Received: 4 February 2021 | Revised: 31 August 2021 | Accepted: 2 September 2021

DOI: 10.1111/phn.12973

PHN PUBLIC HEALTH NURSING WILEY

POPULATION STUDY

Identifying community needs of the Hispanic faith community to develop a research agenda

Keneshia Bryant PhD, APRN, FNP-BC[1] | **George Pro PhD, MPH**[1] | **Martha Rojo PhD, RN**[2] | **Jenil Patel PhD, MBBS, MPH**[3,4] | **Tiffany Haynes PhD**[1] | **Pearl McElfish PhD, MBA**[5] | **Manny Sepulveda BA**[6] | **Camille Hart MPH**[1]

[1] Department of Health Behavior Health Education, Fay W. Boozman College of Public Health, University of Arkansas for Medical Sciences, Little Rock, Arkansas, USA

[2] College of Nursing, University of Arkansas for Medical Sciences, Little Rock, Arkansas, USA

[3] Department of Epidemiology, Human Genetics and Environmental Sciences, The University of Texas Health Science Center at Houston (UTHealth) School of Public Health, Dallas, Texas, USA

[4] Arkansas Center for Birth Defects Research and Prevention, Fay W. Boozman College of Public Health, University of Arkansas for Medical Sciences, Little Rock, Arkansas, USA

[5] College of Medicine, University of Arkansas for Medical Sciences–Northwest, Little Rock, Arkansas, USA

[6] Arkansas Hispanic Health CoalitionInc., Conway, Arkansas, USA

Correspondence
Keneshia Bryant, PhD, APRN, FNP-BC, Associate Professor, Fay W. Boozman College of Public Health, University of Arkansas for Medical Sciences, 4301 W. Markham Street, Slot #820, Little Rock, AR 72205, USA.
Email: KJBryant@uams.edu

Abstract

Objective: To conduct a community health needs assessment among the Hispanic faith community population to develop a community-partnered research agenda.

Design: A cross-sectional design was used to conduct a community needs assessment using a community-based participatory research approach

Sample: Hispanic faith community members in Central Arkansas.

Measurement: Data collection was led by Hispanic faith leaders using an audience response system at places of worship. An 88-item Community Health Needs Assessment survey was used that included demographic questions and questions related to five domains including community concerns, community resources, healthcare access, health concerns, and hunger and nutrition.

Results: There were a total of 100 participants in the community needs assessment. Hunger and nutrition was the highest ranking community concern followed by healthcare access.

Conclusion: Based upon the results of the study, the university researchers and Hispanic faith community members have begun the initial steps to developing a research agenda to address the major concerns of the community.

KEYWORDS
community engagement, faith, health, Hispanic

1 | BACKGROUND

Minority groups in the United States (US) have higher rates of chronic disease as well as higher rates of morbidity and mortality when compared to their white counterparts (Benjamin et al., 2018). Ethnic minorities in Arkansas experience chronic disease at a greater rate that leads to premature death (Quinones et al., 2019). These health disparities are fueled in part by social inequities, such as unequal opportunities to education, employment, and other factors that may impact a person's position or status in society (World Health Organization, 2010). Arkansas continues to have high rates of poverty, especially in rural areas, with a childhood poverty rate of 26.8%. Additionally, educational attainment is low. The high school graduation rates in Arkansas are among some of the worst in the nation (United Health

Foundation, 2017). Socioeconomic challenges and health disparities are even worse among Hispanics residing in Arkansas with many (48.1%) lacking a high school diploma (Maulden et al., 2012). Widespread inequities also exist in access and availability of healthcare services. Hispanics living in Arkansas are predominantly foreign-born, are young (57%) (median age 25.1), have no health insurance (63%), and are not fluent English (57%). Further, many struggle with Spanish since they speak a dialect (Capps et al., 2013; Kochhar et al., 2005). All of these variables are a major barrier to healthcare access. Further, Hispanics experience other characteristics that lead to health challenges, such as degree of acculturation, immigration status, and the political environment.

Since the 1990s, Arkansas has experienced rapid growth in the Hispanic population. In 2000, the population was 86,866 and in 2016, the number had increased to 205,000 (US Census, 2017). This population is diverse with distinct heritages, demographics, economic profiles, and immigration status, and because of their diversity their healthcare needs vary (Kochhar et al., 2005). To understand the complexity of factors impinging on Hispanic health, we must address the social determinants of health related to the quality of the social and physical environment where Hispanics live, work, and play and pray including neighborhoods, housing, access to healthy and nutritious food, transportation, and environmental conditions. However, there is limited information regarding the healthcare and research needs of the Hispanic community, especially in the Southern States.

Historically places of worship such as the church and parish has played a significant role in community engagement and is seen as a trusted institution by the Hispanic population. Places of worship are safe environments and often cited as their home away from home; places of worship also serve as a major social, educational, and spiritual resource (Caplan, 2019; Dalencour, 2017). Potentially, partnering with faith-based institutions can be an effective way to address health disparities among the Hispanic community, especially because most (77%) Hispanics report a formal religious affiliation (Pew Research, 2014). Though there is published research describing faith-based interventions with Hispanic places of worship, few describe the research partnership or a community-engaged approach (Wilmoth et al., 2020; Wilmoth et al., 2018).

The goal of the FAITH Network initiative was to lay the groundwork for future community-engaged research projects. Therefore, the aims of the internship were to (1) conduct a community health needs assessment among the Hispanic faith community population residing in Central Arkansas and then (2) use the information collected to develop a research agenda that would guide future research priority areas within this population.

2 | METHODS

Researchers at the university in partnership with faith leaders across Arkansas, developed an infrastructure to support large scale faith-based research called the Faith-Academic Initiatives for Transforming Health (FAITH) Network. The FAITH Network seeks to address health disparities experienced by racial/ethnic minority, vulnerable, and under-served populations. As part of the infrastructure a training for faith leaders called the FAITH Network Research Advocate training program was developed. The training program was designed to provide faith leaders the basics in community engaged research. The program was a 15-h face-to-face classroom training with homework assignments. Two cohorts of five Hispanic faith leaders participated in the FAITH Network Research Advocate training. The advocates all resided within three counties in Central Arkansas.

2.1 | Study design

Guided by the principles of community-based participatory research (CBPR) (Wallerstein & Minkler, 2011), a cross-sectional design was used to conduct a community needs assessment within the Hispanic faith community in Central Arkansas. The CBPR principles used for this study primarily focused on acknowledging the Hispanic faith community as a unit of identity; building on the strengths and resources of the community, and fostersing co-learning between the faith leaders and university researchers.

2.2 | Measures

A survey previously used to assess the health needs in the rural Arkansas African American faith community was adapted for the current study (Yeary et al., 2016). The resulting Community Health Needs Assessment was an 88-item survey that included demographic questions, one health literacy question (Chew et al., 2008; Sarkar et al., 2010), and questions that addressed specific health behaviors and outcomes that were obtained from the Center for Disease Control's Behavioral Risk Factor Surveillance System Survey (BRFSS). None of the survey questions were open-ended. Most of the survey included previously published replicated Likert scale questions from five domains: Community Concerns, Community Resources, Healthcare Access, Health Concerns, and Hunger and Nutrition. These were used to identify the areas of highest concern among participants (University of Vermont Medical Center, 2016).

The survey included four unique sections aimed at capturing participant's concerns about additional community issues, including (1) community, social, and environmental concerns [e.g., public safety, clean environment, childcare, housing, linguistic services, economic opportunities, livable wages, drug, and alcohol-free communities, diversity, recreation, youth services, and programs, walkable and bike friendly communities, sense of belonging, services for senior citizens, and access to public transportation], (2) access to community resources [e.g., social services, parenting education, child abuse prevention support, and domestic violence/abuse support and prevention], (3) healthcare access [e.g., access to primary healthcare provider, short term community support, affordable healthcare for adults, substance abuse treatment, bilingual health care providers, and specialist and dental care for children], and (4) physical and mental health concerns

[e.g., alcohol abuse, hypertension, cancer, cholesterol, depression, diabetes, dental problem, drug use, heart disease, obesity, stress, smoking, stroke, childhood diabetes, asthma, and obesity]. Each of the four community issue scores ranged between 0 and 4.

2.3 | Sample recruitment

Prior to the initiation of recruitment for the community needs assessment, the study was approved by the university's Institutional Review Board (IRB) at the exempt level. FAITH Network Research Advocates, faith leaders who participated in the FAITH Network Research Advocate training program, led the recruitment efforts. For places of worship to participate in the needs assessment, the key faith leader (e.g., pastor, priest) was asked to agree to provide space to conduct the needs assessment and to recruit 10 people from their congregation who were 18-years or older, self-identified as Hispanic, resided in central Arkansas, and spoke either Spanish or English. Those unable to provide consent in the session were not eligible to participate.

2.4 | Survey administration

Data collection were led by the FAITH Network Research Advocates using an Audience Response System (ARS) (Bryant-Moore, et al., 2018; Yeary et al., 2016) from participants recruited by the first cohort of advocates in five places of worship (10 participants per place of worship for with a total of 50 participants). Participants were welcomed as they entered the facility. Before ARS data collection began, the hosting church faith leader made a short statement and introduced the research team. A "Participant Information Sheet" (Appendix A) was distributed in English and Spanish, then read verbatim. It provided details about the study and their rights as participants. Written consent was not required to participate in the study. The ARS handheld devices were distributed and an orientation on how to use them was provided. This was followed by a brief description of the community health needs assessment. Each question of the survey was read aloud and displayed on the screen and time was allotted for discussion and questions. At the end of the session, the participants were thanked for their time and input, then they were provided their $10 cash incentives.

2.5 | Data collection process using telephone survey

Due to the COVID-19 pandemic, in-person surveys were discontinued in adherence to social distancing requirements; therefore, phone interviews were conducted to complete the data collection for the other half of the participants. The phone interviews were completed by the second cohort of FAITH Network Research Advocates. Prior to conducting the surveys, the advocates were trained on the process of following the script for data collection on paper surveys, submitting the completed surveys for analysis, and the distribution of the $10 giftcard incentives. Data were collected from personal contacts that the Research Advocate had invited to participate in the community health needs assessment. After completion of the survey, participants were mailed a giftcard.

2.6 | Data analysis

Our major domain of interest was a continuous measure of concern about hunger and nutrition in the community. We assessed hunger and nutrition specifically because it was the topic of concern scored highest by survey participants. The hunger and nutrition score ranged from 0 to 4 and was based on the faith leaders' responses to four survey items, with 0 meaning no concern and four meaning high concern. The four survey items gauged the participant's concerns about access to healthy foods in schools, access to affordable healthy foods, access to nutrition education, and knowledge of health meal preparation.

Independent variables included the participant's age, sex, income, health insurance, physical activity in the past month, county of residence, community, and health concerns, personal health problems (including diabetes, hypertension, high cholesterol, and heart disease), children's health problems (including diabetes and obesity), and barriers to healthcare utilization (including lack of money to buy food, lack of transportation, inability to get time off from work, high cost of health services, and high cost of medications).

We reported means and standard deviations for continuous covariates, and counts and percentages for categorical covariates. We reported means and standard deviations for community issue scores ranging between 0 and 4. Univariate regression analyses were conducted to assess the associations between hunger and nutrition concern score and demographic characteristics, community and health concerns, personal health problems, children's health problems, and barriers to healthcare use. We checked for multicollinearity using a Pearson correlation coefficient cutoff of 0.80.

3 | RESULTS

To ensure the COVID-19 pandemic did not have an impact on the results, we used chi-square tests to evaluate whether there were differences between three general demographic characteristics for the in-person (pre-pandemic) and phone-based (mid-pandemic) versions of the needs assessment survey. We identified no difference in participant demographics between the two survey versions regarding age group ($x^2 = 4.47$, $p = .48$), gender ($x^2 = 0.04$, $p = .84$), or income ($x2 = 0.19$, $p = .66$).

Table 1 shows the descriptive characteristics of the faith community members who participated in the survey to indicate the needs in their community. A total of 100 Hispanic faith community members from 10 different places of worship. Participated in the survey. Approximately 75% of the participants were 18 to 44 years old. Over a half of the participants were females (55%). The majority of participants had an annual household income less than $25,000 (68%), had no health

TABLE 1 Respondent characteristics

Variables	Mean (SD)n (%)	
Outcome		
Hunger and nutrition score (0–4)	3.21	0.95
Independent variables		
Demographic characteristics		
Race/Ethnicity		
Hispanic	100	
Age group (years)		
18–24	25	(25.25)
25–34	25	(25.25)
35–44	28	(28.28)
45–54	14	(14.14)
55–64	5	(5.05)
65+	2	(2.02)
Sex		
Male	43	(43.88)
Female	55	(56.12)
Annual household income		
Less than $25,000	68	(77.27)
$25,000 or more	20	(22.73)
Health insurance		
Any coverage	31	(32.63)
No coverage	64	(67.37)
Past month exercise		
Always	20	(20.20)
Sometimes	76	(76.77)
Never	3	(3.03)
Community and health concerns		
Community concern score (0–4)	2.80	(0.85)
Access to community resources score (0–4)	2.90	(1.08)
Healthcare access score (0–4)	3.19	(0.91)
Health concerns score (0–4)	3.00	(0.99)
Personal health problems		
Diabetes/high blood sugar		
Yes	17	(17.35)
High blood pressure/hypertension		
Yes	18	(18.56)
High cholesterol		
Yes	20	(20.62)
Heart disease		
Yes	6	(6.12)
Children's health problems		
Diabetes		
Yes	4	(4.08)
No	69	(70.41)
No children under 18 years in the household	25	(25.51)
Overweight/obese		
Yes	12	(12.77)
No	52	(55.32)
No children under 18 years in the household	30	(31.91)
Barriers to health		
Concerned about money to buy nutritious/healthy food		
Never	28	(28.57)
Sometimes	50	(51.02)
Always	20	(20.41)
No transportation to health services		
Yes	20	(20.20)
Could not take time off of work		
Yes	26	(26.26)
Cost of health services is too high		
Yes	56	(57.14)
Cost of medication is too high		
Always	32	(32.32)
Sometimes	42	(42.42)
Never	13	(13.13)
No medications	12	(12.12)

insurance coverage (64%), and reported exercising "sometime" in the past month (76%). The mean hunger and nutrition score (0 = no need, 4 = high need) was 3.21. Other community concern scores included healthcare access (3.19), physical and mental health concerns (3.00), community resources (2.90), and community concerns (2.80).

Table 2 shows the univariate regression analyses that were conducted to assess the association between demographic characteristics, community concern scores, and other items with hunger and nutrition needs score. Among demographic characteristics, only annual household income and county of residence were statistically significantly associated with hunger and nutrition score at the $p < .05$ threshold. In particular, compared to those with household incomes of $25,000 or more, those with household incomes of less than $25,000 were more likely to have a higher hunger and nutrition concern score (B = 0.78; $p < .001$).

We identified no multicollinearity between community concern domains, all of which were strongly positively associated with greater hunger and nutrition needs scores. Specifically, greater scores of community concern (B = 0.87; $p < .001$), access to community resources (B = 0.49; $p < .001$), healthcare access (B = 0.71; $p < .001$) and health concerns (B = 0.68; $p < .001$) were more likely to be associated with increase in hunger and nutrition needs score. None of the personal or children's health problems were significantly associated with hunger and nutrition needs scores. Only two barriers appeared to

TABLE 2 Univariate regression modeling hunger and nutrition needs score (n = 100)

Variables	B	SE	p
Demographic characteristics			
Age group (years)			
18–24	(ref)		
25–34	0.04	0.27	0.87
35–44	0.13	0.27	0.62
45–54	0.35	0.34	0.29
55–64	−0.03	0.47	0.96
65+	−0.50	0.71	0.48
Sex			
Male	(ref)		
Female	0.29	0.19	0.14
Annual household income			
Less than $25,000	0.78	0.19	<0.0001
$25,000 or more	(ref)		
Health insurance			
Any coverage	(ref)		
No coverage	−0.08	0.20	0.67
Past month exercise			
Always	(ref)		
Sometimes	−0.08	0.24	0.73
Never	0.32	0.59	0.59
Community and health concerns			
Community concern score (0–4)	0.87	0.08	<0.0001
Access to community resources score (0–4)	0.49	0.07	<0.0001
Healthcare access score (0–4)	0.71	0.07	<0.0001
Health concerns score (0-4)	0.68	0.07	<0.0001
Personal health problems			
Diabetes/high blood sugar			
Yes	0.39	0.25	0.12
No	(ref)		
High blood pressure/hypertension			
Yes	0.26	0.24	0.15
No	(ref)		
High cholesterol			
Yes	0.31	0.24	0.20
No	(ref)		
Heart disease			
Yes	−0.35	0.39	0.38
No	(ref)		
Children's health problems			
Diabetes			
Yes	0.21	0.23	0.67
No	(ref)		
No children under 18 years in the household	−0.10	0.23	0.66
Overweight/obese			
Yes	0.37	0.22	0.64
No	(ref)		
No children under 18 years in the household	−0.10	0.22	0.63
Barriers to health			
Concerned about money to buy nutritious/healthy food			
Always	0.66	0.27	0.01
Sometimes	0.27	0.22	0.23
Never	(ref)		
No transportation to health services			
Yes	0.35	0.23	0.14
No	(ref)		
Could not take time off of work			
Yes	0.49	0.21	0.02
No	(ref)		
Cost of health services is too high			
Yes	0.29	0.19	0.14
No	(ref)		
Cost of medication is too high			
Always	0.51	0.30	0.09
Sometimes	0.05	0.29	0.85
Never	(ref)		
No medications	−0.15	0.38	0.69

be positively associated with hunger and nutrition needs score, which were concerns about money to buy nutritious/healthy food (B = 0.66; $p < .001$) and not being able to take time off from work (B = 0.49; $p < .001$).

4 | DISCUSSION

The domain hunger and nutrition was the highest ranking community concern. Income, concern about money to buy nutritious food, and inability to take time off of work are all related to socioeconomic status. Several indicators of low socioeconomic status were strongly associated with a concern about hunger and nutrition. These concerns regarding socioeconomic status likely have an impact on food

choices, availability, and costs, in addition to diet-related chronic diseases (Pechey & Monsivais, 2016). There may also be a need to further explore the relation of cultural good, efficient time for preparation, and other potential societal barriers impact nutrition (Mikell & Snethen, 2020).

The majority of participants did not report being diagnosed with a chronic disease. This may be due to age of our participants.The average age of respondents was 18–44 years, therefore the reporting of chronic disease, particular metabolic diseases, may increase as age progresses as seen in epidemiologic studies (Quiones et al., 2019; Wray et al., 2006; Campbell, 2016; Pollitt et al., 2008). The identified social determinants of health and restricted access to health care may also have negative impacts on health and accelerate the development of chronic diseases among this population (Jackson et al., 2017). Lastly, high rates of uninsured in the population can impact access to healthcare services including the timely diagnosis and treatment of chronic diseases.

4.1 | Community response to results

Following the collection and analysis of the survey data, the results were presented to the FAITH Network Research Advocates to discuss the findings and brainstorm ideas to address the top concerns. Seven of the ten advocates participated in the discussions. To address hunger and nutrition, the advocates suggested providing health and nutrition (e.g., recipies) information to the Hispanic faith community on a monthly basis via churches and other technological means such as apps to reach a larger audience. They also discussed development of educational videos in a telenovela format. In addition to providing health information in English and Spanish With afocus on healthy cooking and food preparation, accessing health foods, grocery store shopping, reading food labels, and general healthy eating. Lastly, they would like to see more educational activities to promote preventive care related to smoking, exercise, obesity, and chronic health conditions such as diabetes. Beyond programming, the long-term goal is to establish a research agenda with the advocates to address the identified needs and other health concerns.

4.2 | Limitations

There are a number of limitations to this study. These include the use of a limited number of respondents and the participants were not able to elaborate on their responses to provide context. Purposive sampling across a small region of the state, which may impede on the ability to generalize the results.Notwithstanding these limitations, this needs assessment can provide researchers, public health leaders, and medical providers with an improved understanding of the major health needs among Hispanic communities of faith and helps provide the foundation for initiating faith and academic partnerships to address health disparities in Hispanic communities.

5 | CONCLUSION

Hispanics in the U.S. face a variety of health disparities. Partnering with a trusted institution within the community such as places of worship may be a strategy to successfully mitigate these disparities. Understanding the community needs and priorities are an essential component of community-based participatory research and the development of a research agenda. This study not only prioritized hunger and nutrition as a top concern in this community, but the research built the capacity of Hispanic faith leaders to engage in research. Future research studies are needed to better understand the relationship between food access, health education, and the prevetion of chronic disease.

ACKNOWLEDGMENTS

This work was funded by Patient-Centered Outcomes Research Institute (PCORI) Eugene Washington PCORI Engagement Award (EAIN 10703); the project described was also supported by the Translational Research Institute (TRI), grant # UL1 TR003107 through the NIH National Center for Research Resources and National Center for Advancing Translational Sciences. Arkansas Center for Health Disparities (ARCHD) funded by the National Institute for Minority Health and Health Disparities (5U54MD002329).

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

REFERENCES

Benjamin, E., Virani, S., Callaway, C., Chamberlain, A. M., Chang, A. R., Cheng, S., Chiuve, S. E., Cushman, M., Delling, F. N., Deo, R., de Ferranti, S. D., Ferguson, J. F., Fornage, M., Gillespie, C., Isasi, C. R., Jiménez, M. C., Jordan, L. C., Judd, S. E., Lackland, D. … Muntner, P. (2018). Heart disease and stroke statistics, 2018 update: A report from the American Heart Association. *Circulation*, *137*(12), e67-e492. https://doi.org/10.1161/CIR.0000000000000558

Bryant-Moore, K., Haynes, T., Kuo, D., Stewart, M. K., Yeary, K., Smith, J., Ounpraseuth, S., Sullivan, G., McCoy, S., Hudson, B., & Harris, K. (2018). Lessons learned from using an audience response system in a community setting for research data collection. *Public Health Nursing*, *35*(4), 353–359. https://doi.org/10.1111/phn.12397

Campbell, B., Aguilar, M., Bhuket, T., Torres, S., Liu, B., & Wong, R. J. (2016). Females, Hispanics and older individuals are at greatest risk of developing metabolic syndrome in the U.S. *Diabetes & Metabolic Syndrome*, *10*(4), 230–233. https://doi.org/10.1016/j.dsx.2016.06.014

Caplan, S. (2019). Intersection of cultural and Religious Beliefs about mental health: Latinos in the faith-based setting. *Hispanic Health Care International Journal*, *17*(1), 4–10. https://doi.org/10.1177/1540415319828265

Capps, R., McCabe, K., Fix, M., & Huang, Y. (2013). *A profile of immigrants in arkansas: changing workforce and family demographics*. (Vol. 1). Winthrop Rockefeller Foundation and Migration Policy Institute.

Centers for Disease Control and Prevention (CDC). (2012) *Behavioral risk factor surveillance system survey questionnaire*. Department of Health and Human Services, Centers for Disease Control and Prevention, https://www.cdc.gov/brfss/questionnaires/index.htm

Chew, L., Griffin, J., Partin, M., Noorbaloochi, S., Grill, J. P., Snyder, A., Bradley, K. A., Nugent, S. M., Baines, A. D., & Vanryn, M. (2008). Validation of

screening questions for limited health literacy in a large VA outpatient population. *Journal of General Internal Medicine*, *23*(5), 561–566. https://doi.org/10.1007/s11606-008-0520-5

Dalencour, M., Wong, E., Tang, L., Dixon, E., Lucas-Wright, A., Wells, K., & Miranda, J. (2017). The role of faith-based organizations in the depression care of African Americans and Latinos in Los Angeles. *Psychiatric Services*,*68*(4), 368–374. doi: 10.1176/appi.ps.201500318 https://doi.org/10.1176/appi.ps.201500318

Jackson, B., Gutierrez, M., Relyea, G., Carlton, E., Ahn, S., Binkley, B., & Bailey, J. E. (2017). Unmet primary care needs in diabetic patients with multimorbidity in a medically underserved area. *Health Services Research and Managerial Epidemiology*, 4.

Kochhar, R., Suro, R., & Tafoya, S. (2005). The new Latina South: The context and consequences of rapid population growth. *Pew Research Center*, Retrieved from: https://www.pewresearch.org/hispanic/2005/07/26/the-new-latino-south/

Maulden, J., Goodell, M., & Phillips, M. (2012). Health status of Latinos in Arkansas. https://publichealth.uams.edu/wp-content/uploads/sites/3/2012/06/2012-Latino-report-Feb-2013.pdf

Mikell, M. J., & Snethen, J. (2020). Perceptions of health promotion and maintenance among Latinos in faith communities. *Journal of Christian Nursing : A Quarterly Publication of Nurses Christian Fellowship*, *37*(2), 100–107. https://doi.org/10.1097/CNJ.0000000000000709

Pechey, R., & Monsivais, P. (2016). Socioeconomic inequalities in the healthiness of food choices: Exploring the contributions of food expenditures. *Preventive Medicine*, *88*, 203–209. https://doi.org/10.1016/j.ypmed.2016.04.012

Pew Research Center (2014). "The Shifting Religious Identity of Latinos in the United States" https://www.pewresearch.org/wpcontent/uploads/sites/7/2014/05/Latinos-Religion-07-22-full-report.pdf

Pollitt, R., Kaufman, J., Rose, K., Diez-Roux, A., Zeng, D., & Heiss, G. (2008). Cumulative life course and adult socioeconomic status and markers of inflammation in adulthood. *Journal of Epidemiology and Community Health*, *62*, 484–491. https://doi.org/10.1136/jech.2006.054106

Quiñones, A. R., Botoseneanu, A., Markwardt, S., Nagel, C. L., Newsom, J. T., Dorr, D. A., & Allore, H. G. (2019). Racial/ethnic differences in multimorbidity development and chronic disease accumulation for middle-aged adults. *Plos One*,e0218462, *14*(6), https://doi.org/10.1371/journal.pone.0218462

Sarkar, U., Karter, A., Liu, J., Moffet, H., Adler, N., & Schillinger, D. (2010). Hypoglycemia is more common among Type 2 diabetes patients with limited health literacy: The diabetes study of Northern California (DISTANCE). *JGIM: Journal of General Internal Medicine*, *25*(9), 962–968. https://doi.org/10.1007/s11606-010-1389-7

United Health Foundation. (2017). Arkansas. http://www.americashealthrankings.org/AR

United States Census Bureau (2017). https://www.census.gov/quickfacts/AR

Wallerstein, N., & Minkler, M. (2011). *Community-based participatory research for health: from process to outcomes*. Wiley.

Wilmoth, S., Carrillo, L., Correa, L., Pan, M., Parra-Medina, D., Sosa, E., Reyes, R., Sass, D., & He, M. (2020). Building a healthy temple diabetes self-management education support program in Hispanic faith community settings: A cluster randomized controlled trial. *Contemporary Clinical Trials*,106192, *99*. https://doi.org/10.1016/j.cct.2020.106192

Wilmoth, S., Martinez, E., & He, M. (2018) Hispanic church attending youths' perceptions of healthy bodyweight in faith-based community. *Journal of Childhood Obesity*, *03*(1), https://doi.org/10.21767/2572-5394.100041 https://doi.org/10.21767/2572-5394.100041

World Health Organization (2010) *A conceptual framework for action on the social determinants of health. Discussion paper*. WHO Document Production Services.

Wray, L., Alwin, D., McCammon, R., Manning, T., & Best, L. (2006). Social status, risky behaviors, and diabetes in middle-aged and older adults. *Journal of Gerontology: Social Science*, *61*, S290–S298. https://doi.org/10.1093/geronb/61.6.S290

Yeary, K., Ounpraseuth, S., Kuo, D., Harris, K., Stewart, M. K., Bryant, K. Haynes, T., Turner, J., Smith, J., Williams, S., & Sullivan, G. (2016). To what extent do community members' personal health beliefs and experiences impact what they consider to be important for their community-at-large? *Journal of Public Health*, *38*(3), 502–510. https://doi.org/10.1093/pubmed/fdv118

How to cite this article: Bryant, K., Pro, G., Rojo, M., Patel, J., Haynes, T., McElfish, P., Sepulveda, M., & Hart, C. (2022). Identifying Community Needs of the Hispanic Faith Community to Develop a Research Agenda. *Public Health Nursing*, *39*, 33–39. https://doi.org/10.1111/phn.12973