Nutrition and Aging Resource Center

East Harlem Village: Fostering cross-sector partnerships and raising community voices to address food insecurity and social isolation among older adults in NYC

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Background and Purpose

A. Goal:

The goal of the project was to address food insecurity and social isolation among older adults, to support the building of a livable community, and to help older adults 'age in place' with dignity.

B. Objectives:

The objectives included to:

1. Establish a technology-based network of services adapted for the target population to reliably and sustainably link them to adequate food and other social services and activities that can help improve their food security, connectedness, and quality of life.
2. Work with community members to create tailored cooking and nutrition education classes, using a food justice lens to promote optimal diet quality and participant buy-in and behavior change
3. Provide Supplemental Nutrition Assistance Program (SNAP) education and enrollment assistance and access to low-cost fresh local produce via a subsidized food box to help improve food access and diet quality.
4. Work with public housing tenant associations and other key partners to help organize the community to create and advocate for services and activities that support their aging in place.
5. Collect and analyze data on referral outcomes and other proposed activities to measure the village's success and long-term viability.

C. Overview of Project:

Public Health Solutions (PHS), in partnership with Carter Burden (CBN), received a 2018 Administration for Community Living Nutrition Innovations Grant to implement the East Harlem Village (EHV), a community services network to combat food insecurity and social isolation among older adults 60+ and help them age in place with dignity. The network linked participants to trusted local food and nutrition programs, socialization activities, leadership support, and other social services, using a secure, closed-loop electronic referral platform. The program adopted a "pragmatic model of responsiveness," wherein community members identified their needs and the menu of services needed, and we responded to the community to ensure the ability of the network of organizations to address those needs, and streamlined communication between service providers to solve problems.

D. Project Results:

- EHV has enrolled 313 active members.
- Screened needs and assisted members to receive 377 referrals to services from partner organizations and other available services provided, in the following areas: Benefits Navigation, Food Assistance, Housing & Shelter, Individual & Family Support, Legal, Mental/Behavioral Health, Physical Health, Social Enrichment, and Wellness. (See service screening forms in Appendix D)
- Created 11 innovative programs in the project, with 166 activities/workshops/events conducted to respond to community needs and address service gaps.
- Generated 7,028 total participation across all new programming.
- Hosted 4 Partners Convening Meeting over the grant period and scaled up partner network size from 10 to 20 organizations.

- Quality of Life and Food Insecurity changes data (See Appendix F)

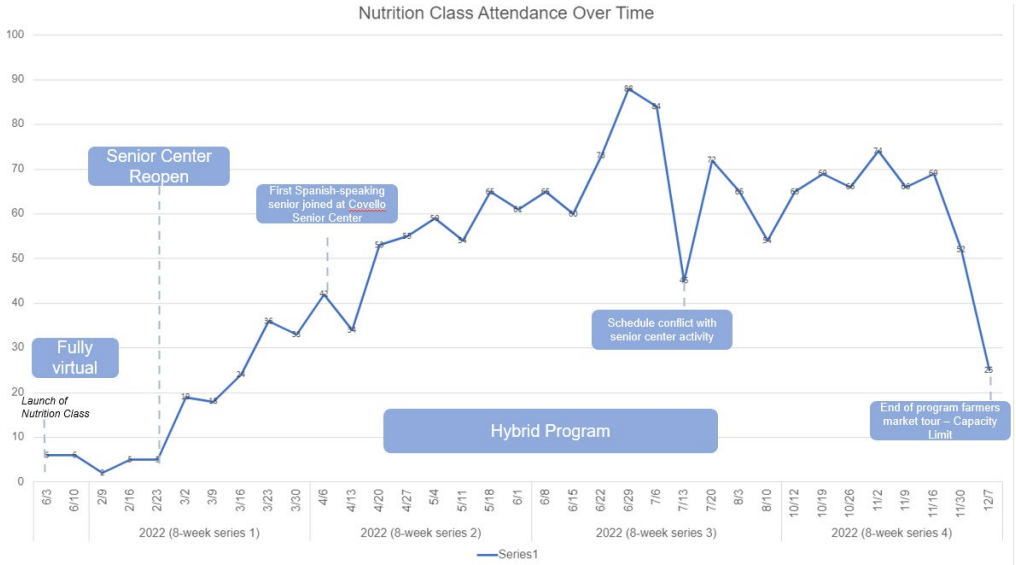


Figure A. Nutrition Class Participation Attendance Over Time

Table A. List of EHV-developed Programming and Attendance

Program developed by EHV	**Number of Activities**	**Non-duplicated participants**	**Total Participation**
Legacy Cookbook Series with Life Story Club	12	15	66
Nutrition workshops	50	210	1710
GetConnected Tablets	1	49	49
Grocery Store Tours	5	11	12
Farmers Market Tours	14	37	44
Weekly COVID check-in Call to Older Adults	1	105	105
Teen Tech Technology	3	3	3
NYCP produce bag delivery to home	37	86	1,591
Food and Racial Justice Conversations Workshops with Activist Karen Washington	2	36	54
Guided Community Conversations	15	58	139
Geriatric Clinic Tour at Metropolitan Hospital	1	15	15
COVID response: emergency food bags to public housing residents	9	2,560	2,560
COVID response: GrowNYC fresh produce to public housing residents	1	125	125
Nutrition education pre-COVID using a FEAST curriculum license	15	37	555
total	**166**	**3347**	**7028**

Partners and Project Staff

A. Partners:

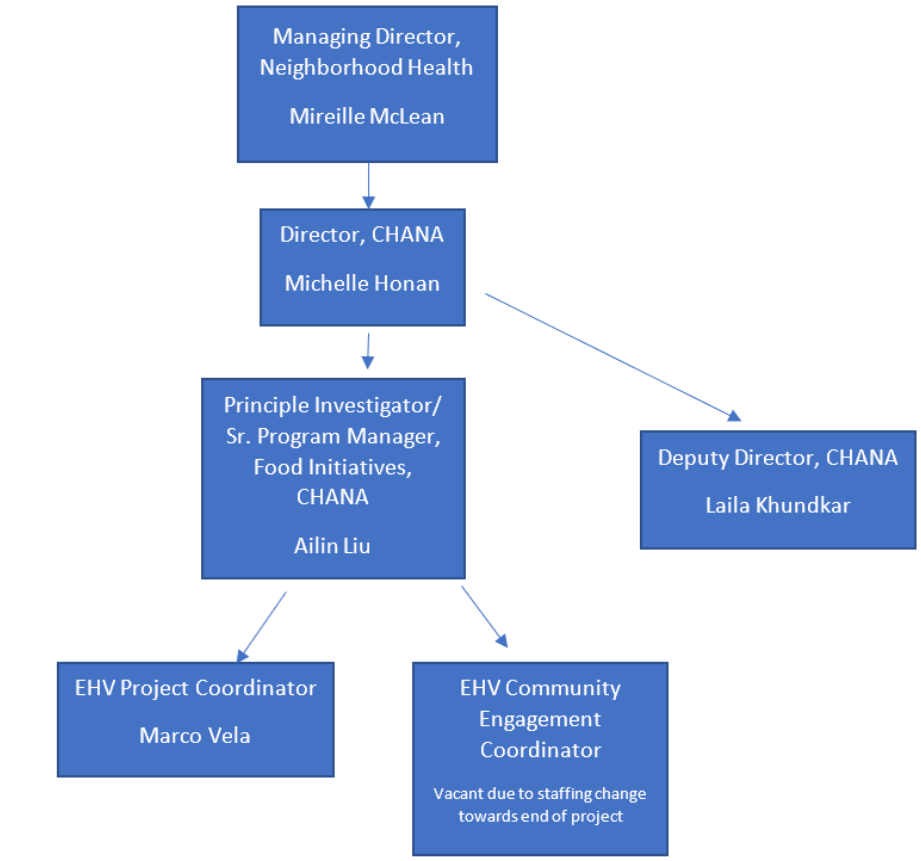
- Carter Burden Network (Subcontractor and Primary Partner): CBN runs two older adult centers in East Harlem area and has extensive older adult service offerings and experiences.
- New York Common Pantry (NYCP)(community partnership): NYCP is one of the main food pantries in NYC and has a distribution location in East Harlem. They offers bi-weekly free fresh produce bags to neighborhood residents that face financial hardship to meet food needs.
- NYC Health and Hospitals/Lincoln: Clinical partnership to pilot loneliness screening and to obtain social isolation referrals from the Geriatric Clinic.
- NYC Health and Hospitals/Metropolitan: Clinical partnership to connect patients with community resources and social supports via onsite presence and referrals to EHV.
- Northwell Hospital: Clinical partnership to provide geriatric mental health services.
- Institute of Human Nutrition Food Cooperatives, Columbia University: Academic partnership to support first nutrition education cohort via Zoom.
- East Harlem Health Outreach Partnerships (EHHOP) at the Icahn School of Medicine at Mt. Sinai: Clinical/academic partnership to work with volunteers to develop QI project for nutrition curriculum and create a guided conversation series to hear and raise community voices and conduct thematic analysis.
- Clio Connect/Department for the Aging (DFTA) (Community Partnership): Clio was a nonprofit volunteer-based organization that provides weekly wellness calls to older adults during the pandemic. Clio was later acquired by DFTA.
- DFTA Healthy Living Initiatives: Public Sector Partnership to provide individualized nutrition counseling to older adults.
- GrowNYC (community partnership): GrowNYC runs multiple food access programs in NYC including a focus in East Harlem.
- Invisible Hands (community partnership): IH is a nonprofit that provides free grocery delivery services to homebound residents via volunteers.
- Lenox Hill Neighborhood House: Community Partnership to provide Meals on Wheels program in East Harlem area.
- Life Story Club: Community partnership to facilitate themed story telling club.
- Mom's Meals: Community partnership to provide emergency meal delivery under Medicaid.
- Public Health Solutions' SNAP enrollment program: a PHS program that provides direct SNAP enrollment services in NYC including East Harlem.
- Public Health Solutions' Benefits Bridge program: a PHS program that provides housing support to residents through a Community Health Worker.
- New York Public Housing Authority (NYCHA): Public Sector partnership to connect residents in public housing to EHV.
- Selfhelp Community Services, Inc.: Community partnership in our technology access pilot to provide virtual senior center services.
- CanDoo Tech: Community partnership in our technology access pilot to provide 1:1 and group technology classes.
- Teen Teach Technology: Community partnership to offer free virtual technology classes by high schoolers.

B. Project Staff Roles:

- As of Year 3:
    - PHS: 2.45 FTE (federal funds) + 0.57 FTE (donated, in-kind)
    - Carter Burden Network (subcontractor): 0.95 FTE
- Senior Program Manager, Food Initiatives: Served as Principal Investigator and provided oversight of the project including: direct supervision to project staff, monitoring project progress to meet deliverables, designing and implementing project programming, developing multi-lingual program materials, developing and maintaining partnerships, communicating with NRCNA/ACL monthly as required, subcontractor management and communication, data analysis, and supporting the development of project sustainability.
- EHV Project Coordinator/Community Engagement Coordinators: Engaged the community, conducted outreach, communicated with partners, designed and implemented project programming, ensured project data collection and entry in databases, developed multi-lingual program materials, supported data analysis, and supported bi-weekly and ad-hoc subcontractor communication.
- Director, Community Health and Nutrition Access: Provided high-level oversight and leadership to the project, managed the project's budget and grant requirements, and supported project sustainability by identifying additional resources and funding to continue project activities.
- Deputy Director, Community Health and Nutrition Access: developed and monitored contracts, supported external partnership development, and supported program development and data analysis.
- Managing Director, Neighborhood Health Services: Provided thought leadership and direction to the project and worked across the Neighborhood Health Division and PHS' operational departments to support and promote the goals of the EHV project.
- Director, Quality and Evaluation: Supported project evaluation and data analysis.
- Director, Communications: Supported development of communication materials for EHV programming and outreach.

Subcontractor (Carter Burden Network) Staff

- Dietitian Consultant: Developed tailored nutrition curriculum, provided group education classes, carried out cooking classes, facilitates extra-curricular activities (supermarket tour and farmers market tour).
- Director, Health and Wellness Initiatives: Served as point person to PHS, oversees health and nutrition activities, staffing, and reporting on behalf of CBN. Leveraged expertise to provide guidance on the Village Model, and helped build community partnerships.
- Researcher: Provided coordination for activities and events, and supported engagement with seniors including outreach and intakes. This included case worker responsibilities.
- Administrative Assistant: Supported education and outreach programming.
- Health & Wellness Coordinator, Leonard Covello Older Adult Center: Promoted Village activities and encouraged seniors' participation and enrollment into EHV.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EHV Project Coordinator
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EHV Community Engagement Coordinator
Vacant due to staffing change towards end of project

Funding and Sustainability

A. Initial Funding:

This project was funded by the 2018 Administration for Community Living Administration on Aging Innovations in Nutrition Programs and Services (INNU) grant, a 3-year project with $250,000 annual funding and a is $1 non-federal match for every $3 federal dollars spent. Matching funds included direct PHS staff time spent on project oversight, research and evaluation, media and communications, accounting, and tech support, as well as private funding to support fresh produce subsidies and deliveries, a "Get Connected" tablet pilot project, supplemental workshops, and incentives for participants.

B. Continued Funding:

In 2022, PHS was awarded a 5-year grant from the New York City Department of Health and Mental Hygiene to operate the Harlem Health Advocacy Partners (HHAP) program, a Community Health Worker initiative through which PHS will carry over elements of the EHV project and continue to serve the East Harlem community and offer a range of wellness, advocacy, and engagement activities. The project aims to improve the health and wellbeing of adult New York City Housing Authority (NYCHA) residents in East and Central Harlem through one-on-one health coaching, health workshops and activities, partnership building, community engagement, and advocacy. PHS is carrying over several elements of its EHV model and activities through HHAP, including:

- HHAP continues to serve EHV members living in East Harlem – as the EHV pilot was winding down at the end of 2022, all members were informed of HHAP so that they may continue to participate and benefit from EHV-related services offered in the community.
- Key members of the East Harlem Village Project team are involved in implementing community engagement and advocacy for HHAP, including the Project Coordinator, who is now the Community Health Worker Supervisor for the Community Engagement team for HHAP; and the Senior Program Manager of Food Initiatives, who oversaw EHV project implementation and is now supporting the management of the HHAP program.
- The HHAP program is building on existing partnerships, relationships, and experiences in the community to organize residents around important advocacy issues and campaigns. Through this project, we will continue to collaborate with East Harlem-based coalitions and NYCHA leaders on engagement, outreach, and workshop development with partners such as Life Story Club and Carter Burden Network.

C. Sustainability:

PHS will sustain successful elements and activities of its East Harlem Villages project by embedding them into new and existing funding opportunities and initiatives. PHS will continue to operate its SNAP and health insurance assistance services out of East Harlem Health Action Center and will continue to maintain important EHV referral relationships when serving these clients, including with emergency food providers such as the New York Common Pantry and the Department for the Aging's friendly calling program. We will continue to use the Unite Us referral platform to connect community members to additional services. Through HHAP, we will continue to build on important lessons learned from the East Harlem Village project, including our community-focused strategy of regularly obtaining participants' feedback and input to shape and constantly improve program activities to best meet their needs and interests through surveys and community conversations. We will also continue to work with Carter Burden Network and other East Harlem partners to continue to bring nutrition-focused workshops and food access programming into the NYCHA developments and East Harlem community. For example, components of the nutrition education curriculum developed through EHV are being utilized and adapted for a HHAP workshop series. Additionally, we will continue our work to support community organizing among residents to advocate for services and activities that support better quality of life, which will be continued and expanded through year-round community advocacy campaigns (at least 3 will be conducted each year). Finally, we will continue to utilize successful community engagement and outreach strategies developed through EHV (see recruitment section below).

Recruitment

A. Participants

a. Requirements
   - Older adults aged 60+, live, work, OR receive healthcare in East Harlem (zip codes 10029 and 10035)

b. What recruitment methods were used?

Successful:

- Identifying group leaders: Throughout activities, we Identified leaders among groups of friends who were generally highly vocal about their group's needs and played the role of linking friends with activities. Working with them allowed us to expand our reach to friends and family members who were less engaged and increase our attendance and enrollment into the program. We sent these individuals home with extra workshop handouts and flyers and encouraged them to share with peers, friends, and family members. We also engaged them in program planning through beta activity testing, where we tested new activities with this group and gathered their feedback before rolling out a broader audience.
- Rolling recruitment: Community members were able to enroll in the project at any given point in time during the course of the program.
- Increasing languages used in activities: As we expanded our activity offerings and increased our reach in the community, members of different language groups began participating on a regular basis. To ensure the consistent participation of these community members, we utilized the various language capabilities of our staff to ensure activity materials (e.g., handouts, surveys, PowerPoint presentations) reflected the most common languages spoken by participants (English, Spanish, Chinese). This built trust and comfort and maximized accessibility of our services in the community.

Not successful:

- Mailing Campaign: Midway through our project, we partnered with CBN to conduct a mailing campaign providing 4,296 residents with a postcard with information about ongoing project activities and staff contact information. While we received some calls inquiring about more information and a few recruitments into the project, the vast majority of individuals that did receive the postcard did not follow up for more information or enroll in the project.
- Tabling at partner sites: We set up tables at a given area of partner sites with heavy foot traffic (i.e. a hospital waiting room, the entrance to a NYCHA building site, a lunch room of a senior center, etc.) and talked to individuals who stopped and expressed interest in our project. Overall, while a great way to spread information of upcoming activities and greet individuals, this strategy did not substantially increase levels of enrollment or participation.

B. Volunteers or Students

a. Requirements
   i. Bilingual in Spanish/Mandarin preferred
   ii. Meet with assigned supervisor from EHV staff once a week
   iii. Trained on relevant materials for project
   iv. Commitment to supporting all EHV project needs, specifically conducting outreach, follow-up assessments, and building relationships with participants

b. What recruitment methods were used?

Successful:

- Partner with local school programs - We were matched with students with ongoing academic interests that aligned with our project's goals through the following two successful partnerships:
  - Volunteers joined through the Mt. Sinai's community-focused organization, East Harlem Health Outreach Partnerships (EHHOP).
  - Students joined through the Borough of Manhattan Community College's human services internship program and earned school credit.
- Allow room for volunteers/students to take ownership: volunteers/ interns were provided freedom to voice their feedback on project activities and were empowered to take the lead on creating materials.

Not successful:

- Competing with school schedules –There were times during the project when scheduling meetings with the student interns/ volunteers became challenging due to school-related scheduling conflicts (e.g. finals exams, classes).

C. Marketing Tips

Successful:

- Word-of-mouth was the most effective marketing tool that helped the project activities succeed. Individuals who previously had not been involved in activities joined because of encouragement from their friends/family members who had testimonies as to how the activities were impacting them.
- Flyers in multiple languages (English, Spanish, and Chinese) were distributed in heavy foot traffic areas at the Carter Burden Network's older adult centers. Additionally, flyers were distributed during announcements at the older adult centers.
- Phone call/text message/email reminders were provided by the Project Coordinator, Senior Program Manager, and CBN keep older adults updated on any upcoming activities and changes to scheduling. This encouraged regular communication between the older adults and the project staff.
- CBN posted all activities on their weekly calendar and website. This encouraged participants to update their personal calendars to reflect the recurring and upcoming activities.

Not successful:

- Social Media was an ineffective marketing tool for our project. We created a Facebook page to present recordings of our activities for EHV members to watch back or share with friends, but there was minimal participation. Many members did not have Facebook and were not interested in creating an account solely to join our group.

Tools

A. Technology

- Unite Us is a cross-sector collaboration software that facilitates needs assessment data collection and real-time referral exchange and outcome tracking among platform user partners. Each time a new member was enrolled in EHV, their contact and demographic information, needs assessment, initial food insecurity screening, and a Quality of Life assessment were entered in Unite Us. All of the program activities a member attended throughout the project were entered in Unite Us, as well as Follow-up QoL assessments every 6 months. We also used Unite Us to make referrals to external providers based on members' needs using the platform's closed-loop referral system that tracks referral outcomes.
- NowPow is a referral platform that is primarily used by hospitals and healthcare providers in NYC. Referrals from clinical partners were securely received via NowPow.
- Microsoft Power BI is a software used to connect to and visualize data for reporting and project monitoring. We used Power BI to develop an EHV dashboard to track and monitor the project's progress.
- Zoom is a communications platform that allows users to connect with video, audio, phone, and chat. All our virtual programming was offered on Zoom.
- Microsoft Forms is an Office 365 product to create a form, such as a survey or quiz, and invite others to respond to it using almost any web browser or mobile device. This tool was used to collect pre- and post-program surveys from participants.
- Samsung Galaxy Tab A 8.4" 32GB SM-T307U: This tablet was provided to members for a minimum of 6 months if they signed up for our "Get Connected" pilot project to improve technology access and usage. An 8.4" size tablet was recommended by our virtual services partner as the minimum size for a positive visual experience.
- EZ Texting is a paid text messaging service that allowed us to upload lists of contacts for bulk text message outreach. This was used to send programming information and reminders to our members.
- Outlook email listserv: This was used to connect partners and share monthly updates and newsletters with them.

B. Resources

- Grocery delivery services - C7 Delivers (delivery vendor), Invisible Hands We Deliver (non-profit community partner): these were used to deliver free grocery bags (provided by New York Common Pantry) to participating members.

Project Timeline

2019

Spring 2019

- Wrote proposal in response to ACL Innovations in Nutrition grant opportunity and obtained letters of commitment from key partners.
- Continued SNAPilicious pilot project providing cooking demos and fresh food in NYCHA senior centers.

Fall 2019

- Received ACL INNU Innovations in Nutrition Grant
- Established primary partnership with Carter Burden Network.
- Recruited 10+ partners to start.
- Configured screening tool in the UniteUs referral platform.
- Conducted community needs assessments to 82 East Harlem NYC residents and identified Recreation, Safety, Education, Accessibility (food, healthcare, social services), and Living Condition as top five needs.

2020

Spring 2020

- Provided SNAP enrollment assistance to participants.
- Provided emergency food support to New York City Housing Authority residents during the onset of the COVID-19 pandemic, when access to food was significantly disrupted.
- Coordinated weekly wellness check-in calls for EHV members.

Fall 2020

- Collected ongoing participant referral data .
- Launched six-month “Get Connected” tablet initiative providing loaned tablets with unlimited access to internet and virtual senior center activities with 6 participants.
- Launched partnership with Northwell Hospital for geriatric mental health services referral.
- Launched partnership with New York Common Pantry and Invisible Hands We Deliver to deliver pantry food bag to up to 15 homebound members.

2021

Spring 2021

- Implementation of virtual six-week nutrition education curriculum with a food justice component (Cohort 0).
- Expanded tablet pilot to 49 participants with the help of donor funds.

- Updated electronic screening tool and referral tracking process.
- Launched collaboration with Geriatric Clinic at Lincoln Hospital, administering the UCLA loneliness scale.
- Launched new programming and partnership with InCultured Company to facilitate intercultural dialogue between different culture groups in the community to understand differences, hold space to learn about each other's common experiences, and reimagine a shared future without conflict.
- Launched a two-part conversation with consultant Karen Washington around the food system in NYC: intersection between racial justice and farming, and discuss how growing your own food can transform our food system.
- Expanded pantry food bag delivery to up to 100 homebound members.
- Expanded to 20+ partners.

Fall 2021

- Launched grocery store tours/farmers market tours in the neighborhood with a Registered Dietitian.
- Developed a data dashboard.
- Provided ongoing technical assistance coordination for tablet project participants.
- Implementation of monthly newsletter for partners.
- Launched new programming and partnership with Life Story Club around family recipes and food culture workshops.
- Launched partnership with Clio Connect to provide weekly volunteer check-in calls.
- Raised funds to support EHV activities, specifically case management and individual support.

2022

Spring 2022

- Launched 1st and 2nd cohorts of the hybrid 8-week tailored nutrition education curriculum with a food justice component.
- Launched Quality Improvement (QI) of nutrition curriculum in partnership with EHHOP.
- Implemented technology training sessions with Teen Tech Technology.
- Received New York City Department of Health and Mental Hygiene Award of Funding for HHAP.

Summer 2022

- Launched 3rd and 4th cohorts of the hybrid 8-week tailored nutrition education curriculum with a food justice component.
- Launched virtual grocery store tour video.
- Continued grocery store tours/farmers market tours in the neighborhood.
- Implemented 6 sessions of Guided Community Conversation.
- Implemented Geriatric Clinic Tour at Metropolitan Hospital.

Fall 2022

- Collected follow-up assessments from final cohort of EHV members.
- Analyzed data

Frequently Asked Questions

Q: What if participants could not attend a class in-person? Could they still participate and receive incentives?

A: Most of our programming was available in a hybrid format, so participants were welcome to join us from home if they were comfortable doing so via Zoom. Their attendance was accounted for and the Project Coordinator or Senior Program Manager coordinated with the client about the best way to distribute their earned incentive.

Q: How did you come up with your Nutrition Curriculum? Was there a specific source you pulled your topics from?

A: Our nutrition curriculum was created by our EHV project team alongside a Registered Dietitian who also facilitated each workshop. Our topics were selected based off of her recommendations and expertise, our past experience conducting nutrition workshops for older adults in the East Harlem community, and based on input we received from participants about their interests.

Q: Were program materials provided in other languages besides English?

A: Our materials were provided in three languages (English, Spanish, and Chinese), which were also spoken by our EHV project team. Our participants spoke one of these three languages so we made sure to have translated materials readily available for them to ensure our maximum accessibility to our services.

Q: How were new activities planned? Was community input a factor?

A: Our staff took the time to meet with key partners about what could be offered for the community on a regular basis, or for a special event. Initial ideas were discussed with key stakeholders, and as activities were rolled out, we took the time to take in community members' input on what was being presented to them and what they would like to see more of. As time went on, we tailored new activities with this input in mind to meet the community's needs/wants.

Q: Where did activities/ services take place?

A: Most of our in-person activities and services took place at our key partner's location, Carter Burden Network's Covello Older Adult Center. This center had the capacity to host intimate activity settings for small groups of participants (~5-15) and large activity settings for big groups (~50-70). Other in-person activities took place in the community, such as local farmer's markets, grocery stores, the East Harlem Neighborhood Health Action Center, and hospitals. Virtual and hybrid activities gave individuals the opportunity to join us over Zoom.

Q: What resources were used to obtain ingredients for cooking demonstrations, and incentives for participation?

A: We utilized the budget of our ACL grant and non-federal private funding (matching funds) to make purchases of all required materials and acquired our incentives from various providers. For example, the New York City Department of Health and Mental Hygiene has a program called Health Bucks, where individuals can receive $2 food coupons to be used at farmer's markets in the city to offset the costs of fresh produce. We purchased these coupons to be distributed as incentives for participation in our nutrition related programming.

Q: What was the goal of creating cooking demonstration menus the way you did?
A: Our participants were primarily composed of Asian (Chinese), Hispanic (Puerto Rican and Dominican), and African American heritage, so we worked with our Registered Dietitian to compose recipes that were culturally relevant to our participants, as well as full of nutritional value.

Q: If participants were seeking resources or services outside the program's capabilities, how did you handle it?
A: If the resources or services our participants were requesting were outside our immediate program's capabilities, we utilized a closed-loop referral platform (Unite Us) to refer individuals to other PHS programs and partner organizations to meet their needs. We also maintained relationships with local partners and service providers off of Unite Us and made referrals to them on a regular basis (e.g. New York Common Pantry, Department for the Aging's friendly calling program).

Q: Can anyone participate in the project activities?
A: Participation in our activities was open to anyone aged 60 and over living, working, or receiving healthcare in East Harlem. Our programming was not limited to individuals who enrolled in the East Harlem Village as "members."

Q: Was it difficult to conduct screenings over the phone and how did you handle it (e.g. Quality of Life Questionnaire)?
A: There were sometimes challenges conducting follow-up screenings over the phone due to language barriers, the length of the questionnaire, and the volume of follow-ups that were required. We combatted these challenges by bringing printed copies of our assessments to activities highly attended by participants that we needed to contact for follow-up. This allowed us to more quickly conduct the follow-up screenings in-person and limit inconvenience for participants.

Advice for Replication

1) Listening to the community and your participants and adjusting programming based on their feedback is essential – ultimately, they will be more engaged with the intervention and the project will have a greater impact by directly addressing their needs.

"Older adults are enthusiastic about food and more motivated to participate in activities if it's fun and food-related or through connections they made from a previous food activity. That's also a great way to build trust with older adults. With the trust, they are willing to voice their needs to us. Older adults are also more likely to participate in an activity they ask for, so we create a nice circle to keep their desired activities running and keep their voices coming in." - Ailin Liu, MS | Senior Program Manager, Food Initiatives | Public Health Solutions

See Appendix E. EHV Programming Development Roadmap to Address Needs and Encourage Voices.

2) There is no simple solution for improving food access for any given older adult community – your approach must be flexible and multi-pronged, considering available resources as well as individuals' economic, cultural, and mobility-related circumstances and preferences.

See Appendix E. EHV Multi-Pronged (Mobility-Affordability-Preference) Model for Food Access Assistance

3) Hybrid-programming, which we originally implemented as a response to the pandemic, has been a very useful tool for engaging community members based on their needs and preferences and meeting them "where they are"—some participants prefer the experience of learning and socializing in-person or may experience technology barriers that make it hard to connect digitally; others have needs that make remote programming more desirable, including mobility and health challenges, COVID-19 hesitations, or travel limitations. One challenge was engaging those with both technology and mobility barriers—to address this, we launched our "Get Connected" pilot to offer tablets, internet, technology support, and a virtual "senior center" to East Harlem Village members. Similar strategies could be deployed to address this barrier alongside interventions in other communities.

4) Open your ears to your partners, ask what they need, leverage their expertise in different sectors, and build win-win partnerships. That's the key to how we built and sustained successful partnerships and braided resources with 20 partners across sectors (see details in Partners section.)

In one of our partner convening meetings, we asked how our partners would like to stay connected and make this network inclusive and beneficial to all. Partners voted most for monthly newsletters and listserv (among options like Slack channel, instant messaging group, and others). So, we created a monthly partner newsletter since then and partners responded well to it.

Appendix List

A. Flyers

B. Monthly Partner Newsletters

C. Nutrition Programming Materials

D. Survey Instruments and Needs Assessment Tools

E. Model for Replication and Programming Sub-Reports for Best Practices

F. Quality of Life and Food Insecurity changes data