1. Fit Sista Diaries: The Impact of Healthy Lifestyle Change on Muslim Women

Amani Abdallah

Community Partner: Muslim Community Association

Background: Muslim women at local mosque in Santa Clara, Ca. want: Assistance in changing lifestyle habits (physical activity and diet), a culturally sensitive program, and a program geared toward 40 year-olds. Women feel challenged but hopeful to: Adopt healthy lifestyle changes including nutrition and physical activity, lose weight, eat healthier, build confidence in changing lifestyle and sustain change- increase personal self-efficacy, become positive pillars in their families to perpetuate healthy change

Objectives: Challenge women to adopt healthy lifestyle habits, build self-efficacy, encourage personal appraisal, build social network and leaders within Muslim community. **Methods:** 5 week challenge, educational talk each week on different topics, weekly surveys on effectiveness after each challenge, individual support and motivational interviewing provided at end of study before beginning of Ramadan. **Results:** 7 out of 11 women said they will continue drinking flavored water instead of sugary beverages.

5 out 11 women said they feel confident enough to invite their family and friends to try quick at-home workouts. 88% of the women said making food substitutions permanent change is "quite a bit" and/or "very" important. 4 out of 8 women said they will continue tracking their steps and reach their 10K steps/per day goal. 90% of the women said they will use more holistic methods to deal with and manage their everyday stress. **Future Directions:** Participants believe a longer program (one year) would help them become the leaders they want to become in the Muslim community. Designing a program that is tailored to Ramadan lifestyle changes can be extremely popular- for many women this is the toughest time of year to hang on to positive and healthy habits.

Implications: The women believe that they have the potential and strength to adopt healthy lifestyle habits. This program offered a culturally sensitive experience, which helped the women feel comfortable, vulnerable, and hopeful all at the same time. Moving forward, Fit Sista will continue to meet twice a week for support and regular check-ins will continue to occur.

2. Health and Wellness Workshops that Make a Difference to the Unhoused; Using Mentoring to Increase Interest and Attendance

Laura Becker-Lewke, Aparna Jayaraman, Lynelle Bilsey, Michael Hollingshead, Mudra Josephson, Meredith Wilkinson

Community Partner: InnVision Shelter Network

Background: Mentoring program designed to reward clients (both residents and drop-in) as part of a new three track program instituted at the Opportunity Services Center (OSC) April 7, 2014. While the primary goal for both groups is survival, health is often compromised/ ignored due to circumstances. ~50% of clients are smokers. Mentors to assist clients during smoking ban transition – enacted 4/1; enforced 7/1. Client workshops are offered (e.g., resume writing, budgeting etc.), but not well attended. There is limited/no workshop follow-up. Few if any workshops are held on health and wellness. **Objectives:** Use the mentor program to help encourage mentees to attend workshops and follow-up on useful information obtained during the workshops, use workshops as an activity mentors and mentees can participate in together, create explicit health and wellness workshops that will be meaningful for this community, and create a work project that mentor/mentees can do together, e.g., a serenity garden that they build and maintain together. **Methods:** Survey population to determine topics of interest. Create four health and wellness workshops: two on stress management – walking the labyrinth at All Saints' church, one on smoking cessation – a train-the-trainer event for mentors and IVSN staff by Stanford's Dr. Judith Prochaska, one on mindfulness engaging another H4A Fellow, Dr. Maile Jachowski,

creator of Nativefit. Create a work project: Work with IVSN staff to identify the location in the OSC to build a serenity garden, and use the knowledge of a volunteer who previously created a serenity garden to help start this project. **Key Learnings:** Workshop timing is critical. Workshops held early in the month will be poorly attended because clients have just received their Social Security. Personal invitation is critical, especially right before the event. Posters displayed on site are considered impersonal and do not result in attendance. Being on-site the day before an event is extremely helpful in persuading people to come and having them show up. **Takeaways:** As Maslow showed, need to feed and clothe a person before you can expect him/her to focus on other aspects of life, e.g., health. By providing food and shelter IVSN empowers people to take the next step. **Recommendations:** Send all mentors a list of workshops for each month and a contact person for more information. Encourage mentors to attend at least one workshop per month with their mentee and follow up with them. Create a simple feedback document that is administered in the last five minutes of the workshop in order to evaluate workshops to be offered in the future. Track the feedback to know which workshops are attended and useful. Think creatively about how to engage this community. Workshops on health and wellness basics: nutrition, physical activity, and getting enough sleep, while important, need to be rephrased and restructured in order to engage this community. Track the extent to which mentors as a result of working with mentees increase their attendance at workshops and use the information given in their lives. Work with IVSN staff/ clients to help with smoking cessation as the need arises after July 1.

3. Characterization of Super-Users of the Stanford Hospital Emergency Department

Charles H. Bowden, M.D.; Ann Lindsay, M.D.; Sanjay Basu, M.D., Ph.D.

Community Partners: Stanford Hospital and Clinics, Stanford Coordinated Care

Background: A small minority of individual patients account for a disproportionately large number of visits to the SHC emergency department. Data from FY2013 indicate that 1,673 unique patients (4.13%) visited the ED 4 or more times within a 12-month period and accounted for 9,451 ED visits (16.41% of total encounters) during that year. A sub-group of 123 patients visited 10 or more times (range 10 – 34) within the same 12 months and accounted for 1,711 ED visits – nearly 3% of all visits in that year. These observations are similar to those reported by a 2010 meta-analysis showing that 4.5% to 8% of ED patients account for 21% to 28% of all ED visits. Many hospital emergency departments – particularly those in major urban areas and in large academic medical centers – have become the community health safety net and the de facto venue for primary care for some patients. These phenomena are symptomatic of important preventive medicine and public health problems within the US health care delivery system. **Objectives:** We sought to identify and characterize the demography and clinical presentation of frequent visitors to the SHC emergency department; quantify the cost to SHC, patients, payers, and other stakeholders; determine the causes underlying the frequent visitors' pattern of use; and design cost-effective interventions to reduce their reliance on the ED for services and support that can be best provided in other venues. **Methods:** This was a retrospective cohort study using data extracted from the electronic health records (EHRs) of patients seen in the Stanford Hospital emergency department from FY2010 through the first 7 months of FY2014.The Stanford IRB reviewed and approved the study. Based on published thresholds, we defined "Frequent Users"

as those making 4 – 9 visits / year, and "Super Users" as those making 10 or more ED visits / year. For comparison, we obtained a Control Sample of 1000 patients chosen randomly from FY2013, each making 1-3 visits to the ED. The original data were converted to .csv files and analyzed using R statistical software. We used descriptive statistics to characterize patients in each cohort. ED visit data for Frequent- and Super-Users during the period FY2010 – FY 2014 were analyzed to determine the persistence of visit frequency over time. For all other analyses, the primary dataset was derived from ED visits occurring during the 12 months of FY2013. ICD-9-CM diagnostic codes, assigned to each patient for each ED visit, were mapped to "chronic" or "non-chronic" classifications using the Chronic Condition Indicator (CCI) software algorithm. The CCI algorithm was also used to classify primary diagnostic codes into "body systems." We also constructed regression models and classification trees to identify variables which were predictive of Frequent- or Super-User status. **Conclusions:** Although more than 80% of Super-Users had some form of health insurance, only 1 of 123 reported having a primary care physician (PCP) versus 41.3% of the control cohort. Some form of disability (by self-report) was highly prevalent within the Super-User cohort; 43.8% of such patients reported being disabled versus 4.4% of controls. A chronic disorder was the primary diagnosis in 24.5% of Super-User visits, versus 3.4% in controls. This is especially problematic in a population lacking a stable connection to continuous and coordinated care. Frequent- and Super-Users are highly concentrated geographically. Interventions and resources could be targeted within the patients' own community. A small set of presenting problems accounted for a large fraction of all visits in each cohort (the 25 most frequent diagnostic codes represent 30% - 40% of all visits). Substance abuse and psychiatric disorders – sometimes in combination – are more common among Super-Users (data not shown). Less than 20% of Frequent- and Super-User patients in a given year continue their pattern of use beyond one year (data not

shown). This secular attrition has important implications for outcomes assessment of any intervention programs. Predictive analytic methods applied to EHR records and other datasets could provide early and pre-emptive identification of high-risk patients, intervention, improved care, and prevention of future ED visits.
Recommendations: Establish and maintain a continuously-updated registry of the most frequent visitors to the ED; flag members of this registry in Epic on arrival in the ED; develop and maintain a concise clinical and psychosocial summary of each of the highest utilizers for reference by caregivers at subsequent visits. Connect Super-Users to a primary care physician or clinic and ensure follow-up within 72 hours of discharge from the ED. Create an interdisciplinary team at SHC to monitor, coordinate, and manage the comprehensive care of the highest utilizers of the ED. Assign each of the highest utilizers to a social worker or case manager for ongoing support. Ideally, co-locate resources within the specific communities where the highest utilizers live. Identify patient-specific needs and apply appropriate interventions pre-emptively to patients at high risk of becoming Frequent- or Super-Users. Develop and maintain alliances with Federally Qualified Health Centers and other clinics in San Mateo and Santa Clara counties for expedited referral and longitudinal care of ED patients. Establish a regional Health Information Exchange within San Mateo and Santa Clara counties to improve coordination and continuity of care. Consider the adoption of standard protocols for the initial assessment of the most common presenting complaints in the ED.

The women had an opportunity to teach their learned knowledge to other women within their community and spread healthy habits. **Method:** A nutritional 6-week 1-hour course focused on improving eating habits to 12 low income Hispanic women at the Siena Youth Center. The course was taught using an informal conversational style that promoted social support. A pre and post test was conducted. Ongoing tracking of healthier choices improvement was assessed to determine acceptability and feasibility. **Milestones:** Curriculum Developed. Participant Recruitment. Class Facilitation. Pre/Post tests administered. Partnership with community partner established. **Key Reflections and Learnings:** The simplest recipes were the most valued among the participants. "Portion Sizes" was the most highly rated session by the women. Small incentives were significant for participation. Small informal class format was advantageous to encourage discussion among the participants.

6. Evaluation and Development of School Gardens Across Palo Alto Unified School District

Jessica Ferrell, Brenda Carilla, Cati Brown-Johnson, PhD; Christopher Gardner, PhD

Community Partner: Palo Alto Unified School District

Background: The Health Council of the Palo Alto School District (PAUSD) recognizes the link between healthy students and academic success. The council's focus is on the whole child, which includes the social, emotional and physical states as well as their engagement and motivation levels. Few spaces in a student's academic day have a health component. PAUSD students reflect the national trend of children and adolescents falling short of the USDA daily recommended intake of 5 or more servings of fruit and vegetables. As childhood obesity has become the leading national public health concern for this age group, school garden programs have increasingly become one of the antidotes. A national school garden movement has gained momentum as studies show increases in healthful eating habits, nutrition knowledge, and

academic achievement. **Objectives:** Assess, support and create gardens at willing elementary schools. Evaluate current state of school gardens at local, district and national level. Use results to inform a sustainable support system. **Method:** Local: Contacted principals of all 12 elementary schools to gauge interest in support or creation of a garden. 3 robust existing programs. 3 existing. 6 non-existent. 3 schools at varying levels of need participated in internship. Barron Park- needs were instructional support in existing program. Created teacher survey to gauge involvement interest. Stanford service learning undergrad assisted in class. Fairmeadow- attended parent interest meeting, presented at PTA meeting. Nixon- researched garden bed dimensions, secured plantings, held garden meeting, posted information in newsletters, led K-2 classes in garden. District: Researched robust existing programs, collected qualitative data through key informant interviews. Attended district functions related to social/emotional learning, healthy food initiatives. Held Edible Education Community Brunch to organize key stakeholders. National: Reviewed previous School Garden Intervention results, attended 4 conferences related to school gardens and children's health. **Results and Conclusions:** Local- Barron Park- teacher survey unable to go out before end of year, in the process of working on support measures through creation of a central website and service learning interns. Fairmeadow- PTA approved financially supporting garden beds, awaiting approval of incoming principal. At the district level what emerged from the qualitative data collected was a network of key stakeholders that play diverse roles in the subsistence of school gardens. PAUSD is a district of schools with very individual personalities governed by protective principals. Knowing contributory roles leads to a structured support system, greater communication, effective collaborative efforts. **Key Learnings:** Regional School Garden Models that organize across school districts have most comprehensive and successful support plans. Garden education is most impactful when integrated within school day. Most effective healthy behavior change programs include kitchen and garden education alongside

healthy school lunch offerings. **Recommendation:** District level support in the form of a full time Garden Education Specialist and funding programs, teacher training, website. Inclusion of community partners in an organized system. Increase Farm to School involvement- more local procurement in school lunch and further healthy eating education.

cohort to extend commitment until September and plan on starting new cohort in Fall with more recruiting. Monthly check-ins to be mixed with different cohorts so that new mentors can interact with more experienced ones. Have a running list of mentees such that pairing can happen quicker. Advertise mentorship in volunteer orientations and other IVSN events.

9. A Community-Based Participatory Research Approach to Modifying the Indigenous Peoples Survey for a Diabetes Prevention Clinical Trial

Nicole Jeffery, Jan Vasquez, CHES, MPHc; Ramin Naderi, MA; Randall S. Stafford, MD, PhD; Lisa Goldman Rosas, PhD, MPH

Community Partner: Indian Health Center of Santa Clara Valley

Background: Historical- American Indian/Alaska Native (AIAN) history of trauma. "500 Years War" of community massacres, genocidal policies, pandemics, forced relocation, forced boarding school policies, prohibition of traditional language, spiritual and cultural practices. Historical Trauma: the cumulative emotional and psychological distress across generations and in one's own life, originating from massive group trauma. Despite a history of grievances, AIANs demonstrate continued resilience. National- AIANs are twice as likely to have diabetes compared to Whites and also have high rates of depression, substance abuse, and suicide. Urban AIANs represent a diverse array of cultural experiences, identities, and heritages, and therefore may benefit from a novel approach to wellness. Growing body of research of how AIAN historical trauma relates to mental/emotional/physical health and wellbeing. Community- American Indian Community Action Board (AiCAB) identified historical trauma as an essential concept related to AIAN health and diabetes prevention. Need for a measurement tool to assess if intervention strategies are effective in addressing historical trauma. Indigenous Peoples Survey (IPS), developed by Dr. Maria Yellowhorse Braveheart and colleagues, identified as a potential tool – necessary to evaluate the IPS for the urban AIAN

context, chronic disease prevention, and wellness promotion. **Objectives:** All objectives fit into the larger research goal of a comparative effectiveness diabetes prevention clinical trial. 1) Develop conceptual framework connecting healing from trauma to a healthy lifestyle, 2) Adapt Indigenous Peoples Survey (IPS) for diabetes prevention clinical intervention, a) Identify additional subscales appropriate to urban AIAN context. **Methods:** Community-based participatory research (CBPR)- Weekly meetings with IHC staff and Stanford researchers, monthly meetings with American Indian Community Action Board (AiCAB) made up of AIAN community members from the San Jose Area, ad-hoc meetings with scientific advisors on methods and research literature. **Key Learnings and Reflections:** Historical trauma generates diverse perspectives among researchers and the AIAN community that are often dynamic through the learning process. With the complex history of AIANs, it is difficult to measure interrelated concepts of trauma and healing. The CBPR process may slow project advancement, but obtaining community feedback is extremely important for AIAN research. As an Alaska Native researcher, learning about historical trauma and its impacts inspired greater understanding of myself, my family, and my tribal history. **Future Directions:** IPS pilot testing by AiCAB members and Historical Trauma Action Project members in a variety of tribes and settings. Further revisions to the IPS post-pilot testing based on feedback. Administer the modified IPS as part of the Diabetes Prevention Program clinical trial.

10. Impact of Dining Ambassador Program on Undergraduate Students

Jenna Kim; E. Montell; H. Yendler; S. Basu, M.D., Ph.D; S. Thadaney, MBA; C. Gardner, Ph.D

Community Partner: Stanford Residential and Dining Enterprises-Dining Ambassador Program

Background: Stanford Residential and Dining Enterprises (R&DE) created the Dining Ambassador (DA) program with the mission

the eating behavior and health of DA's and/or undergraduates.

11. Vivamos Activos en Familia Turbocharged- Using Altruism and Online Social Media Tools to Incentive Healthy Lifestyle Choices Among Low-Income Latino Adolescents

Reynold Lewke BS, MS, LLB, MBA; Elidia Contreras Tafoya BA, MPHc; Rick Sutton, Rafael Avendano BS; Lisa Goldman Rosas PhD, MPH

Community Partners: Vivamos Activos en Familia and Siena Youth Center

Background: Obesity is common among Latino adolescents. Few Latino adolescents meet the guideline of ≥60 minutes per day of physical activity (PA). Vivamos Activos en Familia (VAEF) is a family-based lifestyle intervention targeting overweight/obese adolescents (11-14 years) and their parents in North Fair Oaks, Redwood City, CA. North Fair Oaks is a predominantly low-income Latino neighborhood spanning 1.2 square miles with major railroad and traffic arteries. Online social networks that assist users in monitoring and increasing their PA may be helpful for promoting active living among low-income Latinos such as those in North Fair Oaks. However, these online networks have traditionally only reached those who are already physically active, highly motivated, and data-driven. Low income Latino adolescents and their parents increasingly have access to these technologies and research is needed to examine the acceptability and feasibility for promoting PA given their high prevalence of obesity and low levels of PA. **Objectives:** To assess the acceptability and feasibility of an online social network to increase PA among low-income Latino adolescents. 2. Use PA challenges, such as long bike rides, to motivate adolescents to expand their traditional comfort zone. **Methods:** To assess acceptability: Collected verbal feedback on challenges, barriers, and successes on a weekly basis using a semi-structured questionnaire. To assess feasibility, collected 3 types of data: 1. Baseline data from VAEF. 2. Daily data logged in

Plus3Network entered at home computer, on mobile device, or SYC computer. 3. Data from paper forms for those who were not comfortable entering data online or smartphone app. Data analysis: Analyzed Plus3Network data on which activities and lifestyle habits chosen most frequently. Examined changes from pre- to post-test by comparing baseline VAEF data with logged Plus3Network data. **Key Learnings:** Youth can be motivated – just takes patience and consistency of support and active listening to identify motivators. Parents are very motivated to help their children be healthy and will act accordingly. New activities that involve new technologies and language translations require more training and follow up than initially planned to implement successfully. Having an internal champion to lead a new intervention is critical to achieving impact. Ease or automation of data entry is critical to the consistency and volume of data obtained. Running multiple interventions simultaneously is challenging as subjects can only absorb a limited amount of input at once. **Milestones Accomplished:** 1) The project launched in the target low-income Latino community and is steadily building support with over 35% of target community actively logging healthy behaviors. 2) Two group bike trips, 20 and 26 miles, exposed the children to places in their community they had never seen and motivated them to travel further on their bikes than they ever had. 3) Recruited Heffernan Insurance to provide $6000 for fund Climbing Wall for Siena Youth Center as large community motivational challenge. 4) Achieved well over $300 of this challenge in this first 6 weeks. 5) Community is excited to continue to record activities as a way to raise funds for community projects. **Next Steps and Future Directions:** Identify additional projects that the community needs to stimulate healthy behaviors, such as built environment issues that need to be changed to facilitate safe pedestrian and bicycle movement. Identify additional partners, both for large community projects, and as challenges for individuals, to continue to motivate participation by the broader community. Regularly celebrate Healthy Lifestyle goals achieved, both individual and group. Track actual data to explore what

activities/lifestyle choices most popular/what challenges have most impact. Use Plus3Network's ability to integrate multiple sensors, e.g., FitBit, Garmin, Android/Apple Apps, hand-entry, etc., to gain insight into sustained behavior patterns by the participating community. Use Plus3Network's diversity of data, including heart rate, steps, calories, etc., to explore alternative analyses as to what actually happens to participating populations over time. Identify ways to ease data entry for participants, especially children.

12. E-Cigarette Use and Awareness Among Asian Americans in California

Dale Arvy Dagar Maglalang, BA, BS; Catherine Brown-Johnson, PhD; Judith J. Prochaska, PhD, MPH

Background: High rates of tobacco use in Asian American populations, specifically in particular groups such as Vietnamese, Korean, Cambodian, and Chinese. Electronic Nicotine Delivery Systems (ENDS) such as e-cigarettes, vape pens, and e-hookah have gained popularity within the past few years. There is little evidence regarding the use of e-cigarettes among young adults ages 18-25 years old in the Asian American population. **Methods:** Data Collection: Administered an anonymous voluntary online and paper survey approved by the Stanford Institutional Review Board (IRB) using Qualtrics through various online social media platforms, college and non-profit organizations among 18-25 year olds in the state of California from 7/8-7/31 2014. Data Analysis: N = 249. Used a combination of Excel and R software to evaluate the quantitative and qualitative data from the survey. **Conclusions:** Among Asian American populations there is a high number of ENDS Ever-users. There are more female ENDS Ever-users than male. Some of the main reasons for using ENDS are to quit smoking tobacco, fun, and social purposes. Most participants were exposed to ENDS through friends & peers. Future studies on ENDS use should include Asian American Native Hawaiian Pacific Islander populations. Further studies should look into the success or failure rates of using ENDS to quit the use of conventional cigarettes.

13. Neighborhood Needs Assessment of Downtown Stockton Using Photovoice; A Community Based Participatory Research

Dale Arvy Dagar Maglalang, BA, BS; Grace Santuya, BA; Cathy Casiquin, Cedric Salvadia, Jay Calonsag, Pearljane Bonjoc, Redjan Quarto, Rheannamarie Toquib, Robert Michael Z., Teczon, Brian Anthony Barayuga Batugo, BA

Community Partner: Little Manila After School Program

Background: Little Manila Foundation in Stockton, CA is considering having a physical site in Downtown Stockton. There is a concern among parents, students, and community members regarding the safety of Little Manila After School Program(LMASP) participants due to Downtown Stockton's stigma of lack of businesses, violence, and dilapidated structures. LMASP participants chose to conduct a CBPR to assess the area where Little Manila Foundation is proposing to have its site to highlight the positive aspects and areas of improvement. **Methods:** N = 7. The project spanned five weeks where the participants and facilitators discussed the theory and practice of CBPR, data collection methods, and data analysis. Using Photovoice as a tool of data collection, participants walked around Downtown Stockton and took photos using disposable and digital cameras. They also recorded their initial thoughts and feelings for each photograph they took. The participants analyzed the photos and chose two photographs each to write a narrative based on the SHOWeD prompt. **Results:** I see graffitis that symbolizes a peaceful environment. It seems that these graffitis are created to show the people of Stockton its artistic side. These graffitis relate to our lives because through this we can visualize that many people do care for our community but need a push. We can enhance these strengths by hiring more graffiti artists. – Jay Calonsag. I see "No Dumping"

signs and overflowing trash on abandoned streets. It leaves an impression that there hasn't been anyone present to clean up the area. People are careless enough to throw trash on the floor and in sewers that lead to the delta. What we need is a clean neighborhood and what we also need are more street sweepers. – Rheannamarie Toquib. I see a mural of a kid's drawing. Seeing this at first made me smile. Something like this does have an effect on people. Growing up drawing was a way for me to have fun. Most of us kids don't have the luxury of new gaming systems & we're surrounded by a lot of negatives in the community, so art is an outlet for both staying out of trouble and having fun. We can enhance these strengths by putting up more kids' artwork throughout Stockton. – Pearljane Bonjoc. **Recommendations:** Fund local artists to create more art (murals, sculptures, etc.) in Downtown Stockton, including the possibility of painting murals on abandoned buildings. Preserve and remodel dilapidated historic buildings. Provide more trash cans for trash, recycling, and compost on street corners. Improve the physical safety and health of Downtown by fixing sidewalks and streets to encourage physical activity. Improve the aesthetics of Downtown by providing recreational facilities and more greenery.

14. Increasing Consumption of Less Popular Vegetables and Promoting Healthier Ways of Cooking Among West Oakland Residents

Ambri Pukhraj

Community Partner: City Slicker Farms

Background: West Oakland fits squarely within the definition of a food desert - lack of access to grocery stores, farmers' markets, and healthy food providers. Food deserts are heavy on local corner shops that provide an abundance of processed, sugar- and fat-laden foods that are known contributors to the obesity epidemic in the U.S. Residents of West Oakland can expect to live on average 10 years less than those who live in the Berkeley Hills. City Slicker

Farms is changing the landscape in West Oakland by providing fresh produce to residents on a sliding payment scale. **Objectives:** Increase consumers' knowledge of unfamiliar vegetables through conversations and informational cards placed next to vegetables. Model low-cost and easy different ways to prepare unfamiliar vegetables and increase consumption of vegetables identified as unfamiliar. Demonstrate ways to cook that maximize the nutrients of all vegetables being sold at the community markets on the day of the demos. Share information about the pros and cons of cooking vegetables in different ways. **Methods:** Observations – document purchasing and consumption trends among customers to identify which vegetables are less popular. Needs Assessment – survey customers to determine how they decide which vegetables to purchase. ABAC Experiment Design. Evaluation – measure increase in consumption of less popular vegetables, change in cooking methods of vegetables, and customers' interest in trying new vegetables. **Key Reflections and Learnings:** At the mercy of nature- An extraordinary challenge of working with produce was being unable to control several variables. For example, despite the detail and planning of the experiment design, when it was time to measure the difference between Weeks 1 and 2 of the ABAC design, the harvest was significantly lower for Week B, which made it a challenge to isolate and measure the impact of the intervention on consumers' purchase and consumption. Another week, it rained so heavily that hardly any customers stopped by. Making comfort food uncomfortable- One of the objectives of the intervention was to introduce new methods of cooking traditionally significant vegetables such as collard greens. However, the idea of changing cooking methods that have been passed on from generation to generation was, understandably, met with resistance. There may not be a measure yet of how comfort food can make one feel nourished in ways not captured by nutrients, but it was evident that customers deeply value the process of choosing the greens, preparing a treasured recipe, and sharing that meal with loved ones. More than ingredients- This service learning project reaffirmed that the availability of produce is

not enough to increase consumption of vegetables and fruits. A myriad of socioeconomic factors influence the consumption of a population. There is a large homeless population around the farm stand area. An obvious method to make sure all the produce left over from the market would be consumed by people who need it would be to donate the produce to this population. However, they were unable to take the greens because they do not have access to utensils to prepare the greens. When one person was offered fruit instead, he had to refuse that, too – because he did not have enough teeth to chew the fruit. Unwelcome changes- The gentrification of West Oakland is one of the most intensely discussed topics around the farm stand. Residents are concerned about the rapidly changing demographic because they can no longer afford to live in neighborhoods where they grew up. This climate has an effect on customers' perception of outsiders coming in with recommendations on how to improve their health and lifestyle. **Recommendations:** Community-Based Participatory Research (CBPR)- Spending a lot more time with community members outside the host organization, listening to and learning about their needs, would greatly improve the relevance of the intervention. This time would also be useful in establishing trust within the community. Partner With Other CBOs- There are several organizations serving West Oakland, but staff often do not have the capacity to collaborate. It would be useful to act as a liaison between organizations with similar missions. For example, an organization offering health services could recommend clients to City Slicker Farms for access to produce, and members from a community kitchen could provide cooking lessons on preparing healthy food. Demonstrate Respect for Neighborhood-It is essential to convey respect for the history of community members and to be aware of one's status as an outsider, when applicable.

the small percent change in participants for fitness classes during the Winter Quarter 2013-2014. Facility unavailability is a limitation for face-to-face, instructor-led classes. Additional information: BeWell Workshops (blended classes that include a pre-assessment, attending a 1 hour workshop, 3 weeks of goal setting and a post-assessment) had 3,269 employees that completed the stress management or nutrition workshops. Additional persons participated with, but were not captured in the data. In 2013, the workshops reached 24% of Stanford's 13,400 employees. 2014 data was not available. BeWell Walkers (a technology-based physical activity program including a pedometer, online logging, goal-setting booklet and weekly email messages) had 1,365 participants in 2013. Data for 2014 is incomplete, but so far 1,134 persons have either completed the program or have signed up and started! **Future Implementation of Innovations:** Technology-based health promotion programs are essential to achieving our goal of providing access to high-quality health promotion programs to employees, family members and retirees to ensure access, appeal to preferences, offer affordable services and decrease health care costs. Additionally, the Stanford/CECHCR Project requires delivery of programs statewide to thousands of California's public education staff and families. We are exploring incorporation of Smart Phone Apps, Virtual Health Advisor, Text messaging, OpenEdX and Google Hangouts into future programs.

16. Culturally Acceptable Food Choices and Mindful Eating: The Secret Ingredients to Encourage Diet Change at Silicon Valley Gurdwara (SVG)

Sumita Vasudeva

Community Partner: Silicon Valley Gurdwara

Background: Compared to other racial/ethnic groups in the U.S., Asian Indians have a greater risk of obesity-related conditions, such as diabetes. Physical inactivity, diets low in fruits and vegetables,

a genetic predisposition to insulin resistance and central adiposity may contribute to this disparity. Asian Indian immigrants may initially be involved in activities that revolve around traditional norms, such as participation in customary religious services, in order to obtain social and other supports. **Methods:** 1) Promote: low-energy/calorie, high-fiber foods, 2) Provide: culturally acceptable meal options, 3) Conduct: motivational interviews to encourage mindful eating. **Results and Conclusions:** Volunteer Cooks- "I don't cook like this at home. We put more oil and spices in the food here as the sangat (congregation) likes it this way...". "We take care to provide a wholesome meal but are dependent on the food donations." Congregation- "We want less oil and salt in the food but we do not want to offend the cooks.". "We will be willing to donate better quality oil and whole grains. We see the langar as a sacred instrument of wellness." "We are restrained by the fact that our rented facility does not even have a commercial kitchen. However, we can start by reducing oil and salt. We can also provide some fruit option for dessert." Langar Committee- "The kids were a little disappointed to see fruit instead of ice-cream but they loved the grapes and there were none left!" Khalsa Kids Committee- "We could teach the kids about food and cooking while teaching them their native language and cultural heritage." "It resonates with us when you talk about eating mindfully. We are motivated to create such an environment at SVG." 30% of the regular attendees articulated a shift in a commitment to their health and were motivated to sign up for a free health screening provided by the South Asian Heart Center. **Recommendations:** 1. SVG: To consider setting up a food bank sponsored by the local Sikh community to aid diet change. 2. Collaborators: In order to engage an immigrant community, concerted effort is needed to translate and customize evidence-based nutrition guidelines. 3. SPRC: Motivational interviews about mindful eating should be considered a powerful tool when designing nutrition guidelines for chronic disease prevention.

quickly as many participants reported the time required to prepare the food was a deterrent to maintaining healthy lifestyles outside of the program. **Future Directions:** Given that Homemade is marketed as a weight-loss program, future research might examine the effects the program has on participants' weights, which would require a rigorous gathering of relevant data and significant participant cooperation.

18. A Formative Study on Sustained Dietary Changes of Ceres Meal Program Clients

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Community Partner: Ceres Community Project

Background: Ceres Community Project supports individuals/ families dealing with serious illness with home-delivered nutrient-rich meals for 2 to 6 months. In 2013, 408 Ceres teen volunteers prepared 72,809 meals for 451 clients in Sonoma and Marin Counties. Ceres is evaluating how program participation impacts sustained changes in cooking behavior and eating habits of both teen volunteers and clients. Currently clients are surveyed upon intake, completion, and a three month follow-up to determine impact. **Objectives:** Design and implement a telephone survey to determine: If former clients made/maintained healthy dietary changes, and if so to identify key changes. What additional factors besides meal delivery contributed to making and sustaining changes. What factors contributed to challenges in maintaining changes. What additional support would assist individuals and their families in maintaining changes. **Methods:** Created survey (with Ceres Executive Director). Conducted telephone surveys with people who received meals between 4 and 18 months ago. Phone surveys were conducted between June 5, 2014 and July 20, 2014. Over 100 calls were placed and 15 individuals completed the survey. For the 15 participants who completed survey: Average length of time meals were delivered: 13.73 weeks. Average time since meals were delivered: 11.93 months. Average number of

people in home who received meals: 1.8. **Results and Key Learnings:** Diet improved after Ceres, and improvement was sustained. Vegetable and fruit servings for Ceres participants higher than California and US daily average. Diet changes were positive (% based on total comments): More vegetables – quantity, variety, cooking method (26%), more whole grains and fiber (19%), less sugar (11%), more vegetarian meals (11%), eating organic (7%). High confidence to continue eating healthy. Healthy eating was supported by increased awareness, technical education (recipes), and social support. Participants reported that Ceres meals contributed to improving health. Barriers to healthy eating included expense, energy level, location of items and smaller household size. Participants' ideas for helping to support/sustain healthy diet: provide all recipes with the meals and more educational materials on benefits of foods. Shopping lists with the recipes. Classes on nutrition/eating healthy on a budget. Nutrition consultations. Another Ceres cookbook. **Recommendations and Next Steps:** To build upon their success in improving healthy nutrition among clients these recommendations, in review with Ceres Leadership, are being pursued: Expand education component by providing all recipes in weekly emails and additional "Nutrition Bites" (information on value/benefits of specific foods) with weekly meal delivery. [Health Benefit Model and Self-Efficacy]. Expand role of "Client Liaison" to more directly address individual's stages of change in building sustainable behavior change to include Motivational Interviewing training and specific weekly client check-in guidelines. Develop "client transition program" prior to meal completion to prepare client and provide resources available. [Theory of Planned Behavior]. Integrate pre- and post- meal program nutritional counseling services into program through community partners. Further promote ongoing classes to all former clients when they are more able to participate and adopt cooking/learnings into their lives. [Social Cognitive Theory]. Continue to identify venues and collaborate to diffuse innovation into the general population to share learnings impacting obesity prevention.