WHAT ARE THE PERCEIVED HEALTH CARE NEEDS OF THE HOMELESS?

by

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ABSTRACT

Although efforts have been made over the years to assist the homeless in their access to health care, and in improving their overall health, many remain in great need. Health care organizations and well-meaning providers may be lacking in the provision of appropriate holistic care, consequently having a limited effect on improving the health status for many of these individuals.

Advanced practice nurses and other providers must listen to the expressed needs of the homeless in order to address those needs in more comprehensive and relevant ways. This Qualitative Research study aims to answer the research question, “What ARE the perceived health care needs of the homeless?”

Opinions of 18 homeless individuals and concepts from Madeleine Leininger’s Cultural Care theory were used to explore and clarify the health care needs of the homeless as expressed by the homeless themselves.

CHAPTER 1

WHAT ARE THE PERCEIVED HEALTH CARE NEEDS OF THE HOMELESS?

Background of the Study

Although efforts have been made over the years to assist the homeless in their access to health care, and consequently in improving their overall health, many remain in great need. Health care organizations and providers may be lacking in the provision of appropriate holistic care, consequently having limited effect on improving the health status for many of these individuals. More research needs to be done to understand the needs of the homeless, as seen through the lens of their reality, and to positively contribute to the improvement of overall health status and health care for this population.

Nurses have been in the business of caring for people and their individual needs for as long as illness and disease have existed. From Florence Nightingale to Madeleine Leininger, nurses have positively affected generations of patients in their care. Nurses have a unique opportunity to contribute to the overall health status of the patients they are privileged to interact with (McFarland, 2010, p. 459). Therapeutic nursing practice involves sensitivity to what may be going on in a physical sense with a patient, as well as the emotional, psychological, and spiritual dimensions as well.

As Maslow (1954) discovered and formalized so precisely, human beings by nature have basic needs that must be met in order to survive and ultimately thrive. “The first and foremost need is a biological and physiological one: the need for air, food, drink, shelter, warmth, sex, and sleep. The next set of needs, assuming that the biological and physiological needs are met, relate to safety: protection, security, order, limits, and stability. Further needs in Maslow's hierarchy include that of love and belonging, self-esteem, and self- actualization" (Maslow, 1954). Human care, in the form of nursing care, has provided for the welfare of individuals for generations, meeting not only physiological needs, which include physical health care, but also indirectly by contributing to the betterment of the individual's safety, their sense of belonging and love, self-esteem, and self-actualization. The goal for many nurses worldwide continues to involve being an active part of providing holistic care to patients, in all settings, socioeconomic backgrounds, and walks of life. Caring for the homeless is no exception.

Statement of the Problem

Quality of care and access to care have historically been a challenge for the homeless in the United States, thus affecting the nursing profession's efforts to provide nursing care to all. Disparities in health care and consequently, in health status, have been researched among those citizens of racial minority, decreased socioeconomic status, as well as those living in rural areas (National Coalition for the Homeless, 2009). National trends include both the rise in homelessness and a growing shortage of affordable rental housing. Additionally, the percentage of people living in poverty is on the rise. Consequently, these people are unable to afford housing, food, child care, health care, and education. The homeless are being forced to choose which necessities they will seek (NCH, 2009). This research discussed these disparities in health care and health status specifically among the homeless.

Current concerns within the homeless population include the following: fewer job opportunities, less public assistance, and long wait lists for public housing, each of which result in increased use of shelters or inadequate housing arrangements. Domestic violence is reportedly experienced by 63% of homeless women. Sixteen percent of the homeless population suffers from mental illness, and addictions are disproportionately high in this particular demographic (National Coalition for the Homeless, 2009). “Living without a home increases one’s health risks. The homeless have more morbidity, as well as higher age-adjusted mortality rates than the general population” (Lewis, Anderson, & Gelberg, 2003, p. 921).

On a more local level, Kaiser Family Foundation (2011) reported that the geographical context for this author’s research, the state of Montana, consisted of 970,900 residents, as of 2011. The local population living in poverty numbered 147,800, or 15%. There were 126,203 individuals utilizing the Food Stamp program. Furthermore, the uninsured population consisted of 153,500 residents, or 16%, 11% of which were children. Twenty percent of the population was enrolled in the Medicaid program, while 15% were enrolled in the Medicare program. There were 20,330 individuals utilizing this state’s Children’s Health Insurance Program (CHIP), a low-cost, private health insurance plan based on family size and income for eligible children age 18 and under.

The state’s annual cost of care provided to this population is astounding. In 2008, Medicaid spending for health services totaled about $339 billion, with federal government funding only about 57% of the state’s Medicaid costs overall. In 2010, the Medicaid program funded 16% of all personal health spending in the U.S., covering 60 million uninsured people (Kaiser Family Foundation, June 2010). Additionally, annual emergency department visits by a single homeless person in the U.S. cost taxpayers as much as $50,000 in 2011 (Neighborhood Service Organization, 2012). These statistics indicate the disparities and decreased health status among the homeless, as well as the resultant high cost to Montana's citizens.

Efforts have been made for decades to improve access to medical care to this population. In 1965, community health centers were nationally funded to provide a defined set of medical services for all of the community's residents, "regardless of their socioeconomic status and ability or inability to pay for health care" (Bureau of Primary Health Care, 2006). More recently, in 2002, the Bush administration created a health center initiative (Bush, G.W., 2008) to both increase health care coverage for uninsured people, and to increase the number of these community health centers (CHC) nationwide, in an effort to continue to improve access to health care for those in need. One of the initiative's goals was to serve populations with limited access to quality health care, particularly those without insurance. The primary beneficiaries were low-income individuals (more than 91 percent of the CHC patients) and minorities (64 percent of the CHC patients) (Bush, 2008).

In addition to providing primary care, these centers aimed to provide access to pharmacy, and preventive dental, mental health, prenatal, and substance abuse services. By 2008, 1,200 community-based health centers were reported to be in operation in the U.S., largely due to faith-based and other community organizations. Additionally, the number of low-income people utilizing care in these centers reached 5.8 million (Bush, 2008). A particular target of interest in this initiative was homeless citizens. The Bush administration report estimated that the health center initiative had helped to provide health care and housing for 50,000 homeless people from 2002 to 2007 (Bush, 2008).

Currently, and more locally, one Montana-based community health center provided health services for 10,226 patients in 2011. Almost 11% of these were homeless citizens. Over 98% of these individuals were considered 200% below poverty level (UDS Summary Report, 2011).

Purpose of the Study

While federal and local programs have improved access to care for the homeless on some levels over the years, the downside of this assistance lies in the incredible price paid by U.S. citizens. Estimates for health care dollars spent on homeless initiatives exceed $2.2 billion. Homeless persons often cycle through public systems, shifting from the streets to jails, hospital emergency rooms, or temporary shelters – costing taxpayers approximately $40,000 per person living on the streets every year (Bush, G.W., June 26, 2006). This presents an unbearable economic burden at both the local level as well as nationally. It highlights the need for additional research in which to increase health care availability to needy populations, such as the homeless, using meaningful yet cost effective interventions. These strategies may directly and indirectly result in improved health status for the homeless. Research has shown that "Homelessness and health care are intimately interwoven. Poor health is both a cause and a result of homelessness…Inadequate health insurance is itself a cause for homelessness" (National Health Care for the Homeless Council, 2009).

In reality, the problems of under service and poor health status remain for homeless individuals of all ages, and they are often the most vulnerable of all. Health professionals and policy makers have yet to find effective ways to fully alleviate this vulnerability. It is the homeless population themselves who best understand what is needed to improve their health and health care. Advanced practice nurses and other providers must first listen to their expressed needs in order to address those needs in more comprehensive and relevant ways. Thus the research question posed by this author was: "What are the perceived health care needs of the homeless?" The purpose of this study was to explore and clarify health care needs as expressed by the homeless themselves.

Significance of the Study

Federal and local programs have had limited success in providing adequate care for low income populations such as the homeless. These patients, as well as their providers, continue to struggle to cover rising health care costs. Additionally, research has shown that underutilization of services as well as homeless perceptions of barriers to care have continued to be a problem for the homeless in accessing health care and other needed services. According to Cook, Hicks, and O'Malley (2007), "insurance coverage and an increase in numbers of community health centers have not sufficiently improved access or health status among the homeless" (p. 1462). Evans (2010) stated that although health care reform has enabled 31 million low-income individuals to obtain insurance, these people, as well as their providers, still face significant expenses such as co-pays, non-covered medical bills, and fees for specialty services. As a result, providers experience lack of reimbursement, and many of the patients opt to forego needed tests, treatments, and follow-up care (p. 29).

Homeless people continue to experience poor access to health care, leading to the delay of routine treatment, and ultimately, to the increased utilization of emergency departments and hospitalizations for preventable health conditions. "Yet the extent to which homeless adults are able to obtain health care across the spectrum of health needs is largely unknown" (Baggett, et al., 2010, p. 1326).

Research on the poor overall health among the homeless continues to abound, emphasizing the need to identify additional ways that advanced practice nurses and others in the health care professions can better meet the needs of the homeless, as identified by the homeless themselves. In a study by Daiski (2007), a group of homeless individuals reported their perceptions of the effects of homelessness on their health status. This population stated that they had many physical problems that were chronic and "reinforced through poverty and the homeless lifestyle, which lacks consistent health care" (Daiski, 2007, p. 275). Some of their reported health concerns involved respiratory disease, skin infections, musculoskeletal pain, dental problems, accidental injury, malnutrition, and addiction. These are only a few of the ongoing needs of the homeless that warrant further attention and intervention by primary health care providers of all disciplines.

In the health care profession, nurses care for individuals in many settings and from all backgrounds and socioeconomic status. It would be remiss to try to continue the efforts to facilitate care by implementing current ideas and tools that the homeless may perceive as less than effective for them. Nurses need to understand the unique culture and needs of the homeless, as they identify their own challenges and needs in terms of overall health status.

By increasing awareness of problems and barriers they face, nurses can be a part of providing more effective and holistic care. Efforts must continue to be made at the federal, state, and local levels if health care providers are to successfully provide care that is relevant and impacting to homeless people.

Additionally, individual health care professionals must continue research efforts to understand the real needs of the homeless, and meet the unique needs of this population. As nursing theorist Madeleine M. Leininger stated, "nursing theory must take into account creative discovery about individuals, families, and groups, and their caring, values, expressions, belief, and actions or practices based on their cultural life ways to provide effective, satisfying, and culturally congruent care" (McFarland 2010, p.459). Leininger emphasized that "if nursing practices fail to recognize the cultural aspects of human needs, there will be signs of less beneficial or efficacious nursing care practices and even evidence of dissatisfaction with nursing services, which limits healing and well-being" (p. 459). "Leininger found that cultural blindness, shock, imposition, and ethnocentrism by nurses continue to greatly reduce the quality of care offered to clients of different cultures", while "culturally congruent care is what makes clients satisfied that they have received good care; it is a powerful healing force" (McFarland, p. 463).

By taking time to interact with and listen to the views of the homeless, methods and services can be further developed to make a more positive contribution to the health care and overall health status of these individuals. This endeavor will require continued nursing research efforts and collaboration between health care providers and the homeless in various local settings for years to come.

Definition of Terms

Several terms were discovered in review of the literature, and are addressed in this particular research. Defining these terms will be helpful in understanding key concepts and ideas. These definitions are as follows:

1. Culture: beliefs, values, and practices shared by a group, that guide thinking and acting in patterned ways (McFarland, 2010, p. 460).

2. Culturally congruent care: the explicit use of culturally based care and health knowledge in sensitive, creative, and meaningful ways to fit the general life ways and needs of individuals or groups for beneficial and meaningful health and well being, or to face illness, disabilities, or death (McFarland, 2010, p. 460).

3. Health: A state of well-being or a restorative state that is culturally constituted, defined, valued, and practiced by individuals or groups and that enables them to function in their daily lives (McFarland, 2010, p. 461).

4. Holistic care: attempts to treat both the mind and the body; the view of human care in terms of overall health status and well being; "discovering the people-truths, views, beliefs, and patterned life ways of people" (McFarland, p. 461). Holistic care addresses every dimension of a person: biological, psychological, social, economic, and institutional (Dykeman, 2011, p. 35).

5. Homeless: individuals who live in the streets, utilize the local shelter system, or are continuously moving between temporary housing arrangements (Haldenby, Berman, & Forchuk, 2007). A homeless individual "lacks a permanent place of one's own" (Daiski, 2007, p. 274).

6. Perceive: to regard as being such; to become aware of through the senses. To discover first hand through the lens of one's personal reality; to gain personal insight (Haley & Woodward, 2007, p. 346).

7. Need: The biological and physiological requirements for human life (Maslow, 1954).

Theoretical Framework

The ideas and accomplishments of nurse theorist Madeleine Leininger have provided much of the framework for this research. Leininger has inspired nurses since the 1950's to focus on and provide culturally sensitive and holistic care to their patients. Leininger had the foresight to research, practice, and then teach the principles that she discovered and called 'culturally congruent care'. For over fifty years, this researcher made it her goal to "discover and explain diverse and universal culturally based care factors influencing the health, well-being, illness, or death of individuals or groups" (Leininger, 2002, p.190). Additionally, Leininger's theory aimed to "provide culturally congruent, safe, and meaningful care to clients of diverse and similar cultures" (p. 190). This framework for the provision of health care is timeless and relevant for current and future nursing research.

Leininger (2002) explained her Cultural Care Theory as follows: the central goal, is to provide "culturally congruent care in a diversely multicultural world". Her work focused on the interrelationship of culture and care, and its effects on well-being, health, illness, and death. Her theory, illustrated by her Sunrise Model (McFarland, p. 466), showed the different dimensions of cultural care, including commonalities and differences among unique cultures. This model is included in the appendix, and its information is important to providers that work within health care institutions where cultural diversity is found. Leininger's model was helpful to this author in terms of the research question and in striving to promote culturally congruent interactions and care among the homeless population in this research context.

Unique to Leininger’s cultural care theory are eight distinct features. First, as stated by the researcher herself, the theory is one of the oldest theories in nursing, dating back to the 1950’s. Second, it is the only theory with the focus on the close interrelationships of culture and care on well-being, health, illness, and death. Third, it is unique in that its emphasis is on comparative cultural care. Fourth, it is a holistic and multidimensional theory that focuses on culturally based care meanings and practices. Fifth, it is the first nursing theory to focus on both the differences and the similarities of global cultural care. The sixth feature is that, with it, a research method called ethnonursing was developed to fit the theory. Seventh, it has abstract and yet practical applications in providing culturally congruent care. Lastly, it is the first theory to blend both the perspectives of the patient and the knowledge of the professional nurse to better guide patient care (McFarland, p. 190).

Use of Leininger’s theory has been widely accepted into all forms of nursing care and is taught in universities, health organizations, and seminars throughout the United States and all over the world (McFarland, 2010, pp. 454-458). Her theory of culturally sensitive care may likely be applied to every population on the planet, regardless of ethnicity, geographical location, or socioeconomic status. It provided the framework for this research and as well as future practice as nurses strive to provide holistic and personal care that is based on the patients’ perceptions of need. Competent nurses are those that provide care not necessarily based on their own beliefs, values, and goals, but on the patients’ individual cultures and beliefs. As the world and its people continue to grow and diversify, so must nursing practice.

The principles of Leininger's theory were highly applicable to this researcher in interacting with and caring for the needs of the homeless population as they themselves identified their need. These individuals have a culture all their own, with unique needs, beliefs, and goals that nurses would do well to consider and respect in the provision of their care. Meaningful dialogue and genuine concern must take place between nurses and homeless individuals to more fully understand their definition of optimal health status and ideas for better health care. Only then can nurses and other primary care providers implement strategies to provide the care that the homeless truly need.

Assumptions

This researcher identified several assumptions. They include the following:

1. The homeless continue to experience unmet health care needs. "Social disparities in health are large and persistent in the United States" (Braveman, et al, 2004, p. 2139). Research shows a recurrent theme among the homeless in regard to health care. "There was insufficient help during times of crisis" (Bhui, et al, 2006, p. 158).

2. The homeless perceive barriers that prevent them from obtaining the care they need. "Homeless people have strong views about the adequacy of services to meet their needs. They were particularly concerned about stigma, prejudice and the inadequacy and complexity of services that they have to use" (Bhui, et al, 2006, p. 152).

3. Primary care providers lack the knowledge to provide culturally congruent care to the homeless. "In research with medical students, more negative attitudes toward homeless people were found at the end of their courses than at the beginning. It is possible that health professionals' attitudes regarding homeless individuals dissuade this

population from accessing needed health care and, in turn, contribute to their poorer level of health" (Haldenby, Berman, & Forchuck, 2007), p. 1234).

4. Nurses have an opportunity to rub shoulders with and understand the needs of the homeless, as they perceive their need. "People of different cultures can inform and are capable of guiding professionals to receive the kind of care they desire or need from others" (McFarland, p. 459). "The qualitative criteria of credibility and confirmability from in-depth studies of informants and their contexts are becoming clearly evident" (McFarland, p. 471).

5. Nursing theory and practice can positively impact the health and well being of the homeless population. "Findings from Leininger's theory are being used in client care in a variety of health and community settings worldwide to transforming nursing education and service" (McFarland, p. 471). "Beneficial, healthy, and satisfying culturally based care influences the health and well-being of individuals, families, groups, and communities within their environmental contexts" (McFarland, p. 463).

Limitations

Limitations in regards to this research included the following:

1. There may have been an inability of certain homeless individuals to honestly share their concerns and needs with the researcher due to different cultural backgrounds. This may have resulted in an initial lack of trust or rapport that may limit full disclosure of their experiences and needs. Efforts were made to be culturally sensitive and respectful of each participant.

2. Local organization heads and environments where the researcher sought to conduct her research may have had varying degrees of agreeability to the researcher's presence and interaction with those individuals in their care. Full disclosure of the research topic and methods were made. Consents were obtained prior to initiation of the research. Another context could have been to be utilized.

3. Information obtained may not have fully reflected the common needs and concerns of the homeless population in other communities, states, or countries. An adequate sample size was utilized in an attempt to understand the real needs of this population. Open-ended questions were used to promote honest and accurate dialogue.

4. Concerns and needs identified may not have been immediately addressed or met by the researcher or members of the local health care community due to lack of funds, tools, manpower, or community support. All efforts were made to understand and facilitate change for this local homeless community through education, research, and theory development, as well as improved provision of holistic care. Ongoing research, funding, and relationships between the homeless and health care providers is necessary.

5. Because of the transitory nature of the participants, follow up interviews may not be possible.

Organization of the Study

Chapter 1 provided the background for this study as well as important aspects of nursing care and theory that was utilized in this author's research. Significant disparities in health care among the homeless population continue to warrant change. In the health care profession, nurses care for individuals in many settings and from all backgrounds and socioeconomic status. It would be remiss to attempt to continue the efforts to facilitate care by implementing current practices and tools that the homeless perceive as less than effective for them. This researcher sought to understand the unique culture and needs of the homeless population, as they identified challenges and needs in terms of health care and health status. Through active listening, accurate interpretation, and by increasing awareness of the problems and barriers that the homeless face, this research study may enable health care providers to implement more effective and holistic care to homeless individuals in this particular context and in other settings.

Chapter 2 provided a review of current literature regarding perceived health care needs of the homeless, which includes six common themes: 1) the homeless are very concerned about their health status and unmet health needs; 2) The homeless strongly desire early and holistic care; 3) Homeless individuals want to be treated with dignity, respect by health care providers, and in a culturally relevant manner; 4) Homeless people need help in navigating the health care and social services that are available to them; 5) Most homeless people strongly desire human connection; and 6) Homeless individuals have important views and want to their concerns to be heard.

Chapter 3 will provided the methodology for this research. Chapter 4 and 5 presented the study’s findings as well as the summary of those findings and the conclusions for implementation and incorporation of those findings into nursing practice and further nursing research.

CHAPTER TWO

LITERATURE REVIEW

Historical Background of the Problem

The purpose of this chapter was to describe all aspects of the author's literature search and systematic review pertaining to the following research question: "What are the perceived health care needs of the homeless?" To date, little is known about the personal health beliefs, practices, and desires for health care among this population. This literature review was completed to provide a better understanding of the challenges the homeless population faces in regards to health and health care. The findings illuminated these challenges from the personal perspectives of this population and offer first hand insight into improving health and health care for the homeless.

Literature Search Methodology

The author briefly discussed the search methods utilized and how information selected was organized from general to specific. An explanation of current research on homeless' health care needs was addressed, as well as gaps in this literature and common themes found pertaining to the homeless population's perceptions and desires for their own health and health care.

The author performed several topical searches within CINAHL and PubMed, as well as utilizing various annual reviews and government documents. Search words were chosen based on key concepts of homelessness derived from the research question.

General terms were searched first, with greater specificity of terms searched last. Search words included the following:

- Homeless AND Health Care (yielding 94 results)
- Homeless persons AND Perceptions AND Health care (yielding 15 results)
- Homeless persons AND Health care (yielding 12 results)
- Homeless Perceptions AND Health Care, (yielding 1,933 results)
- AND Needs AND Health care (yielding 9 results)
- Homelessness AND Health care (yielding 6 results)

Inclusion criteria included full-text publications written within the past 5 years, publications that were available in English, those that included homeless people who were at least age 18, and articles written from the perspective of the homeless population themselves. Approximately 40 research sources were studied in detail, while only 12 were deemed applicable to the research question and chosen for this literature review. Several additional sources were also used and cited to add structure and depth to the topic of cultural care.

This literature review was based, in part, on the framework of Madeleine Leininger's Cultural Care Theory and her line of thought regarding transcultural nursing, the care of culturally diverse people populations. As Leininger identified in her first two books, *Nursing and Anthropology*, published in 1970, and *Transcultural Nursing: Concepts, Theories, Research, and Practice*, published in 1978, and also in an article she wrote in the *Journal of Transcultural Nursing*, "care is the essence of nursing and had meaning within cultural contexts" (2002, p. 189). She emphasized that nursing care must be provided in a holistic and yet culturally-specific manner that is both meaningful and multifaceted. Leininger called this approach "culturally congruent nursing" (McFarland, 2010, p. 462).

The homeless population may be considered a unique culture of its own, with specific norms, values, beliefs, and lifestyle choices not fully understood by other people groups. Over the years, studies have found that homeless people valued health care services that take into account their specific circumstances and preferences. Culturally competent care was recently defined by Narayan (2002) as "care that is sensitive to, responsive to, and compatible with the patient's encultured health beliefs, values, and practices. Culturally competent care links professional knowledge with cultural knowledge to address the patient's health needs and cultural preferences" (Narayan, 2002, p. 379). "Adapting clinical practice to the health needs and living situations of the homeless has remained a challenge for clinicians" (Nickasch & Marnocha, 2009, p. 39).

Historically, studies have been conducted regarding the adequacy of health care for the homeless from the perspectives of health care providers, but limited studies have been done to determine adequacy from the perspective of the homeless themselves. It is important to understand this culture and their own wishes for health and health care in order for providers to adequately address these issues and become a valuable part of the solution. When properly informed, advanced practice nurses can better provide holistic and effective care. According to former Surgeon General, David Satcher, "the quality of national health care may be measured by the care we provide to the most vulnerable among us" (Folsom et al., 2005, p. 7). Advanced practice nurses can significantly impact the quality of health and health care among the homeless population by first understanding their unique needs and then by collaborating with other providers and available community agencies to help address and meet their ongoing needs. Additionally, "improving the health of the homeless in the community will result in improvements in the overall health of the community" (Nicklasch, 2008, p. 39).

Current Status

A recent definition of 'homeless' was identified by the U.S. Department of Housing and Urban Development (HUD) (2010), and included "a person who lacks a fixed, regular, and adequate nighttime residence and who has a primary nighttime residence that is either (a) a supervised shelter providing temporary living accommodations, or (b) an institution providing residence for individuals intended to be institutionalized, or (c) a public or private place not designed for regular sleeping accommodations for human beings" (HUD, 2010). The National Coalition for the Homeless (2009) further defined homeless to include "those individuals with no permanent residence, yet residing temporarily with friends or relatives in what is often an overcrowded living arrangement" (NCH, 2009).

Homelessness is a growing problem. In 1984, the Alliance Housing Council estimated that there were between 150,000 and 350,000 homeless people in the U.S. (Hunt, 2007). Currently, there is an estimated 13.5 million Americans who have been homeless at some point in their lives, and three to five million people will experience homelessness in any given year, representing approximately 1% of the national population (National Law Center on Homelessness and Poverty, 2009). Studies have shown that this group has poorer health and greater need of emergency care than the general population (Haley, et al., 2007).

Support For the Purpose of the Study

Homeless people expend tremendous energy on survival strategies that those with adequate housing may take for granted, such as food, shelter, and a place to rest. These challenges overshadow health needs, and common ailments may turn into chronic illnesses as a result. Additionally, many homeless people have limited support, inadequate or no health insurance, and receive fragmented and inadequate primary care. Consequently, this country spends millions of dollars in emergency department and hospitalization costs in caring for this population. For example, one study showed that in Boston's Health Care for the Homeless Program (BHCHP) alone, the annual operating budget in 2009 exceeded 30 million dollars. In the first five years of this program's operation, the homeless in Boston had 18,364 emergency department visits, and a group mortality rate of 40% (O'Connell, 2007).

What Research Has Already Been Cited in Relation to this Problem?

After review of current nursing research, it is clear that services to meet the health care needs of the homeless remain less than adequate. While providers' perceptions of the homeless population's needs are well researched, the voices of the homeless have gone largely unheard. According to Hudson et al., (2010), "the perceptions of how the homeless view the health care system have not been well studied" (p. 213). Additionally, Hudson states that “formal institutions, such as clinics and emergency departments, are not equipped to provide the kinds of opportunities and positive social experiences that homeless young adults need at this stage of their development” (p. 220).

Several findings, based on needs expressed by homeless individuals themselves, were identified in this literature review and may be used to develop new nursing strategies that will positively impact health and health care for the homeless in the future. A brief overview of findings was discussed and the identification of specific themes follow. A summary of these findings can be found in Table 1.

Table 1.Summary Data from Literature Review

Study	Findings
Baggett (2010)	A national sample of homeless adults reported significant unmet needs for multiple types of health care. Addressing the unique challenges inherent to the homeless will be required.
Baggett et al. (2010)	High rates of unmet needs for health care services of the homeless are due to many factors, some of which are no insurance, food insufficiency, employment, and vision impairment. Expansion of health insurance and addressing the unique needs of the homeless is essential to improving health care access for these individuals.
Clayton & Dilley (2009)	Awareness of health disparities among the homeless population can facilitate interdisciplinary communication and collaboration to provide basic health care and health promotion for homeless individuals.
Daiski (2007)	Views of homeless people are often omitted. To provide appropriate care for this population, health care professionals need to be aware of their perspectives.
Dykeman (2011)	The needs of the homeless population are many and varied. Intervention must begin with the basic needs of food, clothing and shelter, and asking “What is needed and wanted to make the world work?” (p. 34)

Table 1 Continued

Study	Findings
Haley & Woodward (2007)	Little is known about homeless individuals' perceptions of their own health needs and wants. This lack of information directly impacts the provision of emergency department services to this population.
Hudson et al. (2010)	Young homeless adults failed to access care due to perceived structural and social barriers, and admitted they needed more help. This population reported experiencing chronic health conditions as a result.
Hudson & Nyamathi (2008)	Little is understood regarding homelessness as a culture. Understanding the perspectives of this population may facilitate therapeutic relationship, connectedness, and support for homeless individuals.
Irestig & Wessel (2010)	Homeless people's trust in authorities and organizations such as the health care system varies. Some among this population agree that the implicit values and attitudes of certain providers contribute to the perceived infringement of the basic human values of the homeless.
Martins (2011)	The health status of the homeless population is extremely poor when compared with the general population. An increased understanding of health care experiences from the homeless persons' perspective can guide providers in a more humanistic and empowering approach that positively affects health and well-being among the homeless.
Nicklasch & Marnocha(2009)	Focusing on the homeless as a population is necessary for effective management of chronic disease, fewer long-term complications, and reduced medical costs not only among the homeless, but for the entire community.
O'Connell (2010)	To improve the health of homeless persons, providers and policy makers must develop programs for comprehensive and preventative care among this population, as well as expand collaboration between health care providers, social service professionals, and other sectors such as education, labor, and housing.
Zlotnick (2005)	Marginalized populations tend to fall easily through the cracks and represent a challenge to health care workers. What these individuals say has great relevancy for health care professionals who work with the homeless and other marginalized populations.

Common Themes

During the process of this literature review, six common themes emerged. These themes were derived from the perspectives of homeless individuals themselves, and are highlighted below for the purpose of giving fresh insight for providers who may have opportunity to care for this population.

1. Homeless people are very concerned with their health status and other health related issues that are largely unmet.

In a recent national study by Baggett et al. (2010), 46% of homeless respondents reported two or more medical conditions. Forty eight percent reported being treated for a mental illness. Vision problems were noted by 26% of respondents, and 30% reported dental problems in the past year (p. 1328). Additionally, 73% reported having an unmet health need in the past year, and 49% reported two unmet health needs in the past year. Interestingly, all of the respondents reported that they had been seen in a clinic at least once in the past year (p. 1329). According to this study, reasons for unmet health issues were primarily attributed to inability to afford care and lack of insurance coverage (p. 1328). Medical or surgical care, prescription medications, and mental health care also reportedly went by the wayside for reasons which included having “no usual source for care”, experiencing competing priorities such as food insufficiency, and choosing to work during day time hours over getting health care (p. 1330). Not only did this population report a challenge regarding available clinic hours, but also scarcity of service sites, difficulty getting appointments due to lack of a physical address, lack of transportation, and long wait times (Hudson et al., 2011, p. 216).

Daiski (2007) also found that there were many chronic health problems among this population, most of which were perpetuated by poverty and the “homeless lifestyle, which lacks consistent health care” (p. 275). Among the various medical conditions were seizure disorders, chronic respiratory diseases, musculoskeletal problems, dental problems, and tuberculosis. These ailments were expressed by older participants as “age-related”, however, younger participants reported having many of the same illnesses. The younger group suggested that their bodies were likely feeling the effects of homelessness prematurely. According to Daiski, “life on the streets takes a heavy toll”, and “many are unaware of their own health conditions, as few have had regular check-ups” (p. 278).

A study by Hailey and Woodward (2007) found that homeless adults are often only motivated to seek care when bodily trauma or serious illness is visible to others, “when blood is present in a noticeable amount, when they could no longer ambulate or remain upright, or when they experienced severe pain or seizure” (p. 350). Treatment in these situations was often initiated by someone other than themselves. Homeless people stated in this study that they try to keep hidden their acute illness, trauma, exacerbation of chronic disease, and especially mental illness, to avoid appearing vulnerable while living on the streets. Major health concerns are prevalent among the homeless, however, whether seen or unseen by others.

2. Homeless people want holistic care which encompasses more than just their physical health needs, and that also includes health promotion and disease prevention.

The homeless population’s needs are “many and varied, and these needs cross broad dimensions of biological, psychological, social, economic, and institutional domains" (Dykeman, 2011). Valuable insight was gained from Daiski's (2007) Canadian study in which participants described their health and health care needs in a holistic sense. They reported concerns about physical illness, as well as mental health, addictions, stress, violence, employment, and the spread of disease in homeless shelters. They also reported distress over social exclusion and depersonalization. Most homeless people have suffered under severe circumstances such as physical and sexual abuse, childhood trauma, poverty, disability, addiction, and disease (Martins, 2008, p. 420). Other common ailments reported in Martins' study were skin ailments, lacerations, wounds, parasites, malnutrition, vitamin deficiency, frostbite, and hypothermia (p. 421).

According to Dykeman (2011), the first steps of intervention for the homeless should include caring for the basic needs of food, clothing, and shelter. Only then can progress toward lifestyle enhancement be made through collaborative care in areas such as health, work, self-concept, social support, education, and spirituality. Nicklasch (2009) recommended that health care providers "make sure the most basic physical needs are met before trying to address concerns related to health. Assisting a patient to find shelter may be the most important step that can be taken by a health care provider. It is essential to get back to the basics" (p. 45).

Several studies have shown the homeless population's desire for simple health care items such as hot showers, toilets, refrigerators, washers, over the counter medications, healthy foods, haircuts, and proper clothing. In a study by Clayton & Dilley (2009), the homeless expressed the importance of basic health teaching as well as more preventative interventions, such as blood pressure checks, needle exchange programs, immunizations, flu vaccinations, education on risky behaviors, stress and mental health management, and getting fit (p. 138).

Findings of a study by Haley & Woodward (2007) showed that homeless individuals want “early and generous expert intervention” as well as “interdisciplinary health care services that provide continuity, compassion, and connection” (p. 351). This research also showed the importance of addressing the homeless individual’s needs, knowing that they may be providing care in a potentially very complex medical situation.

3. Homeless people want to be treated with patience, basic respect, human dignity, and cultural competency by health care professionals.

Several qualitative studies have shown that homeless individuals often feel rushed, devalued, dehumanized, invisible, and misunderstood by health care providers (Martins, p. 425). Communication by providers was described as “harsh, authoritative, uninformative, non-engaging, and hurried” (Hudson et al., 2008, p. 1283). Additionally, almost half of the respondents in a Scandinavian study (Irestig et al., 2010) perceived bad or very bad attitudes on the part of social and health services (p. 226).

By contrast, homeless young adults appreciated providers who were empathetic, sensitive, nonjudgmental, available, and trustworthy. They reported value in being treated with equality, and not as if they were homeless. They expressed the need for humane and nonjudgmental treatment to be the norm in health care. “First and foremost, homeless people, simply by virtue of being human, deserve respect while seeking health care” (Martins, p. 429). Therefore, it is essential for providers to “have basic respect for the dignity and worth of each individual and a belief that all people are subject to homelessness given events beyond one's control" (Dykeman, p. 35). A study by Irestig et al., (2010) emphasized the homeless population's desire for a "higher level of knowledge of the medical problems prevalent in the group" (p. 225), as well as "medical and caring competence regarding their homelessness" (p. 228). They also expressed the value of being cared for by professional, competent nurses and staff who won't look down upon them. One client in the Daiski study said that feeling cared for by nonjudgmental nurses motivated him to take care of his own health, take care of his teeth, and find employment (Daiski, 2005, p. 34).

"Adapting to the health needs and living situations of the homeless has remained a challenge for clinicians" (Nicklasch & Marnocha, 2009, p. 39). Providers will give better holistic care to this population as they improve their skills, knowledge, and comfort level, and "readjust their interventions to better serve this population" (Nicklash & Marnocha, 2009, p. 45).

4. Homeless people want help navigating the health care system and other community services.

Homeless people, by nature of their condition, may require comprehensive services. This population will need advocacy to access needed services. In the study by Martins (2008), homeless people stated they needed help with tasks such as completing emergency department paperwork, hospital documentation, and other red tape associated with the system (p. 427, 428).

O'Connell's study (2010) also detailed how providers in Boston actively locate, enroll, and recertify Medicaid-eligible homeless patients, as many patients are eligible, but simply need help in navigating the system. They assist these individuals in obtaining state-issued identity cards and birth certificates so that they have proper documentation for obtaining needed health care and disability benefits.

An Alaska study of homelessness and health care revealed additional challenges the homeless faced as well as their requests for help (Bemben, 2009). This population wanted assistance with transportation, managing medical appointments, accessing care, record keeping, and obtaining dental, vision, and mental health coverage. They expressed the desire for help in learning more about and establishing rapport with the health care and mental health systems. This study showed that the homeless population wants to "enter the health care system and decrease emergency department use" (p. 7,8)

5. Homeless people want connection with family, friends, health care providers, and community resources.

Hudson's (2010) study showed that homeless young adults "craved support from family, friends, and homeless peers" (p. 218). This population stated that they are able to better deal with life when they had the help and support of others. They expressed gratitude toward family members and health care providers that gave them information on services previously unknown to them and where to go to get community support with the challenges they faced. They also appreciated free or reduced-cost medical and dental care and medicine.

O'Connell et al., 2010, found that the homeless population desired continuity of care "from street to shelter to hospital", as well as multidisciplinary teams to care for their unique needs (p. 1401). They felt that providers could also bridge medicine and public health, and create and implement respite care for them, such as post-operative and palliative care.

Another study by Hudson (2008) revealed that homeless young adults want more community-based programs that specifically address their social and health needs by establishing social networks among themselves and adult mentors. They desired connection with social resources where helpful individuals were available to them and where relationship and reciprocity could be fostered (p. 1287). They expressed interest in helping out a neighbor and giving back to their community through peer counseling, fund-raising, and participation in other community services.

6. Homeless people want to be heard and reached out to by their community.

Participants were very verbal in expressing their perspectives and experiences (Hudson, p. 5, 7). Daiski (2007) found that a community-based approach to understanding the homeless population's needs may be the most effective way to improve their health, "starting from the 'bottom up' with the wants and needs of those affected, as they are seen as the experts on their lives" (p. 274).

Vulnerable populations are often unable or unwilling to access mainstream health care services. Nicklasch (2009) stated that "health care providers must be aggressive in their outreach efforts to get the services to those in need" and "assess their situation and seek alternatives for obtaining necessary resources for patients" (p. 45). For example, O'Connell et al. (2010) found that 400 migrant and homeless workers living and working in the stables of a local racetrack were concerned that if they left the stables to get medical care, they would lose their place to live as well as their jobs. Consequently, primary and preventive care teams came to them on a weekly basis and set up mobile clinics at the racetracks. Additionally, clinics were set up regularly at local shelters and soup kitchens to bring health care to homeless individuals who may not have otherwise sought needed medical care. This program anticipated the acute, intensive, and unpredictable needs of the homeless and sendt out small teams with flexible schedules to the same settings, so that clients became familiar and comfortable with these providers. This concept of "street medicine" brought direct delivery of health care and continuity of care to parks, encampments, below bridges, in alleys, and in doorways (O'Connell et al., p. 1405).

Identify Gaps in the Literature:
What Do We Still Need to Know?

Additional research is needed in regards to the personally specified needs and desires of the homeless as they pertain to health and health care. This information is vital for the implementation of culturally competent care for this population, and more generally to improve public health and health care for all people, both of which will increase satisfaction of care and reduce annual health care spending in this country. These goals will be best achieved by listening to the voices of this vulnerable group and then tailoring interventions based on these interpretations. As Madeleine M. Leininger (2002), a leader in caring for culturally diverse populations, stated "What is most crucial is listening with a very open mind to the informant, learning from them, and not imposing your ideas" (Leininger, 2002, p. 192). Nurses have the obligation to "advocate for social justice, including a commitment to the health of vulnerable populations and the elimination of health disparities" (American Association of Colleges of Nursing, 2008). Advocacy and care for the homeless continue to be an area of significant need in nursing research.

Summary

Much knowledge and background information was gained in this literature review for the purpose of moving toward an answer to this author's research question, "What are the perceived health care needs of the homeless?" Understanding the perceived needs of this population in terms of both physical health care as well as holistic care will better enable the researcher to ask questions and listen for answers from the homeless population. This is a complex demographic group with unique needs that require professionals to be attuned to the group's views and lifestyles rather than from an outsider's perspective.

Throughout this literature review process, understanding and empathy for this population has been enhanced as well as sensitivity to the unique cultural care required in providing health care to the homeless. Culturally congruent care, as developed by Leininger, was of high importance to this researcher as methods were devised, implemented, and analyzed in the future. The promotion of access to health care among the homeless is an exciting and challenging aspect of nursing. An increased understanding of this populations' perceptions of needs and desires for care was the goal of this researcher, as well as to become more actively involved in the homeless community with the hope of making a notable impact on the physical, emotional, psychological, and spiritual well being of these individuals.

CHAPTER 3

METHODOLOGY

Introduction

> To care for someone, I must know who I am
> To care for someone, I must know who the other is
> To care for someone, I must be able to
> Bridge the gap between myself and the other (Anderson, 1987, p. 10).

Today's world is marked by diversity, whether a person looks across the street, across the country, or across the globe. It is the challenge of humanity to identify differences, set the 'self' aside, and meet people where they are at. This is true in business, politics, family, and religion, and health care is no exception. Advance practice nurses have opportunities daily to come alongside someone who is often much different than themselves, and enter into the person's culture, belief system, and perceived need, and then make a positive impact on their health and well-being by meeting that need. According to Madeleine Leininger's theory of culture care diversity and universality, (McFarland, 2010), a major focus in the profession of nursing is to "arrive at culturally congruent care decisions and actions to support well-being, health, and satisfactory lifeways for people" (p. 459). Leininger further explained that this is best achieved through "explicit use of culturally based care and health knowledge in sensitive, creative, and meaningful ways to fit the needs of individuals or groups" (McFarland, p. 461). According to Leininger, "no longer can nurses practice unicultural nursing" (p. 468). This approach must begin at the research level and be carried out into all aspects of patient care.

The purpose of this research was to identify the perceived health care needs of a homeless population in a rural western community so that primary care providers may better understand these needs and implement ways to more effectively meet these needs. The methodology for obtaining this understanding was the focus of this chapter. Chapter Three included identifying the population, sample, and setting, as well as discussion of the rights of human subjects and consent process. It provided information on the study's design, procedures for data collection, and the specific data collection methods that were be utilized. Finally, this chapter provided explanation regarding the method of analysis of the data that was obtained.

Population and Setting

The population of interest was the homeless community in Montana. As defined in chapter 1, this term includes those individuals who live in the streets, utilize the local shelter system, or are continuously moving between temporary housing arrangements (Haldenby, Berman, & Forchuk, 2007). A homeless individual "lacks a permanent place of one's own" (Daiski, 2007, p. 274). The Montana Coalition for the Homeless (2011) defined homelessness as "the state or condition of being without permanent housing, including living on the streets, staying in a shelter, mission, abandoned buildings, or vehicles or other unstable or non-permanent situation." This coalition reported that in 2010, 12% of this state's population reported being homeless at some point in their lives. For the purpose of this particular study, the researcher narrowed the inclusion criteria to focus on homeless individuals within a northwestern state who are at least 18 years of age.

Research Sample

Within the eligibility criteria of homeless people who are at least 18 years of age, this researcher identified a target population from a local public assistance organization which provides temporary shelter, food, medical care, and other needed resources for the community's homeless. This organization is well known and well respected within this northwestern state and is closely associated with a nearby community health care center which provides for the health needs of this particular population. A purposive sample was selected using a short interview to assure that each individual meets the eligibility criteria.

According to Norwood (2010), purposive sampling utilizes the "researcher's personal knowledge of a population to consciously select the elements that will constitute the study sample" (p. 234). Thus, the researcher chose accessible informants from this setting, and then verified via brief interview that the individuals had no permanent residence or shelter and were at least 18 years of age. "Purposive sampling", Norwood (2010) states, "is a means by which the researcher can generate a small group of individuals who…can provide insight, clarity, and ease of complying with a research protocol" (p. 234). Furthermore, purposive sampling results in information-rich cases because of the participant's knowledge of the phenomenon (p. 239).

A sample size of 10 to 25 informants were chosen and verified as eligible data sources. This sample size was chosen due to the qualitative nature of the study. Within this sample, no less than 10 key informants were then utilized for more in-depth discussion and study. According to Norwood (2010), "sample size in qualitative research is ultimately a matter of judgment about the quality and sufficiency of the information collected". What is highly important is the "information-richness of the individual elements selected and the analytic capabilities of the researcher rather than the sample size" (p. 240). Norwood states that "ethnographic studies typically require 25 to 50 data sources and a smaller number of key informants" (p. 241). This researcher used an ethnographic approach, which will be discussed shortly. To choose a larger sample may result in sampling beyond the point of 'saturation', a guideline suggested by Norwood (2010). This principle refers to "informational redundancy, or the point at which no new information is forth-coming from the data collection process" (p. 241). Additionally, as stated by Lunenberg and Irby (2008), it is appropriate to initially "identify 25 potential participants. Then if only 10 from the 25 are appropriate for the sample, credibility still remains, as the 10 participants are still based on the initial sample purposively selected" (p. 177). Reasons for participant elimination were no interest in remaining in the study, language barriers, illness, and relocation.

The limitations of this sample size may be in not obtaining an 'information-rich" sample in which to obtain and analyze information about perceived health needs of the homeless. If information obtained is not comprehensive, the results of this study may not be adequate or 'fit' with other populations of similar status and background.

Rights of Human Subjects and Consent Process

This researcher obtained approval from Montana State University Institutional Review Board (IRB) before beginning the sampling and data collection process. The procedure for approval was provided in Appendix A. Verbal permission from the director of the public assistance organization for conducting research was also obtained, as well as a signed Letter of Agreement (see Appendix B). Additionally, written participants' consents were obtained. This researcher earned the Human Subjects Certificate from Montana State University, via the CITI Collaborative Institutional Training Initiative (CITI). A copy of the Responsible Conduct of Research Curriculum Completion Report can be found in Appendix C.

Research Design

The chosen methodological approach for this research consisted of a descriptive qualitative ethnographic design. According to Norwood (2010), the use of a descriptive study helps the researcher glean more information about a situation and then document characteristics pertaining to the area of interest. Norwood goes on to say that "most qualitative research uses some variation of a descriptive design…and uses self-report data collection strategies such as interviews and questionnaires to describe and tally the characteristics of a group" (p. 206). This type of research design is effective in obtaining information about "attitudes, opinions, perceptions, behavior, knowledge, health care needs, satisfaction with care, and similar issues" (p. 206).

The ethnographic approach to nursing research that directed this research was largely developed by Madeleine Leininger, who focused on describing and interpreting cultural patterns of thought and behavior. With ethnography, cultural groups of interest may include ethnic groups, populations with similar background and circumstances, or individuals who share the same role or setting (Norwood, p. 51). The target population of this research study met these qualifications, as they were individuals with similar circumstances who find themselves in a unique and common setting. Therefore, an ethnographic approach was appropriate. The data obtained from an ethnographic study can be used to “develop culturally relevant interventions for addressing a problem or situation” (p. 51).

According to Lunenburg and Irby (2008), ethnographic research requires personal involvement and participation as a way to gather data and tell a group or individual’s story. Lunenburg states that “it is also important for the researcher to clearly identify his/her own biases, about who the ‘other’ is, about the impact of the researcher on the group being studied, and about basic respect” (p. 99). Lunenburg goes on to say that “this type of research requires understanding of the culture, the ability to write in narrative style, the ability to be part of the group, yet remain apart from the group. This process can be very time-intensive” (p. 100).

This methodology was also chosen based on studies found in the literature review. Of particular note, the recent study by Hudson, Nyamathi, Greengold, et al (2010) provided an applicable methodology for this study. According to their study, these researchers explored the perspectives of homeless youth on barriers and facilitators to health-care-seeking behavior and their perspective on what can be done to improve existing programs for homeless persons. This researcher used a similar method of collecting data, which included developing relationship and trust among this homeless population. Semi-structured interviews directed the conversations. The variables of interest were the perceptions of need and suggestions for health care providers in better caring for this population’s needs. Common themes were identified by the researcher.

Interviews were recorded with permission and field notes were utilized to note verbal and non-verbal information obtained during interaction with the focus group.

Procedures for Data Collection

This researcher used similar data collection strategies as in the Hudson (2010) study, as the type of study, topic of interest, methodology, and sample size were similar to this researcher's study. Rapport was established by the researcher spending several hours per week for four weeks at the research site, serving meals and having conversation with this population. Permission from the director of the organization was obtained for this volunteer role. The next step in the qualitative data collection process was recruitment of participants by posting colorful flyers at this public assistance center. These informational posters provided a brief overview of the work that was to take place and a description of participants needed, as well as the day, time, and location that the study was initiated. An small incentive of a pair of tube socks for each willing participant was also specified on the flyers.

On the day of face to face interaction with potential participants, the researcher provided a brief explanation of the purpose for the research study, and emphasized the research question in statement form. Potential participants were informed of the goal of this research, which was to better understand needs as identified by the participants themselves so that the nursing profession can better provide for those needs. As noted by Lunenburg, "it is essential to gain the trust of the individuals in charge as well as the participants themselves" (p. 99). This can be accomplished using honest, genuine, and up-front dialogue with all involved at the outset of the study. Initial relationship was established by this researcher with the director of this organization as well as some of the staff.

The third step was to review a short informed consent form consisting of the previously mentioned eligibility criteria. The participant's signature on this form provided consent of their participation. This form was included in Appendix D. This took no more than a total of fifteen minutes. The goal of this researcher was to include 10 to 25 eligible participants in this research.

Fourthly, a verbal survey was administered to each participant and included five open-ended questions pertaining to this population's perceived health care needs and suggestions for providers. Among these, an open-ended question was included with regards to how the participants described their current health, as well as suggestions for how the nursing profession can be a part of helping to improve their overall health and well-being. This verbal survey took no more than twenty minutes to complete and can be found in Appendix E. Participants' answers were handwritten word for word by the researcher so that no writing by the participants was necessary. Steps one through four were completed by week six of the data collection process.

Lastly, a follow-up, non-structured interview was then conducted with each participant as needed for research clarification. Survey answers as well as additional concerns were addressed for as long as the participant chose to dialogue. This took approximately ten to twenty minutes, and was done to ensure that the data collected from the survey was correctly interpreted by the researcher, with patterns and themes accurately identified. Further data obtained was handwritten by the researcher and applied to the participants' initial survey data. The researcher allowed week six through eight to complete these individual interviews.

Instrumentation

Norwood (2010) states that, with qualitative studies, the primary data collection instrument is the researcher. The quality of data gathered depends on the unique relationship between the researcher and the participants. Norwood points out that "sampling, data collection, and data analysis occur somewhat simultaneously" (p. 264). This researcher's goal was to spend time in the field with each participant to facilitate meaningful dialogue, thorough sampling, data collection, and data analysis.

Other data instruments that were previously identified and discussed include an informed consent form, a one-time verbal survey, with individual follow up as needed and as the participants were willing. The verbal survey utilized five questions, both semi-structured as well as open ended questions. Follow up interviews included non-structured and open dialogue. According to Lunenburg and Irby (2008), "interviews that are composed of both semi-structured and open-ended questions allow the participants more freedom and creativity to respond to the questions" (p. 193), as well as provide unexpected answers and insight into the topics discussed. Draw backs to this instrumentation, as noted by Norwood (2010), are that "open-ended questions are more time-consuming for respondents to complete and for the researcher to analyze. They usually require more effort than close-ended items, which requires the respondents to be able to organize and articulate their thoughts" (p. 275).

Unstructured time was spent with participants and natural observation was utilized, with occasional questions from the researcher to facilitate discussion. Existing participants were given the choice to excuse themselves from the study without penalty. In this event, other participants were chosen from the same population to maintain an adequate sample size. The goal of this researcher was to further understand the participants' reality, including perceived health needs, as well as steps the nursing profession can take to positively impact the health and well-being of this population.

This researcher utilized audiotapes at the time of the interviews to document the participants' experiences and thoughts in a way that most accurately captured, transcribed, and allowed for discussion review. Additional consent was obtained prior to the use of any recording device to promote full disclosure of research instrumentation.

Field notes were also be used by the researcher to keep track of and record information obtained outside of the survey and interview answers themselves. Information obtained through observation included nonverbal communication, emotional behaviors, and other visualized or verbalized responses at the time of the interactions. Photography was also utilized for the same reasons, as long as consent was obtained for this type of instrumentation. According to Lunenburg and Irby (2008), surveys, interviews, observations, audiotapes, photography, and field notes are all acceptable qualitative instrumentation devices (p. 192-194). The use of these devices increased the reliability and validity of the researcher in the conduction of this study.

Qualitative Criteria

An important part of any qualitative research study, as mentioned by Norwood (2010), is determining the quality criteria of confirmability, dependability, and credibility. Norwood states that “confirmability depends on objectivity and neutrality, which is facilitated by the process of bracketing. This means that, given the same set of data and the same set of guidelines for data analysis, an independent researcher should be able to come up with the same conclusions about the meaning of the data” (p. 264).

According to Norwood (2010), other ways to ensure bias-free interpretation of the results is the development of an audit trail as well as a decision trail. An audit trail includes the use of documentation obtained in the research process such as interview transcripts, field notes, and personal notes that someone else could study to confirm the findings. A decision trail entails the use of rules used by the researcher for identifying categories and themes in the data that another researcher could review and arrive at the same conclusions. These rules will be noted by the researcher as the data unfolds, so that the decision trail is in writing and clearly identified.

Dependability is achieved if the information found from the research can remain unchanged over time, i.e. put away for a period of time, then re-examined later to obtain the same conclusions. Fittingness occurs “when the researcher’s conclusions are perceived to fit the data” (Norwood, 2010, p. 195). Dependability also occurs when the information can be applied in different but similar conditions.

Credibility is also important in the instrumentation process. Norwood describes this term as “the confidence in the truth value of qualitative data and its interpretation”.

This is achieved when “the study is carried out in such a way that the results are believable, confirmable, and dependable” (p. 265). The purposive sampling style of this research, as well as clarifying participant’s thoughts and ideas through follow-up interviews, spending sufficient time in the field, use of detailed quotes from the study participants, immediate transcription of interviews, field notes, and personal notes, added to the credibility, confirmability, and dependability of this research. Copies of the specific instrumentation utilized in this study were included in Appendix E. All data obtained was handled and analyzed only by the researcher and was stored in a locked safe in the researcher’s home. All data was shredded after the completion of the study.

Analysis

Data analysis is a core activity in any qualitative research study, and described by Norwood (2010) as “a process of fitting data together, of making the invisible obvious, to make sense of seemingly massive amounts of information”. This is done by “reducing the volume of data, identifying meaningful patterns, and clearly and effectively communicating both the essence of what the data reveals, and its implications for nursing practice” (p. 341). This analysis process somewhat overlapped with the data collection activities previously discussed, as this type of research requires reflection at the same time that data is being actively gathered in the field. Constant comparison was also employed, where every interview was compared to the others as they are collected to determine similarities and differences (Norwood, 2010, p. 349).

The qualitative analysis utilized for this research included the systematic process of analyzing the narrative data obtained and identifying prominent themes, relationships, patterns, and variations among themes. Specifically, the stages of Norwood's qualitative data analysis process were utilized, and included "in-field reflection, data preparation, data familiarization, searching for themes and patterns, and interpreting and attaching meanings" (p. 343). Through audio recording and word for word transcription, data was read and re-read, listened to, and listened to again. Naming identified themes helped to create word pictures, often making them more concrete. Line by line color coding of all data and noting the emerging themes was the primary activity of this researcher's analysis. These themes were then further refined throughout the analytical process, and verified for accuracy with the participants using follow up interviews for further clarification.

Classification and coding was similar to Leininger's ethnonursing method, where the focus of classification was "based on care beliefs, values, and practices subjectively known by a designated culture" (McFarland, 2010, p. 462). Additionally, themes such as care, health, and environment were identified and color coded. According to Leininger, by utilizing various aspects of the ethnonursing research method, "the credibility and confirmability from in-depth studies of informants and their contexts will become clearly evident" (McFarland, 2010, p. 471).

Leininger's sunrise enabler model (2004) also provided direction in analyzing and naming cultural themes and patterns derived from interviews, observations, listening to life stories, and viewing photographs (refer to Appendix F). The sunrise enabler model was used to organize various themes that influence the participants' views of health, wellness, and care expressions to further identify content categories that may emerge.

According to Lunenburg and Irby (2008), "generalizability is promoted when replication is done with other subjects matched as closely as possible who share the same problems" (p. 203). Common themes will be clearly identified after data analysis.

By understanding cultural patterns and influences, this research can ultimately lead to the improvement of culturally sensitive care for this population, and more adequately providing for their perceived needs. Ideally, greater understanding may lead to better care of this population. Norwood's Critical guidelines for reports of qualitative analysis (2010) was utilized to provide a critical review of the research findings. Some of the questions this researcher asked of the results included: "Was the results section clearly identified? Was there sufficient documentation of the analytic process? Was the category or thematic schema clearly described, logical, and complete? Does there appear to be redundancy or overlap in the categories? Does the data analysis result in a clear depiction of the phenomenon of interest and provide answers to the study's research questions?" (p. 355). Each question provided in Norwood's guidelines was asked of the individual data derived from this study to ensure thorough analysis.

Summary

This chapter discussed the methodology of this qualitative research study, to identify perceived health needs among the homeless in a rural western community so that the nursing profession may better understand this population's needs and implement ways to more effectively meet these needs. The population and sample were identified as well, and include individuals with no permanent housing or shelter of their own, who are at least 18 years of age, and who live within a western county in a rural western state. A purposive sample of 25 participants was selected after meeting the eligibility criteria. The settings for identifying eligible participants as well as conducting the research included a local community assistance facility which is well known for providing services to homeless citizens.

This researcher earned the Human Subjects Certificate from the CITI Collaborative Institutional Training Initiative (CITI) and obtained permission to conduct this study from Montana State University Institutional Review Board (IRB). Additonally, written consents were obtained from all administrators and participants involved. This researcher also received approval from participants prior to utilizing audio recording and photography for data collection.

The methodological approach for this research consisted of a descriptive qualitative ethnographic design and was influenced by both Madeleine Leininger’s ethnonursing model and the research of Hudson et al (2010). Procedures for data collection included posting an informational flyer to request participants at the chosen research site, followed by a verbal survey with questions pertaining to perceived health needs of the above mentioned population. This survey welcomed suggestions for the nursing profession regarding ways nurses may be a part of helping to improve the participants’ overall health and well-being. Individual interviews were performed as needed for the purpose of ensuring that the data retrieved was correctly interpreted by the researcher. All data collection sessions were audio recorded and field notes were taken. Data obtained was immediately transcribed to achieve accuracy and assure complete information for analysis.

Analysis was performed using Norwood's qualitative data analysis process, which included in-field reflection, data preparation, data familiarization, searching for themes and patterns, and interpreting and attaching meanings (Norwood, 2010, p. 343). For finding themes and meanings within cultural context, Leininger's sunrise enabler (McFarland, 2010, p. 466) was utilized and data was color coded for analysis. Final analysis was reviewed with the participants for increased accuracy.

In alignment with Leininger's goal of providing culturally congruent care, it was the aim of this research to identify emerging patterns so that "cultural care, values, beliefs, and lifeways can provide accurate and reliable bases for planning and effectively implementing culturally-specific care" (McFarland, 2010, p. 463). In identifying patterns and themes among this homeless population, nurses can utilize this information in providing care that could result in increased accurate cultural understanding, as well as greater satisfaction of both the patient and nurse, and a deeper sense of receiving and providing good care, which may ultimately impact the patient's health and well-being. The chapter to follow contains the presentation and analysis of the data.

CHAPTER 4

ANALYSIS OF DATA

Introduction

The purpose of this study was to better understand the perceived health care needs of this unique population so that primary health care providers as a whole may become more culturally sensitive to their homeless patients, and then implement more effective ways of meeting their health care needs. This study sought to explore and clarify the health needs of the homeless, as described from their own point of view. Efforts were made to identify and interact with a small sample of this population locally, and to listen to their views and suggestions regarding health care concerns and specific needs.

This chapter presents the results of the data analysis for the five questions posed in a verbal survey to the sample group. The presentation of these findings were arranged by themes, and meaningful patterns were identified during and after the verbal surveys.

Themes

More specifically, eight themes became prominent upon data analysis. Themes identified related to this population's beliefs, patterns, values, and relationships. These themes were then further refined into subthemes and participant data was verified via member checks for greater accuracy. Prominent themes included: 1) Care and wellness practices, 2) Health status and illness, 3) Environment and context, 4) Economic hardship, 5) Religious or philosophical factors, 6) Kinship and cultural factors, 7)

Political or legal factors, and 8) Suggestions for Nurse Practitioners. These themes were discussed individually in the remainder of this chapter.

Theme 1: Care and Wellness Practices

This study's sample group which included 18 participants, had much to say regarding what kinds of formal health care and personal care practices they utilized in an attempt to optimize their individual health. Ten of the 18 participants (56%) reported that they go to a low-income community health center for their regular health care. One stated, “I go to (local community health center (CHC)). They help me out”. Another reported that he went to “regular check ups every two weeks” at the CHC. Many reported that this facility was close by and has a clinic location “right inside the shelter”.

Six participants (34%) reported the local Emergency Department as their primary source for health care. One of those surveyed stated that “I usually go to the emergency room if anything serious happens – like if I cut myself and I don't have needle and thread”. One woman stated “I just took my daughter the ER for really high blood pressure. They caught it quick and gave her medicine for it”. Another subject reported that he recently “went to the ER for a blood clot in my leg”. A male participant stated that “I cut my hand when I was fishing in the Clark Fork – all the way through my tendons. I went to the ER and went to surgery immediately”. This same man stated that he used the ER again later that year “because I got pulmonary edema and was in 95% heart failure”. Another interviewee reported that he “tries to fix myself, but sometimes end up in the ER anyway”.

Of the 18 interviewees, 7 (39%) stated that they frequent the local homeless shelter for services such as food, clothing, and temporary housing. One man stated "I get clothes and shoes from upstairs" (the shelter's supply room for guests). Another participant stated, "you can stay here (at the shelter) for one month. Then you have to leave for a month before you can come back. That's usually what I do".

Three of the interviewees (17%) specifically mentioned using Veteran's Affairs services for basic health care and mental health care, although 6 participants (34%) identified themselves as having prior military experience. Government disability assistance was reportedly utilized by 4 participants (22%).

Various self-care methods were reported by 7 participants (39%) surveyed. One participant stated, "My dog keeps me grounded. He's my mental health". Another interviewee reported "I don't smoke. I do my exercises, and I try to watch my sodium intake". Also reported was that "I come in to the shelter (to the CHC) and get my blood pressure checked once a week". One man reported, "I'm kind of a naturalist myself. I get herbs from the herbalist lady who comes to the shelter on Thursdays at breakfast". Another participant stated "Most things I can fix myself".

Lastly, four of the interviewees stated that they have used other resources, such as free food at a local eating establishment, the food bank, government housing vouchers, or spending the night with a relative at some point in their homelessness.

Theme 2: Health Status and Illness

When asked how participants "perceive their current health", 12 (67%) reported that they were in good or satisfactory health. However, upon further questioning, 8 of the

12 verbalized specific health problems, and changed their answers to “fair” or “ok”. Four of the remaining participants (22%) rated their health as “poor”.

Participants were also asked to discuss their greatest health need at the present time. Current health issues reported among participants included mental health issues such as post-traumatic stress disorder, major depression, bipolar disorder, schizophrenia, drug and alcohol dependency, and suicidal ideation. Seven of the 18 surveyed (39%) reported some kind of mental health problem. One participant reported, “I don’t want to talk about the past”. Another stated, “I drink too much. It’s a Montana thing. But I’m not from Montana. I just adopted the habit”.

Other chronic ailments included hypertension, acid reflux, respiratory infection, allergies, headaches, residual effects of stroke, blood clot, Lupus, pain from physical injury, dental problems, congestive heart failure, and memory deficits.

Theme 3: Environment and Context

Throughout the interviews, common elements pertaining to this population’s environment and context were noted. For example, all of the respondents reported that they had no permanent address, and all were currently living within the county limits. Additionally, all participants said that they came daily or several times daily to the local homeless shelter. Several stated they came to the shelter “from camp”, where they currently resided. At the time of the interviews, participants were either inside eating a meal, or outside on the shelter property standing alone, or talking with other homeless patrons. One female interviewee who was alone reported, “I like the shelter. It’s the people living in here I don’t like”.

Six in the sample group (33%) spoke from the perspective of having past military experience, specifically in the Vietnam War. Branches of the military identified were the Army and the Marines. Eight interviewees (44%) reported that they were from out of state. Many spoke of their homelessness as a chronic problem, and not a new life event. Several were noted to have had backpacks or bags which reportedly contained their personal belongings.

Several of the participants agreed that the environment of “living outside” can sometimes be very dangerous. As one man stated, “It’s easy to get injured, stabbed, or beat up around here”. Another reported that her belongings were frequently stolen if she doesn’t “keep a close eye” on her “stuff”. Other statements made were, “Most of my friends are already dead” and “I’ve really beat myself up over the last 54 years”.

Theme 4: Economic Hardship

One of the survey questions was “What has prevented you from getting needed services?” Eleven of those surveyed (61%) cited “lack of money” or “unemployment” as the primary reason for not being able to obtain needed health services. Six of the 18 respondents (33%) referred specifically to “not being able to afford the co-pays”. Seven participants (39%) stated they are sometimes unable to obtain the medicine they need due to lack of money to pay for them. This included both prescription drugs and over-the-counter medicine.

Others surveyed said they were in need of specialty services that they reportedly could not afford, including major dental care, advanced imaging such as MRI, mental health counseling, and addiction rehabilitation. Other stated services needed included long-term management of pain, autoimmune disease, and congestive heart failure.

Some participants also cited economic hardship as a reason for not being able to obtain proper housing or transportation to a state Veteran's Hospital for needed services. Two interviewees stated that their disability checks were "often late", therefore they were unable to get their needed medications on time. One participant stated, "It all comes down to money. Stuff costs money, no matter how poor you are".

Theme 5: Religious or Philosophical Factors

Results of this study showed that a significant number of participants held religious or philosophical beliefs that they cited as providing them with the help they need. Three participants specifically stated that "God" helped them to cope with the experience of being homeless. One man stated, "I think about God constantly. That's how I survive". Another stated, "I'm a believer. I wouldn't have what I have without Him (God).

Five of those surveyed (28%) referred to maintaining a positive mental attitude as their philosophy for living with hardship. One participant stated "If you think healthy thoughts, you dissipate the unhealthy". Another man mentioned the importance of avoiding negative people and places, stating that he "went off into the mountains to get away from bad habits and bad people".

Five participants reported the importance of working hard in order to get what they need. Other identified philosophies included "taking one day at a time", "don't sweep stuff under the carpet", "it could be worse", "you are what you think", and "live simply".

Other participants held more negative views, reporting "I'm getting dumped on right now", "I get no help. I'm all alone", "Don't rely on the mental health system. They control everything", and "If you want something done, you gotta do it yourself".

The subtheme of resiliency was prominent in eight of the 18 participant interviews (44%). Statements were made that indicated an attitude of toughness and perseverance, despite life's challenges. These included "We just piece ourselves back together", "We'll get there", "I always see the light at the end of the horizon", "God always takes care of me", and "I've lived outside for years. It's nice". One man reported, "I've been to every state except Hawaii. If they have railroad tracks there, I've been there".

Theme 6: Kinship and Cultural Factors

Another prominent theme identified in the interviews was that of kinship, camaraderie, and being part of a unique culture. During the surveys, interviewees mentioned several key terms indicating that they were part of a bigger whole. Four of the 18 participants (22%) stated that they "live out at camp". One of them reported, "I betcha there's 400 families living out in the woods in Missoula county – at least!" Another camp dweller stated, "We're a family. We have each other". Others stated, "We're sheep without a shepherd, a dying breed", and "We live simply. It's nice".

Those surveyed who had previous military experience used terms to refer to veterans collectively. Terms used were “us”, “we”, “guys like us”, “We’ve been through a lot”, and “I was *in* between ’80 and ‘86”.

One interviewee described his role at the local homeless shelter as “a mission” where God has given him the opportunity to encourage people and “to work on human hearts”. He stated that “God keeps moving me to new places. I just want to ease someone’s pain for one day. And if I don’t see people again, my prayers are always with them”.

The cultural norm of “taking care of each other” was evident during this research. During two of the interviews, two different shelter residents who overheard the discussions on current health concerns interrupted with their own personal advice for getting needed treatment. The first resident recommended “a place downtown that will give you whatever dental care you need”. The second resident stated “Take a shot glass of aloe vera juice every day. It cures acid and other stomach problems”.

Theme 7: Political or Legal Factors

Some of the interviews included discussion involving state or national issues, as well as legal restrictions placed on some of the participants at the time of the surveys. Four participants (22%) cited state or national health care coverage as a way to get needed services. One interviewee stated “They (Montana) should have to have a health care package for us like Washington state – that would work”. Another stated that “John Tester (Senator) can help me”. One participant stated “I wish I had Medicare”, while another stated he was currently “working on getting Medicare”. Another reported, “I think the U.K.'s health care is worthwhile. If everyone was covered, it would ease a lot of fear and suffering".

Participants also cited legal problems as factors contributing to their poor health and lack of health care utilization. One veteran reported that "we were shunned away (from VA services) to save a nickel and then later on we have criminal problems and mental health issues and drug addiction. All this is going on without receiving the proper care we need". Five participants (28%) stated they had been or were currently in legal trouble, ranging from "probation", "criminal problems", "thrown in jail", "under a narcotic contract", and "married to the state of Montucky since 2010".

Theme 8: Suggestions For Nurse Practitioners

When asked "Who can help you get the services you need?" , two participants (11%) specifically mentioned nurse practitioners (NPs) as being a resource for obtaining needed health services. One stated, "I receive most of my care through a nurse practitioner" (at the community health center). He reported, "I think it's up and coming and a lot of clinics are solely run by NPs. NPs can write scripts in all 50 states now". Another reported that "nurse practitioners can help me", and stated that "my NP actively manages my blood pressure right now".

Many participants suggested mental health services as a need that nurse practitioners could assist them in obtaining. Thirty-three percent of those surveyed specifically mentioned the need for individual mental health support. One interviewee stated, "I'm sick and tired of the 'one size fits all' attitude (in mental health). It doesn't work". He suggested that "a voucher system would be good for mental health. Then you could choose your own provider".

Three participants (17%) stated that their greatest health need at the moment related to long term mental stability. One stated, "What I really need is someone to listen to me. I think that's half of health care. It's therapeutic to be listened to, to get stuff off your chest, to talk about stuff". This same participant stated, "I think nurse practitioners can help with this. They care". Another reported, "I need help with the fluctuations in my mental health", stating that he was bipolar and doesn't always stay on his meds. The third participant reported, "I have a mental health appointment (at the community health center) about every two weeks. I wish I could go more often. I don't have anyone else".

Additional suggestions for nurse practitioners that were reported by participants included "we need more funding for mental health and support groups", "we need more local mental health help", and "we want providers who really care". Five of those surveyed (28%) reported that they would like help with managing their medications, specifically, "helping me stay on my meds" and "helping me follow my (narcotics) contract". One stated, "I need help getting health care earlier. I let things go too long sometimes". Another stated "I would like an NP to oversee my daily care and then refer me to a specialist if I need one".

One military veteran stated that he needed "help with transportation to my appointments". Another requested help in scheduling and keeping his health care appointments. Three participants (18%) requested assistance with "long term care", indicating that their chronic conditions would likely require more help than they were currently utilizing. They reported suffering from illnesses like “Lupus”, “CHF and kidney failure”, “bad lungs (COPD)”, and “head injury”.

Three participants (18%) reported that they were unsure of who specifically could help them. They requested the need for more information on “what kind of help is out there”, and “where to go for different kinds of help”. One man stated, “I imagine I could go to (community health center) for mental health care, but even with the co-pays, I can’t afford it”. He discussed the need for “help with co-pays”. Another stated, “I’m not sure what’s available”. Another interviewee stated “I help myself. I don’t know who else can help me”. One reported that “pride prevents me from getting help”. It was also suggested, “I need someone to help me get specialty services. I was told I need my parathyroid out”.

Analysis

The homeless population studied was a heterogeneous group of individuals whose who verbalized both a strong sense of personal responsibility as well as the need for institutional support. Participants’ ages ranged from approximately 24-55 years old. All except one participant were male. Thirty- four percent stated that they had prior military experience, 44% stated that they were from “out of state”, and 39% reported having current mental health needs. Those surveyed had positive perceptions of nurse practitioners and the care that they offered. Most were open and honest in sharing their perceived needs and very personal insight. Resiliency was another overarching trait among the homeless, as demonstrated by their resourcefulness, their sense of belonging to a community, and the high value placed on taking care of each other.

Summary

In this chapter, an introduction was given to reiterate the purpose of this study. To become more culturally sensitive as primary care providers in regards to a local homeless population's views and percieved health needs was the aim of this research. A presentation of findings was organized and discussed based on 18 participant interviews. Prominent themes, subthemes, and meaningful patterns were identified and developed in the results section.

Results revealed that there were many common concerns among the sample group, with similar needs also identified. Participants reported multiple health problems ranging from physical ailments to mental health issues, as well as self-help methods currently utilized. Many felt that they lacked the care they need due to limited or no income, not knowing where to obtain services, and the inability to manage their chronic health problems alone. Participants had a variety of suggestions for primary care providers, nurse practitioners included, to help them get the services they need. Overall, this population felt that "nurse practitioners care" and could assist them in obtaining better health and more consistent health care.

The next chapter will further discuss the summary of the study, as well as research findings and conclusions derived from the 18 participant interviews. Implications for future practice and recommendations for further research will also be discussed.

CHAPTER 5

SUMMARY, DISCUSSION, AND CONCLUSIONS

Introduction

In the preceding chapter, the presentation and analysis of data were reported. Chapter five included a summary of the study, discussion of the findings, implications for practice, recommendations for further research, and conclusions. The purpose this chapter was to further expound upon the themes, subthemes, and meaningful patterns in order to further understand the health care needs of the homeless from their own perspective, and to emphasize their suggestions to health care professionals in caring for this unique population. The goal of this study was to find more effective and relevant ways to care for the homeless, ultimately impacting their health in positive ways. Implications for practice were also discussed.

Finally, suggestions for further research were discussed in an effort to guide health care providers in the future, so they may become increasingly culturally sensitive in the treatment of their homeless patients. A concluding statement was offered to synthesize the research.

Summary of the Study

It is well documented that the homeless population faces disproportionately high health risks and chronic health issues, which include both physical and mental disease (National Coalition for the Homeless, 2009). Various attempts have been made over the years to improve access to medical care for this vulnerable population. Despite the efforts of health care providers, federal and local programs, and homeless initiatives, the homeless continue to report poor health status, limited access to needed services, and a lack of sensitivity on the part of primary care providers. Thus far, the health care profession has not fully understood the unique health needs of the homeless or adequately provided care in culturally relevant ways. Until this takes place, appropriate, holistic care for this population will have limited effects on the overall health and well being of the homeless.

The purpose of this study was to better understand the health needs of the homeless as expressed by the homeless themselves. As stated by Baggett, et al (2010), “The extent to which homeless adults are able to obtain health care across the spectrum of health needs is largely unknown” (p. 1326). Only as these needs become fully realized will nurse practitioners and other primary health care providers be in a position to better meet these needs, which may both positively affect the overall health of the homeless and reduce the economic burden of providing health care to this population. It was the intent of this study to spend time with and listen to patrons of a local homeless shelter to better understand their perceived health needs, to be a voice for the homeless by report those findings, and to provide future care to the homeless population in ways that positively impact their health and well being .

The theoretical framework of nurse theorist Madeleine M. Leininger was utilized for this research. Leininger’s Cultural Care Theory (2002) has provided helpful direction for nurse practitioners in their care of unique populations such as the homeless. The premise of her work is that as the world and its people continue to grow and diversify, so must nursing practice and care within multi-cultural contexts. Individual cultures have unique beliefs, goals, needs, and challenges, which the health profession should consider and respect while providing for their care. Leininger's theory may be applied to every local, national and world population, regardless of ethnicity, geographical location, or socioeconomic status. The homeless culture is no exception.

This research attempted to answer the question, "What are the perceived health care needs of the homeless?" Five open ended interview questions were presented to the study's participants to more specifically answer this question. The five survey questions were as follows:

1) How do you perceive your current health?
2) What do you perceive to be your greatest health need(s) at the moment?
3) What care/services do you feel you need the most?
4) What has prevented you from getting these services?
5) Who do you feel can help you obtain what you need?

The methodology for this study included spending unstructured time with a sample group of 18 homeless people in an effort to better understand their reality. Survey questions were discussed with each participant. Other related conversation developed and took place as a result of these questions. Natural observation was also utilized in the process of the interviews as well as during additional volunteer time spent in the shelter setting prior to and following the interviews. Conversations were documented by a hand held recording device with participants' consent. Field notes and follow up interviews were also utilized to optimize accuracy and correct interpretation of the interviews conducted.

Findings were relatively consistent among those surveyed, with similar needs and concerns expressed. Participants, in general, were very forthcoming with their concerns and opinions related to their perceived health status and health care practices. Robust and honest conversations took place during and following the interview process. The information that follows was a compilation of survey results. Eight themes were identified and summarized.

Theme 1: Care and wellness practices. Study participants reported a variety of ways that they care for themselves. Practices included formal health care, such as through a local community health center, military veterans' health care facilities, and emergency department services. Alternative care practices including utilizing government and local assistance, naturopathic resources, self-treatment methods for illness and injury, and avoiding treatment altogether.

Theme 2: Health status and illness. Fourteen of the 18 survey participants (78%) reported at least one specific health problem they were currently needing treatment for. Twelve of the 18 participants (67%) described their health as “fair”, “ok”, or “poor”. Identified illnesses included chronic physical ailments such as hypertension, acid reflux, ongoing pain, COPD, heart failure, dental decay, and infection. Mental illness was also admitted among 39% of participant, including PTSD, depression, bipolar disorder, schizophrenia, drug and alcohol dependency, and suicidal ideation.

Theme 3: Environment and context. Participants reportedly spent time “at camp” or at the homeless shelter or both, as all of them stated that they had no permanent address currently. Some reported that outdoor living was dangerous and took a toll on their health. Thirty three percent of those surveyed spoke in the context of being “ex-military”. Forty four percent stated they were from “out of state” and were in the state for work or legal reasons.

Theme 4: Economic hardship. “Lack of money” was the primary reasons participant reported for not being able to obtain needed services. Thirty three percent specifically mentioned “I can’t even afford the co-pays”. For economic reasons, participants stated that they had foregone needed services such as dental care, specialty services and tests, mental health counseling, primary and preventive care, and prescription and over-the-counter medications.

Theme 5: Religious or philosophical factors. Participants cited a variety of personal beliefs they held in the midst of homelessness. These included the belief that “God” was taking care of them, that a positive mental attitude helped them cope with hardship, and that hard work and “taking one day at a time” was helping them to “get there”.

Theme 6: Kinship and cultural factors. Among those surveyed, references were made in regards to comradery, being part of a family, and taking care of each other. One participant estimated that 400 families lived together at a nearby homeless camp. Natural observation during the interviews showed that several of the participants, as well as other shelter patrons, were familiar with each other, talked and joked amongst themselves, and offered advice and help to each other on a regular basis.

Theme 7: Political or legal factors. A number of subjects arose out of conversations during the surveys that pertained to participant opinions of current policies and programs for military veterans and homeless people. Many participants attributed their current living situation and poor health care to state and national deficiencies. Others stated that they were on probation or in other legal trouble, and that this has prevented them from leaving the state and finding work to improve their current situation.

Theme 8: Suggestions for nurse practitioners (NPs). Another prominent theme was identified throughout the course of the interviews that related to ways health care providers can help the homeless get better care. Several participants made positive statements about NPs, stating that NPs care and do a good job managing their day to day needs. Other participants verbalized that they would like more individualized and consistent health care, that “one size does not fit all”. Many asked for help with mental illness and ongoing medication management, as well as transportation to appointments and help with co-pays. Some stated that they would like more information regarding what services are “out there” and available to homeless population.

Discussion of the Findings

Findings were relatively consistent with the identified themes previously identified in the literature review. The eight identified themes parallel and supplement previous literature and contribute to the validity of this study’s assumptions regarding the homeless population’s perceived needs and desires as they relate to health status and health care. Each theme was analyzed, explained, and discussed, and data were examined to determine the extent to which the themes made sense in the context of the research question.

The theme of care and wellness practices verified existing research data which showed that homeless individuals desire health intervention as well as interdisciplinary health care services, as indicated in the study by Haley & Woodward (2007). Participants of this study reported various approaches and avenues to seeking health care and improving their health, although those surveyed did report that they felt limited in where they were able to receive care and what types of care they had access to. This data showed that homeless people do desire holistic care which encompasses more than just their physical needs. Furthermore, this data indirectly contributed to answering the survey question, “What care/services do you feel you need the most?” Participants identified ways they care for themselves and some of the places they go for services, indicating that health interventions and services are needed among this population, and are indeed, important to them. This is consistent with Leininger’s Cultural Care Theory, which describes each culture as having unique needs, beliefs, and ways of life.

The theme of health status and illness was another common discussion point and resulting data were consistent with the theme identified in the literature review, which stated that “Homeless people are very concerned with their health status, and other related health issues are largely unmet”. Participants in this research study voiced many of the same concerns shown in previous studies. Specifically, 78% of these participants reported having at least one medical condition, and 39% reported some kind of mental health problem. This data is comparable to results of the Baggett et al. (2010) study, which reported that 73% of respondents reported an unmet health need in the past year, and 48% reported some type of mental illness. Participants also rated their health status as “fair”, “ok”, and “poor”. Specific data were obtained that related to this theme, and was consistent with data from the Dykeman (2011) study, which reported that the needs of the homeless population are many and varied. This data also helped to answer the survey question, “How do you perceive your current health?” by identifying consistently poor health status and specific health problems among most of those surveyed.

Another theme consistent with current research was environment and context. This study was consistent with other data, such as from the Daiski study (2007), which stated that “life on the streets takes a heavy toll”. Lack of food, shelter, and appropriate health care was implicated for higher rates of morbidity and mortality among the homeless compared to those who are housed (Lewis, Anderson, and Gelberg, 2003). Data obtained from survey questions showed that the local homeless population’s environment is “dangerous and hard on the body”. Homeless people expend more energy on survival strategies than those with adequate housing, thus presenting a more challenging environment in which to maintain a healthy lifestyle (O’Connell, 2007). This is consistent with Maslow’s Hierarchy of needs, which states that the primary human need is a biological and physical one and includes food, shelter, and warmth. Nicklasch (2009) reported that “assisting a patient to find shelter may be the most important step taken by a health care provider”. Data obtained from the survey question, “What care/services do you feel you need the most?" helps to support the expressed need for a more stable environment as well as assistance in obtaining it.

Economic factors also became a prominent theme during the conduction of this research. This theme arose when participants were asked, "What prevents you from getting the services you need?" The overwhelming answer to this question was "lack of money" or "unemployment". Respondents reported difficulty "even coming up with the co-pay" for needed services, such as health care, housing, medications, transportation to and from appointments, and mental health counseling. As one participant put it, "It all comes down to money". These data were consistent with Baggett et al. (2010) who reported that higher rates of unmet needs among the homeless are due to many factors, such as no insurance, food insufficiency, and unemployment. Each of these factors contribute to the prevention of homeless people in obtaining the services they need. The Hudson study (2010) reported that young homeless adults failed to access care due to structural and economic difficulties. Some of those surveyed in this research study blamed government assistance programs for lack of funds, while others stated they were willing to work but couldn't find a job. One participant stated that without a physical address, it is difficult to get employment and other assistance. According to the National Coalition for the Homeless (2009), homeless people are being forced to choose which necessities they will seek. This data emphasizes the current literature that states that the homeless population's desire is for more holistic care, which encompasses more than just health needs (Daiski, 2007).

The theme of religious and philosophical factors also become apparent throughout this researcher's data collection and analysis. Data that contributed to this theme also helped to answer the survey question, "Who do you think can help you obtain what you need?" Answers pertained to "God" being the One to provide help for the individual, as well as self-help methods, a few "no one can help me" philosophies, and some verbalized uncertainty regarding who, specifically, can help them obtain what they need. Current data obtained from the literature review revealed little about the religious and philosophical beliefs of the homeless population, making it more difficult to compare the data obtained from this research. Bhui et al. (2006) did highlight, however, a current theme among the homeless, which stated "There was insufficient help during times of crisis" (p. 158). It is possible that there is other literature that is consistent with this theme, and it simply was not discovered in this literature review.

The theme of religious and philosophical factors among the homeless does consistently emphasize Leininger's work, which states that each culture has its own unique beliefs, values, and practices which are held by the group (McFarland, 2010, p. 460). This participant sample was no exception. Many held strong opinions about God, helping yourself, working hard, and keeping your eye on the light at the end of the tunnel. Overall, this sample group maintained a very positive attitude in the face of adversity and personal challenges.

Kinship and cultural factors was also a predominant theme and somewhat paralleled the philosophical factors previously stated, in that some participants reported a culture of "taking care of each other" . Another participant stated, "We have each other", referring to the "camp" where 400 local homeless families reportedly reside. This data also contributed to answering the question, "Who do you think can help you obtain what you need?" As previously stated, several participants offered help and advice in regards to expressed concerns. This data was similar to data from the study by Hudson (2010) which showed that homeless young adults "craved support from family, friends, and homeless peers". These same adults also reported that they were able to better deal with life when they had the help and support of others, which may indicate a unique bond among this population.

The data obtained from this research study also showed that some participants felt that "the right doctors who care" can help them obtain what they need. Another participant reported that he appreciated being able to have his blood pressure checked at the homeless shelter clinic. These statements support the work of Hudson (2008) revealing that homeless young adults want more community based programs, social networks, and adult mentors, where "relationship and reciprocity could be fostered". The assumption from the current literature also validates that homeless people desire connection with family, friends, health care providers, and community resources.

The theme of kinship and culture is consistent with Leininger's cultural care theory as well. She emphasized the important interrelationship of culture and care, and its positive effects on well being and health. As early as the 1950's, Leininger's focus was on providing culturally sensitive and holistic care to her patients. She stated that in discovering diverse and universal culturally based care factors, an impact was made on that culture's health and more meaningful care was provided.

Political and legal factors was another theme discovered in this particular research. Some of the participants relied on government programs for living assistance and health care. Several stated they were grateful for military veterans' services, reporting "I get everything I need from the VA. They renew all my scripts without even asking me questions". Others interviewed criticized the system for "trying to monopolize and control mental health services", "not having enough funding", and "having a back log of cases". One veteran stated, "They'd rather not take care of guys like me (from the Vietnam era). They've shunned us away to save a nickel". Another veteran reported, "There isn't enough local help for us here. I can't rely on them (VA mental health providers)". One participant stated "I wish I could choose my own (mental health) provider" and "there are no support groups here". Another reported frustration was with the state's disability program, as "the checks are always late, so I can't buy my meds". This data is consistent with the research of Irestig et al. (2010), who reported that almost half of respondents from that study perceived bad or very bad attitudes on the part of social and health services.

Legal factors were also discussed during the interviews, with 28% of participants reporting that they were on probation or currently in a mandatory drug or alcohol rehabilitation program. Others reported past legal troubles that stemmed from IV drug use or alcohol abuse. Some of those surveyed reported needing long term help for mental health issues and long term mental stability.

These reports add validity to Leininger's assumption that "if nursing practices fail to recognize the cultural aspects of human needs, there will be signs of less than efficacious nursing care practices and dissatisfaction, which limits healing and well-being" (McFarland, 2010, p. 459). Nicklasch & Marnocha (2009) found that health care providers should "readjust their interventions to better serve this (homeless) population".

The last theme identified was suggestions for nurse practitioners and other health care professionals. One participant stated that he needed a provider "that really cares and will really listen". Among those surveyed, other suggestions to providers were "help staying on my meds", and "help with day to day health management like keeping track of my blood pressure and adjusting my meds". Suggestions also included providers assisting with more mental health issues and helping people find support groups. Other requests were for help managing appointments, creating a voucher system in which to obtain needed health and mental health services like dentistry, surgery, and one-on-one psychological counseling. One participant suggested help with chronic pain management and "being listened to". Another stated he needed a safe environment in which to "open up" and "the right doctors who care".

This research was similar to Haldenby, Berman, & Forchuck (2007) which found that many primary care providers lack the knowledge to provide culturally congruent care to the homeless. They also concluded that it was possible that health professionals' attitudes regarding the homeless have dissuaded them from accessing needed health care and may have also contributed to their poorer level of health (p. 1234). These data were also consistent with Leininger's suggestion for future practice in nursing, that "nurses must strive to provide holistic and personal care that is based on the patient's perception of need". She also stated that "competent nurses are those that provide care not necessarily based on their own beliefs, values, and goals, but on the patients' individual cultures and beliefs".

These suggestions for nurse practitioners voiced by the homeless are consistent with the assumption made previously that homeless people do want holistic care which encompasses more than just their physical health needs, and that also includes health promotion and disease prevention. They are also congruent with Haley & Woodward's (2007) research, which found that homeless individuals want "interdisciplinary health care services that provide continuity, compassion, and connection" (p. 351).

Implications for Practice

The findings of this study offer much insight into the perceived health needs of the homeless. Data obtained from this research was generally consistent with current literature in regards to the unique needs, challenges, and suggestions of homeless people. This study has far-reaching implications for nurse practitioners and other primary health care professionals who provide care to homeless patients and their families. Providers must put their own values and assumptions aside and listen to their patients' expressed needs, concerns, and cries for help. Only then will they be able to understand their reality and provide meaningful and effective care.

Providers would do well to take adequate time in obtaining subjective information, such as chief complaints, what measures the patient has already taken to alleviate the problem, and the family and social history of the patient. Regardless of appearances, providers must not assume or judge, but instead strive to see the context and bigger picture that the patient is painting. By offering a safe environment, sensitivity, and genuine concern, compassionate, more holistic care can be provided. These qualities are essential if providers are to do better in meeting the unmet health needs of the homeless and offering present help in times of crisis.

Continued collaboration among health care professionals must remain a priority in caring for the homeless population. The expressed needs of the homeless are great, and so are the health disparities. Providers who care for these patients must keep abreast of local and government services which are available to homeless people, and then make a concerted effort to see that the patient receives these services as needed. Nurse practitioners should make education regarding resources available at every office visit and help to schedule appointments, specialty services, and follow up care as needed. Assistance in navigating health care options and services is essential to provide comprehensive and holistic care. This may include helping to meet the most basic of needs, such as shelter, food, or social connection.

Nurse practitioners should also practice preventive care at every opportunity, and provide health teaching and clear, concise written information on a variety of preventive measures and chronic illness management. Research has shown that homeless people have specific health issues and are concerned about their health and well-being. Nurse practitioners can take part in community-based services such as local health fairs, homeless outreach efforts, and free shelter-based health services such as immunizations and health screenings. Increased efforts should be made to identify the needs of local homeless community members and offer early and targeted intervention. This may help to reduce emergency room visits and exorbitant health care costs among this population.

Greater emphasis must be made on providing mental health care to the homeless, as was a widely expressed need in current literature and in this research study. Nurse practitioners should take opportunities to advocate for funding, and increased access to services for their homeless patients in need of psychiatric care. Involvement in government programs and establishing policies for comprehensive and preventive care will enable the voiced needs of the homeless to be heard by those who have the ability to bring about positive change for this vulnerable population. Providers would do well to offer mental health and primary health care services to those homeless people who have criminal records, legal judgments against them, or who admit to drug or alcohol dependency. By addressing and treating mental health issues, practicing providers can help to meet real needs and improve the overall quality of life and health for the homeless population.

Nurse practitioners have the ability to foster trust and a therapeutic relationship with their homeless patients. They are in a unique position to positively influence and validate their beliefs, ideas, and feelings. Nurse practitioners must utilize opportunities to encourage, empower, and restore self-worth, value, and dignity among the homeless. In the context of providing primary and preventive care to this unique culture, nurse practitioners can bridge the gap between the homeless patient and themselves, enabling mutual respect and empathy to flourish.

Limitations

Data from this research study were obtained locally, and cannot necessarily be generalized to other homeless populations. The views of the homeless represented in this study do not reflect the perceptions and opinions of all homeless individuals, particularly those in other geographical locations age groups, and gender ratios.

Recommendations for Further Research

Additional research should be done regarding ways that homeless people can become better connected with their community and build local support systems. This may foster the sense of belonging, being needed, and having a place to go for help in time of need.

Advocacy and meaningful care of the homeless must also remain a focus in future research. Establishing effective ways to make the unique health needs of the homeless known will continue to be important in providing culturally sensitive care.

Further study of Leininger's theory as it relates specifically to homeless populations would be beneficial. Other underserved populations may benefit from the application of Cultural Care Theory as well.

Research on ways to provide comprehensive and cost effective mental health care to the homeless is still needed. Research on the use of a voucher system in providing this type of care to this population would beneficial.

Research on ways to provide comprehensive and cost effective primary care to the homeless is also needed. Increasing preventive services may also be important in reducing health care spending among this population.

More information needs to be obtained regarding ways to promote a safer environment and context in which the homeless live. By finding ways to increase access among the homeless to basic necessities for living, health and safety may be enhanced.

Further investigation of ways to adequately manage chronic disease among the homeless and finding ways to increase compliance with this management will be required to reduce morbidity and mortality among this population as well as to reduce overall health care costs of chronic disease in this nation.

Conclusions

Data obtained during this research study helped to validate the current literature which reported that homeless people continue to have significant unmet needs and face increased morbidity and mortality as a result. Disparities in health care, mental health care, and other needed services were evident in the research. Consequences of lack of services result in poor health and a reduction in the quality of life among this population. In spite of these challenges, the homeless are resilient, resourceful, and largely optimistic.

Homeless people desire holistic and culturally sensitive care, and would like assistance in obtaining needed services and navigating the health care system. They value meaningful relationship and open dialogue with both health care professionals and peers. They are particularly interested in obtaining greater physical and mental stability through health care services, housing and employment assistance, and emotional and social support.

This population also reports some negative attitudes toward government and state assistance programs, and have many suggestions to offer existing programs to better provide for their needs. Homeless people sometimes feel disrespected and overlooked by certain health care providers and state agencies. They want to feel listened to, respected, and treated with the dignity that every human deserves.

Nurse practitioners have the privilege and responsibility as health care professionals to positively influence the lives and health of the homeless population through the provision of culturally sensitive and holistic care. By increasing awareness of the problems and barriers that homeless people face, and by taking steps to reduce these barriers, nurse practitioners can lead the way in promoting appropriate and meaningful care to this vulnerable population.

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APPENDICES

APPENDIX A

INSTITUTIONAL REVIEW BOARD
APPLICATION FOR REVIEW

MONTANA STATE UNIVERSITY
Institutional Review Board Application for Review
(revised 10/14/11)

****

THIS AREA IS FOR INSTITUTIONAL REVIEW BOARD USE ONLY. DO NOT WRITE IN THIS AREA

Application Number: Approval Date:
Disapproved: IRB Chair's Signature:

****

Date: 9-1-12

I. Investigators and Associates (list all investigators involved; application will be filed under name of first person listed)

NAME: Heidi Efinger TITLE: RN, MSU NP student
DEPT: Graduate Nursing PHONE #: 406-396-1046
COMPLETE ADDRESS: 6336 Forest Hill Trail, Missoula, MT 59804
E-MAIL ADDRESS:efinger2@earthlink.net
DATE TRAINING COMPLETED: __9-26-11___ *[Required training: CITI Training; see website for link]*

Do you as PI, any family member or any of the involved researchers or their family members have consulting agreements, management responsibilities or substantial equity (greater than $10,000 in value or greater than 5% total equity) in the sponsor, subcontractor or in the technology, or serve on the Board of the Sponsor? No

II. Title of Proposal: What Are the Perceived Health Care Needs of the Homeless?

III. Beginning Date for Use of Human Subjects: October 15, 2012

IV. Type of Grant and/or Project : Thesis project

V. Name of Funding Agency to which Proposal is Being Submitted (if applicable): NA

VI. Signatures

Submitted by Investigator
Typed Name: Heidi Efinger, RN
Signature:
Date: 9-1-12

Faculty sponsor (for student)
Typed Name: Carolyn Wenger, Committee Advisor Signature/Date:
Michele Sare, Committee Member
Lori Glover, Committee Member

VII. Summary of Activity. Provide answers to each section and add space as needed. Do not refer to an accompanying grant or contract proposal.

A. RATIONALE AND PURPOSE OF RESEARCH

“What are the Perceived Health Care Needs of the Homeless?”

B. RESEARCH PROCEDURES INVOLVED. Provide a short description of sequence and methods of procedures that will be performed with human subjects. Include details of painful or uncomfortable procedures, frequency of procedures, time involved, names of psychological tests, questionnaires, restrictions on usual life patterns, and follow up procedures.

Participants will be given information regarding the research project. Full verbal and written consent will be obtained by each participant. Interviews will be conducted by the researcher, answers written and recorded by the researcher. At least one interview, and a follow up interview if necessary will be performed. Total time involved for each participant will be no more than one hour total. A questionnaire will be administered in the interview, with 5 questions relating to current health, greatest health needs and services, and suggestions for health professionals in assisting the homeless to obtain more adequate health care, thus improving their health and well-being.

C. DECEPTION - If any deception (withholding of complete information) is required for the validity of this activity, explain why this is necessary and attach debriefing statement. NA

D. SUBJECTS

1. Approximate number and ages: Approx. 10 subjects, over age 18.
   How Many Subjects: 10
   Age Range of Subjects: Age 18-70
   How Many Normal/Control: NA
   Age Range of Normal/Control: NA
2. Criteria for selection: Homeless individuals who are at least 18 years of age.
3. Criteria for exclusion: Non-English speaking, under 18 years of age, not homeless.
4. Source of Subjects (including patients): Homeless individuals who utilize the Poverello Center.
5. Who will approach subjects and how? Explain steps taken to avoid coercion.
   Rapport will be established by researcher volunteering at Poverello Center once a week x 4 weeks. Informational flyers about the study will be posted in and around the Poverello Center one week prior to initiation. Research study will then be explained to group of willing participants, and consents will be signed.
6. Will subjects receive payments, service without charge, or extra course credit? Each participant will receive a pair of socks.
7. Location(s) where procedures will be carried out: Poverello Center

E. RISKS AND BENEFITS (ADVERSE EFFECTS)

1. Describe nature and amount of risk and/or adverse effects (including side effects), substantial stress, discomfort, or invasion of privacy involved. Personal questions will be asked in an open-ended, non-threatening manner. Some participants may feel uncomfortable sharing their private information. They may freely leave the study at any time without penalty.

2. Will this study preclude standard procedures (e.g., medical or psychological care, school attendance, etc.)? No.
3. Describe the expected benefits for individual subjects and/or society. Participants will receive a pair of socks, as well as having their opinions and concerns heard. Data collected may be used to help the health care profession better care for the needs of the homeless, as perceived by they themselves.

F. ADVERSE EFFECTS

1. How will possible adverse effects be handled? Any perceived distress by the participant will result in their choice to discontinue participation without penalty.
   By investigator(s):
   Referred by investigator(s) to appropriate care: Debbie Saylor, Director of Poverello Center will be notified so that further follow up may be done as needed.
2. Are facilities/equipment adequate to handle possible adverse effects? Yes.
3. Describe arrangements for financial responsibility for any possible adverse effects. Poverello Center assumes full responsibility. See Appendix.

G. CONFIDENTIALITY OF RESEARCH DATA

1. Will data be coded?   Yes.
2. Will master code be kept separate from data?   Yes.
3. Will any other agency have access to identifiable data? No
4. How will documents, data be stored and protected?
   Locked file: In researcher’s home
   Computer with restricted password: Yes.
   Other (explain): All identifying research data destroyed when project complete.

VIII. Checklist to be completed by Investigator(s)

A. Will any group, agency, or organization be involved?   Yes. Poverello Center, Missoula.
B. Will materials with potential radiation risk be used (e.g. x-rays, radioisotopes)?   No.
C. Will human blood be utilized in your proposal?   No.
D. Will non-investigational drugs or other substances be used for purposes of the research? No.
E. Will any investigational new drug or other investigational substance be used?   No.
F. Will an investigational device be used?   No.
G. Will academic records be used? No.
H. Will this research involve the use of:
   Medical, psychiatric and/or psychological records No.

Health insurance records No.
Any other records containing information regarding personal health and illness No.

I. Will audio-visual or tape recordings or photographs be made? Yes.
J. Will written consent form(s) be used? Yes.

APPENDIX B

LETTER OF AGREEMENT: POVERELLO CENTER

Letter of Agreement – Poverello Center, Inc.

535 Ryman St., Missoula MT 59802

406-728-1809

www.poverellocenter.org

I, Debbie Saylor, Volunteer Coordinator, hereby give my permission to Heidi Efinger, RN, MSU NP student, to conduct research at the Poverello Center. I understand the consent form that will be provided to each participant, and also that the MSU IRB regulations will be adhered to in the conduction of all research by this student.

Signed:____

Date: ____

APPENDIX C

CITI RESPONSIBLE CONDUCT OF RESEARCH COMPLETION

CITI Collaborative Institutional Training Initiative (CITI)

Responsible Conduct of Research Curriculum Completion Report
Printed on 11/18/2011

Learner: Heidi Efinger (username: heidi.efinger)
Institution: Montana State University
Contact Information Phone: 4063961046
Email: efinger2@earthlink.net

Social and Behavioral Responsible Conduct of Research Course 1.: This course is for investigators, staff and students with an interest or focus in Social and Behavioral research. This course contains text, embedded case studies AND quizzes.

Stage 1. RCR Passed on 09/26/11 (Ref # 6773693)

Required Modules	Date Completed	
The CITI Course in the Responsible Conduct of Research	09/26/11	no quiz
Introduction to the Responsible Conduct of Research	09/26/11	no quiz
Introduction to Research Misconduct	09/26/11	no quiz
Research Misconduct 2-1495	09/26/11	4/5 (80%)
Data Acquisition, Management, Sharing and Ownership 2-1523	09/26/11	4/5 (80%)
Publication Practices and Responsible Authorship 2-1518	09/26/11	4/5 (80%)
Peer Review 2-1521	09/26/11	4/5 (80%)
Responsible Mentoring 01-1625	09/26/11	5/6 (83%)
Conflicts of Interest and Commitment 2-1462	09/26/11	4/6 (67%)
Collaborative Research 2-1484	09/26/11	6/6 (100%)
The CITI RCR Course Completion Page.	09/26/11	no quiz

For this Completion Report to be valid, the learner listed above must be affiliated with a CITI participating institution. Falsified information and unauthorized use of the CITI course site is unethical, and may be considered scientific misconduct by your institution.

Paul Braunschweiger Ph.D.
Professor, University of Miami
Director Office of Research Education
CITI Course Coordinator

APPENDIX D

SUBJECT CONSENT FORM

SUBJECT CONSENT FORM FOR PARTICIPATION IN HUMAN RESEARCH AT MONTANA STATE UNIVERSITY

Project: Perceived Health Care Needs of the Homeless

- You are being asked to participate in a research study to help the nursing profession better understand the health care needs of the homeless. Information obtained may help the health care profession better provide needed health services to the homeless.
- Eligibility criteria include participants that are at least 18 years old and currently without a permanent residence.
- Participation is voluntary and you can choose to not answer any questions you do not want to answer or you can stop at any time without penalty.
- Participants will be interviewed for no longer than 30 minutes and will be asked questions pertaining to their perceived health care needs. Time will be allowed for asking questions of the researcher as well as offering suggestions on ways to improve health care for the homeless.
- Conversations may be audiotaped to ensure accurate transcription. Photos may also be taken with participant’s permission.
- There are no foreseen risks from participating in this study.
- There is no cost and no financial compensation for the participant.
- All personal disclosure will be kept confidential, with data stored in a locked box in the researcher’s home. At the conclusion of the research study, all audiotapes, written records, and photos will be shredded to protect the participant’s privacy.

- You may contact Heidi Efinger, MSU student researcher, at any time, with questions you may have. (Phone number: 406-396-1046)
- You may also contact the Chair of the Institutional Review Board, Mark Quinn, at 406-994-4707, or e-mail him at mquinn@montana.edu

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AUTHORIZATION: I have read the above and understand the discomforts, inconvenience, and risk of this study. I, ____, agree to participate in this research. I understand that I may later refuse to participate, and that I may withdraw from the study at any time. I have received a copy of this consent form for my own records.

Signed: ____

Investigator: ____

Date: ____

APPENDIX E

SURVEY QUESTIONS

SURVEY QUESTIONS

1. How do you perceive your current health?

2. What do you perceive to be your greatest health needs at the moment?

3. What care/services do you feel that you need the most?

4. What has prevented you from getting these services?

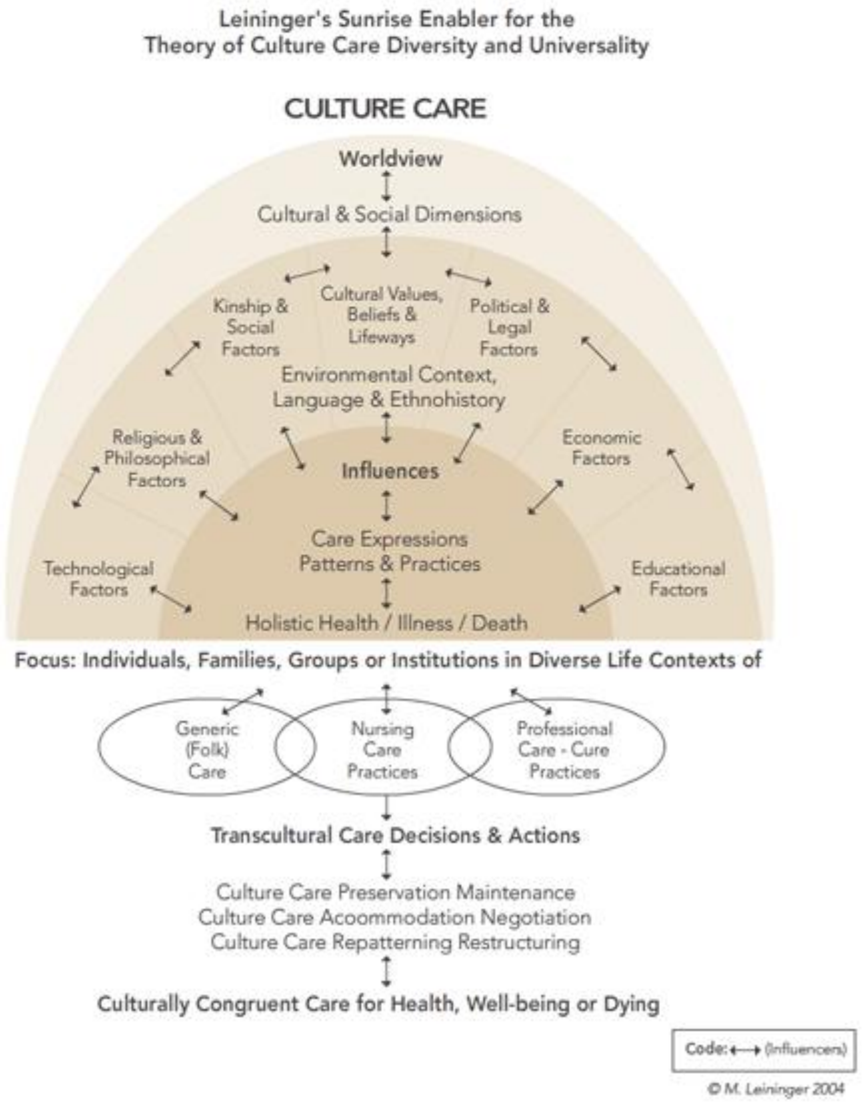
5. Who do you feel can help you obtain what you need?

6. What suggestions do you have for the nursing profession to help better meet your needs in terms of improving your health and well-being?

Thank you!

APPENDIX F

LEININGER’S SUNRISE ENABLER MODEL



Permission to be obtained via written request prior to use at:

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