Central Valley Health Network's (CVHN) Nutrition Education Non-profit Demonstration Project: A Case Study Report Summary

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Background

California's Obesity Prevention Plan identifies health care providers and insurers as a major sector for helping to create the shift to healthy eating and active living. Showing the way is the Central Valley Health Network's (CVHN) nutrition education demonstration project with the *Network for a Healthy California (Network)*. CVHN's member community health centers represent a strong, coordinated and large scale infrastructure with outreach to low-income residents throughout the northern, Central Valley and Inland Empire areas of California. In 2006, they provided medical, dental and related health and support services to 102 clinical locations and almost a half million patients through over two million encounters. Overall, 70 percent of the participating health centers' clients live at or below the poverty level and an estimated 50 percent are farm workers or their families.

CVHN's member health centers' commitment to providing quality health services to the medically underserved has led them to innovate and implement an array of nutrition education strategies for the promotion of healthy diets and physical activity that will contribute to chronic disease prevention. The purpose of this case study is to document the experience of CVHN's member health centers in order to

- highlight accomplishments and factors that contribute to their achievement,
- generate recommendations for future collaboration and discover possible areas for project strengthening, and
- improve prospects for replication.

Methods

The case study draws upon several sources, including regular project documents such as CVHN's progress reports, an on-line survey completed by representatives of the participating health centers, as well as site visits and in-depth interviews with three health centers. It also incorporates results from small group discussions and surveys conducted with health center clients by nutrition education staff during regularly scheduled nutrition education activities.

Findings

- **Reasons for not eating more fruits and vegetables:** During small group discussions, participants most frequently mentioned the following categories of reasons for why they did not eat more fruits and vegetables: 1) expensive or lack of money; 2) not accustomed to eating or serving; 3) lack of time; 4) I don't like or we don't like; 5) I like but others in the family don't like (most often specified children or husband); 6) do not know how to prepare; 7) and alternatives are easier, more available or liked better.
- **Nutrition Education Strategies:** The health centers participating in CVHN's demonstration project employ a tremendous range of nutrition education strategies at the health centers and in their communities.
- **Member health centers integrate nutrition education into existing clinic operations** by providing nutrition information and promotional materials
  - in waiting and examination areas
  - at intake and enrollment
  - during insurance enrollment and nutrition education
  - combining dental health and nutrition education
  - as part of one-to-one counseling sessions
  - to pre-existing groups who are already meeting regularly such as Substance Abuse Recovery Programs, Perinatal Care and Breastfeeding Promotion, Teen Movie Night at the Health Center, and "Lunch with the Doctor" sessions.
- **Several of the heath centers have organized nutrition education classes either for adults or families.** These classes have demonstrated positive results among participants. Although the sample size was small (less than 30 people), participants' knowledge and behaviors promoted by the classes showed improvement when measured by pre- and post-surveys. A major challenge has been to sustain participation over multiple meetings and, in some cases, to generate sufficient interest and attendance at even a single session class.
- **Each of the participating health centers also provides nutrition education and physical activity promotion to a great variety of community venues** including: health fairs and farmers' markets, low resource schools and preschools, community gardens, churches, family agencies, food banks, and farm field worksites.

- **Education Materials:** The nutrition educators working with the various health centers generally agreed that the educational materials from the *Network*, the Fruit, Vegetable and Physical Activity Campaign (formerly 5 a Day), and USDA, among others, compiled by CVHN's program coordinator were helpful. The 5 a Day Latino recipe book was especially popular, as were materials with the following characteristics:
  - Address the importance of making lifestyle changes
  - Provide practical changes or recommendations while being culturally sensitive
  - Are language-appropriate and written for a low-literacy audience
  - Provide information on food portions and serving sizes; use visuals to show portions
  - Provide recipes and activity/exercise tips
  - Emphasize how healthy eating can help prevent chronic diseases
  - Direct clients to community resources where they can access food (e.g., day old bread, food banks, school meal programs)
  - Provide information on canned fruits and vegetables clients receive through commodity distributions

Promising or Best Practices

Many of the health educators' observations of effective strategies pertained to a client centered approach for promoting positive behavior change with several reinforcing features:

- **Think, Feel and Act:** Nutrition education is seen as a process that aims to make a small shift in the way that the client thinks, feels and acts in regard to their own health and health oriented behaviors. The goal is to encourage small shifts that can open the way for other change.
- **Support and Self-esteem:** The importance of social support was also emphasized to build clients' self-esteem and positive body and self-image, especially among the young. Some educators thought the group format was especially effective because it allowed the best forum for this type of encouragement; others thought the confidentiality of the one-to-one sessions worked best. For children and adolescents, a family-oriented approach was also identified as especially important.
- **Practical Options:** The health educators also emphasized the importance of tangible and practical options. They point out that nutrition education really has to do with change and these changes have to be feasible and grounded in people's real situations. For example, the economic benefits of eating well, as well as strategies for saving time and money, are emphasized.
- **Culturally Appropriate:** Staff of each health center also mentioned the importance of culturally sensitive or culturally appropriate materials. This refers to more than simply materials translated into the appropriate language. For example, one nutrition educator explained that she begins her nutrition classes by asking people to talk about their favorite traditional meals. Sharing these memories helps people to connect and relate to one another.

Conclusions and Recommendations

CVHN member health centers provide their clients with a tremendous range of nutrition education opportunities. The staff commitment, skill and enthusiasm are truly impressive at each of the participating health centers. For health centers, as well as community health-oriented agencies, the importance of healthy eating and physical activity are issues of growing concern and priority. This case study also helped identify recommendations for strengthening the demonstration project:

1. Continue and augment training and networking opportunities for participating health centers
2. Provide additional training and resource materials on FSNE allowability
3. Continue to update and augment nutrition education materials and reinforcement items
4. Improve outcome/impact evaluation
5. Look for opportunities for streamlining programmatic reporting

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