12-2018

Building Shared Values in the Community: Culture of Health

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BUILDING SHARED VALUES IN THE COMMUNITY: CULTURE OF HEALTH

by

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ACKNOWLEDGMENTS

I would like to take a moment to first express my gratitude and appreciation for Dr. Jean Dols for making this project possible. She provided guidance and wisdom throughout this endeavor. She is both advisor and mentor. Thank you for your patience and expertise! And, a big thank you to Dr. Dianna Beckmann-Mendez for suggesting that Dr. Dols would be the ideal project advisor for a community outreach program!

Several community leaders were also helpful in better understanding the needs and resources in San Antonio, Texas. The assistance of the District 6 councilman office of Greg Brockhouse was invaluable to this community project. Raul provided me with resource after resource as well as an understanding for how this community is best served. The office of District 4 councilman Rey Saldana provided yet more resources including their aim at improving the social determinants of health by providing better sidewalks to the neighborhood where the project was implemented.

Thank you to Communities in Schools and the San Antonio Public Library for passing out flyers and advertising the program. I would also like to thank the Cable-Westwood Neighborhood Association and the Springvale Neighborhood Association for their support. Chapel Hill United Methodist Church graciously provided the space for the community class including use of their kitchen for food storage and clean up!

Thank you to those who kindly edited and translated the community surveys. You all generously revised and re-revised the surveys so that they would accurately capture the data needed. I appreciate your time and skills: Sophia London, CHW; Rosa Carrasco, RN; and Minilu Gutierrez, RN.

Acknowledgments—Continued

Thank you, Sophia London, community health worker, for recruiting, gathering resources, and attending and assisting with each class. Thank you to the program members who volunteered their time to help with class preparations and cleaned up afterwards. You all made the labor light and fun: Vicki Lopez and Randine Besosa.

Last but never least, I would like to thank my family, my parents for their unwavering support throughout my education. My sister graciously sampled trial recipes and helped me to troubleshoot ways to make the program more effective. Even more, she bore extra burdens while I was immersed in this community project. Thank you for your sacrifices while I have worked on this degree.

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Abstract

The zip codes where patients live are stronger determinants of health outcomes than the frequency of visits with a primary care provider. Providers have a unique opportunity to extend health care beyond the clinic walls and engage in efforts to improve the communities where their patients grow, live, work, and age. In order to impact the health of patients, a culture of health needs to be developed. The Robert Wood Johnson Foundation culture of health action framework directed the build of a foundation of health as a shared value in a neighborhood with high morbidity and mortality rates in southwest San Antonio, Texas. This community quality improvement intervention was designed to equip participating community members with knowledge, skills, and supplies to be drivers for health as a shared value. Prior to implementation, community surveys assessed perceptions regarding health as a shared value. A one-time class offering opened discussion regarding the effects of stress on heart health. A 7-week class, Health to the Fourth Power, was developed to equip community stakeholders using healthful education, physical activity, community responsibility, and plant-based meal preparation. Post implementation survey results revealed moderate understanding of health interconnectedness. Health to the Fourth Power participants increased daily fruit and vegetable consumption, decreased body mass index, and decreased mean systolic blood pressures. It is imperative for medical providers to advocate for a culture of health in their patients' communities.

Keywords: culture of health, community, Robert Wood Johnson Foundation, morbidity, mortality

Social determinants of health are the aspects of environments and communities where people are born, live, learn, work, play, worship, and age that affect quality of life as well as morbidity and mortality rates (HealthyPeople2020, 2017). Ultimately, the zip codes where patients reside are a stronger predictor of health outcomes than the frequency of visits with a primary care provider (Prevention Institute, 2012). In order to truly impact the health of patients, providers must extend health care beyond the clinic walls and engage in efforts to improve the communities where these patients live. A culture of health is a community that promotes healthful living for all (HealthyPeople2020, 2017). By utilizing the Robert Wood Johnson Foundation (RWJF) culture of health action framework, it was possible to lay a foundation for a culture of health in a neighborhood within a large Texas city with low social determinants of health.

Statement of the Problem

Each year chronic diseases are responsible for seven out of 10 deaths in the United States (Centers for Disease Control and Prevention [CDC], 2018). Many of these diseases are preventable (CDC, 2018). The heart age of 45% of Texans, who do not have a history of stroke or heart attack, is 5 years or more than their actual age (CDC, 2015). An individual with a heart that ages more rapidly has an increased risk for cardiovascular disease, stroke, and cardiac failure (CDC, 2015). Almost one third of Texans have hypertension and heart disease, a number that is expected to more than quadruple from 2010 to 2030 (Segal, Rayburn, & Martin, 2017). Another complication often associated with heart disease is obesity. Obesity rates in Texas have tripled since 1990, and cancers related to obesity are expected to more than double by 2030 (Segal et al., 2017).

While the health measures of the 28.3 million Texas residents are a concern for the future, the health measures of Bexar County are even more concerning. Bexar County has 1.3 more cases of type II diabetes than the state of Texas itself with almost 10% of residents diagnosed with diabetes (Metro Health Strategic Plan Steering Committee [MHSPSC], 2017; CDC, 2016). Two-thirds of Bexar County adults are either overweight or obese (CDC, 2016). More than 25% of the county's African American and Hispanic children are also obese (CDC, 2016). The social determinants in this same county include lower incomes and education (MHSPSC, 2017). Bexar County residents have limited access to healthy foods and safe places for physical activity (MHSPSC, 2017).

Assessment

A community survey ($N = 347$) was disseminated within San Antonio, the largest city in Bexar County, at neighborhood association meetings, in faith community nurses' offices, and at a community heart health awareness program for Hispanic women. Responses were obtained from individuals representing 53 different zip codes in and around San Antonio. Of the 302 survey participants who completed the survey's questions on race and age demographics, 86% identified themselves as Hispanic women ($n = 261$) with 77% ($n = 234$) between the ages of 46 and 75 (Figure 1).

The survey participants demonstrated a general understanding of the interconnectedness of personal and family health being affected by their community environments (Figure 2). Only 78% ($n = 272$) of the participants reported on their perceived community's health in which they responded to the questions: To what extent do you believe that the following things affect your health? -2 (no effect) to +2 (very strong effect).

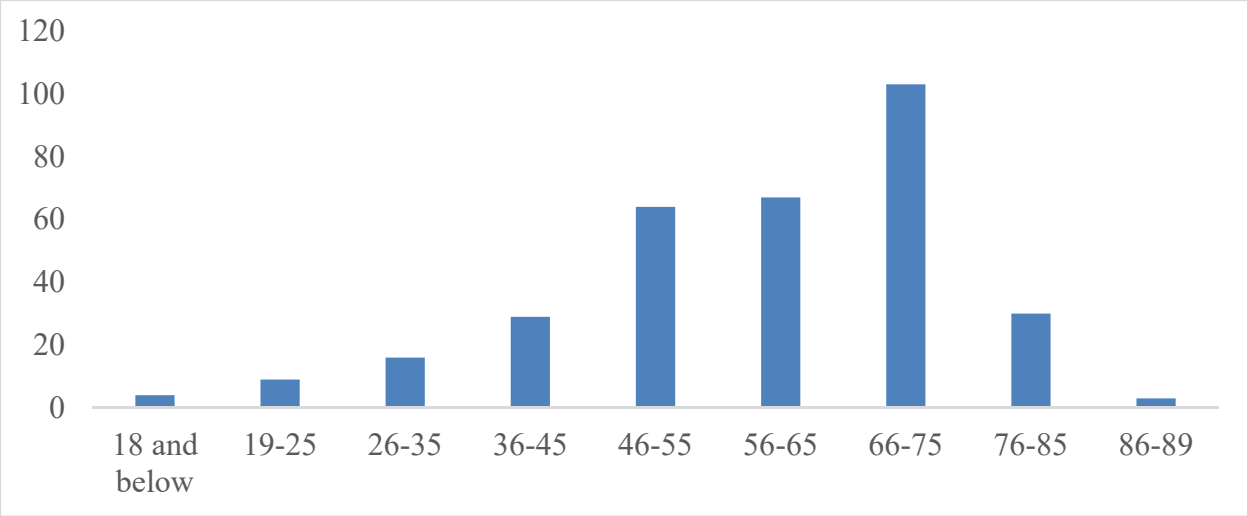

Figure 1. Age of participants. Community survey participants (n = 302) identified by age group.

On a 5-point scale ranging from very unhealthy (-2) to very healthy (+2), the mean of the responses (-.17) indicated that the communities are viewed as unhealthy to somewhat healthy. Personal health averaged (.35) between somewhat healthy and healthy as did familial health (.21) to a lesser degree.

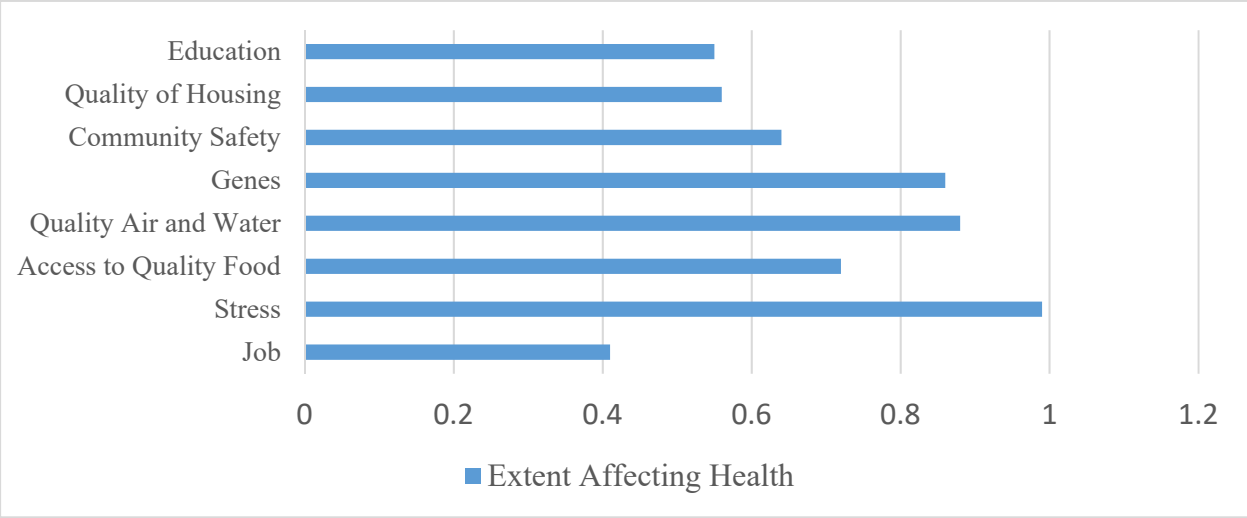

Figure 2. Community perception of health factors. Community survey responses regarding extent to which their health was affected by the listed categories.

San Antonio city data available from 2014 provided morbidity and mortality rates for its 89 zip codes. Using these data, a neighborhood in a zip code with low life expectancy rates of 75 to 79 years and income less than the city mean was selected for this community project (MHSPSC, 2017). Additionally, city government officials' input identified this area as needing healthful interventions to improve social determinants of health. Almost 10% (n = 34) of those who completed the community survey listed this southwest zip code as their residence.

Readiness for Change

Fortunately, several community stakeholders, who were approached by the project leader, were open to opportunities for promoting health as a shared value in southwest San Antonio. A church in the target zip code with a health ministry team was receptive when asked to host a program which could strengthen the health of the surrounding community. Even more support was provided during neighborhood association meetings by representatives from two district councilmen's offices interested in improving resident well-being. After the local elementary and middle schools were approached, Communities in Schools conveyed a desire for affordable health programming for the parents of their students. Additionally, a Christian non-profit health organization offered to provide financing and resource assistance for health improvement interventions.

Project Identification

Purpose

The focus of this community outreach project was to lay a foundation for a culture of health in a designated neighborhood in a zip code with a vulnerable population in San Antonio, a large Texas city comprised of 89 zip codes, following the RWJF culture of health action framework. The first step toward building a culture of health using this framework was to

develop health as a shared value (RWJF, 2017). RWJF (2017) divides this step further into mindset and expectations, civic engagement, and sense of community. The desired outcome for this project was to equip community stakeholders with knowledge, skills, and supplies in order to create drivers for health as a shared value.

Objectives and Anticipated Outcomes

In order to assess mindset and expectations, baseline community data were needed regarding health perspectives and community engagement. This information was obtained using community surveys. Civic engagement and sense of community was evaluated and developed in a free community health class, Health to the Fourth Power (H^4). The participants in this class also completed the community survey as well as pre and post program surveys identifying physical activity and dietary behaviors in addition to measurements of body mass index, non-fasting blood sugar, blood pressure, and waist measurements (Table 1).

Summary and Strength of Evidence

There have been a variety of community initiatives which have shown that building a culture of health improves morbidity and mortality rates (McGrath, 2014; RWJF, 2017). These initiatives have strengthened the prevention of cardiovascular disease when it is considered within the context of where community members live (Diez Roux, Mujahid, Hirsch, Moore, & Moore, 2016). Equipping residents with knowledge, skills, and supplies within these communities that further promotes the creation of a culture of health (McGrath, 2014). By targeting behaviors such as physical activity, healthful dietary choices, including increasing consumption of fresh fruits and vegetables, families are empowered to improve their own health outcomes (CDC, 2017; MHSPSC, 2017). However, it is imperative that the members of the community are involved when making cultural changes since equipped community stakeholders

Table 1

Goals for Making Health a Shared Value

Interventions	Participation Goal	Details
Baseline community data	100 surveys	Completed in faith community nurses' offices, neighborhood association meetings, and community education classes.
Follow up phone calls	20 individuals	Extracted from surveys to continue discussion of health as a shared value.
Community education classes	50 attendees	Provide education during public health program and neighborhood association meetings.
Health to the Fourth Power	20 students with 70% attendance rate	Recruited at community hubs.

sustain the progress for the development of a healthful culture (Gavin, Seeholzer, Leon, Chappelle, & Sehgal, 2015; Subica, Grills, Douglas, & Villanueva, 2016). Additionally, local leadership discussed the importance of creating communities that allow residents to thrive with safe places for physical activity, accessible healthful food choices, an environment with clean air and water, with health equity for all (MHSPSC, 2017).

Methods

RWJF culture of health action framework identifies three unique characteristics of promoting health as a shared value: mindset and expectations, civic engagement, and sense of community (RWJF, 2017). Mindset and expectations considers the value of the interconnected aspects of health such as physical environment, familial and personal health, while also taking

into account access to healthful dietary choices and education (RWJF, 2017). Civic engagement is reflected in the voices of the community when voting and participating in local efforts to maintain or improve the health of the area (RWJF, 2017). The final aspect of promoting health as a shared value, sense of community, encourages social connections between residents which provide support and improve health outcomes (RWJF, 2017). This project focuses on each of these attributes for creating health as a shared value.

The San Antonio Community Survey 2018 was offered in both English and Spanish and had been developed to assess perceptions of personal, familial, and community health and inquired about community engagement. Surveys were distributed at a community heart health awareness program for Hispanic women (n = 324), faith community nurses' offices (n = 11), and neighborhood association meetings (n = 12). The surveys also included an option for participants to receive a follow-up phone call from a registered nurse or community health worker to further discuss health promotion and concerns. Phone calls were requested by 37% (n = 127) of survey participants. These phone calls further explored health as a shared value as well as provided community resources requested by the participants such as locations for mammograms, free food distribution, and free exercise classes.

Project Intervention

The majority of the community surveys were distributed during the initial intervention of a community heart health program which included education regarding the physiological effects of stress. The program topic was requested due to stress contributing to higher morbidity and mortality rates particularly in vulnerable populations. This interactive class encouraged audience participation in discovering ways to identify and decrease stress. These public discussions are a

part of health promotion and well-being which are included in the first aspect of the RWJF (2017) action framework of mindset and expectations.

The latter two aspects of developing health as a shared value, civic engagement and sense of community, were addressed with the creation of a free 7-week community class, H^4. Funding for course supplies was obtained from a non-profit Christian health organization that included a requirement that cooking supplies and utensils be distributed to participants following the program. The project leader purchased induction burners, pans, and cooking utensils for the class. Several community stakeholders contributed gift cards for groceries and exercise equipment after hearing about the program plan, and a local church in the designated zip code agreed to provide use of their fellowship hall for H^4.

Flyers were created in English and Spanish which were disseminated through Communities in Schools, an educational program connecting students and their families with community resources. These same flyers were also shared at neighborhood association meetings, faith community nurses' offices, and at local public libraries. Program participants were encouraged to invite friends and family to the program by providing the participant with extra incentives for an increase in attendance. A bilingual community health worker was recruited to attend each class and translate for Spanish speaking participants. Speakers and an exercise instructor were enlisted for a variety of health topics.

The 7-week course was offered at three different times (morning, afternoon, and evening) in the interest of inclusivity. Each of the first six classes incorporated community responsibility with health education, physical activity, and the creation of a plant-based vegan meal to be taken home and shared with family (Table 2). The seventh class was a celebration with the participants

bringing plant-based dishes to share a meal together. This class also included a giveaway of the cookware and utensils used during the classes.

On the first day of class, participants signed consents for physical activity and participation. Registered Nurses measured the body mass index (BMI), waist circumference, blood pressure, and non-fasting blood sugar of each participant. Each person was given a *Forks Over Knives* cookbook to take home, which provided vegan, plant-based recipes (Sroufe, 2012). The class members then completed the San Antonio Community Survey 2018, Food Stamp Program Food Behavior Checklist by Sylva, Townsend, Martin, & Metz (2008) or the Spanish version SNAP Supplemental Nutrition Assistance Program: Lista de Habitos Alimenticios (Banna, Townsend, & Sylva, 2010), and the University of California Physical Activity Assessment on the Go/de Prisa! (Banna & Townsend, 2007). The San Antonio Community Survey 2018 was developed by the project leader based on a review of the literature and expertise as a community leader (Appendix A). Permission for use of the Food Stamp Program Food Behavior Checklist, the SNAP Supplemental Nutrition Assistance Program: Lista de Habitos Alimenticios, and University of California Physical Activity Assessment on the Go/de Prisa! was granted by Mary Townsend (Appendix B).

During the first class, the structure of the course was explained to the participants including the giveaway for the seventh class. For each class attended, each participant received a ticket. Each time a participant invited a friend or family member to the class, she received an additional ticket. At the seventh and final class, tickets were drawn for participants to choose supplies to take home. The first weeks' health education lesson included a class discussion about the mind, body, and soul as aspects of health. To allow initial framing of the program and instructions for participants, there was no physical activity during this first class. Each

participant made a vegan dish of quinoa pan casserole following a discussion on plant-based nutrition and its impact on health. Individuality was allowed in the preparation of food, specifically in the amount of seasoning, while encouraging the use of healthy foods new to the participants.

The second class explored community and familial influences on personal health. This lesson emphasized strategies to empower members of a community to make healthful changes in neighborhoods. All of the participants participated in chair yoga exercises with modifications as needed. The class finished by making penne pasta with vegan white wine mushroom sauce.

The third meeting opened with yoga stretches followed by a group discussion regarding the effects of genetics and generational habits on individuals' health. The impact of these generational habits on neighborhoods and communities was also deliberated. During this third class members began exchanging phone numbers and interacting more. The vegetable fried rice recipe, chosen at a request of a participant, was prepared.

Following a conversation during the previous week's class about eggplant, eggplant ratatouille lasagna was chosen for the fourth class. The class began with making the ratatouille sauce. Then while the lasagna cooked, the class discussed stress and practiced breathing exercises. The breathing techniques chosen were specifically designed to reduce the body's stress response.

The fifth class opened with line dancing for the physical activity. The class then had an in-depth conversation about love languages, that is, personal preferences for expressing and receiving love. It was important for this lesson to occur later in the program to cultivate intimacy and trust in the participants. At the completion of the class, each participant took home their

versions of vegetable miso soup. By enabling participants to customize their dishes, for example adding or avoiding mushrooms, the recipes are more likely to be enjoyed and tried again.

The penultimate class meeting began with more line dancing following by twisting stretches. Several health issues affected by the environment were discussed including liver health and sleep hygiene. This class also re-emphasized community empowerment for creating healthful changes. The meeting concluded with making vegetable white bean hash.

On the last day of class, each participant's BMI, waist circumference, non-fasting blood sugar, and blood pressure was measured. Each participant then completed the original surveys: The San Antonio Community Survey 2018, Food Stamp Program Food Behavior Checklist, and University of California Physical Activity Assessment on the Go/de Prisa!. The participants were given an additional packet to reflect upon and record the program's highs and lows. These reflections assisted in the evaluation of the effectiveness of H^4 in creating a shared value of health. To demonstrate their recently acquired skills of plant-based meal preparation, the final class included a participant-provided potluck dinner.

The outcomes for the participants in the H^4 intervention group were measured using pre and post surveys and biophysical metrics. The community survey assessed changes in the understanding of the interconnectedness of health and participation in civic engagement. The physical measurements determined body mass indices and blood pressure metrics in conjunction with increased or decreased time performing physical activity. The food survey assessed changes in the consumption of a variety of fresh fruits and vegetables.

Table 2

H^4 Class Schedule

Week	Physical Activity	Health Education	Plant-Based Meal(vegan)
1	No activity due to consents and assessments	Health defined	Quinoa pan casserole
2	Chair yoga stretches	Influences on personal health	Penne with white wine mushroom sauce
3	Yoga	Genetics vs generational health behaviors	Vegetable fried rice
4	Breathing exercises, brain activity	Stress related to personal, familial, and community health	Eggplant ratatouille lasagna
5	Line dancing	Love languages	Miso soup
6	Line dancing, twisting stretches	Liver health, importance of sleep, empowered to create community change	Vegetable white bean hash
7	Potluck and giveaway		

Organizational Barriers and Facilitators

There were several organizational barriers in this community outreach project. Surveys and recruits for H^4 were selected where the community gathers. The results were not an accurate reflection to include the population that is not involved community activities. Of the 347 surveys obtained from the public, only five of the surveys given to men were returned. Therefore, survey results are a stronger representation of women involved in their communities.

The H^4 program would be difficult to duplicate without financing. The Christian non-profit health organization, which provided funds for supplies, stipulated that the supplies would be distributed to the class participants at the completion of the program. This generosity

facilitated H^4 as a class, but it did not allow for the program to be repeated with another group of community stakeholders at a later time.

Using induction burners allowed the participants to create their meals simultaneously adding or discarding ingredients to suit their own tastes; however, the host church had not been renovated in the past 25 years. There were several electrical outages during class. Extension cords were used to divide the demand on the breakers, but the cords presented an increased fall risk.

The church's willingness to host H^4 was a true facilitator. The pastor promoted the program by word of mouth which increased community awareness. The bilingual community health worker assisted with each class and was available for translating as needed.

After the first class, two participants offered to help with set up and clean up for the rest of the classes. These helpers arrived early to move tables, set up supplies, and cut vegetables. They stayed late cleaning dishes and storing leftovers. They not only demonstrated civic engagement and sense of community, they were facilitators in the success of the program.

Results

The San Antonio Community Survey 2018 completed by community members and H^4 participants revealed the public's perception of health as a shared value. Though most of the survey used multiple choice responses, the free text answers provided strong feedback regarding needs in the community such as needs for transportation, access to parks and walking trails, and desire for community emotional and social support. The data from these surveys demonstrated more areas in building health as a shared value that may be explored in the future.

The H^4 community program grew in size from the first class through the last. The first week, there were four participants for the three times that the course was offered. After three

classes, the early morning class was canceled due to low attendance. In the end, there was one afternoon class and one evening class on Sunday nights. For the final celebration, which combined all of the classes together, eleven participants attended. Though meals had been planned prior to the program implementation, the menu was adjusted to reflect interest from the class. Participants were motivated to try new things. One participant explained that she had never prepared eggplant and would like to learn how. This request resulted in one of the more popular dishes of eggplant ratatouille lasagna.

Relationships developed between the participants as the classes progressed. Several members exchanged phone numbers and checked on one another during the week. Additionally, the project facilitator received calls and had visits with participants during the week. Conversations ranged from personal and family health questions to ways of creating change in the community. Participants became more supportive of one another, encouraging one another.

There were measurable changes in the H^4 group as well. The community survey reflected a substantial increase in awareness of the importance of education to one's health (Table 3).

Table 3

San Antonio Survey Response: To What Extent Do You Believe Education Affects Your Health?

	Initial Community Survey	Post Community Survey
Perception of Effects of Education on Health	.56	.8
Likert Scale	Some effect	Strong effect

Though not statistically significant, there was an increased understanding of the interconnectedness of health and employment, stress, quality of air and water, community safety,

and quality of housing. Interestingly, there was a decrease in the perception that health is affected by access to quality food.

The food behavior survey showed an increase in daily vegetable servings as well as an increase in the variety of vegetables consumed on a daily basis (Table 4).

Table 4

Food Stamp Program Food Behavior Checklist Response for H^4 Class

	Initial Food Behavior Survey	Post Food Behavior Survey
Daily Vegetable Servings	2	3
Daily Variety of Vegetable	sometimes	often

Paired sample t-tests were conducted to compare pre and post program metrics including height, weight, BMI, waist circumference, systolic and diastolic blood pressures (Table 5), and non-fasting blood sugars. There was a significant difference in the H^4 participants' waist circumference ($M = 47.47$, $SD = 4.83$) at the beginning of the program and on the last day H^4 met ($M = 47.08$, $SD = 5.08$); $t(5) = 2.026$, $p = .093$. There was also a change in diastolic blood pressure readings ($M = 70.67$, $SD = 11.78$) from the initial class when compared with the final meeting ($M = 63.22$, $SD = 16.73$); $t(8) = 2.214$, $p = .058$. Both a decrease in waist circumference and diastolic blood pressure decreases the risk of cardiovascular disease (CDC, 2015). Also, the mean systolic blood pressure decreased from 125 to 114 mm/Hg. This improvement was not considered statistically significant.

Table 5

Waist Circumference and Diastolic Blood Pressure Readings Pre- and Post-H[4] Community Class

	Pre and Post H[4] Program	Mean	Standard Deviation
Waist Circumference In Inches	Pre measurements	47.71	4.838
	Post measurements	47.08	5.076
Diastolic Blood Pressure mm/Hg	Pre measurements	70.67	11.787
	Post measurements	63.22	16.734

After the conclusion of H[4], the program facilitator followed up with the participants. As newly equipped drivers for health as a shared value in the community, more than 80% of the participants had made healthful changes in their own lives and were influencing those around them. One participant started an exercise group using equipment received during the giveaway (yoga mats, free weights, physio-ball). Two other participants started a walking group that walks through the neighborhood 2 to 3 times a week. A couple of the participants joined a new church (community and spiritual support) and began attending a bi-weekly exercise program. One member had shared recipes from *Forks Over Knives* with her family and children's friends. These families are now experimenting with plant-based dishes. One participant was able to take advantage of a work program by volunteering to help with class preparation and clean up for H[4]. Her employer provided monetary credits for the participant's volunteer time allowing her to

donate funding to a charity of her choice. Her volunteer time therefore resulted in investing in the community. Another member joined her neighborhood association.

Discussion

This community outreach program exceeded expectations. The goal of receiving 100 completed surveys was surpassed. The data from these surveys provide new areas in building health as a shared value that may be explored in the future. Day, Ashcroft, and Scott (2017) express the importance of first assessing the needs and understanding of health in a community before implementing strategies to build a culture of health. This community assessment guided the interventions as a part of building health as a shared value.

In a study by Lefler, Jones, and Harris (2017), they realized that a positive, unanticipated outcome of bringing older women together for a health intervention yielded a shared value which created a community. The H^4 class became a community. Over time, the group was empowered to try new foods, new exercises, ask questions, and offer input and experience. The embarrassment seen initially in the group activities vanished quickly. New class members were welcomed enthusiastically and encouraged to return, which they did. Reports of trying new fruits and vegetables at home became a regular part of the discussion time. Sharing with co-workers and friends breathing exercises to reduce stress resulted in feedback from community members as well as the participants themselves. This group is laying a foundation for health as a shared value in this community.

The initial goal for participation was twenty members for the H^4 class. Fortunately, this goal was not met. The fewer numbers provided more intimacy during the class. Consistent attendance included six evening participants and four afternoon participants. Funding would have been strained to provide equipment and food for more attendees.

Limitations

The San Antonio Community Survey 2018 was distributed at community meetings and events. The results only reflect those who are already engaged to some extent with the community. Though helpful in learning from stakeholders, it did not provide input from the community at large. Also, the surveys have a self-reporting bias. Subjective questions are easily influenced by mood or events that occurred on that same day. Additionally, participants' interpretation of the questions affected the results. For example, many surveys listed a job as having little effect on health; in the note section, these same participants reported their health has improved since retiring. Another limitation of the community surveys was incomplete data. Rather than discard incomplete surveys, the partial data were tabulated. Therefore, some responses are much stronger than others due to a greater number of respondents completing the survey question.

The H^4 class had inconsistencies in the metrics obtained. Several nurses assessed the participants, but not uniformly. Waist measurements were missing from 40% of the group.

This program would be difficult to duplicate without grants and/or donations. Each class was scheduled for 90 minutes with a guarantee of taking a meal home at the end of class. The time constraints presented challenges. Some activities were shortened to accommodate longer exercise times or food preparation needs. Several community speakers were enlisted to participate with selected classes. As a result of the class date conflict with a virulent flu season, none of the speakers were able to participate. Each speaker or speaker's family was affected by the flu, prohibiting their participation in H^4.

It was difficult to secure a host location for H^4. The use of induction burners, the need for readily available sinks, and food storage, in addition to exercise space demanded a very specific locale to host this program.

Recommendations

When duplicating this program, it would behoove the facilitator to preregister attendees. In the interest of encouraging participation, guests were invited to join the class at any time. Though inclusive and welcoming, this open invitation created a challenge in providing supplies for each person present. Keeping the program close to where the residents live, as that is the targeted focus of H^4, an apartment complex might be selected as an ideal site with a kitchen facility and sinks closely available.

An orientation class with hands-on demonstration for the Registered Nurses helping with measurements would have helped standardize the pre and post measurements. This class would have also provided an opportunity to share the concept of health as a shared value. Additionally, capturing laboratory results such as lipid profiles would help to validate the results of the program (Koniak-Griffin et al., 2015).

This program to develop drivers for health as a shared value does not need to be limited to one location. Having the class meet in a nearby park or taking the group to the grocery store together would provide experiential education. Facilitators for H^4 should capitalize on the strengths of the class members by allowing them to share or demonstrate their expertise as is appropriate.

Implications for Practice

Zip codes where patients live are a stronger predictor of morbidity and mortality rates than time spent with a primary care provider (Prevention Institute, 2012). This evidence-based

project does not make the job of a primary care provider irrelevant, but it does suggest that providers must consider the communities where their patients live. In order to truly impact their patients' health, it is imperative that advanced practice registered nurses use their advocacy to create cultures of health in these communities: identify stakeholders, encourage drivers for health as a shared value, discuss community responsibility with patients, and vote for policies that help patients to thrive. The health of a community can change when the people are empowered to change it.

Conclusions

The initial community assessment showed a need for health as a shared value. For those who valued health, there was no drive to share that value. The interventions from this community improvement project provided community members with actionable outlets for health to become a shared value. They were empowered to make changes in their own lives, at home and at work, while also engaging their neighbors. In this South San Antonio neighborhood, health is a more strongly held value than before this intervention.

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Appendix A

San Antonio Community Survey 2018

Please place an X or fill in the blank as appropriate.

How do you rate your…

	Very unhealthy	Unhealthy	Somewhat healthy	Healthy	Very healthy
personal health					
family's health					
community's health					

To what extent do you believe that your…

	No effect	Very little effect	Some effect	Strong effect	Very strong effect
health affects your family					
health affects your community					
community affects you and your family's health					

To what extent do you believe that the following things affect your health?

	No effect	Very little effect	Some effect	Strong effect	Very strong effect
Having a job					
Stress					
Quality food available to the community					
Air and water quality					
Genetics inherited from parents					
Community safety					
Housing quality					
Education					

Zip code	Age	Sex

Would you be willing to receive a follow up call from a Registered Nurse?

First Name_____ Phone number_____

San Antonio Community Survey 2018

In the past 6 months have you…	Yes	No	Unsure
volunteered in your community			
contributed money or time to a candidate or organization concerning a health issue			
contacted a newspaper or TV station concerning a health issue			
contacted your representative or a public official about a health issue			
Voted for or against a candidate because of his/her position on a health issue			
Participated in a civic group concerning a health issue (ex. Neighborhood association, PTA, community council, etc.)			

Please circle the ethnic group or groups you most identify with:

African American/Black
Asian/Pacific Islander
Hispanic/Latino
Native American
White/Caucasian
Other

How often do you use the following community resources?	Never	Rarely	Somewhat	Frequently	Very frequently
Parks					
Community Center					
School track/field					
Sidewalks					
Playgrounds					

What community resources do you think are missing in your neighborhood?

_____

Have you attended a previous community education offering in 2018?

Yes	No	Unsure

If 'yes' please list changes, if any, that have been made in direct response to the community education.

Appendix B

Communications for use of surveys:

Hello! I am a faith community nurse as well as a nurse practitioner student in San Antonio, Texas. I have been given permission to do my DNP project in a community setting. I am following the Robert Wood Johnson Foundation action framework for building a culture of health.

The first thing needed is a community assessment. After scouring the internet and journals, I found your food behavior checklists as well as your physical activity assessment. The graphics, the user-friendly language, the overall approach is exactly what I'd like to use. I have access to a lovely printer and colored ink. I would very much like to download these forms for assessing behaviors in my chosen community.

Food Stamp Program Food Behavior Checklist:
https://ucdavis.app.box.com/s/15zey9263csmjjev2l4k

The Spanish version: https://ucdavis.app.box.com/s/72genndic3tkxclxciwm

On the Go—de presa!: https://ucdavis.app.box.com/s/dlrlkv50ls9vec691ajv

If it is a possibly to download the forms, please let me know whatever I need to do to make it happen as well as where to pay. Time is of the essence, so I appreciate your help!

Donnelle Storrs, RN-BC

Yes you may download and print as is. Good luck with your project.
Marilyn
Marilyn Townsend, PhD, RD| Nutrition Specialist Emerita | Nutrition Dept| Meyer Hall| UC Davis