Bridging Capacity to Deliver EFNEP Classes Via Tele-Nutrition in a Rural Native American Community

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Objective: To apply a community engagement process to establish strategic partnerships for implementing Healthy Kids Tele-Nutrition in remote rural communities.

Use of Theory or Research: Community-based Participatory Implementation Science Framework and Community-Engaged Dissemination and Implementation Approach.

Target Audience: Native American caregivers of young children living in remote rural communities.

Program Description: Healthy Kids Tele-Nutrition consists of 8-weekly classes delivered remotely by an educator from the Expanded Food and Nutrition Education Program (EFNEP). Traditional Eating Smart Being Active EFNEP curriculum was augmented with evidenced-based components to target child malnutrition prevention. Components include food-related parenting topics, guided goal setting, and storytelling. Formative work and capacity-bridging activities were conducted to inform recruitment and implementation of the program in a remote, rural, Native American community.

Evaluation Methods: An environmental scan was conducted to appraise available community resources and suitable sites to host classes. Key community partners were convened to ascertain interest in the program and considerations for implementation, including barriers, facilitators, motivators to enroll, and preferred communication channels. A medical provider was interviewed to explore considerations in referring patients to the program.

Results: A community liaison was identified. A memorandum of understanding formalized a partnership between the Community Health Center and the University for the project. Four monthly meetings with a community advisory board of tribal members were held to identify socially and culturally acceptable and feasible approaches to remote delivery of the classes. Suitable space and equipment to implement the program were identified and secured. Engagement of key partners (n=10) resulted in informing program schedule (day, time, dates), recruitment (referrals, advertising, communication channels), on-site facilitation (class greeter), and participation incentives (food, meals, child care).

Conclusion: Access to healthcare providers and health-promoting resources is scarce in remote rural communities. Bridging existing local resources (or assets) with external resources can increase community capacity to improve food-related health outcomes. Establishing a process to engage key community partners is paramount to identifying a sound and contextually acceptable program implementation strategy.

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Caregiver-Reported Barriers to Redemption of Pediatric Fruit and Vegetable Prescriptions

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Objective: The current study explored perceived barriers to redemption of fresh produce prescriptions among caregivers of pediatric patients who participated in a fruit and vegetable prescription program (FVPP) in Flint, Michigan.

Use of Theory or Research: The pediatric FVPP was grounded in Social Cognitive Theory (SCT), which suggests that behavior is explained by a three-stage, dynamic model between personal factors, environmental factors, and behavior. With self-efficacy central to behavior change, pediatrician issuance of a prescription for fruits and vegetables to every child at each office visit was designed to support fresh food access as well as self-efficacy to consume healthy foods.

Target Audience: Caregivers of pediatric patients (0-18 years) across three large pediatric clinics in Flint, Michigan that offered the identical FVPP.

Program Description: The FVPP provided one $15 prescription to pediatric patients at each office visit. Prescriptions (valid for 90 days) were ordered via electronic medical records, printed on prescription paper, and redeemable for fresh produce at a downtown farmers’ market or local mobile market/food hub. The program was introduced to the first pediatric clinic, co-located with a farmers’ market, in 2016. It was expanded to two additional clinics in 2018 and 2021.

Evaluation Methods: Barriers to prescription redemption were assessed through one qualitative question included in a caregiver survey that was designed to examine program effectiveness. Answers were then coded into discrete categories and analyzed.

Results: A total of 496 caregivers completed surveys. Of those, 379 caregivers (76%) answered the question related to barriers to redemption. Although 265 reported no challenges with prescription redemption, 114 caregivers identified at least one barrier. Primary barriers across three clinics were lost, forgotten, or expired prescriptions (25%), transportation to or distance from farmers’ market (24%), and lack of time (23%). Differences in responses based on pediatric clinic location were also noted.

Conclusion: Results indicated several consistent barriers to prescription redemption that could be addressed to improve program utilization among participating families.

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