://pediatrics.aappublications.org/content/139/5/e20170647
This open access publication provides evidence-based recommendations for the pediatric outpatient practice.

California Department of Public Health 9 Steps to Breastfeeding Friendly: Guidelines for Community Health Centers and Outpatient Care Settings.
http://www.calwic.org/storage/documents/bf/2016/9StepGuide.pdf
This resource provides guidelines on implementing breastfeeding friendly policies and practices within a health center setting.

8 Steps to Breastfeeding Friendly: Guidelines for Healthcare Providers Working in Maternal and Child Health
https://azdhs.gov/documents/prevention/nutrition-physical-activity/breastfeeding/8-steps-to-breastfeeding.pdf
This resource provides adapted guidelines for those found in the resource above.

CDC Breastfeeding Report Card

https://www.cdc.gov/breastfeeding/pdf/2016breastfeedingreportcard.pdf

Describes the status of breastfeeding goals in the United States, and includes short case studies from the field.

The Role of Law and Policy in Assisting Families to Reach Healthy People's Maternal, Infant, and Child Health Breastfeeding Goals in the United States

https://www.healthypeople.gov/2020/law-and-health-policy/topic/maternal-infant-child-health

This report is part of the Healthy People 2020 Law and Health Policy Project, and is a comprehensive resource on both legal and policy strategies for supporting breastfeeding, along with the supporting evidence and research.

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7. Offer Healthy Food and Beverage Options in Vending Machines

Explanation of Strategy

This strategy involves creating a healthy eating environment within your health clinic by providing and promoting food items that meet a nutritional standard in vending machines.

Why Implement this Strategy

Although vending machines are a popular option for convenient snack foods and beverages, they have traditionally been a source of unhealthy products. The vast majority of the most popular options are high in calories, fat, and added sugars, and low in nutrients.[1] Nutrition standards encourage stocking vending machines with fruits, vegetables, low-fat dairy, low sodium and low sugar cereals and cereal bars, proteins, and items with no added sugar.[2] Research has shown that sales were not affected and employees consumed less saturated fat and sugar when nutrition guidelines were implemented in vending environments.[3]

Possible Implementation Steps

This strategy has multiple components, including: (1) planning and implementing guidelines for vending items that meet a nutrition criterion,[4] (2) developing a partnership with vendors that supply healthy snacks and beverages, and (3) promoting healthy vending via signage and nutritional labeling.

Implementation tips from Choose Health LA include:[5]

- Only products that meet nutritional standards should be advertised on vending machines.
- The health clinic should prominently display signage that identifies the healthy items within vending machines.
- Check nutritional labels as a habit before stocking, as similar snacks can vary greatly in content.
- Ensure clinic employees understand the nutrition changes; hold a meeting or distribute a newsletter or memo.

Additional Resources

Nemours Health and Prevention Services: Healthy Vending Guide
http://www.nemours.org/content/dam/nemours/www/filebox/service/preventive/nhps/resource/healthyvending.pdf
This guide offers sample vending setups and policy examples.

National Automatic Merchandizing Association: Nutrition and Wellness Center
http://fitpick.org/
This website provides simple program guidelines to make it easier to determine if a food item qualifies or not.

CDC: Healthier Vending Machine Initiatives in State Facilities
https://www.cdc.gov/obesity/stateprograms/pdf/healthy_vending_machine_initiatives_in_state_facilities.pdf
This document for state facilities contains many resources for healthy vending standards as well as state-level toolkits and guides (towards the end of the document).

References:

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3. Gorton D, Carter J, Cvjetan B, Ni Mhurchu C. Healthier vending machines in workplaces: both possible and effective. N Z Med. J. 2010;123(1311):43-52.

4. Centers for Disease Control and Prevention. Smart Food Choices: How to Implement Food Service Guidelines in Public Facilities. https://www.cdc.gov/obesity/downloads/strategies/Smart-Food-Choices-508.pdf. Accessed November 1, 2021.

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8. Improve Free Water Access, Taste Quality, Smell, or Temperature

Explanation of Strategy

This strategy includes increasing access to safe drinking water and providing water as an alternative to high calorie, sugar-sweetened beverages (SSBs) that are associated with chronic disease.

Why Implement this Strategy

While SSBs, such as sodas and juices, can be quick, easy, and appealing options, consumption can lead to overweight, obesity, and associated chronic diseases[1] among both children and teens,[2] and especially among those from households on a low-income.[3] Disparities exist in the United States based on race and income related to the availability of safe drinking water which is also associated with disparities in water consumption.[4,5] Clinics have an opportunity to encourage and provide safe drinking water to a community that may not have access. Access to safe drinking water may especially be a critical issue for rural, low-income communities that often get water from small community systems or wells that are not regulated by the Environmental Protection Agency (EPA).[6]

Young children are particularly at risk of the effects of contaminants in unregulated water from:[6, 7]

- nitrates and lead
- chemicals and minerals that occur naturally, such as arsenic or other heavy metals
- viruses, bacteria, and parasites
- pesticides
- sewer overflow and failing septic systems

In addition to increasing access, clinics can promote the importance of drinking water for health during patient appointments and within the clinic's physical environment (e.g., posters on exam room walls or pamphlets on tables in the waiting room), which can be more effective than excluding SSBs or restricting community members' choices of beverages.[2] In fact, Patel and Schmidt note: *"The early experience of programs, primarily in schools, shows that water supply clean-up efforts must be coupled with ready access to appealing water sources and promotional campaigns to successfully increase water intake, reduce SSB consumption, and stabilize weight gain."* (pg. 1356)[8]

Possible Implementation Steps

An overall approach to develop and implement a water access plan involves four steps:[9]

1) Conduct a needs assessment

2) Develop a water access plan

3) Implement the plan

4) Evaluate water plan progress

The Centers for Disease Control and Prevention published several recommendations for planning and implementing a water access plan that can be used within clinics. These recommendations include assessment of policies, practices, stakeholder perceptions, and the community water environment; identification of key water champions; choosing a water delivery method; and the development of promotion strategies.[6]

Additional Resources

Water First: A Toolkit for Promoting Water Intake in Community Settings
https://docs.wixstatic.com/ugd/ee8930_56239d118cca42db897c2564e3ab1d94.pdf
This toolkit includes evidenced-based strategies for promoting water, including strategy suggestions specifically for health clinics.

Is My Water Safe? A Guide to Finding Out What is in Your Water and How to Protect Yourself From Unsafe Water
http://d3n8a8pro7vhmx.cloudfront.net/communitywatercenter/pages/51/attachments/original/1394382743/CWC_Is-my-water-safe_English.pdf?1394382743
This guide is helpful for determining the safety of the available drinking water and how to address water quality concerns.
The following resources from other settings can be adapted for health clinics:

CDC Increasing Access to Drinking Water in Schools
https://www.cdc.gov/healthyschools/npao/pdf/water_access_in_schools_508.pdf
This toolkit includes three sections: key steps schools can take to meet federal requirements and make drinking water more available and accessible; a School Drinking Water Needs Assessment Checklist and Planning Guide; and resources.

CDC Increasing Access to Drinking Water and Other Healthier Beverages in Early Care and Education Settings
https://www.cdc.gov/obesity/downloads/early-childhood-drinking-water-toolkit-final-508reduced.pdf
This toolkit explains the importance of providing safe water to children and offers guidance on how to do it. It also describes how providing water fits in with serving other beverages and provides sample action plans for reaching healthier beverage goals.

CDC Drinking Water FAQ

http://www.cdc.gov/healthywater/drinking/public/drinking-water-faq.html#health.

Responses to commonly asked questions related to general water systems and well water systems.

Keep It Flowing: A Practical Guide to School Drining Water Planning, Maintenance & Repair.

Information from the Keep It Flowing guide on adequate access to safe drinking water at schools might be transferable to other settings, including those reliant on bottled water instead of water fountains:

https://cdn1.sph.harvard.edu/wp-content/uploads/sites/84/2014/09/Keep-It-Flowing.pdf

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2. Barnhill A. Impact and ethics of excluding sweetened beverages from the SNAP program. Am J Public Health. 2011;101(11): 2037-2043. doi: 10.2105/AJPH.2011.300225.

3. Brady A. SNAP-Ed Implementation Evaluation: A Study of Health and Nutrition Education in Low-Income Minnesota Communities. University of Minnesota Extension, Center for Family Development (report). http://hdl.handle.net/11299/192421. Accessed November 1,2021.

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6. Centers for Disease Control and Prevention. Healthy Housing Reference Manual. https://www.cdc.gov/nceh/publications/books/housing/housing_ref_manual_2012.pdf. Accessed March 1, 2022.

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9. Centers for Disease Control and Prevention. Increasing Access to Drinking Water in Schools.https://www.cdc.gov/healthyschools/npao/pdf/water_access_in_schools_508.pdf. Accessed November 1, 2021.

9. Expand or Improve Transportation Options to the Health Clinic

Explanation of Strategy

This strategy aims to ensure that patients without a reliable source of transportation have a safe way to reach the health clinic and return home. This could include working with public or private transportation systems.

Why Implement this Strategy

Access to health care has a significant effect on every aspect of a person's health, yet transportation barriers prevent basic access to care. Almost one in four Americans do not have access to a primary care provider or health clinic where they can receive routine medical services.[1]

While some households with a low-income in suburban or urban areas do not have a vehicle, or share one among multiple family members, households in rural areas are often faced with additional transportation challenges.[2] These difficulties often lead to rescheduled or missed appointments, delayed care, and missed or delayed medication use, which can result in poorer management of chronic illnesses and health outcomes.[3]

Studies have shown there are multiple benefits to providing public transportation to a clinic.[2,3] With increased access to care, patients are more likely to receive preventative or routine services. Patients are also less likely to miss their appointments and misuse Emergency Medical Services (EMS).[2,3]

Limited transportation is a barrier for accessing healthy foods in low-income communities.[4] Implementing the other strategies in this toolkit while at the same time ensuring patients have transportation to and from the clinic can help address healthy food access issues.

Possible Implementation Steps

The CDC recommends that clinics and other health entities try to grow public transportation efforts via policy development. These policies may focus on:[5]

- Increasing funding for the expansion of public transportation by focusing on the positive impacts of public transportation itself.
- Implementing model transportation planning policies that encourage transit-oriented developments and other mixed-use development, increasing connectivity among neighborhoods and communities.

Sometimes a third party option is the most helpful, especially for an established clinic that is set in its ways. This option involves working with local agencies and non-governmental organizations to establish a policy that would promote bicycling and walking to nearby public transportation stations by making these connecting trips easier, faster, and safer.[6] Such a policy could do this by:[5]

- Providing bicycle storage at public transportation stations.
- Addressing safety hazards and integrating enhancement for pedestrians and bicyclists, such as well-lighted crosswalks and signal timing.
- Removing barriers to pedestrians and bicyclists on roads and intersections near public transportation stations and bus stops.
- Enhancing the public transportation system to accommodate bicyclists and pedestrians.

In places where these options are not available for patients or limited due to distance, other models to increase access to transportation have been developed and adopted in some areas. Some of these include rideshare, volunteer, voucher, and coordinated-services models. Community Health Workers (CHW) – *"lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve"* – are a stakeholder group to explore partnering with, as they have been reported to help patients with transportation, either by providing or arranging it for the patients they work with.[6,7]

Additional Resources

Rural Health Information Hub: Rural Transportation Toolkit
https://www.ruralhealthinfo.org/toolkits/transportation
This toolkit compiles promising models and resources to support organizations implementing transportation programs in rural communities. The modules are focused on developing, implementing, evaluating, and sustaining rural transportation programs.

Rural Health Information Hub: Rural Services Integration Toolkit, Community Health Workers Model
https://www.ruralhealthinfo.org/toolkits/services-integration/2/care-coordination/community-health-workers
This site explains the role of rural Community Health Workers. A toolkit and model programs are provided that touch on the role of Community Health Workers in increasing access to transportation for patients.

Promising Practices for Increasing Access to Transportation in Rural Communities
http://www.norc.org/PDFs/Walsh%20Center/Rural%20Evaluation%20Briefs/Rural%20Evaluation%20Brief_April2018.pdf
This publication outlines models to strengthen rural transportation options, with a discussion on how to sustain and evaluate the strategies.

Rural Health Information Hub: Transportation to Support Rural Healthcare
https://www.ruralhealthinfo.org/topics/transportation
This website provides resources for transportation to support rural healthcare, including information specific to the elderly and those living with disabilities.

CDC's Recommendations for Improving Health through Transportation Policy
https://www.cdc.gov/transportation/docs/final-cdc-transportation-recommendations-4-28-2010.pdf.
This document provides considerations and recommendations on how public transportation can contribute to public health.

Health Outreach Partners (HOP) Transportation Initiative
https://outreach-partners.org/about-hop/transportation-initiative/
This link connects to multiple reports and toolkits on "the impact of transportation barriers on healthcare costs and promoted patient-centered transportation solutions through data gathering tools and effective collaborations." Other resources include: Rides to Wellness Community Scan; Transportation and Health Access: A Quality Improvement Toolkit; Overcoming Obstacles to Health Care: Transportation Models that Work; and Transportation and Health Access: Where Are We and Where Do We Go?

References:

1. HealthyPeople2020. Access to Health Services. https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services. Accessed November 1, 2021.

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10. Establish Worksite Wellness Policies and Opportunities for Health Clinic Employees

****Note on SNAP-Ed rules related to this strategy*

In order for SNAP-Ed employees to be able to provide technical assistance to health clinics on worksite wellness strategies, Human Resources (HR) will have to confirm that this criterion is met:

(found on pg. 53 of the SNAP-Ed Plan Guidance at https://snaped.fns.usda.gov/sites/default/files/documents/FY2023_SNAPEd_PlanGuidance_FV.pdf

- To deliver worksite wellness programs, SNAP-Ed providers can work with HR employees to ensure that 50 percent of the employees at the worksite are at or below 185 percent FPL.
- The Bureau of Labor Statistics maintains a website with mean and median wages for different occupations at http://www.bls.gov/oes/current/oes_nat.htm. States can use this website to identify which types of occupations would most likely fulfill SNAP-Ed eligibility requirements.
- One State used data from the American Community Survey and Bureau of Labor Statistics to determine an hourly wage that would equate to no more than 185 percent FPL for an average SNAP household with at least one member who earns income.
- More than half of workers must earn annual wages comparable to 185% of the FPL for the State to qualify for SNAP-Ed programming.
- Worksites would be required to complete a form verifying the site's eligibility using this method. States may also choose to identify a minimum number of employees per worksite to justify the time, effort, and cost necessary to implement a multi-component worksite wellness program.

Explanation of Strategy

This strategy focuses on encouraging healthy behaviors in the workplace such as healthy eating and physical activity. The purpose of this strategy is to support employees in developing or maintaining healthy behaviors each day in the workplace that they then continue at home. This can start with simple approaches such as offering healthier snacks at workplace meetings or placing flyers by the elevators encouraging employees to take the stairs.

Why Implement this Strategy

According to the CDC, full-time American workers spend an average of 1/3 of their day, five days a week at work.[1] Thus, integrating wellness into the everyday life of an employee has the potential to change unhealthy behaviors such as poor nutrition and physical inactivity.

Worksite wellness strategies for employees have been shown to increase healthy eating, daily physical activity, quality of life, and workplace productivity and decrease health care costs for the employer.[2]

Possible Implementation Steps

The Guide to Community Preventive Services offers several different strategies for incorporating wellness into the worksite:[3]

- *Informational and educational strategies to increase knowledge about a healthy diet, such as lectures, written materials (electronic or print), or educational software.*
- *Behavioral and social strategies to support positive beliefs and social factors, such as counseling, skill-building, rewards, or reinforcement, and building support systems.*
- *Environmental approaches that make healthy choices easier and target the entire workforce by changing physical or organizational structures. They may include improving access to healthy foods and providing opportunities to be more physically active at work.*
- *Policy strategies may change rules and procedures for employees such as health insurance benefits or cash incentives for health club membership.*

It is important to get both employee and management buy-in of a worksite wellness program in order to develop a workplace culture that promotes health and wellness.[4]

AmeriHealth provides how-to steps on implementing a worksite wellness program, which include the following:[5]

1) *Conduct an organizational assessment*
2) *Obtain management support*
3) *Establish a wellness committee*
4) *Obtain employee input*
5) *Obtain external support*
6) *Develop goals and objectives*
7) *Design and implement programs*
8) *Select incentives*
9) *Evaluate outcomes*

More information on each of these steps can be found at: https://www.amerihealth.com/worksite_wellness/how_to_implement/index.html.

Additional Resources

CDC Current Practices in Worksite Wellness Initiatives
https://www.cdc.gov/nccdphp/dnpao/state-local-programs/pdf/current-practices-worksite-wellness.pdf
Some examples of worksite wellness initiatives across the country.

Creating an Effective Wellness Strategy: Plan Sponsor Wellness Guide
https://silo.tips/download/creating-an-effective-wellness-strategy
Aetna's step-by-step guide for developing a worksite wellness plan.

Champions for Change Worksite Program Success Stories: Creating a Culture of Wellness in the Worksite Environment
https://snaped.fns.usda.gov/sites/default/files/resourcefinder/Worksite%20Success%20Stories.pdf
A collection of 14 success stories across California on creating a culture of wellness in the worksite.

WellSteps: 50 Employee Wellness Examples for any Budget
https://www.wellsteps.com/blog/2018/01/09/employee-wellness-program-examples-budget/
This article focuses on nutrition and physical activity examples.

References:

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11. Provide An Opportunity for Health Clinic Employees to Participate in a State or Local Food Policy Council

Explanation of Strategy

A food policy council (FPC) works to establish and maintain relationships among diverse organizations and community members to strategically shift the food system to one that is sustainable, supportive of the community, and betters the nutrition of residents.[1] By working across sectors and with many different stakeholders, councils attempt to establish platforms for coordinated action at the local or state level, often around policy barriers or prevalent health issues. FPCs across the country often include members from the health care sector, such as doctors, nurses and support employees from hospitals, health clinics, and local health departments, because they share a common goal of decreasing nutrition-related chronic disease prevalence within the community.

Why Implement this Strategy

By engaging with a FPC, clinics can actively work towards establishing policies that improve the food environment, in collaboration with others including patients experiencing food insecurity. FPCs can be an effective way of addressing specific food systems and health issues on a local or state level. Participation could also help foster partnerships for implementing many of the other strategies covered in this toolkit, such as identifying local farmers to set-up at the clinic, municipal planners to provide expertise in transportation systems, or grant makers interested in funding produce prescription coupons for patients.

Possible Implementation Steps

For clinic employees to participate in a FPC, the first step is to identify which ones currently exist. This interactive map provides a list of FPCs nationwide: https://www.foodpolicynetworks.org/councils/fpc-map/

To make participating in a FPC mutually beneficial for the other members of the council and the clinic, employees should determine what they want to get out of it as well as what expertise or other resource(s) they are able to contribute before joining.

Below are some examples of the most common themes identified among health care institutions participating in FPCs:[2]

- *Support of farmers' markets and nutrition incentive programs;*
- *Enrollment of food pantry clients in the Patient Protection and Affordable Care Act;*
- *Support of health clinic-based fruit and vegetable prescription programs;*

- *Discounts from health insurers for healthy diets; and*
- *Hospital investments in healthy food infrastructure.*

If a FPC does not exist where the clinic is located, Scott et al. (2012) published a guide for creating a FPC that a clinic could use in spearheading or encouraging another entity to start one, including steps for:[3]

- *Determining target audience, engaging diverse stakeholders and conducting sustained outreach throughout planning and implementation;*
- *Forming a steering committee and recruiting volunteers to guide the committee;*
- *Initial steps, including recommendations for holding open meetings with stakeholders, community, and local government; and*
- *Initial activities, including networking opportunities and conducting a Community Food Assessment.*

The full guide can be found here: https://s30428.pcdn.co/wp-content/uploads/sites/2/2019/09/Getting_Started-Food_Policy_Council_Toolkit.pdf.

Additionally, hospitals are becoming a more common partner in FPC development and activities[4] – entities that clinics might have stronger relationships with than other stakeholders in a community – and might be well resourced and positioned to help initiate the creation of one. Clinics could work with hospital contacts or partners to educate them about FPCs, their importance, and specific ways hospitals could contribute to and gain from helping form one. A couple of examples include:

- *Hospitals providing funding, such as through community benefit resources, or in-kind assistance to FPCs for completing community food assessments, or*
- *Hospitals gaining support from FPC members in completing required hospital administered Community Health Needs Assessments.*[2]

Additional Resources

Drafting a Resolution to Create a Food Policy Council
https://www.publichealthlawcenter.org/sites/default/files/resources/Drafting%20a%20Resolution%20to%20Create%20a%20Food%20Council.pdf
This comprehensive guide is for local governments to create a food policy council. It includes how to draft a resolution, a sample resolution, who should be a member, sample member job descriptions, and examples of existing resolutions. Although the audience is local governments, the information and examples can be helpful for any entity.

Johns Hopkins Center for a Livable Future Food Policy Networks
http://www.foodpolicynetworks.org/about/
This website provides comprehensive information on food policy councils, including a directory and map, resource database, research, and a place to sign up for their listserv.

Doing Food Policy Councils Right: A Guide to Development and Action
https://www.markwinne.com/wp-content/uploads/2012/09/FPC-manual.pdf
This guide provides information on food policy councils starting with why to start one and ending with lessons learned.

USDA: The Economics of Local Food Systems
https://assets.jhsph.edu/clf/mod_clfResource/doc/amstoolkit.pdf
USDA has developed a toolkit about local food systems and policies.

Food First Food Policy Councils: Lessons Learned
https://foodfirst.org/wp-content/uploads/2014/01/DR21-Food-Policy-Councils-Lessons-Learned-.pdf
A report on the experiences of a wide-range of food policy councils, including their functions and structures, first steps, successes and challenges.

References:

1. ChangeLab Solutions. Policies for Produce: Opportunities for Food Policy and Obesity Prevention Advocates to Work Together. http://www.changelabsolutions.org/sites/default/files/Food-Policy-Convening-Report_FINAL_20150520.pdf. Accessed September 29, 2021.

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4. O'hara JK, Palmer A. Health Care Sector Support for Healthy Food Initiatives. https://aese.psu.edu/nercrd/publications/what-works-2014-proceedings/health-care-sector-support-for-healthy-food-initiatives-1. Accessed September 29, 2021.

12. Provide an Opportunity for Health Clinic Employees to Participate in a Community Coalition for Addressing Obesity

Explanation of Strategy

Community coalitions can be a group of people working together to achieve a shared public health goal (e.g., addressing obesity) through the coordinated use of resources, leadership, and action.[1]

People on a community coalition can be from:

- *public organizations (e.g., schools, health clinics, libraries, etc.)*
- *private-sector organizations (e.g., a small business interested in helping the community, etc.)*
- *local governments (e.g., city and/or county council, Departments of Education, Departments of Agriculture, and Departments of Health, etc.)*

Why Implement this Strategy

Building partnerships, including formal partnerships, is a critical part of building community coalitions. Partnerships can offer a variety of resources and assistance to achieve a shared public health goal and/or promote and implement healthy eating strategies (e.g., creating a community garden, having a farmers' market at the health clinic). Types of resources and assistance provided by formal partners can include:

- *participant referrals,*
- *providing meeting space, child care, and transportation,*
- *providing food demonstration supplies, and offering equipment and cash for supplementary resources.*[2]

Collaborative and diverse community coalitions, including formal partnerships, can be more effective than the efforts of individuals, or even individual groups, because they:

are composed of partners representing multiple sectors,

reduce duplication of effort, and

use various resources to accomplish a common goal.[3]

Possible Implementation Steps

To participate in a coalition for obesity prevention, a clinic first has to identify active coalitions in their area. A national database for this does not currently exist, however, SNAP-Ed implementers should be able to help make these connections, as SNAP-Ed implementers

are often already plugged into local, regional, and state-level obesity prevention coalitions. SNAP-Ed implementers can then help a clinic think through what they want to gain from participating and what they are able to contribute. Ideally, gains and contributions from participating in a community coalition should align with the planning, implementation, and sustainability of other strategies in this toolkit.

Additional Resources

The CDC's Healthy Communities Program Sustainability Guide for Building Community

https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/pdf/sustainability_guide.pdf

A comprehensive guide on sustaining coalitions and the efforts of the coalition, including a section dedicated to sustaining implemented PSE strategies.

Community Tool Box

https://ctb.ku.edu/en/table-of-contents/assessment/promotion-strategies/start-a-coaltion/main

This link provides guidance on when and how to start a community coalition.

https://ctb.ku.edu/en/table-of-contents/assessment/promotion-strategies/maintain-a-coalition/main

This link provides guidance on how to maintain a coalition.

References:

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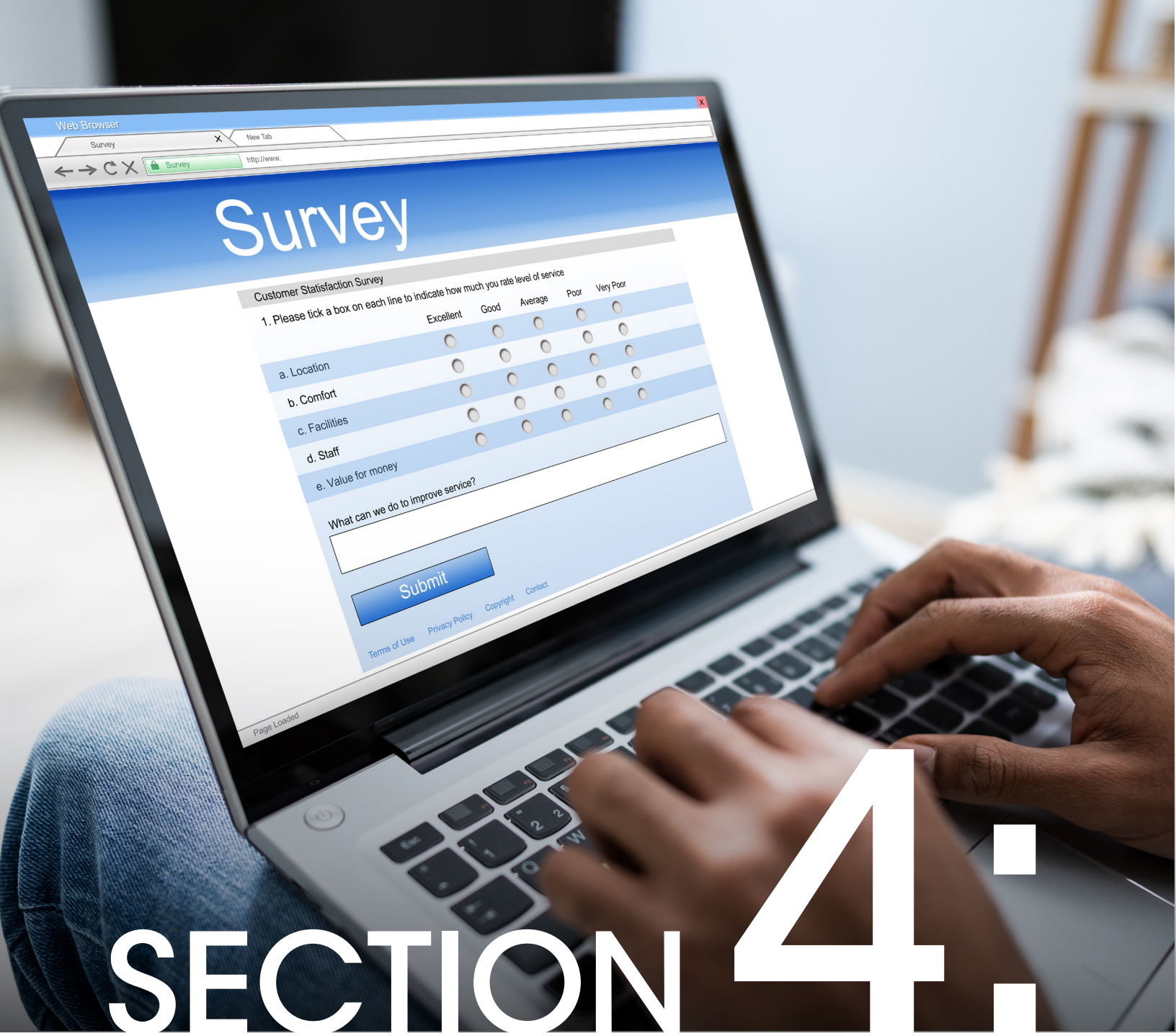

SECTION 4:

Evaluation

Explanation of Evaluation

After selecting one or more of the strategies to implement at your health clinic, it is important to have an evaluation plan. This includes thinking about how you are going to tell your story and sharing both successes and lessons learned with the community and other stakeholders. Sharing your story has many benefits; it can help other clinics learn how to start something similar, and for understanding the effectiveness of implementation when applying for future funding.

There are four main types of evaluation as defined by the SNAP-Ed program.[1]

- *Formative*
- *Process*
- *Outcome*
- *Impact*

Refer to Table 1 for definitions of each type along with corresponding examples and data collection methods for some of the PSE strategies.

Possible Implementation Steps

Planning how to capture your story should be considered when you select a strategy to implement rather than after the strategy has been implemented. When you choose your strategy, also create a plan for assessing the impact. For example, one way to evaluate your strategy is to determine how many people you reached. Nutrition education should be incorporated into each strategy and, therefore, also part of determining reach.

Refer to Table 2 for examples of collecting reach for each strategy.

Table 1: Types of Evaluation

TYPE OF EVALUATION	DEFINITION	EXAMPLE	DATA COLLECTION METHODS
Formative	Usually occurs up front and provides information that is used during the development of an intervention.	Survey target audience to determine the best location or type of fruits and vegetables to plant in the garden	Surveys Focus groups Participatory approaches (e.g., human-centered design)
Process	Systematically describes how an intervention looks in operation or actual practice.	Interview with health clinic staff on how food insecurity screenings and referrals are going	Qualitative interviews Participatory approaches (e.g., journey mapping) Surveys
Outcome	Addresses the question of whether anticipated group changes or differences occur in conjunction with an intervention.	Number of food insecurity screenings and referrals completed at a health clinic	Focus groups Medical records
Impact	Allows one to conclude authoritatively, whether the observed outcomes are a result of the intervention. In order to draw cause and effect conclusions, impact evaluations incorporate research methods that eliminate alternative explanations.	Randomized control trial assigning patients to a produce prescription program or control group	Pre/post intervention survey Biomarkers, including blood pressure, A1C, weight, etc.

Adapted from the FY 2023 USDA SNAP-Ed Plan Guidance document available at https://snaped.fns.usda.gov/sites/default/files/documents/FY%202022%20SNAP-Ed%20Plan%20Guidance.pdf.

Table 2: Evaluation Examples by Strategy

STRATEGY	EXAMPLE MEASURE OF REACH
Host a farmers' market	Number of people who attend each market day; Number of people who purchase foods using SNAP, WIC, or Senior Farmers Market Nutrition Program coupons/vouchers
Establish a produce garden	Number of beds and/or how much produce is grown; Number of people in the priority population(s) with whom produce from the garden is shared
Screen patients for food insecurity and make referrals to community or on-site resources for nutrition	Number of patients screened and number of patients referred (could be managed through electronic medical records)
Provide prescriptions for fruits and vegetables	Number of patients given a prescription; Number of patients who "fill" their prescription
Start a food pantry focused on wellness and nutrition	Number of patients who access the pantry
Offer healthy food and beverage options in vending machines	Quantity of each item sold
Improve free water access, taste, quality, smell, or temperature	Amount of water provided; Number of people accessing water
Expand or improve transportation options to the health clinic	Estimated number of people in the priority population(s) who have increased access to or benefit from the community design and safety policy or intervention
Establish worksite wellness policies and opportunities for health clinic employees	Number of employees reached by policy
Provide an opportunity for health clinic employees to participate in a state or local food policy council	Number of employees who participate and the number of community members living on a low-income reached through the efforts of the council
Provide an opportunity for health clinic employees to participate in a community coalition for addressing obesity	Number of employees who participate and the number of community members living on a low-income reached through the efforts of the coalition

More Than Numbers: Why it is Important to Conduct an Evaluation

In addition to tracking numbers, create a way to assess the process at your clinic by interviewing key informants, which can include employees, patients, and/or community partners. Ask key informants questions to better understand their perspective about how things are going (process) and what changes were made (outcome). Create a list of questions before implementation and a plan for when you will interview employees. It can be as formal or informal as you would like, but the questions should be designed to capture what is going well and what could be improved. Ask if they have ideas about making changes or adaptations to the strategy. For employees in particular, this will ensure they are invested in the strategy and they are also likely to have insightful recommendations if they are on the front lines of implementation. For patients, this could help increase buy-in and participation. Take notes or record the interviews to keep track. Depending on the strategy, take pictures, too (with consent, when applicable). Referring to your notes and pictures will be helpful if you plan to do something similar in the future or want to share feedback with another clinic who is interested in implementing the strategy.

Sharing Your Story

While capturing your story is helpful to determine how much of an impact was made, making sure to share the story is just as important. Gather all the information you collected about implementing the strategy (process, reach, photos, and any quotes from employees or patients) and put it together in an easy-to-read story that can be shared as a handout or even on social media. You can have different versions available and tailor it to the audience. For example, you can create a one-page flyer for a quick eye-catching synopsis to draw interest. Text could consist of a brief background statement, a breakdown of each strategy implemented with the challenge and results, lessons learned, and next steps. Include icons as appropriate, bold and enlarge key findings or numbers, and include your contact information.

Sharing your story will be helpful for other clinics and may also appeal to funders. A template and example are provided on the next two pages.

While the one-page handout can draw interest, to share your story more in-depth, consider writing a case study that outlines and explains how the strategies were planned, implemented, and measured. Refer to the case studies section of the toolkit on page XX to see some examples and learn from other clinics.

References:

[1.] United States Department of Agriculture. SNAP-Ed Evaluation Framework. https://snapedtoolkit.org/framework/index/. Accessed March 26, 2021.

Template for Sharing Your Story

The Example Clinic

The Example Clinic

We offer compassionate, quality care for communities in and around Cityville, SC.

Background

Our clinic has experienced an increase in patients that have made comments about having trouble accessing food for their household. We decided to partner with SNAP-Ed to address these issues.

> It's been getting harder and harder to find quality foods for a good price for my family. It's really a struggle. - Patient

Challenge	Strategy	Results
Knowing which patients are experiencing issues in feeding their households.	Including household food security screening into standard of care for every patient.	275 patients screened for food insecurity.
Patients that experience food insecurity having limited access to healthy food.	Veggie Rx. Patients experiencing food insecurity are given a voucher for a free produce box in partnership with a local program.	56 patients given Rx voucher for free produce box.

Lessons learned and next steps

One lesson we learned for the Veggie Rx strategy is to have consistent communication with the produce box program so that we know whether vouchers have been redeemed.

Our clinic is planning to attend a local community food access coalition to spread the word about our new food security screenings and Veggie Rx protocols.

For more information visit exampleclinic1.com or visit us on Facebook

Additional Resources

CDC Criteria for Identifying Organizations that Can Support a Community-Clinical Linkage

https://www.cdc.gov/dhdsp/pubs/docs/ccl-practitioners-guide.pdf

This resource includes a chapter that provides a more in-depth guide to evaluating community-clinical linkages.

CDC Approach to Evaluation

https://www.cdc.gov/eval/approach/index.htm

For a comprehensive resource on evaluation, the CDC has many resources including frameworks, logic models, guidelines, recommendations and more.

Produce Prescription Evaluation Resources

https://www.nutritionincentivehub.org/resources/searchable-resource-library

The GusNIP Training, Technical Assistance, Evaluation, and Information Center (NTAE) Center developed the Nutrition Incentive Hub, a coalition of partners and thought leaders that provide industry insight, operations guidance, and technical assistance to nutrition incentive and produce prescription projects. The website is a great resource for implementation guidance as well as recommendations for evaluation metrics and indicators.

SNAP-Ed Evaluation Framework and Interpretive Guide

https://snaped.fns.usda.gov/program-administration/snap-ed-evaluation-framework

The USDA SNAP-Ed Evaluation Framework and Interpretive Guide provides details, background, research, and measurement instructions for 51 indicators, including the strategies listed in this toolkit.

The Community Guide Tools

https://www.thecommunityguide.org/tools

The Community Guide is a collection of evidence-based findings of the Community Preventive Services Task Force (CPSTF). The website includes a tools section with links to evaluation frameworks and guidelines.

SECTION 5:

Case Studies of Health Clinics that Implemented Healthy Eating, Active Living Strategies

The following case studies represent success stories from across the country. Most summaries were written by those closest to the story and, therefore, are uniquely structured.

The Lana'i Community Health Center

Since 2008, Dr. Diana Shaw, Executive Director of a federally qualified health center (FQHC) in Lana'i City, Hawaii, has been committed to providing care for the Lana'i community. The Lana'i Community Health Center's (LCHC) mission is to provide physical, mental, emotional, intellectual, and spiritual welfare by enriching and empowering lives to help build healthy families in a supportive environment. Lana'i is a community of 3,100 people, where about half of the island's population lives below the federal poverty level. The employees provide primary medical and dental care, behavioral health services, prenatal, family planning, nutritional, and preventive health education services focusing on uninsured and underserved residents.

Strategies

Produce gardens

Community partners

Social media

❖

"Since we started seeing patients in 2008, we've acquired a really decent knowledge of what works within our community and our patients and what doesn't. Clearly, becoming really engaged with the patient is critically important. The effect that a health care provider can have on a patient is minimal if they rely totally on what they do in the doctor's office." Along with traditional services provided by a health center, Shaw explained LCHC implements healthy eating and active living strategies to prevent, delay, and best manage health conditions like diabetes and heart disease.

LCHC'S HEALTHY EATING STRATEGIES

MEDICINAL GARDEN - The medicinal garden is in the courtyard area of LCHC. It includes daikon radishes, chili peppers, lotus berry plant, bitter melon, and hibiscus, which have healthy properties. A resource booklet is being produced to be distributed at a free seminar about the benefits of these foods. LCHC also creates recipes that feature produce grown in the garden.

VEGETABLE GARDEN - LCHC also includes a vegetable garden. The garden includes mizuna and scallions, along with other produce which are familiar to Japanese, Filipino, and Hawaiian cultures, as these are the major cultures in the Lana'i community. Future plans include establishing a pop-up healthy eating area and cooking classes that emphasize healthy ingredients.

USING SOCIAL MEDIA TO PROMOTE ACCESS AND APPEAL FOR HEALTHY EATING - LCHC uses social media (i.e., Facebook, Twitter, Instagram, and YouTube) to promote healthy eating tips and updates from the garden.

LCHC'S ACTIVE LIVING STRATEGIES

SOCIAL MEDIA TO PROMOTE ACCESS AND APPEAL FOR PHYSICAL ACTIVITY - LCHC uses social media (i.e., Facebook, Twitter, Instagram, and YouTube), as well as the local newspaper to promote their free aerobic classes on site, including kickboxing, yoga, Zumba, and Pilates.

STRATEGIC PARTNERS- Community members that had certifications in fitness classes were hired by LCHC to provide aerobic classes after work hours. For example, a school teacher who was certified in yoga and Zumba was interested in picking up more work after teaching, so LCHC hired her to offer these classes after work hours.

Also, a special education teacher teaches kickboxing at the school, so he was hired at LCHC to provide a weekly kickboxing class. The program has been very popular, especially among men. LCHC is now considering expanding the class to two times per week.

Shaw added, *"We're willing to send people to school to try to get certifications, also. We have a very strong workforce development program for our employees because many of our community members really haven't gone to college, so we do provide the ability for education and certification."*

Native Health's Summer Food Service Program

Strategy

Community partners

❖

"The Summer Feeding Program is such an easy program to administer!" explained Susan Levy, communications coordinator at Native Health, a Federally Qualified Health Center (FQHC). The mission of Native Health is to make health care available for urban American Indians, Alaska Natives, and other individuals who generally experience barriers to holistic, patient-centered, and culturally sensitive health and wellness services.

One of the 39 programs they offer is the Summer Food Service Program (SFSP), which is in its fifth year. The purpose of SFSP, administered by the USDA, is to fill the nutrition gap during the summer months by providing nutritious meals at no cost to children in low-income areas.

Native Health has two main locations in Phoenix, Arizona. One is in the metro Phoenix area where they serve predominately Native Americans, while the second location serves residents living in the suburbs of Phoenix. Both locations serve as summer meal sites.

How does the summer feeding program work?

Native Health receives food daily from their sponsor, St. Mary's Food Bank, also located in Phoenix. Employees from the food bank train employees at Native Health who implement the program. The food bank is reimbursed by the USDA for the food that is purchased and delivered to their sites. Anyone 18 and under is eligible for a free meal, and no identification is required. Levy noted that participants of the summer meal program do not have to be affiliated with the health center.

Levy explained that the volume of meals served is high: *"At one site, we serve 150 meals a day."* Therefore, a streamlined distribution process is required. Every morning a delivery truck from St. Mary's Food Bank arrives at each site and drops off the food, which is packed in a box labeled with the meal it represents (breakfast or lunch). Each meal is also prepackaged, so it can be given out quickly and follow food safety guidelines. The meals, including milk, are placed in a refrigerator that is on loan from the food bank. An employee at the SFSP site is required to log the temperature of the refrigerator twice a day. When a child receives their meal, an employee checks off the meal on a tracking form, which is faxed to the food bank weekly. The children and youth then eat their meal together in a provided area at the site. *"So, it's easy. It's not a hard program to institute. It's simple," Levy said. "I think the only cost to us is, I bought some kids' rugs, kids' tables and chairs, some trash cans, and a broom."*

In an effort to reduce food waste, there is also a *"sharing basket"* at each meal. If a child does not want part of their meal that was unopened, they can put it in the sharing basket for another child to receive. Flyers and posters are used to promote the program in strategic locations, including the transit center, WIC clinics, and schools.

"We know that we have families that come every single day. They count on us," Levy relayed. When school starts back, the program ends until the next summer. However, this past year the USDA supported Native Health in serving dinner year-round. *"We're the only community health center in the country that serves dinner throughout the year, and it has been very successful. We have a phenomenal CEO who is always willing to try things and he said, 'Yes.' And so we went with it and did it."*

A win-win for the health clinic and community

SFSP at the health center works only because it is supported by the community: the CEOs, employees, and administrators of Native Health and St. Mary's Food Bank, as well as US Congresswoman Krysten Sinema, all champion this program. As a result, when the children receive their meals at the meal sites the whole community benefits. Native Health has seen increased foot traffic in the clinics, which has increased their opportunity to share other resources and services the clinic offers, including legal services and Medicaid enrollment. These services also provide respite from the summer heat for families, which the site uses as an opportunity to deliver nutrition education.

As Levy observed, *"The community embraces this as a place to go."*

The Whittier Street Health Center

Strategies

Worksite wellness

Produce garden

Community partners

❖

Roxbury is a diverse neighborhood located in Boston that historically has had leading rates of crime and unemployment. Its residents have a life expectancy of only 59 years- well below the national average of 78.8 years. However, the town's notoriety is giving way to revitalization in many ways, including how health services are being provided. The Whittier Street Health Center is a national model for Patient Centered Medical Homes, including the implementation of innovative healthy eating and active living strategies.

Rachel Dziedzic, registered dietician and health coach, works with the health center's patients, who often have high rates of obesity related chronic diseases, such as diabetes and heart disease. *"So, pretty much every patient has one of those [conditions], unfortunately,"* said Dziedzic. To address these risk factors, the health clinic uses a prescription program, but rather than just focusing on prescription medication, there is a focus on physical activity and nutrition as well. Dziedzic explained that often one of the doctors in the clinic will give the patient *"a prescription for exercise if they feel that it's necessary."* The prescription includes information about their blood pressure and weight, as well as a recommendation for frequency of exercise. Then Dziedzic works with the patients, individually and in groups, to set goals and provide education on topics like nutrition and diabetes.

Sometimes residents of Roxbury do not feel safe exercising in their neighborhood, so the health clinic offers a gym membership on-site for patients and employees for only $10 per month. The gym offers group exercise classes, including yoga and Zumba, which Dziedzic noted is *"really good for motivation."* She added, "*a lot of people have never even exercised before, and they might be in their 50s or 60s, and have never been on a treadmill or never had any form of fitness really besides walking or maybe playing sports as a child."*

To help patients feel more comfortable with exercising in a gym, they also provide a personal trainer. *"We have a trainer here who can give exercise instruction for our patients because that was a major barrier [to] people joining the gym. It was very intimidating because [some of the patients have] never set foot in a gym before, not knowing where to begin, and how to do that safely,"* said Dziedzic. She has observed that those that come to the gym regularly see improvements, including lower cholesterol and blood pressure, and better weight management, *"and that really hits home with a lot of people."*

In addition to Dziedzic helping patients set nutrition goals, she explains the importance of having a community garden at the health clinic: *"There's not a lot of places in the city that there are gardens. Many people are not very well connected with where their food comes from. There are so many corner stores with just processed foods. A lot of kids may never have even seen fruits or vegetables growing, or even tasted a lot of different types of fruits and vegetables."*

In response to this need, the health clinic offers opportunities to join a weekly garden club. During the garden club, patients *"participate in weeding and maintenance of the garden, and then actually get to take stuff from harvest to the home,"* Dziedzic explained. Further, the garden is directly connected to the nutrition classes Dziedzic teaches. *"I will talk about the vegetables, and we'll do cooking demonstrations with some of the produce from the garden so that people can learn what to do with the produce that they're taking home. We may have an education session on high blood pressure and sodium reduction and then tie in how using herbs can be a good way to flavor your food without using salt."* To promote the garden club, produce is also made available in the health clinic's gym.

For children, the health clinic offers a camp in the summer for gardening and learning about fruits and vegetables and the growing process. The clinic uses produce from the garden in recipes for the kids to try. Dziedzic explained the health clinics' motivation: *"Whether it be kids or adults… we have an extremely high depression rate here, and exercise and gardening can be good strategies for stress management."*

In addition to the garden, the health clinic partners with Fair Food, a non-profit food rescue organization that provides surplus goods at low or no cost to those in need. The health clinic sells the produce every other week to both patients and employees. Although the produce may have imperfections, it is *"perfectly suitable"* to eat, and patients can buy a 16 oz. bag full of produce for only two dollars. Dziedzic said this partnership provides *"more access to healthy foods at a lower cost."*

With these healthy eating and active living strategies, the Whittier Health Clinic continues to show their commitment to addressing barriers to forming or maintaining healthy habits and increasing the life expectancy of Roxbury residents.

WHITTIER STREET HEALTH CENTER'S
HEALTHY EATING STRATEGIES

COMMUNITY GARDEN - Each patient has an opportunity to participate in the weekly garden club that focuses on maintenance of the garden, as well as harvesting produce from the garden that patients can take home. There is also an opportunity for children to participate in a summer camp, where they have an opportunity to learn about gardening, work in the garden and try some foods from the garden.

COMMUNITY PARTNERSHIPS - The health clinic partners with Fair Food to sell surplus produce every other week, providing low-cost access to a variety and quantity of healthy foods.

USING SOCIAL MEDIA TO PROMOTE ACCESS AND APPEAL FOR HEALTHY EATING - The health clinic uses social media (i.e., Facebook and Twitter) to promote healthy eating tips, including eating on a budget.

WHITTIER STREET HEALTH CENTER'S
ACTIVE LIVING STRATEGIES

PROVIDING ACCESS TO A GYM ONSITE AT LOW COST - The health clinic has a gym with fitness equipment and a personal trainer to address barriers to physical activity, including a safe and welcoming environment with supportive professionals and offering membership that is affordable for most.

MEDIA TO PROMOTE ACCESS AND APPEAL FOR PHYSICAL ACTIVITY - The health clinic uses social media and local news outlets to promote the health clinic services, including their gym membership.

PROMOTIONAL POSTERS AND FLYERS - Health clinic employees regularly distribute and post promotional posters and flyers of fitness events and gym membership offers.

Hilltown Community Health Center

Strategy

Signing community up for SNAP benefits

❖

Hilltown Community Health Center (HCHC) is a federally qualified health center (FQHC) dedicated to providing care in Hampshire County, Massachusetts. The mission of HCHC is to provide high quality, accessible medical, dental, counseling, and behavioral health care, eye care, and related services to people in an area in rural Western Massachusetts covering multiple towns. The health center also assists community members in applying for SNAP benefits.

Many individuals in the communities served by the clinic do not have access to crucial resources, including public transportation and internet access. To address these common barriers, HCHC employees will pick up clients lacking transportation or assist with signing up for SNAP from their homes. In the process of helping patients apply for SNAP, staff members often hear the difficult financial decisions they have to make when determining which basic needs are most critical.

By helping individuals apply for SNAP, HCHC is helping their local community members manage financial stress. Diane Meehan, Social Services staff and HealthWise Program Director, explained, *"Well, I think often, you know, people will come in and normally we're talking about what's going on in their life and the barriers and challenges that they're facing, and we start talking about their financial stuff, and we do hear people say, 'you know, some months I've got to choose between, you know, paying my electric bill or making sure there's enough food on the table or buying the medicine someone in the family needs and getting enough food.'"* These challenges impact the lives of the individuals and cause a significant amount of stress. Meehan added, *"… having SNAP available to people so that they can, you know, lighten their financial load a little bit and not feel that anxiety every month so they're like 'I have to make a choice between things that are crucial in our life.'"*

Some patients with whom Meehan works do not see the advantage of applying for SNAP benefits because of the small amount they will receive. *"The different stigmas that are still attached to applying for help like this. And whether it's 'I'm only going to get $16, it's not worth the paperwork for me to do it for $16 a month,'"* Meehan went on to say, *"we try to convince them, well, you know, that's four gallons of milk. You know? That might get your milk for the month, and then you have that $16 for gas in your car to get to the store."* HCHC uses real world examples of how receiving SNAP will assist with clients' finances; an approach that can help change the perception of what it means to be receiving SNAP.

Corner Health Center

Strategies

Farmers market
Cooking classes
Food pantry

The Corner Health Center was started in 1981 and is located in an underserved urban community in Ypsilanti, Michigan. The mission of the Corner Health Center is to provide judgment-free, high-quality, affordable health services to young people aged 12 through 25. The Corner offers a full range of health care, mental health, and supportive services for young people as they transition to adulthood. Staff members, including physicians, nurses, psychiatrists, social workers, nutritionists, and health educators, are well-versed in young people's unique needs. They provide services to young people regardless of their insurance status or ability to pay for care. Their goals are to increase access to health care, reduce risk-taking, help clients understand the long-range implications of their health behaviors, and encourage and develop participation in and responsibility for their own health and well-being.

Over the past four years, Corner Health Center's primary health promotion strategy has been using a farmers' market as part of its wellness programs. Given the high prevalence of obesity in the area, the associate director of the health center was passionate about expanding behavioral health services by including cooking classes and the farmers' market program. The health center hosts these wellness programs, in which any community member between 18 and 25 years old can participate. The health clinic is located near a bus stop, which helps make the programs accessible to community members. Program participants usually take a 30-min workshop first, and then walk to the farmers market for activities. The workshops occur weekly and have an average of ten participants each session.

According to staff member Adriana Diaz-Marinelarena, who is also the health coach with the farmers' market program, the biggest challenge is to design activities that can fully engage the participants interactively. To address this challenge, she spent a considerable amount of time researching evidence-based curricula, and incorporated pre- and post-testing, group brainstorming, and games into program activities. There is a *"taste test"* at the end of each class when the health coach asks participants to judge the taste of each item at the farmers' market in order to help participants develop interest in various fruits and vegetables and prevent waste of farmers' market tokens on items they do not like. The health coach provides raffles as an incentive and to keep participants engaged.

In addition to the farmers' market program, the health center also provides a food pantry where patients and clients can come pick up fresh produce and non-perishables. Most of the clients come to the program either after seeing the posters from the health center or by way of referrals made by clinicians.

The Native American Health Center: VeggieRx Program

Strategy

FVRx

For over 40 years, The Native American Health Center (NAHC) has been serving the California Bay Area Native Population and other under-served populations. The health clinic provides comprehensive services including medical, dental, behavioral health, and management of chronic diseases, including diabetes.

In 2013, NAHC was connected to the VeggieRx program, an evidence-based grant funded program that provides cooking demonstrations, weight monitoring, and vouchers that can be used to purchase fresh fruits and vegetables at local farmers' markets.

Jessica Gutierrez, manager of nutrition and fitness programs at NAHC, explained that, *"VeggieRx has been able to continue to get funding year after year because they [have] really good results for weight loss for their participants, including at [follow-up] at six-months. They'll check in with the [participants], and they continue to have lost weight."*

VeggieRx is a behavior change program for low-income individuals who are identified through a screening process by NAHC. Potential participants would benefit from weight-loss and may suffer from high blood pressure and/or diabetes. Then the NAHC staff recruit clients to participate in the program, which entails eight classes over a 16-week period, meeting every other week. Class facilitators encourage participants to engage in discussions about food, nutrition, and cooking.

During their participation, health measures are collected by medical assistants to obtain their Body Mass Index (BMI) and blood pressure, and they also have an opportunity for a 10-15 minute visit with a doctor.

Gutierrez adds that, because the patients are seeing a provider, as a Federally Qualified Health Center (FQHC), they are able to get reimbursed for services provided to the participants. Before the end of the session, each participant also receives a *"prescription"* in the form of vouchers that can only be used to purchase fruits and vegetables at local farmers' markets. *"Each member who is enrolled gets $8 per household member per session, so patients get a significant incentive to show up each week. [If a participant] lives with five people, [they] are getting $40 worth of farmers' market vouchers, and they're usable at any of the Pacific Coast Farmers' Markets,"* Gutierrez said.

For health clinics interested in implementing a program similar to VeggieRx, Gutierrez suggests doing a needs assessment to determine a time participants can attend. She also recommends aligning program schedules with that of the clients: *"The time that they're available, it's crucial. We offered a group in the evening - 5:00 to 7:00 - and we did that to try and accommodate work schedules, and schools, and things like that."* It has also been important to collaborate with the medical staff in the clinic. *"Make sure you have the buy-in from your medical department, so there's support of providing a medical assistant, so working along with them, but from the beginning."* Gutierrez emphasizes conducting a continual program evaluation and explains that *"it's a process for implementing a change into a process and tracking it."* The evaluation process includes collecting the demographic data for patients and comparing their starting weights and ending weights.

The VeggieRx program benefits extend beyond better health for the participants. *"For our providers, they love this because these are a lot of chronic disease patients."* She continued to say that during traditional visits the focus is on *"adjusting medications, or titrating insulin, and kind of nitty-gritty things. And so the providers really like this chance to meet with the patients about lifestyle change and reinforcing good habits, and praising the patient for their weight loss or for the behaviors that they changed."*

Siouxland Community Health Center

Strategy

Healthy vending machines

❖

Both Siouxland Community Health Center (SCHC) locations, in Sioux City, Iowa and a satellite clinic in South Sioux City, Nebraska, are in urban settings. SCHC provides medical, dental, pharmacy, and social services under one roof. As the health center does not have a cafeteria of any sort, the staff has access to vending machines and refrigerators to keep food and drinks cold in their break room. Reliance on vending machines led to an initiative to include healthy items in the machines.

SCHC started implementing healthy vending machines after the district health department completed a Nutrition Environment Measures Study (NEMS) assessment. After the assessment, vending machines received colored labels indicating how healthy the food being dispensed is. Green indicates the choice is healthy, yellow indicates the choice is slightly healthy, and there is a choice of red to indicate the choice is unhealthy but SCHC chose to not label those foods as to not shame employees who wanted it. Along with the change in vending machines the human resources department has used an employee assistance program to create a healthy food culture.

Theresa Krueger, purchasing agent at the center, suggests involving staff in choices regarding healthy vending options. At SCHC the staff initially pushed back on the idea of having someone else control their food choices. Since then the staff has been involved in choosing what goes into the vending machines along with how the machines are displayed. Krueger explained, *"So we created the sign-up sheets. We have two vending areas one on either side of the break room. And so, there's a sheet next to each side and it has worked. There have been a few things that have been stocked off that list. They're not all healthy but some of them are. Some of them aren't."* Involving staff is also important when it comes to the layout of the vending machines. Before Krueger was brought on to work with the healthy vending machines the food was all turned backward so that staff could see the nutrition labels. This was not a popular choice in the eyes of the staff, who could not tell what they were getting without seeing the labels.

The staff has since grown to appreciate the strategy. While there was initial resistance, Krueger conveyed that the transition to healthy vending was ultimately successful because the district health department worked with the vending distributors to change the options. The distribution company owns the machines so they do all the supplying and restocking of the machines twice weekly.

Sonoma Valley Health Center: Roundtable of Partners Develop Diabetes Resource for the Community

Strategies

Community partners

Diabetes management

The Sonoma Valley Health Center (SVHC) serves predominantly rural residents in the Sonoma Valley regions, and their mission is *"to provide accessible, quality health care to those who need it, especially the underserved."* Joyce Giammattei, a diabetes educator and dietician at SVHC, saw that health center patients were in need of available resources and information pertaining to managing diabetes. She recalled when community partners took time to gather for their first roundtable discussion. She remembers thinking, *"Wow- we really don't have a lot here in the community for diabetes."* In response to the need, the health center created a roundtable of community partners.

The Sonoma Valley Health Roundtable consists of area health professionals to improve the community's health, with a particular focus on diabetes. Partners include area hospital systems, SVHC, the City of Sonoma, and non-profits that serve low-income families. In 2012, the Roundtable became a chapter of the Sonoma County Health Action (SCHA), a collaborative group that aims for Sonoma County to be the healthiest county in California.

Giammattei explained that an initial needs assessment was important: *"We did a needs assessment, and sent a survey out to all the doctors asking them, 'how many diabetic patients do you see?' When you get a new diabetic, what do you do with them? Who do you refer them to?' And then we found out that there aren't a whole lot of resources in the Valley."* They found that the survey itself *"raised awareness for the physicians that there needs to be something more to offer diabetic patients."*

As a result of the survey, the roundtable group decided to address the informational gap for diabetes by developing a bilingual client brochure for all the partner agencies, area health organizations, and a senior living facility to disseminate. Giammattei said, *"We developed a brochure in both English and Spanish that had all of the different things that were going on in Sonoma Valley to help people with diabetes."* The brochure includes a list of area health organizations' physicians, dieticians, and fitness centers that could be a resource for individuals who want to prevent or are impacted by diabetes.

YMCA of Metropolitan Washington and DC WIC

Summary

During the COVID-19 Public Health Emergency, Washington, DC WIC clinics looked to expand partnerships with nutrition education providers in the District for virtual, synchronous nutrition education. DC's WIC State Agency and the SNAP-Ed State Implementing Agency approached the YMCA of Metropolitan Washington for this partnership due to their SNAP-Ed program's strong focus on family-based nutrition education.

In December 2020, DC WIC and the YMCA of Metropolitan Washington embarked on this partnership with the aim of leveraging the YMCA's established SNAP-Ed culinary and nutrition education program to provide virtual evidence-based, series education to WIC families across the District. The YMCA is in the second of its five-year SNAP-Ed contract, and anticipates that this partnership will continue to grow each year. This coordination between a community-based organization and a healthcare organization brings more care towards the patient, and in a setting that for some, may be more comfortable to receive health information. Furthermore, it leverages the historic strengths of both parties: social services (the YMCA) and health services (DC WIC).

Since the onset of the COVID-19 pandemic, the YMCA has transitioned to offering virtual programming. The YMCA offers two levels of Simple Cooking with Heart, an evidence-based curriculum created by the American Heart Association which emphasizes increasing the consumption of fruits, vegetables, and whole grains, and aims to decrease consumption of salt, fat, and sugar. While participants are enrolled in the YMCA's SNAP-Ed program they receive two free home-delivered bags of local produce. Upon completion of the program,

participants are eligible to receive free enrollment in the YMCA's Blood Pressure Self-Monitoring and/or three sessions of personalized nutrition counseling.

Since the launch of this partnership, the YMCA has offered a 4-week Simple Cooking with Heart series each month to DC WIC participants. While the sense of community that is traditionally gained during in-person classes has decreased, positive unintended consequences of virtual programming include more mothers of young children being able to participate in cooking classes, as well as participants growing more comfortable in their own kitchens. This resolved two challenges: a consistent nutrition education resource for DC WIC providers to refer to, and a more coordinated system for participants to navigate. Furthermore, the SNAP-Ed classes could serve as an entry to the YMCA's other health programs or social services, such as Blood Pressure Self-Monitoring and the Diabetes Prevention Program, thereby enhancing a participant's continuum of care.

Program Planning

Prior to program implementation, YMCA SNAP-Ed and DC WIC leadership met to assess the needs of the WIC audience, to construct a referral system, and to determine potential class times and dates that have historically worked with the DC WIC audience. It was determined that over the course of April, a YMCA and DC WIC representative would present at each DC WIC clinics' monthly staff meeting to discuss the benefits of the YMCA's Simple Cooking with Heart program and to review the referral process with clinic staff. For the pilot, three classes were scheduled in the months of May, June, and July. Each class would take place on a different day of the week and at a different time to create many opportunities for participation. The classes were scheduled and a registration Google Form was created with an 18-participant cap on each class, with the help of an add-on web extension known as *"FormRanger"*. The Google Form gathered participant name, e-mail address, cell phone number, address (for produce deliveries), home WIC clinic, and class date selection. The use of the FormRanger add-on allows Google Forms to function as a class registration system with strict class size limits. Once a class reached 18 participants, the Google Form registration would close, and participants would be directed to pick another class date.

Program Implementation

At first, it was determined that the DC WIC clinic staff should make referrals directly to participants who they deemed ready to participate in such a lengthy program. The intent was to screen for readiness to ensure the highest possible amount of participation and engagement in classes. It was agreed that once a WIC staff member identified a participant who was ready to engage in a 4-week program, they would either fill out the Google Form together at that moment, or the Google Form would be given directly to the participant so they could fill it out themselves. After approximately one month of referrals coming in slower than anticipated, DC WIC and YMCA agreed the next best course of action was to send a text blast to all DC WIC participants in the District with more information about the series and the link to the Google Form. The text blast was sent out at 10:00am on May 4th, and within 7 minutes, all 54 slots were filled, and a waitlist began to rapidly accumulate.

Once participants registered through Google Form, they were e-mailed a confirmation of their registration and a welcome letter. The week before class, the course instructor called each participant to confirm attendance. Most participants that the YMCA staff spoke with on the phone confirmed that they would attend and expressed excitement at the opportunity to participate.

Lessons Learned and Next Steps

The lower-than-average attendance rates led YMCA to conclude that in future iterations, we should revert to the proposed process of individually screening WIC participants for readiness through on-site referrals made by clinic staff, as opposed to sending out a text blast with the registration link. We feel that if participation is perceived as more personalized, there will be fewer no-shows. We will continue to register participants through a Google Form as this platform is well-known and easy to use for participants, and we will continue to have the instructor reach out to participants personally, with at least one contact occurring over the phone, to increase attendance. However, moving forward, WIC clinics will be encouraged to explain the demands, duration, and benefits of the Simple Cooking with Heart program in person to WIC participants while they are on site, and to assist with the Google Form registration process if a participant is willing and able to commit to a four-week series. Additionally, there was high demand for Spanish classes, and so the next iteration will include courses in Spanish with a Spanish Google Form.

There is value in health organizations connecting with WIC and/or SNAP-Education providers. Such partnerships can connect individuals to additional resources, knowledge, and support, therefore further continuing their care outside of the clinic's four walls. Partnering with local WIC clinics is a sustainable way for institutions implementing SNAP-Ed to increase services provided to local families.

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Clinical-Community Linkages—Maine SNAP-Ed Connects Food Insecure Patients to Hunger Resources in Maine

Summary

In Maine, SNAP-Ed nutrition educators examine community needs and readiness before selecting a strategy from 11 policy, systems, and environmental (PSE) change initiative categories. The healthcare clinical-community linkages strategy is designed to create, enhance, and support healthcare referral systems and policies to encourage patients to consume more fruits and vegetables and participate in nutrition education classes. Local projects are supported at the sector level through partnerships with hospital systems and a statewide food bank. Clinical supports were successfully adopted in the state in FY 2018, increasing from 2 in the first year to 14 in FY 2020, reaching a total of 10,593 Mainers.

Challenge

Maine has the highest rate of food insecurity in New England and one of the highest rates in the United States. A person or family is considered food insecure if they do not have regular access to nutritious food because of limited funds to buy groceries. In Maine, 16.4% of households are food insecure. This means more than 200,000 Mainers, including 1 in 5 children, are impacted by hunger. Food insecure Mainers are at higher risk for diseases associated with diet such as diabetes and heart disease.

Solution

Over three years of implementation, Maine SNAP-Ed local community agencies have worked on strategies such as connecting gleaned produce to patients experiencing food insecurity; creating local emergency food resource guides; establishing a community food cupboard at a Federally Qualified Health Center; training clinical staff on nutrition education referrals; and placing posters in patient rooms with QR (*"quick response"*) codes that link to local SNAP-Ed classes. Essential to the clinical-community linkages PSE change work is supporting medical practices to integrate the validated two-item The Hunger Vital Sign ™ food insecurity screening tool into their workflows. The screening tool identifies Mainers at risk for food insecurity and connects them to SNAP-Ed education and other community partners working to alleviate hunger.

Readiness

Local community staff work with partners to use existing data or readiness tools to plan PSE change that will address unmet need.

SPOTLIGHT – RURAL DOWNEAST MAINE HOSPITAL COLLABORATION

Collaborating with the Bucksport Regional Healthcare (BRHC) health educator, a SNAP-Ed nutrition educator created two free *"pick your own"* community vegetable garden beds at BRHC's campus and promoted them using signage, social media, and free produce distribution days. In 2021, the nutrition educator expanded the number of produce distribution days and coordinated with the Downeast Gleaning Initiative to provide more fresh produce to BRHC patients at the distribution events. The SNAP-Ed nutrition educator also provided recipes and education during these events.

SPOTLIGHT – COMMUNITY PARTNERSHIP

BRHC was already engaged in food security work, with connections to the Hancock County Food Security Network and Good Shepherd Food Bank. The garden beds were a long-time dream of the BRHC's Health Educator, and the nutrition educator had the skills to make it happen. Nutrition educators across the state report how crucial an on-site champion is to establish clinical-community supports – highlighting the role SNAP-Ed can play in supporting critical food security systems.

Implementation

Successful strategies involve developing active partnerships, identifying a champion, creating community- and site-specific materials, identifying environmental and systems changes that address agreed-upon need, and then promoting and evaluating PSE outcomes.

SPOTLIGHT – NUTRITION EDUCATION AND PROMOTION

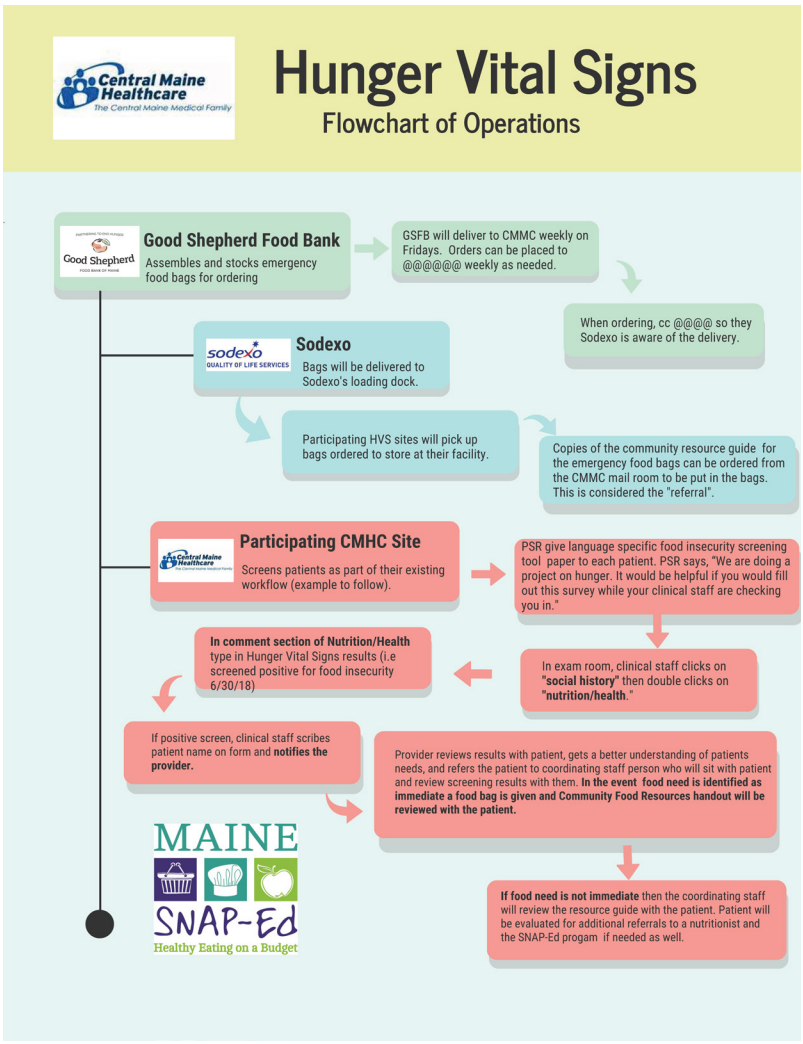
In Bucksport, the local community agency built, planted, and maintained two community garden beds at the main campus. Maine SNAP-Ed staff promoted gardens through BRHC social media, signage, and produce distribution days. Twice monthly produce distribution days began in 2021. The Maine SNAP-Ed nutrition educator also offered virtual education classes to patients to reinforce nutrition messages.

Evaluation methods and outcomes

Monthly Excel-based tracking tools are the primary data source for assessing PSE change. Yearly, semi-structured interviews with local community agency staff provide in-depth reflection on the work, including determining the number of individuals impacted. Data are analyzed by the Maine SNAP-Ed evaluation team using independent and collaborative reviews with a consensus decision-making process. SNAP-Ed Evaluation Framework[1] indicator MT5: Nutrition Supports and associated sub-indicators (sites/organizations, policy/systems/environments adopted, promotion, reach) are assigned annually for new supports adopted. Nutrition educators upload photos and other documentation with their tracking tool data, with an emphasis on pre-post images that provide evidence of the PSE change.

Sustainability

The University of New England (UNE), Maine SNAP-Ed's sole Implementing Agency, is working to increase awareness of hunger and related risk for chronic disease within UNE health profession programs by educating students through food insecurity trainings, rural health immersions, and SNAP-Ed volunteer opportunities. These efforts train students understand and address health disparities and the social determinants of health in underserved communities. Scaling up and replicating projects like the spotlighted example here will increase capacity state-wide to improve food insecurity with clinical supports. Additionally, the Implementing Agency's partnership with Good Shepherd Food Bank creates shared vision and effort at the sector level.



Lessons learned

Consistently using the evidence-based screening tool, the Hunger Vital Sign, increases the replicability of these strategies. Perhaps most importantly, the process of determining needs and

readiness of the site in combination with passion and commitment from local community agency staff has proven to be a good indicator of success. Inconsistent communication from partners was the top barrier to success across clinical strategies in Maine, underlining the importance of establishing a champion at the community site.

SPOTLIGHT – GROW PRODUCE AND ENGAGEMENT

"We have had success maintaining and promoting our garden because it is small enough to be easily watered, weeded, and harvested by one person with limited time. We can focus our time on promotion and vegetable distribution, which will eventually allow the garden to expand sustainably." ~ Maine SNAP-Ed Nutrition Educator

[1.] USDA Food and Nutrition Services. SNAP-Ed Evaluation Framework.

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Delivering Meals to Low-Income Families with Young Children Can Significantly Reduce Food Insecurity and Increase Healthful Eating

The COVID-19 pandemic caused an economic crisis as well as a health one for millions of families. Parents were faced with job loss, reduced access to housing, financial strain and hunger. These struggles were particularly acute for families with young children.

Nutrition during early childhood is critical for healthy development. Without consistent, reliable access to healthy food, young children can face long-term, serious consequences on brain development, coordination, cognitive abilities, and health problems that can follow them into adulthood.

No Kid Hungry works to connect children with the nutrition they need. At the start of the pandemic, they reached out to the team of the Division of Community Pediatrics (DCP) at MedStar Georgetown University Hospital and Chef Erik Bruner-Yang's Power of 10 Initiative (P10) to develop the "Healthy Children and Families program" to test innovative ways of connecting young children with the food they need for good health during this time of crisis.

They teamed up to deliver healthy, heat-and-serve meals, groceries and nutrition education materials directly to families throughout the week.

With The Meal Delivery Pilot, Food Insecurity Decreased

FROM 75% TO 21%

Among Families With Young Children

The results were striking. Among families in the study, food insecurity decreased from 75% to 21%, while three out of four families ate more fruits and vegetables. The pilot program also had both high retention rates and. high satisfaction amongst participants.

"It helped not having to go grocery shopping and spend more money on food so we could have money for other necessities."

Pilot Participant

The Families

The pilot program was designed to support the most vulnerable families with at least one child age 0-5 years old in Washington, D.C., making sure that young patients and their families had access to regular, reliable meals that support good health during this crisis.

- Forty-six families enrolled in the meal program and received at least one food delivery, which included multiple meals, in ten weeks.
- These families represented 229 individuals and 161 children.
- At the beginning of the pilot, 75% of these families reported at least one member missing a meal in the last week because there was not enough food at the start of the program.
- And 74% of families worried their food would run out at the start of the program.

The Pilot

The project was designed by No Kid Hungry and the MedStar Georgetown's Division of Community Pediatrics leadership team, who together facilitated the program vision, implementation and evaluation. First, the medical team identified and enrolled patient families struggling with food insecurity.

Next, healthy, ready to heat and serve meals were prepared and packaged by restaurant staff overseen by Chef Erik Bruner-Yang and his Power of 10-affiliated

restaurants. These meals and grocery bags were delivered directly to families throughout a week along with nutrition education materials. Families were also contacted twice a week by family navigators who facilitated operations and provided hands-on support.

Over The Course Of The Program, There Were 755 Total Deliveries Of **14,191** Meals.

Along With **862** Calls And Texts From Family Navigators.

A secondary priority of the pilot was to help support local food industry jobs that were severely threatened by the closures of the pandemic. It worked.

The program had additional significant economic impact during the covid-19 pandemic by sustaining multiple jobs in the restaurant industry over the ten week period and gaining attention for power of 10 to receive additional philanthropic funding beyond the ten-week project period.

The Findings

- Thirty-one families completed the post-program survey and were included in the analysis. Among these families:
- Food insecurity decreased from 75% to 21%.
- Ninety percent of caregivers reported that this program decreased their worries related to food.
- And 77% percent reported their families ate more fruits and vegetables during this program.

Only 1 family (3%) reported having missed a meal in the past week.

- A focus group of these families showed common themes when it comes to providing food:
- Food cost is primary consideration for how they purchase food.
- Storage space and finances affect frequency of grocery store shopping.
- They usually travel to multiple stores to find least expensive items.
- They value nutrition in order to improve health but difficult to afford and prepare.
- And cooking can be challenging with small children.

Bottom Line

This multi-sector partnership successfully responded to the food insecurity crisis exacerbated by the COVID-19 pandemic with a novel wrap around meal-delivery program supporting children and their families served by the Division of Community Pediatrics. Food insecurity was significantly mitigated, and families reported increased fruits and vegetables consumed. The pilot program had high retention rates and high satisfaction amongst participants.

Up Next

This program will extend for another year and will test, more closely, how healthy food access and education can improve health outcomes for young children who are living with obesity, asthma, allergies or developmental and behavioral outcomes and their parents.

Organizations

No child should go hungry in America. But in the wake of the coronavirus pandemic, 1 in 4 kids could face hunger this year. No Kid Hungry is working to end childhood hunger by helping launch and improve programs that give all kids the healthy food they need to thrive. This is a problem we know how to solve. No Kid Hungry is a campaign of Share Our Strength, an organization committed to ending hunger and poverty.

MedStar Georgetown University Hospital is a not-for-profit, acute-care teaching and research hospital licensed for 609 beds located in Northwest Washington, D.C. Founded in the Jesuit principle of cura personalis, caring for the whole person, MedStar Georgetown is committed

to offering a variety of innovative diagnostic and treatment options within a trusting and compassionate environment. MedStar Georgetown's centers of excellence include neurosciences, transplant, cancer and gastroenterology. Along with Magnet® nurses, internationally recognized physicians, advanced research and cutting-edge technologies, MedStar Georgetown's healthcare professionals have a reputation for medical excellence and leadership.

The Power of 10 is a restaurant industry non-profit initiative whose mission is to aid independent restaurants across America by re-employing staff, sustaining business operations, and providing food to community members who need it the most. By raising $10,000 per week in donations, The Power of 10 can re-employ 10 full-time restaurant workers and provide 1,000 free meals. For those looking to donate or get involved in The Power of 10, please visit www.powerof10initiative.com.

With Support From:

NO KID HUNGRY LEADING PARTNER:
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NO KID HUNGRY INNOVATION AND EARLY CHILDHOOD SPONSOR:
Sodexo Stop Hunger Foundation

Methodology and Contact:

For more information about the study, contact Caron Gremont at cgremont@strength.org.

For press inquiries, contact Adrienne Carter, acarter@strength.org

Leadership from all three organizations worked quickly to develop and stand up the operations of the project.

Key areas included meal content and packaging, delivery operations, communications, rapid-cycle response, nutrition education and evaluation.

The Division of Community Pediatrics (DCP) at MedStar Georgetown University Hospital developed information technology systems to allow for: HIPAA compliant enrollment and evaluation, documentation and tracking of touch-points, operations management including bidirectional communication with P10.

Eighty-six percent of families (n=37) completed the program (at least 5 weeks). Of those, 31 families completed the post- program survey and were included in the paired analysis.

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