Community Health Project Paper: Part I

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Assessment

Introduction

The Healthy Living Center (HLC) in Norfolk, VA was designed to "Enable community members to take charge of their health and healthcare through interactive disease management education, collaborative self-management coaching, and building empowerment skills (HLC Mission Statement, n.d.). The HLC serves the community of Hampton Roads and more specifically the neighborhoods of Middle Town Arch, Bowling Green, and Broad Creek in Norfolk. As a group, we spent the summer providing support to the HLC during their Health Cooking Class. This class is designed as a service to the community in order to educate about plant-based diets and chronic diseases. The HLC caters to patients with diabetes type II, hypertension, and obesity.

We utilized the beginning of the summer to assess our community partner and the needs of the community members. We did this through a Windshield Survey (site), discussion with community partners, and interaction with community members. During this time, we also documented our clinical experiences and performed literature reviews of diabetes education, food insecurity, food deserts, and community-based interventions. After participating in the Healthy Cooking Classes, performing our Windshield Survey, and performing research, we determined that the community exhibits signs of a knowledge deficit on a nutritionally balanced diet as evidenced by the incidence of chronic disease in the community and lack of healthy plant-based food sources. In this paper, we will define our population, review the literature, compare our community to others across the United States, and define the community needs in the form of nursing diagnosis. Additionally, through this paper we will offer a suggested intervention to address the needs defined in our nursing diagnoses in addition to alternative needs we have identified in the aggregate.

Aggregate Characteristics

Norfolk, Virginia is a city of approximately 246,000 residents and more than 100 diverse neighborhoods (City of Norfolk, n.d.). The median household income is $53,062 with an average of 2.43 persons per household. The most prominent races are Caucasians and African Americans, with African Americans being the highest minority group at 40.6% of the Norfolk population (United States Census Bureau, n.d.). African Americans currently experience the highest poverty rates compared to other races and ethnicities in the city. Currently, 27% of African Americans in Norfolk are living in poverty (Poverty USA, 2019). Lastly, as of 2019 32.4% of the citizens were considered obese and 9.2% of the population were diagnosed with diabetes (Greater Hampton Roads Connects, 2019).

An individual's actual health status can be affected in many ways. Food insecurity is the limited or uncertain access to reliable and nutritious meals. This can often be due to poverty, unemployment, disability, etc. As of 2020, Norfolk, Virginia has a food insecurity rate of 13.2% which is higher than the national average of 11.8% (Feeding America, n.d.). Research shows that food insecurity is associated with a higher probability of chronic diseases such as hypertension, coronary heart disease (CHD), and diabetes (Gregory & Coleman-Jensen, 2017). Often, many families struggle to maintain good health due to several factors that are related to food insecurity.

Many individuals in the Norfolk population lack adequate access to healthcare. Currently, 12.9% of the residents under 65 years of age are without health insurance (United States Census Bureau, n.d.). There are over 45 million Americans currently living in poverty in the United States. Furthermore, there are 41,016 Norfolk residents living at the poverty level, which is 18.8% of the population. This surpasses the national average of 13.4% of the American population (Poverty USA, 2019). Lack of health insurance is one of the primary barriers to

healthcare access. Having health insurance is associated with improved access to health services and better health monitoring, on the other hand, lack of healthcare coverage may have adverse effects on individuals' health. Additionally, uninsured adults are less likely to receive preventive services for chronic conditions such as diabetes, cancer, and cardiovascular disease (Healthy People 2030, n.d.). Healthcare access is extremely important to address, however, it may not remove every barrier that citizens may face.

A perceived health barrier refers to how someone feels about an obstacle in the way as one attempts to improve their health. Some perceived health barriers are created from cultural influence. The majority of the population in Norfolk, Virginia are black or African American; the community can have both an internal and external influence on the lives of the individuals. Dietary consumption practices in southern regions include fried foods; fast foods; sugary, carbonated drinks; processed, and high fat and high sodium foods. There is a lack of variety in consumption of fruits, starchy vegetables, and unprocessed cereals in daily meals (Bovell-Benjamin, et al., 2010). This poses a challenge within the community to change what is comfortable and known, to something that is different, foreign, and something that may not be accepted by others around them. Changing meal plans needs support from their family members and friends.

Environmental factors in this community are the lack of healthy food options in a close proximity. Vast food groups are avoided due to the lack of exposure which stems from a lack of accessibility to healthy food groups over decades. The cost of healthy foods and learned dietary behaviors from childhood poses a hurdle for individuals to overcome (Satia, 2009). It is shown that less expensive food items and snack options are purchased more by this community than fruits and vegetables. Peer influence can determine whether someone chooses to eat unhealthy

options to “fit in” so they are not viewed as different. African Americans may also feel less guilty about overeating and tend to consider eating a social experience, and are more accepting with larger body sizes (Satia, 2009). This aggregate has expressed these barriers within the cooking class as they are challenged to cook with foods that are not part of their usual diet. Dr. Newby discusses how their culture has affected their diet and caused increased health disparities that they must overcome together as a community and bring these changes back to their families. Lack of education and awareness of what foods to eat, how to find food that are healthy and affordable, and changing cultural norms have been an expressed problem that the aggregate at HLC is challenging.

Psychosocial factors may affect dietary intakes which can result in chronic disease risk. High self-efficacy resulted in higher consumption of fruit, vegetables, and a lower consumption of fat. A belief between diet and disease is correlated with healthy dietary intakes, as is high self-rated health, knowledge of dietary recommendations, strong social support from friends and family, and familiarity with nutritional guidelines (Satia, 2009).

Literature Review

The purpose of this study was to demonstrate that tracking important clinical indicators of diabetes mellitus can result in improved care as well as help identify and close gaps between evidence and practice in diabetes care **(**Ba-Essa et. al, 2018). This was an observational study where they randomly audited medical records of patients with diabetes who received care at the Diabetes Center, Dammam Medical Complex. They used the quality improvement Plan–Do–Study–Act model, for the period between October 2012 and March 2016. Individual physician performance was also measured for the same duration. All data was benchmarked against peer organizations worldwide. They found that urine examination for proteinuria, foot examination,

annual influenza vaccination, aspirin prescription, structured education, personalized nutritional advice, and self-monitoring of blood sugar significantly improved between baseline and the final observation of the study. The proportion of patients with hemoglobin A1c (HbA1c) greater than nine percent decreased, and for those who achieved the recommended levels of HbA1c, cholesterol and blood pressure significantly decreased. Benchmarking against peer organizations worldwide showed comparable results overall, and better results for certain indicators. Overall, quality improvement indicators can be utilized to improve the quality of diabetes care delivered, and thus reduce the gaps and barriers that exist between recommended diabetes care and practice (Ba-Essa et. al, 2018). This correlates with our aggregate because we are working to close the gap in knowledge of diabetic management and how to reduce the rates of type 2 diabetes in our community.

The purpose of this study was to test a hypothetical path model to estimate the effects of self-efficacy, psychological distress, social support, and health-promoting behaviors on the quality of life of women who experience overweight or obesity and low-income households (E.J. et. al, 2022). This study was a descriptive, correlational, cross-sectional analysis using a convenience sample and self-administered questionnaire. They found that increased self-efficacy and social support among women who experience overweight or obesity and low-income households is associated with higher health-promoting behaviors and quality of life, whereas lower psychosocial distress is associated with higher QoL. Therefore, quality of life among women experiencing overweight and obesity and low-income should be assessed along with self-efficacy, psychosocial distress, and health-promoting behaviors (E.J. et. al, 2022). This is applicable to our aggregate because we work with our community to provide education and support in healthy lifestyle changes to help reduce the body mass index (BMI) in our community.

In this research study, their objective was to examine the practicality and acceptability of interventions like Mindfulness in Motion and Dietary Approaches to Stop Hypertension (DASH), to improve diet, mindfulness, stress, and systolic blood pressure in older African Americans with mild cognitive impairment and hypertension (Wright et. al, 2021). This was a cluster randomized controlled trial in an intergenerational community center in a large metropolitan area. The participants were divided into six groups randomized 1:1:1 to the MIM DASH group, the non-hypertensive education group, or the true control group. The MIM DASH and attention-only interventions were delivered in 2-hour group sessions for 8 weeks. MIM included mindful movements from chair/standing, breathing exercises, and guided meditation. The DASH component used a critical thinking approach of problem-solving, goal setting, reflection, and self-efficacy. The true control group received a DASH pamphlet at the end of their session. There was a clinically significant reduction in systolic BP in the MIM DASH group in comparison to the attention-only group, and no change between the MIM DASH and true control group. In conclusion, they found that MIM DASH intervention was practical and culturally acceptable in African Americans with hypertension (Wright et. al, 2021). Hypertension is one of the HLC classes we assist with and our aggregate is taught mindfulness in motion techniques along with healthy plant-based meals that are aligned with the low sodium aspects of DASH.

This next research study's main objective was to evaluate the impact of the Market to MyPlate program on fruit and vegetable consumption and cooking behaviors. The secondary objectives were to examine factors that affected participant retention and program completion, and analyze program feedback provided by participants. This was a mixed method experiment where adult participants completed a pre- and post-program survey reporting on their fruit and

vegetable consumption and cooking behaviors. In the study, 120 adults and their families participated all coming from central Illinois. The participants who received an intervention that directly increased their access to fresh produce increased their reported fruit and vegetable consumption. Though participants' cooking frequency did not change, interviewees reported increased variety, cooking confidence, and family participation in cooking (Metcalfe et. al, 2021). This study was super interesting because it is similar to our HLC cooking classes and promotes healthy eating and increasing the intake of fruits and veggies. At the HLC we work on promoting plant-based diets.

The last article was a literature review where they looked at appropriate lifestyle strategies that are needed in order to reduce the burden of type 2 diabetes. Dietary patterns characterized by a high consumption of fruits, vegetables, whole grains, legumes, nuts, and seeds, and a minimal consumption of animal products, have been suggested as a dietary approach to prevent and control type 2 diabetes and related micro- and macrovascular complications. They found that planted-based diets especially those following the Mediterranean diet have been effective in controlling Type 2 diabetes and reducing comorbidities. This is extremely interesting because Dr. Newby at the HLC has surrounded the classes and education around plant-based nutrition and how implementing this type of diet in their lifestyle can better them in all aspects of their health.

Comparison

Chronic illnesses in Norfolk are comparable to those of the state and national average (see Appendix A). In 2019, the average persons diagnosed with diabetes and hypertension were below the national average, unfortunately not by much. The obesity rate in Norfolk was slightly higher than the national average. Since 2018, the rate of obesity and diabetes in Norfolk has

decreased. The rate of diabetes in Norfolk was 11.7% and is now 9.2% (Greater Hampton Roads Connects, 2019). The rate of obesity also decreased from 34.4% to 32.4% (Greater Hampton Roads Connects, 2019). Although we are currently in line with the national averages as a city and state, the percentages are trending downwards.

Population Needs

We have identified three nursing diagnoses in order of priority that applies to our aggregate. The priority nursing diagnosis for our aggregate population is knowledge deficit. This knowledge deficit is related to a lack of knowledge on a healthy diet as evidenced by chronic disease or a new diagnosis of diabetes type II. Some of the patients in our aggregate were newly diagnosed with type II diabetes, or had a hemoglobin A1c that put them in the category of pre-diabetes. Additionally, upon analysis of 48-hour food recall many patients in our aggregate regularly consumed processed foods and sugary beverages. This assessment data drove our selection of knowledge deficit and this diagnosis is supported by evidence in research that shows improved metrics for patients with type two diabetes after educational intervention by case managers (Rosa et al., 2020). In this study case managers were the primary point of contact for the experimental group of patients with diabetes. These patients had improvements in hemoglobin A1c and cholesterol (Rosa et al., 2020). Jean Watson's Theory of Human Caring provides a theoretical framework for how important nutrition management is when looking at a patient holistically (Johnson & Weber, 2015, p. 175). Her theory states that nursing is focused on holistic care, including nutritional education.

The second nursing diagnosis we have identified is ineffective health maintenance. This is evidenced by cultural food preferences and cooking styles, demonstrated lack of knowledge about a plant-based diet, and a referral to the HLC from a primary care provider. Research has

shown that coaching patients with a chronic disease like diabetes, leads to more patient satisfaction and better self-management of the disease (Miyamoto et al., 2019). Patients come to the HLC to learn how to effectively manage their health through a class facilitated by a nurse practitioner and followed by a plant-based cooking class. As the HLC utilizes tertiary prevention, the nursing diagnosis of ineffective health maintenance is supported by Betty Neuman's Systems Model. This model demonstrates the need for intervention when patients already suffer from illness so as to return them to their "optimal wellness" (Johnson & Weber, 2015, p. 165).

The final nursing diagnosis we identified for our aggregate is health-seeking behaviors. This is evident in our patients, because they have a chronic disease and are not managing it well, which is why they were referred to the HLC. However, if they landed in our aggregate, then they are utilizing health-seeking behaviors. They have shown up to class and they are learning the information that they need to change their health. Through this class, participants are given knowledge and practical tools about a plant-based diet. They are also given healthy cooking ingredients. This is providing them with the knowledge and tools that they need to change their health. Nola Pender's Health Promotion Model helps explain these phenomena. She defines health as a dynamic state and believes that the ultimate goal for patients is health-promoting behaviors (Petiprin, 2020). By attending classes at the HLC our aggregate is displaying health-promoting behaviors.

Planning

The participants that attend the HLC know that they are in need of help when they sign up. The priority nursing diagnosis for this population is going to be a knowledge deficit and there are a few interventions that can be implemented. Depending on the class they are eligible to sign up for, they either have diabetes, hypertension, or obesity. Each class is specifically tailored to

the chronic condition by teaching them what it is, how to improve it, what to look out for, how to eat healthier, and how to live a healthier lifestyle. The community members agree that they need more education and knowledge when it comes to their chronic condition. One main intervention we can implement into the HLC is a virtual reality video on how to properly shop for their groceries with healthy options and alternatives.

This video has been identified as being a tool to implement into one of the classes. The objective for the specific video will be of what a grocery store looks like, how to shop, healthy alternatives, and how to read a food label. We will hand out the virtual reality (VR) glasses and have the participants watch the video; once they are done watching we will administer a post-quiz to measure how helpful this video was to them. In order to make this happen and implement this into the HLC, there are a few things that we need to plan out. The main resource we will be using is Dr. Newby since this is her program and she is the one making all the decisions. We will need to develop a post-quiz, make the video at the closest grocery store to the HLC, and obtain the VR glasses. This is all very achievable with the number of people we have within our group. This intervention is realistic and ties right into what our community members need. It is another way to teach them about their knowledge deficit in relation to food.

Alternative Interventions

The HLC is a work in progress and is being built from the ground up. The members that attend the HLC not only have a chronic condition but there are some barriers that they have to overcome to make better options. The alternative intervention we also plan to implement is a SNAP application and HbA1c testing. We plan to implement the SNAP application by taking a survey of those that need it and don't already receive benefits. We will pass this questionnaire out on the first day of class and compile a list of those that need it. Once we identify who the

participants are we will contact them by phone to set up a time either before or after class to sit down and help them submit. The resources we need to fulfill this intervention are the students, creating a survey, computer access, and time built into the class. The next intervention we plan to implement for the diabetes and obesity class is the HbA1c testing on the fourth and final class. The resources we need for this are the testing machine, non-expired testing materials provided by ODU, and students to run the machine and testing. These two interventions will help the members of the community by assisting them with food security and giving them an average of their glucose level over the last three months for a baseline.

The HLC is working with members that live in the Norfolk community to enhance their knowledge and understanding of their chronic disease. We are able to immerse ourselves into this community and help them gain more resources to fully understand and manage their disease. Knowing they have a knowledge deficit we can now implement a few interventions to help improve their quality of life.

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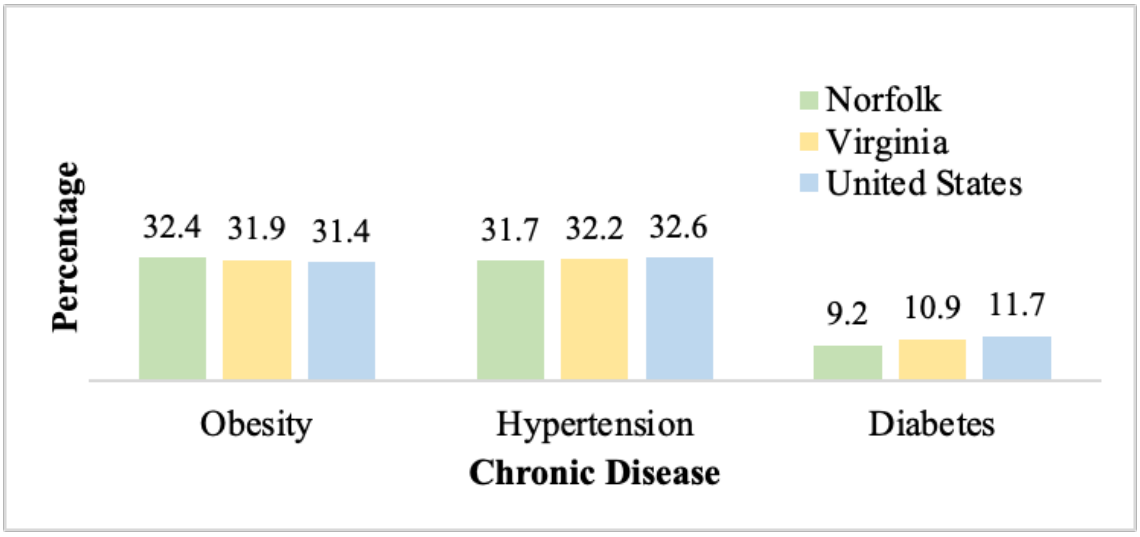
Appendix A



Note: Rates of Chronic Diseases by City, State, and Country

Honor Code

I pledge to support the Honor System of Old Dominion University. I will refrain from any form of academic dishonesty or deception, such as cheating or plagiarism. I am aware that as a member of the academic community, it is my responsibility to turn in all suspected violators of the Honor Code. I will report to a hearing if summoned.

Signature: Elizabeth Kiefer, Briana Leinart, Amanda Pugh, Tricia Souza, Brittany Travis, Sarah Wucher

Rubric

Criteria	Poor	Novice	Proficient	Excellent
Assessment				
Aggregate (10)	Aggregate is not well identified or defined. Rationale for aggregate selection missing. Lacks discussion for how entry to community is gained (0-3)	Aggregate identified but not defined. Rationale for selection not thoroughly discussed. Identifies methods for gaining entry to community aggregate. (4-6)	Discusses introduction to aggregate. Includes rationale for aggregate selection. Methods for gaining entry to the community identified. (7-9)	Discusses introduction to aggregate. Includes rationale for aggregate selection and process. Methods for gaining entry to community discussed, including any research or tools utilized. (9-10)
Aggregate Characteristics (25)	Socio-demographics not supported by data. Health Status determined by student opinion, not supported by objective and subjective data. Internal and External influences missing or lacks accuracy. (0-10)	Socio-demographics supported by opinion and 2 or less data sources. Health Status determined by student opinion, not supported by objective and subjective data. Internal and External influences missing or lacks accuracy. (11-17)	Utilizes 2-4 or more data sources to define socio-demographic characteristics. Discusses **actual** and **perceived** health status. Identifies both internal and external influences affecting aggregate health. (18-23)	Utilizes 4 or more data sources to define socio-demographic characteristics. Discusses **actual** and **perceived** health status. Identifies both internal and external influences affecting aggregate health.(24-25)

Literature Review Resources (15)	Conducts literature review of less than 3 current nursing research articles plus utilizes current research from other professions. Research not well applied to the characteristic, problems/needs of aggregate (0-6)	Conducts literature review of less than 4 current nursing research articles plus utilizes current research from other professions. Research not well applied to the characteristic, problems/needs of aggregate (7-10)	Conducts literature review of less than 5 current nursing research articles plus utilizes current research from other professions. Applies research to the characteristic, problems/needs of aggregate (11-13)	Conducts literature review of 5 or more current nursing research articles plus utilizes current research from other professions. Applies research to the characteristic, problems/needs of aggregate (14-15)
Compare/Contrast (10)	Lacks comparison of target aggregate with similar aggregates, the community, the state and/or the nation (0-3)	Compares target aggregate with similar aggregates, the community, the state and/or the nation (4-6)	Compares and contrasts target aggregate with similar aggregates, the community, the state and/or the nation (7-9)	Compares and contrasts target aggregate with similar aggregates, the community, the state and/or the nation. Provides specific examples and/or current statistics. (9-10)

Population Needs (Nursing Diagnoses) (5)	Nursing Diagnoses identified but lacks 2 or more of the following components- lacks **rationale, theory support**, and or **prioritization (0-2)**	Nursing Diagnoses identified but lacks 1-2 of the following components- lacks **rationale, theory support**, and or **prioritization (3)**	Appropriate **Nursing Diagnoses** (plural) with **rationale** and **theory support** and **prioritization** applied to aggregate. (4)	Appropriate **Nursing Diagnoses** (plural) with **rationale** and **theory support** and **prioritization** applied to aggregate. Health problems/needs include comparative analysis and interpretation of data collection and current research. (5)
Planning				
Health Planning/Needs (15)	Lacks identifies one priority Nursing Diagnosis which needs intervention. Provides generalized objectives. (0-6)	Identifies one priority Nursing Diagnosis which needs intervention. Provides generalized objectives. (7-10)	Selects and discusses one priority Nursing Diagnosis which needs intervention. Provides specific, measurable objectives. (11-13)	Selects and discusses one priority Nursing Diagnosis which needs intervention. Provides specific, measurable objectives. (14-15)
Alternative Interventions (10)	Does not discuss alternative interventions, does not include identification of resources. (0-3)	Identifies but does not discuss alternative interventions, does not include identification of resources. (4-6)	Includes description of alternative interventions necessary to fulfill objectives. Lacks full discussion of resources. (7-9)	Includes description of alternative interventions necessary to fulfill objectives. Discusses either existing, developing or resources. (9-10)

Format (10) APA, Spelling, Grammar	Greater than 5 errors. (0-3)	4-5 errors (4-6)	2-3 errors (7-9)	0-1 errors (9-10)