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A Community-Based Research Approach for Improving Eating and Activity Patterns in a Kansas City Latino Community

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Across the United States, Latinos experience disproportionate rates of adverse health outcomes, including diabetes and other non-communicable diseases, which may be prevented with healthy eating habits. Latinos are about 1.5 times as likely to have diabetes as non-Hispanic whites and are much more likely to be overweight or obese.[1] These same disparities have been observed in the Kansas City, Kansas, metropolitan area, in which Latinos have a life expectancy nearly 11 years shorter than white[2] Local data collection efforts indicate that only 19.8% of Latinos in Kansas City report consuming five or more servings of fruits and vegetables daily.[3] Securing conditions for healthy eating is a key goal for community efforts to reduce the risk for diabetes and other health disparities.

Background: The *Latino Health for All Coalition*

To address the disparities in Kansas City, the University of Kansas formed a community-academic partnership, the *Latino Health for All Coalition* (LHFAC) in 2008. Funded by the National Institute of Minority Health and Health Disparities, and the

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The Digest

Newsletter and Submission Guidelines

Share your expertise and success!

Let other Public Health/ Community Nutrition Practice Group members know what you are doing, how well it works, and how it is done. Consider writing an article or a short description of a program, community or school-based intervention or curriculum that you are involved in. It's a great way to showcase your successful and innovative programs, as well as provide inspiration and guidance to other members. You can submit your contribution by e-mail or CD to *The Digest* newsletter Editor Lauren M. Melnick, MS, RD.

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Health Care Foundation of Greater Kansas City, the LHFAC uses a community-based participatory research (CBPR) approach to engage community members and organizations in creating new programs or changing existing programs, policies, and practices aimed at three core goals: increasing healthy eating; increasing active living; and increasing access to preventive health services. Consistent with the principles of CBPR, community members and academic partners from the University of Kansas share responsibilities for all phases of the CBPR process.[4,5]

Strategies for Promoting Community Engagement and Participation:

Community-Determined Action Plan: LHFAC members developed an action plan that consists of prioritized strategies (i.e., new community programs/policies). These strategies are intended to change the environments in which people live, work, play, study, and worship, as related to the Coalition's three core goals. Developed by the community, this plan includes 39 core strategies. For instance, strategies related to healthy eating include:

- Promotion of home vegetable gardening and gardening in large public places, through training and support.
- Promoting healthy foods at Tiendas (Latino corner stores).

The action plan offers a number of benefits for the Coalition. First, it provides direction for the collaborative action of the LHFAC members and partners. Secondly, it offers members and partners ways that they can contribute to the work of the Coalition.

Resources for Implementation: Resources, including mini-grants, technical assistance, and outreach or mobilization, are provided to LHFAC partners to help facilitate implementation of action plans. The Latino Health for All Coalition recieves over $100,00 each year to fund mini-grants to LHFAC partners. Partners design a way to implement a specific strategy that is tailored to their understanding of nutrition (or one of the other goal areas) and that best fits the population they serve.

Leadership: Governed by a Community Advisory Board (CAB), consisting of predominantly Latino community members and organization representatives, the LHFAC sets an agenda for collaborative action and provides resources for seeing that actions lead to improved environmental changes. The CAB exercises stewardship over these resources through complete control over how, and to whom, these resources are distributed.

Organizational Structure: The broader LHFAC membership is organized into five action committees: nutrition, physical activity, access to health services, community, and media. The Nutrition Action Committee consists of 10-12 community members and organization representatives. These committee members meet (minimally) monthly. They review progress toward implementation of all strategies of the action plan; brainstorm ways of implementing prioritized strategies; and support members/partners who have received nutrition-related mini-grants by providing feedback to address challenges and barriers. The Nutrition Action Committee also plays a role in providing an initial review of mini-grants that are submitted, and determines whether the proposal should be further submitted to the CAB for a final vote.

Key Successes of the Participatory Approach to Promoting Nutrition

The LHFAC uses an online documentation and support system to monitor implementation of community programs, policies, and practices by partners, as well as services that partners provide to achieve LHFAC goals. To date, 63 new community programs, policies, practices, or services have been

implemented by the Nutrition Committee. Examples of community programs include community gardens and nutrition education.

Community Gardens: Initially, the community gardening approach aimed to promote access to healthy foods. Feedback on this approach, however, was that neighborhood gardens, combined with resident/block gardens, would be more appropriate. Committee members also supported the establishment of school gardens. By the end of 2011, LHFAC had assisted implementation of one neighborhood garden; 2 school gardens; and 5 resident/ block gardens. Mini-grants have already been awarded to add 2 more school gardens and 12 more resident/block gardens in 2012.

Nutrition Education: Several key partners have been engaged to provide nutrition education, including the Kansas State Research and Extension office; community-based organizations; and faith-based organizations. Community engagement and participation has been critical in shaping provision of nutrition education, resulting in several changes as to how nutrition education is delivered to the Coalition's target areas. For example, the CAB will not approve any nutrition education classes that are offered using consecutive translation; instead, they have approved mini-grant applications where Spanish-speaking community members achieve certification to deliver specific nutrition education curriculums. The Dining with Diabetes curriculum is just one example.

Conclusions

Use of CBPR has enabled the LHFAC to make changes within the community that create conditions encouraging healthy food consumption among Latino populations. Several processes have enabled the group to determine and produce changes in the community. Key ingredients to the group's success include: development of a community-determined action plan; resources for implementation; leadership from a CAB consisting of community and organizational representatives; and an organizational structure that provides many opportunities for participation and engagement. Encouraged by these early achievements, the Coalition's ultimate aim is to create conditions that reduce the risk for diabetes and other health disparities.

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Teachable Nutrition in Oral Health Care

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Healthy eating habits are important for both general and oral health. Caries and periodontal disease are the most prevalent chronic oral diseases,[1,2] and oral cancer is associated with significant morbidity and low survival rates when diagnosed in later stages.[3] All three conditions are linked to dietary behaviors. Frequent consumption of foods and beverages high in sugar and carbohydrates is associated with a greater risk for caries.[4,5] A decreased risk for oral cancer has been associated with the increased consumption of fruits and vegetables.[6,7] Strong evidence has emerged to support a bidirectional relationship between periodontal disease and diabetes. Uncontrolled diabetes carries a higher risk of periodontal disease, while severe periodontal disease in diabetes has negative effects on diabetic complications and glycemic control.[8,9] Thus, dietary habits can affect general and oral health both directly and indirectly.

Significant efforts are being made to curb the epidemic in obesity and diabetes by promoting healthy eating habits through public media campaigns, clinical care, environmental changes, and social support. To date, dentistry has not played a significant role in this endeavor, but some efforts have been made.[10-13]

Because dentists and dental hygienists see many patients annually, if not more often, these healthcare providers are in an ideal position to deliver a message congruent with that of registered dietitians to make healthy food choices that will benefit oral and general health. Dental hygienists routinely have 30-50 minute visits in which to conduct patient-centered discussion around healthy habits. For many patients, annual or semi-annual contact allows for repeated and progressive dialogue. Effective messages around general diet topics in the primary medical care setting,[14,15] such as USDA's *MyPlate*, can be useful starting points for adaptation.

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From previous work, the need to improve the diet/nutrition discussion in the dental setting has been identified. In particular:

- The frequency and quality of nutrition-related discussions in the dental office are less than optimal.[16,17]
- Missed opportunities to improve communication on this topic often occur.[18]
- There is minimal distribution or availability of written patient materials in the dental setting.
- There is virtually no patient-provider discussion of dietary habits that address benefits for both oral and general health.

To integrate a broader nutrition message into dental care, oral health providers themselves must value the dietary habit discussion. Therefore, we took a participatory approach using formative research with hygienists to determine views of discussing dietary habits in the dental visit. To date, we have completed focus groups and individual interviews with dentists and dental hygienists. Themes identified from qualitative analysis of these formative discussions identified barriers to nutrition conversations, specifically, lack of time, concern about directive advice, and reluctance to criticize. Respondents (mostly hygienists) reported they had adequate knowledge regarding nutrition and caries. Most indicated that they "provide the information, but it is the patient's decision about behavior change—I can't make them do it." Several respondents practiced a type of readiness assessment for tobacco cessation, but not for routine oral hygiene changes or food/beverage choices. Many expressed frustration regarding patients who do not adhere to advice toward changing oral hygiene habits, dietary habits, or tobacco use. These preliminary results suggested that communication skills around engaging patients in behavior change discussions were needed.

We have received local and National Institute of Health (NIH) funding to develop training to improve communication skills of oral health providers by incorporating Motivational Interviewing (MI) skills in their patient discussion.[19] We hypothesize that a theory-based, interactive educational module around nutrition counseling in the dental office, developed with

practitioner input and implemented with feedback measures, will result in increased knowledge, better attitudes toward nutrition counseling, and improved patient-provider communication skills for participating providers.[20] We will determine the feasibility and acceptability of the MI-informed patient discussion around dietary habits in the dental setting. We have targeted adolescents and sugared beverage consumption.

The MI-informed intervention and provider training we are developing include:

- Raising awareness and providing information regarding evidence-based techniques to initiate and guide change discussions.
- Updating knowledge about the association between nutrition and oral health to increase the importance of the nutrition topic in oral health counseling.
- Repeated and varied opportunities to practice the use of MI-based techniques to increase self-efficacy and skills.
- Self-reflection on new skills by reviewing interactions with standardized patients in a simulation laboratory.

Critical components of intervention development and pilot data collection are in progress to implement these approaches in community-based dental settings. Successful completion of this project will lay the groundwork for future research to test the effectiveness of healthy eating messages on knowledge, attitudes, and intentions in patients, ultimately seeking to facilitate and support behavior change among patients, and improve oral and nutritional health status.[21]

These efforts toward individual behavior change will be most successful when combined with community-level and environmental changes in sugared beverage availability and marketing.

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Adapted Intervention Mapping: A Unique Approach to Planning and Implementing Policy and Environmental Change

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Fifth graders from a rural elementary school in the San Luis Valley of Colorado have plenty to say about their health:

"Some kids are diabetic. Like when you eat too much candy, you have to check your blood. If it's too high, you have to go to the doctor and get a shot."

"... think kids have health problems because they are getting too fat. I think we should get an hour recess. When my dad went to this school, he only got one recess a day. But he got a whole hour. We only get a half hour. Recess is important because you get to run. If you don't run, you could get diabetes. I know this 'cause my brother tells me and my mother tells me."

"Since we're on farms, we have to go outside a lot to do chores. But some kids don't. They just sit on the couch and play video games and keep eating."

These students come from a rural school where 50% of their classmates are overweight or obese, and the school's free and reduced lunch rate is 81%. From 2006-2008, the University of Colorado's Rocky Mountain Prevention Research Center (Center) conducted interviews with students, teachers, principals, and superintendents in 23 rural communities with similar demographics. Through those discussions, it became clear that low-income children in rural communities often lack access to healthy foods and structured physical activity. The school environment is one of the only places students can eat fruits and vegetables, receive vital exercise, and develop habits that promote life-long wellness.

School taskforce and AIM facilitator creating an action plan.

While public schools are an important setting for promoting healthy behaviors and reversing obesity trends,[1] access to unhealthy foods in schools, combined with limited opportunities for daily physical activity, undermine schools' potential to follow through on their wellness goals.[2] In addition, despite the recommendation for daily physical education (PE) by several national organizations such as the National Association for Sport and Physical Education,[3] only 4% of elementary schools offer daily PE.[4]

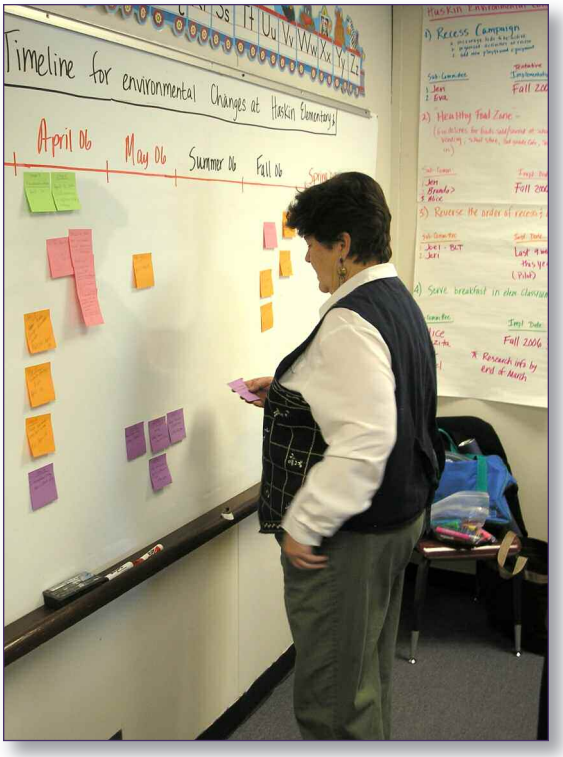
It is challenging for rural school administrators to focus on health and wellness issues given the culture of high stakes testing and the lack of resources for nutrition and activity-related initiatives. As one superintendent explained, "What we continue to hear is 'No Child Left Behind.' I haven't heard 'don't leave overweight kids behind.' It's about keeping kids academically fit. That's foremost on our minds."

Our Center's interviews with public schools suggest that while school administrators want to address student health issues and find ways of making their school environment more supportive of healthy eating and physical activity, they simply don't have the time and resources to accomplish this goal. If we want schools to be settings of health promotion, our data suggest we need

to provide school personnel with outside support and leadership.

The Center has attempted to do just that. Funded by the Centers for Disease Control and Prevention (CDC), the Center strives to "promote healthy lifestyles in rural communities" using a community-based participatory research (CBPR) approach to translate research into practice. The Center developed Adapted Intervention Mapping (AIM), a strategic planning process to implement environmental and policy changes that support healthy eating and physical activity in schools.[5] AIM is based on Intervention Mapping and principles of community-based participatory research.[5] AIM is designed to elicit the community's voice and decision-making power. University researchers bring their knowledge of best practices for increasing healthy eating and physical activity in the school setting, and community members decide which changes to implement based on their cultural values and knowledge about what will be a good fit for their school.

In AIM, elementary schools assemble a task force of seven individuals. The principal needs to be on the task force for a school wellness initiative to succeed. Other members usually include the counselor, secretary, physical education teacher, food service director, classroom teachers, and parents. Task force members attend scheduled planning meetings (one to two per month). Occasionally, task members work on projects outside of the meetings. Their main role is to make informed decisions about which environmental and policy changes the school should make. From there, members plan to implement the necessary changes. In addition to twice monthly meetings, the task force meets at least twice at the beginning of the following school year to discuss the status of last year's changes and next steps.



Classroom teacher and member of the school task force putting action items on a timeline.

The Center also trains outside facilitators to lead school task forces through the AIM process. At each meeting, facilitators use pre-established agendas to develop "products" inbetween meetings for task force members to review and modify at the next meeting (e.g., a needs assessment summary report) and bring research, information, and resources to the task force for review. As one example, facilitators may bring data on childhood obesity; local school data showing how the school environment and policies meet or fall short of best practices; national recommendations for healthy eating and physical activity; and other schools' success stories to support proposed efforts.

In the School Environment Project completed by the Center, AIM led to various new best practices in each school, including: increasing the availability of fruits and vegetables and decreasing availability of high fat/sugar items; removing vending machines; scheduling recess before lunch; providing health and nutrition classes in the classroom; increasing the amount of physical education available; using evidence-based physical education curricula such as SPARK™, providing additional equipment during recess; enhancing playground features (e.g., painted courses, hopscotch, walking track); and encouraging organized games at recess.[6]

School playground in Central part of San Luis Valley.

Intervention Mapping continued on page 8

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Building on lessons learned from our work in schools, the Center received a three-year, $1.86 million grant from the Colorado Health Foundation in October 2010. This grant supports the implementation of AIM in 24 rural, low-income elementary schools in Colorado. We also are exploring the effectiveness of a new version of AIM that has 1-2 fewer meetings, and a school staff person designated as an AIM co-facilitator (with specific responsibilities and concomitant remuneration) to work alongside the trained AIM facilitator.

This grant also funds the San Luis Valley Physical Education Academy—a professional development initiative designed to improve the quality of physical education programs in 47, K-12 schools in the San Luis Valley. There are three components of the Academy:

- Professional development around common curriculum and instructional strategies:
  - The Academy has adopted the research-based curriculum SPARK™[6] and is providing the curriculum along with SPARK workshops and booster sessions, to all PE teachers and their principals.
- Equipment:
  - Each school receives specialized equipment specific to SPARK curriculum, thus supporting effective instruction.
- Monthly site coordinator visits:
  - The coordinators will assess PE teachers' implementation of SPARK, and utilization of instructional practices related to curriculum and planning; management of program; communication of concepts; learning environment; movement of youth; skill instruction and assessment; and program and professional development.
  - They will also review the principal's role in the program, including: promotion of high quality PE via hiring/retaining highly qualified PE teachers; adopting PE standards; aligning curriculum with PE standards; allocating adequate funds to support the PE program; scheduling similar PE class sizes as other subject areas; and conducting meaningful and accurate assessments of PE teachers.

School taskforce (principal, nurse, and classroom teacher) enjoying healthy snacks during an AIM meeting.

This process is aimed at creating school-level environmental and policy changes to increase opportunities for healthy eating and physical activity.

In light of the growing trend to use CBPR approaches in tackling complex health problems such as childhood obesity, processes are needed for collaborative program planning and implementation. Interviews with task force members suggest AIM is a process whereby individuals' expertise, such as a university researchers' knowledge of best practices and access to national resources, and the school task force members' unique and in-depth knowledge of the community and culture, are brought to the table in a careful planning process.[5] This process is aimed at creating school-level environmental and policy changes to increase opportunities for healthy eating and physical activity. Participants exchange information, listen, and learn from each other.

Task force members appreciate outside facilitation of the planning process, as well as the additional resources brought to the table by the University. They also enjoy the idea of a level playing field where task force members, regardless of their place in the school's organizational hierarchy, feel they have an equal vote, which is an important part of the process. In addition, because school administrators and teachers feel overwhelmed with an increasing set of responsibilities and expectations around standards-based curricula and high stakes testing, task force

members appreciate being able to walk into a meeting that is planned and led by others.

Public schools continue to be critical sites for cultivating healthy behaviors among youth. Input from a variety of stakeholders, a practice detailed within CBPR, may be the most complete method of forming collaborations between all participants who play a role in school wellness.

See tables of the Description of the Adapted Intervention Mapping (AIM) Process on pages 9-10. For more information on the program, please visit: www.ucdenver.edu/rmprc.

Mountain Valley Area School playground in Northern part of San Luis Valley.

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Description of the Adapted Intervention Mapping (AIM) Process

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Prior to the first meeting, the AIM facilitator works with the school to assemble a task force comprised of the principal, nurse, counselor, food service manager, physical education teacher, classroom teachers, parents, students, and others (e.g., janitor, community agency representative).

Meeting	Topic
1	**Get Organized:** Introductions, overview of project goals; establish meeting norms, decision-making processes, and other ground rules to create healthy group functioning; select a school liaison to co-facilitate the AIM process and be responsible for keeping the momentum going once the facilitation is over. Document decisions and progress in school's Program Notebook/Toolkit.
2	**Collect and review student level height, weight, nutrition, and activity data; complete School Environment and Policy Survey; and brainstorm the following:** • What student behaviors may be contributing to poor eating and inactivity throughout the school day? • What aspects about your school environment and policies contribute to inactivity and poor eating? • What knowledge, attitudes, beliefs, external pressures, competing priorities resources/lack of resources, etc., does the school community have that contribute to decisions limiting activity and healthy eating? • What student behaviors and school features contribute to healthy behaviors? Task force members are invited to collect additional information and school environment/policies, and student behavior (e.g., informal survey on number of students eating breakfast). Document decisions and progress in school's Program Notebook/Toolkit.
3 & 4	**Decide on evidence-based environment and policy changes to make:** 1. AIM facilitators share national dietary and physical activity guidelines and recommendations. 2. Task force brainstorms changes to help children achieve daily recommendations. 3. AIM facilitators share best practices information from the literature. 4. Task force members individually rate each of the proposed changes based on importance (is this an evidence-based strategy known to increase activity/healthy eating, will it affect the majority of students on the majority of school days?) and changeability (do we have the resources, will, capacity to do this?). 5. Brainstorm ideas are plotted on a poster with four quadrants: high importance/low changeability; high importance/high changeability; low importance/low changeability; low importance/high changeability. 6. After a discussion on the results (usually focused on ideas in the high importance/low changeability; high importance/high changeability quadrants), each task force member votes on his/her top three physical activity changes, and top three nutrition changes. 7. Based on the environment/policy changes receiving the most votes, the task force chooses to implement two to three nutrition changes, and two to three activity changes. Document decisions and progress in the school's Program Notebook/Toolkit.

Description of the Adapted Intervention Mapping (AIM) Process *continued*

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Meeting	Topic
5	**Task force members answer the following questions for each environment/policy change:** • Who needs to be involved to make this change happen? • What are the steps to implementing this change? • What are the possible barriers that might be encountered? • What would it take—inside a task force member and in that member's environment—to accomplish the steps to implement the change? Based on literature searches, behavior change theory, and knowledge of other schools' success stories, AIM facilitators provide information to help answer these questions. Document decisions and progress in school's Program Notebook/Toolkit.
6-10	**Planning for implementation, evaluation, and adoption:** Meeting 6: Task force breaks into subcommittees with two+ members overseeing each change, and set timelines for implementing change. Subcommittees conduct pilot tests as needed. Meeting 7: Report on implementation planning. Meeting 8: Consider program evaluation and report on intervention planning. Meeting 9: Plan for program adoption and public relations. Meeting 10: Celebrate and continue discussions about program implementation, adoption, and evaluation; and specification of activities that need to be completed over the summer. Document decisions and progress in school's Program Notebook/Toolkit.
11-12	**Keep the momentum going:** In the fall of the next school year, subcommittees provide updates on implementation status of planned changes, taskforce finalizes the Program Notebook/Toolkit to ensure sustainable of changes. Task force decides how/if AIM facilitators could be of service in the future, how often the group will continue to meet to ensure changes remain implemented and work well, etc. Document decisions and progress in the school's Program Notebook/Toolkit.

Adapted Intervention Mapping is based on Intervention Mapping, a strategic planning process developed by Bartholomew and colleagues. Bartholomew LK, Parcel G, Kok G, and Gottlieb N (2006). Planning Health Promotion Programs: An Intervention Mapping Approach, 2nd Edition. San Francisco: Jossey-Bass.

For more information about AIM, please see: Belansky ES, Cutforth N, Chavez RA, Waters E, Horch K. An adapted version of intervention mapping (AIM) is a tool for conducting community-based participatory research. Health Promotion Practice. Prepublished June 10, 2009, DOI: 10.1177/1524839909334620. Contact Elain Belansky at elain.bleansky@ucdenver.edu or 303-724-4383.

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Using Community-Based Participatory Research to Address Health Disparities Within the Native American Population

Valarie Blue Bird Jernigan, DrPH, MPH

Health disparities in racial and ethnic minority populations persist in American society.[1, 2] The process of translating health research into practice has seen limited success.[3-5] A critical element lost in this translation may be community engagement in the form of co-creation and implementation of promising programs. Community Based Participatory Research (CBPR) has been shown effective in engaging key stakeholders, building community capacity, and ensuring program sustainability[6-9]—all three of which are essential factors in successfully translating research into practice.

CBPR in health has been defined as: "A collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings."[7] CBPR begins with a research topic of importance to the community, with the aim of combining knowledge and action to improve community health; eliminate health disparities; and advance social change.[7] CBPR is also defined as a: systematic inquiry, with the participation of those affected by an issue, for the purpose of education and action, or effecting social change."[10]

CBPR appeals to practitioners in the health care setting who have limited time with patients, and recognize the need for community partnerships in addressing the growing rates of obesity and diabetes. CBPR appeals to communities, particularly ethnic and racial minority communities, whose members are underrepresented in the health field, and overrepresented in chronic disease morbidity and mortality rates. With its roots in the popular education movement of the 1970s, CBPR uses research as a tool for social changes aimed at reducing health disparities. Practitioners of CBPR have developed several key principles, including the principle of co-learning; the focus on creating a balance between knowledge generation and intervention; and commitment to sustainability.[10] These guidelines, when followed correctly, have the potential to facilitate authentic community-directed research and are increasingly cited in the emerging field of implementation science.[9] The guidelines allow researchers to collaborate with the community, rather than impose their research protocol on the community. Community members move beyond the role of passive subjects, which is the case in traditional biomedical research, to active participants who are involved in a process of gaining and sharing knowledge, and creating change cohesively.[11]

Native Americans have higher rates of obesity (nearly 24%) than other race/ethnic groups combined (totaling 19%).[12] The prevalence of diabetes among Native Americans is almost three times that of non-Hispanic whites of similar ages.[12] CBPR has successfully been used to develop, adapt, and implement several diabetes self-management programs among Native Americans;[13-17] lifestyle interventions to reduce obesity;[18-19] and interventions aimed at changing food policy.[20-23] All programs have engaged the Native American community in the development, implementation, and promotion of the intervention. They have also incorporated culturally-relevant messages, symbols, and strategies, with respect for and inclusion of traditional foods, activities, and knowledge, and the sovereignty of tribal nations. CBPR methods that focus on equitable opportunity and a balance of research and action, in many ways, mirror the guidelines developed and implemented by many Native American Nations for conducting research within their communities.[24]

"A collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings."

In conducting CBPR, there are several important limitations to consider. For example, CBPR is time consuming. It begins with researching issues that the community identifies. Often, these issues are complex social justice issues like poverty and lack of housing that take community priority over implementing a promising public health intervention. Intervention designs and approaches that will meet the needs of public health researchers and community members require fostering mutual respect and authentic collaboration. This is often difficult when funding is limited and priorities differ for researchers and communities. Additionally, many researchers claim to use CBPR approaches, but often do not truly involve community more than in name or in superficial ways.

In summary, CBPR shows promise in restoring trust between university and community partnerships. It promotes

an equitable distribution of resources and builds community capacity, while improving the likelihood for success in implementing evidence-based programs. Despite the initial success of CBPR-guided efforts to address diabetes and obesity among Native Americans, a paucity of data exists and further research is needed. Decisive and innovative programs that are culturally centered and tribally-directed are essential in eliminating these disparities. CBPR is an added value in the translation of research into practice, particularly within the Native American population.

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Community Champions of PHCNPG

Members of the PHCNPG are outstanding examples of practitioners and students who are receiving accolades in the community for their work in the development and advancement of public health nutrition. This year, *The Digest* editors will be asking members via the list serv to tell us more about their own professional accomplishments, and we will feature a few members in each edition of our newsletter.

The Digest is honored to recognize some PHCNPG members for their recent exceptional achievements:

Hope Bilyk, MS, RD, LDN

Hope Bilyk, MS, RD, LDN

Hope is the 2011 recipient of the Rosalind Franklin Award for Excellence in Teaching, as awarded by the faculty in the Department of Nutrition at Rosalind Franklin University of Medicine and Science, North Chicago, Illinois. This award is provided annually to a faculty member who demonstrates "meritorious teaching in medicine or related health science."

Since 1997, Hope has been an assistant professor in the College of Health Professions, teaching nutrition courses both on campus and online. In addition to PHCNPG, Hope is also a member of Sports, Cardiovascular, and Wellness Nutrition (SCAN), and a founding member of Dietitians in Integrative and Functional Medicine (DIFM).

Hope has 20-plus years of experience working in clinical nutrition and holds a Master's Degree in Nutrition and Clinical Dietetics from the then-named Finch University of Health Sciences/Chicago Medical School.

Dayle Hayes, MS, RD

Dayle Hayes, MS, RD

In January 2012, Dayle received the School Nutrition Association (SNA) Silver FAME (Foodservice Achievement Management Excellence) award as a Friend of Child Nutrition. The FAME Awards acknowledge success in the school nutrition industry. Each year, the awards are presented to outstanding leaders, recognizing them for achievement, innovation and service.

Dayle is President of Nutrition for the Future, Inc., Billings, Montana. Her recent award from SNA resulted from work done with the *School Meals that Rock Campaign. School Meals that Rock* is a blog and Facebook page that shares and celebrates what is right with school nutrition. Dayle calls the movement a "counter-revolution to the media bashing of school meals, and a tribute to every lunch lady (and gentleman) working to do amazing things for kids' nutrition." She regularly posts photos of healthy and innovative school meals from around the country, highlighting the work of talented school nutrition professionals.

Since the mid-1990s, Dayle has devoted her career to advancing the goals of schools wellness. She founded the Billings Chapter of *Action for Healthy Kids*; co-founded a grassroots organization called *Be There Billings*: *End Childhood Hunger*; writes the monthly *Eat Right Montana* healthy family packets, and a popular nutrition column in the *Billings Gazette*.

Dayle's blog can be accessed at: http://eatwellatschool.blogspot.com/. The *School Meals That Rock* Facebook page can be found at: http://www.facebook.com/SchoolMealsthatRock#!/SchoolMealsThatRock?sk=info.

Marianella Herrera, MD, MSc

Marianella Herrera, MD, MSc

Fellow PHCNPG member Camella Rising nominated Marianella Herrea to be featured as a Community Champion.

Camella wrote to *Digest* editors: "I'm attaching the CV of my colleague and dear friend who deserves so much recognition for the great work she does. In Venezuela, she is a medical doctor as well as a nutritionist. She is truly exceptional.

A worldwide media representative for the American Overseas Dietetic Association (AODA). Marianella has put her vast communication skills to work as an advocate for young children living on the streets in Venezuela and in need of critical nutrition and medical care. She is a member of the Homeless Street Kids Association (Ayuda a un Niño), where she is the nutrition assessment expert for recovering youth in homeless street situations.

In 2010, Marianella received the Research Diabetes Award and a grant from the Liberty Mutual Foundation (Fundación Seguros Caracas) in Caracas, Venezuela, for the project: Identification of Risk Factors for Future Type 2 Diabetes in Venezuelan School age Children from Private and Public Schools. She also serves as a reviewer for the *Journal Venezuelan Annals of Nutrition (Anales Venezolanos de Nutrición).*

Within the last year, Marianella was appointed as assistant professor at CENDES-UCV, Center for Development Studies,

(Centro de Estudios del Desarrollo) at Central University of Venezuela (Universidad Central de Venezuela). She is also a member of the Venezuelan Health Observatory, and a researcher in the field of public nutritional policies for Venezuela.

Samantha Schaefer, MS, RD, CD

Samantha Schaefer, MS, RD, CDT

An Indiana University Health Outpatient Dietitian, Samantha was recognized by the Greater Bloomington Chamber of Commerce as a Helping Young Professionals Excel (hYPe) 10 Under 40 Award recipient. This honor is given to young professionals between 21 and 40 years who demonstrate leadership in their community and serve as mentors to other young professionals.

Samantha has previously served on the Indiana Dietetic Association (IDA) Board of Directors as the Clinical Practice Chair; is a past president of Southeast IDA (SEIDA), and continues to volunteer on the SEIDA board as web master. In her professional role at IU Health, Samantha develops community nutrition programming; conducts community assessments; and develops action plans for policy, environmental and systems change.

Samantha holds several certifications within dietetics, including a Certificate of Training in Restaurant Menu Labeling (2010) and a Certificate of Training in Childhood and Adolescent Weight Management (2009). She is a graduate of the University of Tennessee (Memphis) with a Master's of Science in Clinical Nutrition.

Letter From the Editor

Lauren M. Melnick, MS, RD, LD

Dear PHCNPG Members,

For the past three years, I have had the pleasure of serving as editor for *The Digest*. In fulfilling the duties of this role, I found it was often a creative challenge to select topics that would entice our readers and provide valuable information on the most current topics surrounding public health nutrition. Knowing that the newsletter is perhaps one of the most critical member benefits for any DPG, my hope is that the last three years of *The Digest* have been useful and enjoyable to you and your nutrition practice.

At this time, I am happy to introduce our new *Digest* editor, Jessica Barron. I first met Jessica when she was my dietetic intern at The Ohio State University Extension. What impressed me the most about Jessica was her unbelievable attention to detail; her intensity and passion for the field of public health nutrition; and her strong writing abilities. While at the Extension, Jessica helped me to edit the *Local Foods Guide* for residents of Cuyahoga County, OH, and quickly conceptualized a better product. Knowing that my tenure as *Digest* editor was coming to an end, I recruited Jessica as our co-editor for *The Digest*.

In May, as Jessica graduates from Case Western Reserve University with a MasterDegree in Public Health Nutrition, and becomes a Registered Dietitian, she will also become editor of *The Digest*. I couldn't be more pleased to pass this role on to Jessica, as I know she will bring a fresh and innovative approach to *The Digest*. Jessica also has a Bachelor of Science in Communications from Boston University.

Because Jessica is also a Clevelander, we have been able to meet numerous times in person to discuss how we can improve The Digest. In the future, we hope to utilize more members as section editors; provide continuing education credits; and highlight more member accomplishments through our "Community Champions" updates. Our current edition of *The Digest* examines research trends in public health nutrition. As Jessica and I were working on putting this issue together, we realized that some of the projects featured, while very much nutrition related, did not employ a registered dietitian. At first, we were disappointed to see so few dietitians involved in community-based projects; however, we now see it as a call to action for more dietitians to become involved in public health nutrition research.

I hope you enjoy reading about these diverse projects, — many of which utilize community-based participatory research (CBPR). I also want to mention that PHCNPG will now post all newsletters on our PHCNPG website. This is the only way to obtain the newsletter at this time. If you have questions or concerns about this, please contact Jessica or me (our email addresses are on last page of the newsletter).

Thank you for your support. I look forward to continuing to serve PHCNPG as Secretary in 2012-13!

Lauren Melnick, MS, RD, LD

The Digest

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