IMPLEMENTING COMMUNITY-LEVEL NUTRITION PROGRAMS

Best Practices and Lessons Learned from the Healthy for Life™ Community Engagement Program

October 2016

EXECUTIVE SUMMARY

The American Heart Association and Aramark are collaborating to help Americans learn to lead healthier lives by eating healthier foods. Their joint initiative called Healthy for Life® 20 By 20 aligns these influential nationwide organizations that are uniquely equipped to significantly change America's health through food and improved eating. As the nation's largest voluntary health organization devoted to fighting heart disease and stroke, the American Heart Association brings more than 90 years as a trusted source of science-based dietary expertise and a network of more than 30 million supporters and volunteers. As the largest food service provider in the United States, Aramark carries a stellar national reputation and the ability to impact healthy foods for millions of people in workplaces, cafeterias and many other public venues.

The Healthy for Life community engagement program was launched in 2016 in Chicago, Houston and Philadelphia. The target population was low-income single mothers or single heads of households responsible for their families' food and meal decisions. They followed a 12-week interactive educational program designed to change behaviors regarding food and nutrition. Specifically, it focuses on teaching simple strategies to change food and health attitudes and behaviors, equipping participants with new skills for healthy living. Culturally-relevant and family-centric activities focused on overall wellbeing, cooking skills and food, grocery shopping and gardening. The results were impressive. Seventy-five percent of participants say they are working to improve their health. And 69 percent have improved their overall fruit and vegetable consumption. These findings prove that the program, designed for underserved communities, can be effective in modifying behavior. Community-targeted initiatives can inspire local collaborations, help sustain health and wellness programs, and directly impact community members. However, engaging community members can be challenging and this white paper provides significant learnings in how to best recruit, implement and evaluate community nutrition programs.

INTRODUCTION

The purpose of this white paper is to share best practices and lessons learned from community-level nutrition program implementation in underserved areas. These findings are based on the 12-week Healthy for Life community engagement program developed by the American Heart Association and Aramark.

Programs such as this are vital because of a growing body of scientific evidence showing the importance of proper nutrition in preventing cardiovascular diseases. In fact, poor diet is the "leading risk factor for death and disability" (1). Instead of eating plenty of fruits, vegetables and whole grains as recommended by public-health experts, many Americans continue to eat large amounts of processed and refined foods. (1). Less than 1 percent of Americans eat the type of diet the American Heart Association advises for ideal cardiovascular health (2). And only 12 percent of Americans eat enough fruits and vegetables despite evidence showing they can help lower risk for heart disease, stroke, diabetes and other serious health problems. Healthy eating can also influence cardiovascular risk factors, including obesity and hypertension (1). Each additional serving of fruits and vegetables consumed is associated with a 4 percent reduction in cardiovascular disease risk (3). Risk factor management plays an important role in preventing and treating cardiovascular diseases.

Community programs should target changing dietary practices including increasing consumption of fruits, vegetable, whole grains and fish while also reducing fat, salt and sugar consumption (4). Community-based health and wellness programs establish a sense of empowerment and ownership and help reduce risk factors associated with cardiovascular disease. *The American Heart Association Guide for Improving Cardiovascular Health at the Community Level* supports targeting community interventions toward "changing the context to make individuals' default decisions healthy." (4) AHA is doing this by developing partnerships with private industry to leverage combined resources and positively impact public health and nutritional profiles in the overall food landscape.

HEALTHY FOR LIFE 20 BY 20 OVERVIEW

Healthy for Life 20 By 20 is a five-year initiative committed to the shared goal of improving the health of Americans 20% by 2020 through the introduction of industry leading healthy menu commitments across Aramark's businesses, in addition to deep collaboration and innovation between Aramark and the AHA in the important areas of community health engagement, consumer and employee health awareness and education, as well as thought leadership research and health impact reporting.

The 12-week Healthy for Life community engagement pilot was targeted at single heads-of-households and tested at five community centers in three cities:

- *Chicago, Illinois*: Casa Central
- *Houston, Texas:* Neighborhood Centers Inc. at the Harbach Ripley Location
- *Philadelphia, Pennsylvania*: Congreso de Latinos Unidos, Federation of Neighborhood Centers, and Episcopal Community Services

Three overarching goals:

- *Empower change in communities, especially those in need.*
- *Enable community centers and other local social service organizations to offer high-impact programs.*
- *Equip individuals with new skills to make healthy choices.*

HEALTHY FOR LIFE (HFL) CURRICULUM FRAMEWORK

The program is built on a framework that emphasizes nutrition literacy and cooking skills. In particular, the participant goals are to:

- *Acquire new skills to prepare healthy foods.*
- *Experience delicious and healthy food.*
- *Receive culturally relevant healthy recipes.*
- *Budget and shop for healthy foods.*
- *Increase level of comfort with healthy foods.*

The HFL program empowers participants to make informed, healthy decisions for their families regardless of socioeconomic status. Prior to the HFL Program, 76 percent of participants had never been involved in a community health and wellness program. The majority of the target population identified as low-income with high school or lower educational attainment. Research continues to prove that lower socioeconomic status is associated with poorer health outcomes (5).

COMMUNITY PARTNERS & MOBILIZATION

The HFL program was possible through a collaboration with the Alliance for Strong Families and Communities, a network of more than 500 community-based social service organizations affecting over 3.4 million people annually (6). The Alliance has also been involved with Aramark through its Aramark Building Community (ABC) program for many years. ABC is Aramark's "global volunteer and philanthropic program that inspires families to lead healthier lifestyles and empowers youth and adults to succeed at work in partnership with local community centers" (7). The success of the community engagement program can be attributed in part to the long standing collaboration between Aramark and the Alliance. The program was implemented in five long time Aramark partner community centers and was also supported by the involvement of local Aramark employees, chefs and registered dieticians.

PROGRAM DEVELOPMENT LESSONS & RECOMMENDATIONS

Community Readiness: The centers were selected based on existing community interest in nutrition and each center's mutual desire to help change the dietary habits of their clientele. Thus, readiness was a key factor of successful implementation.

Program Design**:** The community nutrition program was designed from the community engagement model, emphasizing participants' contribution in refining the program. Specifically, community fit was ensured through consideration of existing offerings and programs along with target population and staffing capabilities. Program material was designed to be culturally relevant, and implementers were selected keeping in mind the need to connect and establish a reciprocal sense of trust and respect among community members (8). Selected community centers chose from two program delivery methods: optimal or flexible. These options varied by duration and recruitment requirements. (See Appendix 1: Program Development.) This allowed centers to adopt the model that fit their state of readiness while testing a comprehensive approach to health and wellness education. The logic model, outlining the program's inputs, activities, outputs, and short-term, intermediate and long-term outcomes can be found in Figure 1. *(See Appendix 1: Program Development.)*

With the assistance of the community center staff, the train-the-trainer approach was executed where possible and is a critical component of the HFL framework as portrayed in Figure 2. In the train-the-trainer method, participants are given ownership and authority to learn the material themselves and then educate their peers. *(See Appendix 1: Program Development.)*

RECRUITMENT LESSONS & RECOMMENDATIONS

Every community center serves a unique population and should explore tailored strategies for recruiting participants. It is a best practice to provide enough time to advertise the program and generate interest in potential participants but also not too much time that participants are no longer available for program dates and times.

Casa Central recruited participants through a survey administered with parents in an already established kids program. The survey asked parents their time, day and lesson topic preferences. Another center recommends recruiting around those most at need and leveraging existing networks to reach participants. Each center was provided fliers in Spanish and English to disseminate throughout the community and an option to tailor to each center's needs to support the varying recruitment strategies. *(See Appendix 2: Program Recruitment.)*

PROGRAM IMPLEMENTATION LESSONS & RECOMMENDATIONS

Program Fidelity: The program implementation process has a tremendous impact on participant retention as well as outcomes. The continuous improvement model approach was applied to allow for communities to provide input and adapt the program according to local needs. However, it was important for the overall curriculum to stay consistent across all centers to ensure all participants received the same information.

Curriculum Content and Application: The program is designed to engage participants and serve a variety of adult learning styles through visual, auditory and kinesthetic materials. The curriculum's content was reported as beneficial and applicable for the majority of community members.

Maintaining Engagement: Participants' lack of motivation or enthusiasm can stem from multiple origins. This section will provide suggestions on how to maintain and increase participant engagement.

As previous literature has shown, individuals better understand and learn through interactive practical application of the content (9) (10). Additionally, it has been shown that interventions involving "skill development" are more effective than other strategies (11). The HFL program integrated both of these concepts.

The four HFL modules contain a variation of demonstrations and hands-on activities. For example, Module 3 focuses on developing and applying healthy shopping skills. It prepares participants in the first

lesson by explaining heart-healthy food items, and creating weekly meal plans and grocery lists. Following this lesson, participants learn how to read food label information and identify the Heart-Check mark and its meaning. These two lessons lead to the grocery store tour where participants make nutritious, budget-friendly choices. Some centers improvised ways to teach. For example, one center played true/false games while another invited participants to lead discussions. Both of these help exhibit the train-the-trainer method.

Cultural Relevancy: To maintain engagement, participants should feel the material is culturally relevant and appropriate for their education level. The HFL program addressed this partially through offering handouts in English and Spanish. The program also provides a lesson on celebrating foods from different cultures, and offers a library of learning resources such as videos and activities to accommodate varying health literacy levels. However, program facilitators recommended offering a program facilitator guide in Spanish so the instructor is not constantly translating.

HFL's Lesson 2.4 highlights the importance of recognizing cultural differences through celebrating heritage foods. Participants share their favorite family recipes and offer healthy alternatives to ingredients. For example, using low-fat plain Greek yogurt in place of sour cream or mayonnaise. Although one of the program's goals was to increase home-cooked meals, program facilitators recognized most participants were already cooking most meals at home. As a result, the focus was shifted on improving the nutritional quality through different cooking techniques and swapping in healthier ingredients. The emphasis should be on maintaining cultural recipes and flavors but simply enhancing their nutritional content.

Gauging Knowledge: Program facilitators are responsible for connecting with participants and gauging where certain topics need to be emphasized or reiterated. As can be expected, community center administrators noticed a difference in engagement when a health professional was facilitating the lessons rather than a less-experienced individual. One key recommendation for similar programs is to ensure facilitators have familiarity or expertise in the subject matter so they can tailor the material for the audience.

Incentives: Incentives have been associated with previously successful community programs and interventions (11) (9) (12) . In the HFL program, incentives were highly utilized and thought to consistently engage participants by reinforcing newly acquired knowledge. Because of their effectiveness, it is recommended that incentives be incorporated into the program and budgeting process. Generally, centers awarded incentives for participation, which encouraged attendance. It was important for incentives to reinforce the program's goals. *(See Appendix 3: Program Implementation.)*

EVALUATION LESSONS & RECOMMENDATIONS

Evaluation is a central component of program implementation and, in particular, pilot study delivery. Without formal evaluations, program outcomes may be considered "invalid" by stakeholders. Particularly, "survey fatigue" and "pilot fatigue" were cited as top challenges among participants and centers. A third-party evaluation was conducted to measure impact on participants' nutritional habits and behavior. Quantitative results were obtained through participant pre- and post-module surveys and site administrator post-program surveys. Facilitators' blog entries, participant feedback and an in-person meeting were provided for the qualitative results. Although the evaluation was necessary to drive a future scalable and replicable model, it was a common area for improvement mentioned by community centers. *(See Appendix 4: Program Evaluation.)*

Impact: The Healthy for Life engagement program was a proof of concept for a community-delivered nutrition program. There were a total of 119 participants who were predominately female (79%), Hispanic (60%), and African-American (27%), lower income (39% < $20K, 40% $20K-$39.9K), young and middle aged adults (45% <34 years old, 27% 35-44), with high school or lower educational attainment (67%), and 52% with two or more children living in their household.

- *Sixty-nine percent increased their fruit/vegetable consumption by at least half a serving.*
- *The median consumption of fruits/vegetables increased by two servings.*
- *Forty-eight percent increased their whole-grain consumption by at least one serving.*
- *The median consumption of whole grains increased by one serving.*

By the end of the program, more than 75 percent of participants had put a moderate amount to great deal of effort in improving their health in the previous 30 days. Nearly 80 percent of optimal model participants mostly or completely agreed that the course experience has changed what they know about healthy eating. Also, following final module completion, 77 percent of participants said they will use all or most of the course information to make changes in their lives. Overall, participants significantly increased their healthy food consumption while reporting increased frequency of at-home meal prep and confidence in preparing healthy home cooked meals. The objectives of the program were surpassed in many areas, validating the usefulness of HFL as a community engagement and nutrition program.

FUTURE RECOMMENDATIONS

AHA and Aramark are working toward developing a sustainable replication model in community centers across the United States with the stretch goal of reaching over 9 million people by the end of 2020. To foster further integration, lessons could be offered in individual modules and incorporated into already existing programs. The centers expressed interest in implementing this type of episodic model (in addition to the 12-week model), in which they could integrate HFL activities into ongoing initiatives. An additional approach would be to provide centers with a base HFL curriculum and a range of optional lessons. As seen in the HFL program, continued participation had a high impact, but short-term engagement still had a significant effect. Additionally, the replication model will focus the content around the activity versus lecture instruction. In the next phase, centers will be provided a facilitator's guide to help them navigate HFL planning, recruitment, implementation and evaluation.

The key objectives going forward are (1) engaging more communities, (2) reaching more families, and (3) sustaining the program's impact. As most of the centers had never engaged in a health and wellness program, a flame has been ignited among their members for more health knowledge. The HFL curriculum provides communities with the resources to inspire healthy change. When people are motivated to change behavior, it can have a ripple effect through a community.

APPENDICES

Please use this section if you are seeking more information on the Healthy for Life engagement program development, recruitment, implementation and evaluation. It also includes quotes from program facilitators.

Appendix 1: *Program Development*

The optimal model required centers to implement three of four learning modules, recruit 50-60 participants (in total) and ensure 25 participants complete all three modules. Each module consisted of four 60-minute lessons. The flexible approach allowed centers to choose two or three modules, recruit 50-60 participant per module and required at least 25 participants complete each module.

Figure 1: HFL Community Engagement Logic Model

INPUTS	ACTIVITIES	OUTPUTS	SHORT-TERM OUTCOMES	INTERMEDIATE OUTCOMES	LONG-TERM OUTCOMES
Materials: HFL curriculum, internet, computers, printer, facilitator guide, binders, incentives, food (depending on module) and other supplies **Staff:** The Alliance, Aramark Building Community partners, AHA National Center staff, Aramark's national team, local Aramark employees and volunteers, local AHA affiliates **Funding:** Aramark	**Participants' activities:** Optimal vs. Flexible *(selection of 3 of 4 modules vs. 2-3 of 4)* which includes the lesson, activity, resources, questions/discussions, check-in/updates on progress/struggles • Module 1: *Your Wellbeing* • Module 2: *Cooking Skills and Food* • Module 3: *Grocery Shopping* • Module 4: *Gardening in Your Neighborhood*	• Number of participants who completed each module • Number of centers who selected Optimal vs. Flexible models	**Increase participants' self-efficacy in:** • Improving own health • Preparing healthy home-cooked meals • Knowing difference between whole grains and refined grains **Increase trainees' knowledge and skills in the following health and wellness areas** *(as applicable)***:** • Your Wellbeing • Cooking Skills and Food • Grocery Shopping • Gardening in Your Neighborhood	• Increase fruit and vegetable consumption • Increase whole grain consumption • Increase frequency of at-home prepared meals	Improve the diet and nutrition of Americans

Figure 2: ***TTT Model***

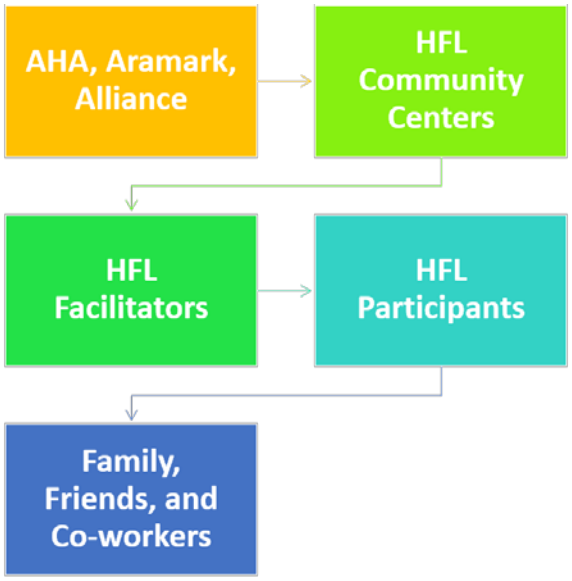

Figure 3: ***Curriculum Modules***

MODULE 1 – *Your Wellbeing*

- Know Your Numbers: My Life Check® Health Assessment
- Healthy Eating Patterns
- Key Health Factors
- Personal Goals

MODULE 2 – *Cooking Skills and Food*

- Kitchen Basics and Terminology
- Healthy Meal Solutions
- Healthy Food Preparation
- Celebrating Heritage Foods

MODULE 3 – *Grocery Shopping*

- Getting Ready to Shop
- At the Store, on a Budget
- The Savvy Shopper (Grocery Store Tour)
- Meal Challenge Storytelling

MODULE 4 – *Gardening in Your Neighborhood*

- Fresh From the Garden: Delicious and Nutritious Fruits & Vegetables
- Growing, Harvesting & Handling
- Flavors of the Garden
- Gardening and Cooking with Kids

Recommendations for implementing community-level prevention programs (8):

- Ensure the community is "ready."
- Build "community coalitions" (collaborative partnerships).
- Program must be appropriate "fit" for the community.
- Program is delivered with high fidelity.
- Provide sufficient resources and focus on evaluation.

Stith and colleagues (2006) recommend applying the community readiness model to assess communities' stage of readiness ("no awareness, denial, vague awareness, preplanning, preparation, initiation, stabilization, confirmation, and professionalization") prior to implementation. It was also important for every center to identify a "key champion" as someone who could "foster internal support" for program implementation and sustainability and serve as AHA/Aramark's point of contact (8).

Appendix 2: *Program Recruitment*

Facilitators reported common recruitment methods:

- Promoting through existing partner relationships and channels (i.e., parent groups)
- Customizing program invitation for community families
- Reaching out to families who previously participated in center programs
- Posting program flier on community website and various social networking sites

Although recruitment and retention rates varied by community center, unanimously they indicated program fliers need to highlight incentives, contain large font and minimal text to better attract participants. Centers suggested attracting future centers through a personalized business plan for program implementation. This would include details about the necessary space, timeline, recruitment tips, coordinator job description, surveys, etc. The centers also recommended possibly supplying a pool of trained facilitators to go out to the various community sites to provide uniformity. They believe a recruitment flowchart would also be helpful to navigate through barriers and help bolster participation rates. For example, the flowchart could show simple scenarios such as, "if you have an existing population, do X; if not, do Y."

Appendix 3: *Program Implementation*

The facilitators brainstormed ways to improve the curriculum:

- *Build content around the activity (i.e. demonstration).*
- *Have a designated person help check in participants so the facilitator can focus on starting the lesson on time.*
- *Gauge the base knowledge of participants, adapt material appropriately and potentially offer a directed instructor guide to consolidate time.*
- *Provide more specific recommendations/objectives for lessons rather than vague generalizations such as "improve overall health."*
- *Ideal duration: 4 weeks; Ideal class length:1.5 hours; Ideal days: Tuesday or Thursday; Ideal time of day: late afternoon*

The program materials were recommended to have a lower literacy level, minimal text, large font and more images to further engage participants. Additionally, visual aids were suggested to post around the classroom to have continual content reinforcement throughout the program. Overall, facilitators felt the program flowed from module to module as new information built on previous lessons. However, HFL's lesson 1.1 was advised to be shifted to a later point in the program. The lesson's activity focused on participants obtaining their heart-health scores using the My Life Check assessment. The assessment required participants to know their blood pressure, blood glucose and cholesterol levels, which were provided through on-site screenings. Through observation, the "numbers" did not impact some participants because they were unaware what they meant or the potential implications.

It was suggested for a health professional to be present and offer on-site consultation as facilitators are not trained to give medical advice. It is recommended for the future HFL model to integrate this idea and allow participants to first become comfortable with the program content, their peers and facilitator. Facilitators enjoyed learning how to make healthy choices, but there was a common concern in terms of enough time to deliver all of the content.

Gauging Knowledge: Some centers suggested surveying initial knowledge and adapting program material appropriately. If program facilitators recognize that a few participants are familiar with the lesson's content, then they can consider inviting them to lead the discussion. This changes the dynamic of lesson instruction and applies the train-the-trainer approach. Also, if participants are seeking out more information on a lesson topic, such as more information on hypertension, then additional resources such as handouts or websites should be available. Engagement of expert volunteers for relevant lessons was also effective such as having an Aramark chef to teach knife skills or an Aramark Registered Dietitian to answer technical nutrition questions.

Incentives: Effective incentives were not elaborate or expensive. For example, the ECS implementer reported great enthusiasm about a raffle for a blender for making the "Big Green Monster Smoothie." This recipe allows kids and adults to consume vegetables in the form of a delicious drink. The implementer also noted how surprised participants were to learn that they could purchase a blender for less than $20. Another successful incentive was providing gift cards for local farmers' markets. The gift cards enabled participants to practice healthy, budget-friendly shopping practices. HFL program centers had the autonomy to choose and distribute incentives at their discretion.

Fidelity: To maintain program fidelity, facilitators were provided a binder with a guided script, lessons, activities and resources. Additionally, they were offered training webinars. The webinars were thought to be valuable for facilitators to review the material and have an opportunity to ask questions with AHA-trained staff. According to the center administrator survey, 88 percent reported an appropriate frequency of communication with AHA. Staff at the AHA provided ongoing technical assistance and support to the centers throughout the program.

Appendix 4: *Program Evaluation*

Survey Fatigue: Participants exhibited "survey fatigue" after repeatedly answering the same questions on different pre- and post-surveys. This may lead to issues with data reliability if participants are quickly answering questions without reading prompts. For example, some survey questions referenced specific time frames (consumption yesterday or last week) and participants may have become confused or not realized if there was a shift in time frame. It was recommended to limit surveys to two pages (front and back), lower literacy level in questions and provide more clarity in question prompts to improve future evaluation surveys.

Pilot Fatigue: Although not directly mentioned by facilitators, "pilot fatigue" should be considered. Pilot studies provide program developers concrete feedback on how to revise and improve their concepts before widespread implementation. Community centers may be popular locations for pilot studies because of their established network of members and therefore proximity to potential participants. However, if community centers are consistently asked to participate in newly developed programs, they may find themselves frustrated with leaving community members "hungry" for more health knowledge. Pilot program centers should receive a clear direction for the proposed program being tested. Following HFL completion, participants felt energized and sought more health and wellness programs. As a result, program planners may consider offering long-term engagement programs to ensure participants' healthy momentum continues.

PROGRAM FACILITATOR QUOTES

"Food, laughter, familia = Healthy for Life!"
(Congreso) (13)

"We are drawing on our existing and future program participants in our Youth programs. Relationship-building is key to building strong connections."
(Anja, HFL Program Coordinator at the Federation of Neighborhood Centers) (14)

"Our participants ... truly engage with the Healthy for Life program and they are making small changes in their daily routines and eating habits. I believe these small changes will eventually lead to big transformations not just for them but for their families as well."
(Onaldo, HFL Program Coordinator at Neighborhood Centers, Inc.) (15)

"We started implementing different activities in our center such as chef demonstrations and cooking classes. When they have the opportunity to apply what they are learning in class with their classmates it turns into something dynamic and fun. This is a great way for them to practice and remember what we are teaching them so they can also implement a healthy diet at home with their families."
(Angelie, HFL Program Coordinator at Neighborhood Centers, Inc.) (15)

"Once we started including the participants in helping teach the class, it really helped improve their interest."
(Katrina, HFL Program Coordinator at Casa Central) (15)

"Some have already experienced weight loss, have made changes to their diet and exercise. Many have shared that they have been more mindful of the food that they are buying and are not afraid to buy new things when they go shopping."
(Jacqueline, HFL Program Facilitator at Congreso de Latinos Unidos) (15)

"Behavior change is difficult and takes a long time, but I believe we are providing our participants with the knowledge and tools they need to begin the change process."
(Cadence, HFL Program Coordinator at Episcopal Community Services) (15)

"Members have been going around the community talking about how interesting … the program [is]. They have expressed gratitude with the program because they have seen changes in their eating habits."
(Onaldo, HFL Program Coordinator at Neighborhood Centers, Inc.) (15)

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