

Community Health Centers: A Promising Venue for Supplemental Nutrition Assistance Program Education in the Central Valley

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ABSTRACT

Health care providers could help achieve the necessary shift to healthful eating and active living; however, lack of coverage or reimbursement, lack of time, and limited information about appropriate interventions are some of the documented barriers. This report highlights the potential for Supplemental Nutrition Assistance Program Education (SNAP-Ed) implementation in the relatively nontraditional setting of Federally Qualified Health Centers based on the experience of the Central Valley Health Network's Nutrition Education Demonstration Project. The report provides a brief overview of the primary prevention role(s) suggested for health care providers, relevant SNAP-Ed policies, how SNAP-Ed has been implemented in Federally Qualified Health Center settings, and recommendations for similar efforts.

Key Words: community health centers, nutrition, community health education, primary health care, government programs (*J Nutr Educ Behav.* 2011;43:S137-S144.)

INTRODUCTION

The World Health Organization states that 1 of the most promising methods in reducing the number of chronic conditions with which people are faced today is the integration of prevention into primary care settings.¹ The purpose of this report is to highlight the potential for Supplemental Nutrition Assistance Program Education (SNAP-Ed) implementation in the relatively nontraditional setting of Federally Qualified Health Centers (FQHC). It begins with a brief overview of the suggested role(s) health care providers could play and some of the challenges for funding this approach through SNAP-Ed. The report focuses on the SNAP-Ed implementation experience of the Central Valley

Health Network (CVHN) and its FQHC members and recommendations for future programmatic enhancement through SNAP-Ed.

Health care providers have been identified as a major sector for helping to create the necessary shift to healthful eating and active living.²⁻⁴ However, it is often challenging for the health care sector to provide health promotion activities because of lack of time, lack of coverage or reimbursement, and lack of information about appropriate interventions, referrals, and evidence about effective prevention methods.⁴ Kearny et al propose what is needed is a new framework for mainstreaming prevention in order to overcome the systematic barriers to public health action in primary care.⁵ They

identify 3 essential elements for such a framework to be effective: (1) routine collection of core data such as body mass index and waist circumference, fruit and vegetable intake, and physical activity levels to assess need and plan prevention services; (2) brief interventions designed around aspects of diet and physical activity that could be done by health trainers or health care assistants in waiting areas, meeting rooms, and pharmacies; and (3) identification of "imaginative new prevention pathways which utilize existing local resources" to which patients who are overweight or have poor diets or who are physically inactive could be referred (eg, cooking and tasting sessions and walking groups).

According to Kearny et al, this proposed framework offers health care providers a practical approach for incorporating prevention into daily operations through tracking relevant data and offering solutions in the form of brief interactions and referral.

Contento proposes there are 3 essential components for nutrition education: (1) a motivational phase, focused on increasing awareness and motivation; (2) an action phase, focused on how to make changes; and (3) an environmental component, in which nutrition educators work with policy makers and others to create

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STATEMENT OF POTENTIAL CONFLICT OF INTEREST AND FUNDING/SUPPORT: See page S144.

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environmental supports for action.⁶ Kearny's proposed framework addresses these first 2 components, and Lawrence et al also acknowledge the third. Similarly to Kearny, Lawrence et al identify the need for incorporating promotion of healthful eating and physical activity into routine clinical practices and more evidence-based strategies. But they also encourage greater attention to the role of an enabling environment through: (1) improving health care environments by providing opportunities for healthful eating and physical activity and (2) engaging health care providers in advocacy for more healthful environment in health care facilities, neighborhoods, and schools.⁴

Both sets of authors point to the need for a much stronger evidence base before public health action can become mainstreamed within primary care.

As described in the Plan Guidance, the focus of SNAP-Ed is (1) health promotion to help Supplemental Nutrition Assistance Program (SNAP; formally known as the Food Stamp Program and currently known in California as CalFresh) eligibles establish healthful eating habits and a physically active lifestyle and (2) primary prevention of diseases to help SNAP eligibles who have risk factors for diet-related chronic disease prevent or postpone the onset of disease by establishing more physically active lifestyles and more healthful eating habits.⁷

Federally Qualified Health Centers have tremendous potential for integrating prevention into primary care settings that reach very large numbers of food stamp and similar low-income, eligible families. Defined by Medicare and Medicaid statutes, the FQHC designation is for "safety net" providers such as community health centers, public housing health centers, outpatient health programs funded by the Indian Health Services, and health programs serving migrants and the homeless.⁸ However, current SNAP-Ed guidance states that "unless an absolute need is documented . . . participation by non-governmental (private) health care organizations is not reasonable or necessary and should be discouraged."⁷

Many of the challenges for health care organizations participation in

SNAP-Ed pertains to the program's funding mechanism. Supplemental Nutrition Assistance Program Education functions as a federal matching or reimbursement program by which public or nonprofit agencies using nonfederal funds to provide allowable nutrition education and physical activity promotion programs to SNAP-Ed eligible audiences can receive federal financial participation dollars.^{9,10} According to SNAP-Ed policy, public entities can be matched or reimbursed for documented allowable in-kind (noncash) contributions, whereas private nonprofit entities cannot. Supplemental Nutrition Assistance Program Education guidance states that "making a valid determination as to the health care organization's status as public or private is difficult to ascertain,"⁷ and this determination is vital, since only government entities can use in-kind (noncash) contributions. In addition, private (nonprofit) health care organizations receive a majority of their funding from Medicare/Medicaid, and these types of federal funds would not be eligible for SNAP-Ed reimbursement. Also, according to the guidance, health care organizations characteristically engage in secondary prevention and medical nutrition therapy (MNT), which are not allowable SNAP-Ed activities. Medical nutrition therapy is defined in the SNAP-Ed guidelines as "the assessment of the nutritional status of patients with a condition, illness or injury (such as diabetes, hypertension, gout, etc) that puts them at risk."⁷ To participate in SNAP-Ed, health care organizations would need to validate that they were providing allowable health promotion and primary prevention activities to the eligible target audience.

Central Valley Health Network's SNAP-Ed Demonstration Project and Case Study

Beginning in 2003, CVHN joined the California Department of Public Health *Network for a Healthy California (Network)* as a SNAP-Ed-funded Nonprofit Incentive Awardee.^{11,12} Central Valley Health Network is a consortium of FQHC that provides comprehensive health care services

to low-income and medically underserved families throughout California's Central Valley.¹³ Central Valley Health Network was able to meet all the SNAP-Ed requirements, including identification of over \$1 million in allowable nonfederal funding for general nutrition education and physical activity promotion. Central Valley Health Network is the largest FQHC network of its kind, serving more than half a million patients annually in 124 community health care sites.¹³ Each year, CVHN estimates that its member health centers provide a total of 2.5 million patient encounters.

The report incorporates the findings of a case study undertaken to profile the various ways SNAP-Ed was incorporated into CVHN's FQHC setting, identify particularly promising approaches, and recommend areas for future program strengthen. Information was collected through a review of project documents, an on-line survey completed by representatives of the participating health centers, and in-depth interviews conducted at site visits to 3 of CVHN's member health centers. As the case study focused on organizational and administrative practices rather than humans as subjects of research, it did not require institutional review by the common rule 46.102f.¹⁴

When the case study was conducted, 12 member health organizations participated in CVHN's SNAP-Ed project; each organization had between 5,000-77,000 clients, three-quarters of whom were living at or below the poverty level. These health centers were operating in the following 13 counties: Butte, Colusa, Fresno, Glenn, Inyo, Kern, Madera, Merced, Stanislaus, San Bernardino, Sutter, Tulare, and Yuba. These counties represent a vast geographical area spanning a distance of over 500 miles, from Chico in Northern California to San Bernardino, east of Los Angeles in Southern California.

Clients' Barriers to Fruit and Vegetable Consumption

Central Valley Health Network's member health centers serve a predominantly Hispanic/Latino, low-income clientele, although there is tremendous diversity in their clients' cultures, ages, and health problems. Data from

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