

CREATING AND IMPLEMENTING AN EDUCATION MODULE FOR ENHANCING  
STAFF EFFECTIVENESS WHEN CARING FOR HOMELESS INDIVIDUALS  
UNIVERSITY OF HAWAI'I AT MĀNOA NANCY ATMOSPHERA-WALSH SCHOOL OF  
NURSING

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## Abstract

**Problem Statement:** Individuals who are experiencing homeless often simultaneously experience mental illness, chronic disease, and general poor health. Though suffering from illness and injury, these individuals neglect to seek healthcare until their condition deteriorates to the point of intolerance. This unwillingness to seek care can be attributed to deficits in basic needs. However, the most commonly reported reasons are the feelings of judgment, discrimination, and powerlessness experienced when the decision is made to seek care. In addition, providers may fail to account for the unique challenges faced by homeless patients. This oversight could be attributed to the minimal education focused on the care of the homeless patient available in traditional healthcare education.

**Purpose:** To address this knowledge gap, training centered on the care of homeless patients and adaptations to practice that can improve their care was implemented at the Institute for Human Services health center.

**Methods:** Pre- and post-test survey tools were developed to gauge the staff's confidence, competence, and knowledge of adaptations for homeless healthcare before and after the implementation of the training. Additionally, a post-implementation patient satisfaction survey was piloted to provide data on the patient's experience in the clinic.

**Results:** Following completion of the pre-and post-test survey, the means of the responses from the participants were analyzed using a t-Test, which revealed that participant's confidence and knowledge post-training completion was statistically significantly improved with controlled error (T-test,  $t= 3.01$ ,  $p=.006$ ).

**Discussion:** This pilot training can be evolved and continue to be administered to improve the staff's ability to provide culturally attuned care sufficient to account for the unique needs of the homeless patient.

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## Creating and Implementing an Education Module on Staff Practice Adaptations for Homeless Healthcare

There are approximately 15,000 individuals experiencing homelessness in Hawai‘i (State of Hawai‘i, 2021). *Homelessness* is defined as circumstances in which an individual lacks a nighttime residence that is fixed and adequate; this definition also pertains to individuals living in a temporary shelter or place that has not been designed for habitation by humans (UH Manoa Law Library, 2021). According to the National Healthcare for the Homeless Council (NHCHC) (2021), injury, illness, disability, or general poor health may be drivers of homelessness, especially when an individual does not possess the financial resources to afford housing. Additionally, being homeless or living in a shelter can exacerbate pre-existing health problems or create new ones (National Healthcare for the Homeless Council [NHCHC], 2021). Numerous studies document the prevalence of cognitive disability and mental illness amongst homeless individuals, and alarmingly these rates continue to rise (Nishio, Horita, Sado, et al., 2016). Among homeless individuals, the mortality rate is approximately eight times higher than the average for men and 12 times higher for women; the average life expectancy is about 52 years of age (Omerov, Craftman, Mattson, & Klarare, 2019).

Homelessness affects individuals of every age, gender, and race. However, nationally, there was found to be an overrepresentation of African American and indigenous people, including Native Americans and Pacific Islanders, among the homeless population (U.S. Department of Housing and Urban Development (HUD), 2021). The 2020 Homeless Assessment Report revealed that approximately 23% of individuals experiencing homelessness identified as Hispanic or Latino. However, though only representing 1% percent of the U.S. population, Pacific Islanders, Native Hawaiians, American Indians, and Alaska Natives accounted for 5% of the homeless population nationwide (HUD, 2021).

Compared to the general population, homeless individuals are at a greater risk of experiencing illness and have higher death rates (Cheung & Hwang, 2004). In addition, the average life span of a homeless person is roughly 17.5 years shorter than the general population (Romazsko, Cymes, & Draganska et al., 2017). According to the State of Hawai‘i Office of the Governor (2021), chronically homeless individuals are the highest Medicaid utilizers in Hawai‘i. The average cost to the health system is \$4,650 per day per person, with the highest utilizers costing approximately \$82,000 per year. This higher cost to the health system can be attributed to the higher use of the emergency department among homeless individuals compared to the rest of the population (McCallum, Distasio, & Chateau et al., 2021). Between 2015 and 2018, there were roughly 203 emergency department visits per every 100 homeless individuals, compared to 42 ED visits per 100 non-homeless persons (Centers for Disease Control and Prevention, 2020).

Homeless individuals have reported that they often neglect to seek health care until their condition can no longer be ignored because of a deficit in basic human needs such as food, water, security, and shelter that must be prioritized over health care (Omerov, Craftman, Mattson, & Klarare, 2019). In addition, homeless individuals often report that an additional barrier to receiving healthcare at local health clinics is the feeling of being judged, disrespected, and unsupported by providers (Nam, Palmer, & Patel, 2020). Discrimination and feelings of powerlessness over their healthcare are possible factors influencing the decision to seek care at the emergency department (McCallum, Distasio, & Chateau et al., 2021). Providers must be aware of the physical and mental strain of being homeless. Implementing a unique education module focusing on compassionate and informed healthcare for the providers of homeless patients could result in better health outcomes.

## **Background**

Founded in 1978, the brainchild of Father Claude Du Teil, the Institute for Human Services or IHS began as a peanut butter ministry offering peanut butter sandwiches and a cup of coffee to the homeless individuals who took up residence on the streets of Chinatown in Honolulu, HI, (IHS, 2021). From these humble beginnings, IHS grew into one of the largest and most comprehensive providers of support and services for people experiencing homelessness in the state of Hawai'i. The organization, which became incorporated as a 501c3 non-profit organization in 1982, now provides a myriad of services intending to end the cycle of homelessness (IHS, 2021). In addition to feeding those in need, IHS also provides emergency shelter to men, women, and children who are now experiencing homelessness. In addition to the shelters, they offer specialty houses for medical respite, substance abuse treatment, mental health stabilization, veterans, couples, and even homeless individuals who found love and support in the form of a pet (IHS, 2021). Under the direction of executive director Connie Mitchell, who stepped into her role in 2006, IHS has grown exponentially. Offering case management services, assistance with locating and sustaining housing, job training and employment, and health services available to all regardless of insurance or ability to pay (IHS,2021).

While all the services IHS provide are pivotal to ending the cycle of homelessness, the most principal may be the comprehensive healthcare services provided in the clinic, on the streets, and in the various shelter settings. For example, in Hawai'i, 3.61% of Medicaid members utilized 61% of the 2 billion dollars budgeted for use annually (State of Hawai'i, 2021). Therefore, IHS's health services team prides itself on offering comprehensive healthcare that simultaneously aids in decreasing the ever-increasing strain on the healthcare system.

Despite the availability of community health centers like that offered by IHS, there is still a disproportionate use of the emergency department. Stigma among healthcare professionals

continues to deter homeless individuals from seeking healthcare until their conditions can no longer be ignored (Nam, Palmer, & Patel, 2020). Common themes related to this stigma that emerged in the study of emergency room visits amongst homeless young adults conducted by Nam et al. (2020) were the experience of being criticized, judged, and dismissed by healthcare professionals. Experiences of disrespect and alienation continue to have a negative effect on the willingness to seek care (Omerov, Craftman, Mattson, & Klarare, 2019).

### **Problem Statement**

Standard 8 of the American Nurses Association's (ANA) Scope of Practice and Standards, Third edition (2015), states that registered nurses have a responsibility to practice in a culturally diverse manner congruent with principles of inclusion. However, there is minimal education provided in traditional healthcare education on the culture of homelessness and the adaptations to care that can be made when caring for people experiencing homelessness. The stigma surrounding homelessness is a known deterrent for homeless individuals seeking healthcare. This lack of education costs the healthcare system millions of dollars annually and contributes to the increased mortality of homeless individuals.

A needs assessment conducted amongst the registered nurses and medical assistants employed by IHS revealed that 50% of individuals received some non-specific training on caring for individuals experiencing homelessness, and 33.3% reported receiving no training at all. In addition, 66.7% of the individuals surveyed were unfamiliar with trauma-informed care. Although somewhat familiar with community resources for people experiencing homelessness, only 33.3% reported inquiring about basic needs during encounters with homeless patients. This gap in the knowledge of care providers serving homeless patients was determined to be significant. It should be addressed to ensure that homeless individuals receive the highest level of culturally attuned care.



### **PICOT**

In healthcare providers (P), how does the implementation of an education module tailored to address the unique healthcare needs of individuals experiencing homelessness (I) compared to the current standard of education (C) improve providers' self-reported level of competence, comfort, and confidence in providing healthcare to people experiencing homelessness (O) over a 4-month period (T)?

### **Purpose**

This DNP project aims to educate practicing providers, including registered nurses, nurse practitioners, and medical assistants, on the culture of homeless and the challenges associated with medication storage, compliance, and following healthcare recommendations. Ultimately this shift toward culturally competent and adapted healthcare could improve the quality of healthcare provided to homeless individuals, subsequently decreasing emergency room visits and hospital readmissions by providing clear guidance on facilitating culturally attuned healthcare.

### **Framework**

The ACE Star model (Appendix A) is a conceptual method designed to aid in the systemic integration of knowledge into practice (Stevens, 2004). The Star Model is comprised of five points, illustrated by the five points on a star. These points demonstrate the stages of transformation that research and knowledge go through to become practice (Stevens, 2013). Therefore, the Star Model can be used to implement EBP by following the five points of knowledge transformation (Stevens, 2013). Guided by the ACE Star Model, this DNP project systemically addressed each of the five points. First, point 1: Discovery Research – Research was conducted, and knowledge was generated about the cultural deficits and care gaps experienced by homeless patients and the possible ways to address the identified barriers. Point 2: Evidence Summary – A systemic review of the literature was conducted, and research was collected and

utilized to formulate a meaningful scientific statement and identify potential biases and limitations. Point 3: Translation into guidelines –An education module was created for practicing providers on the culture of homelessness, the unique challenges of managing care for homeless individuals, and how to provide competent care. Point 4: Practice Integration- Implementation of the practice outlined in the education module was encouraged, and Point 5: Process, Outcome Evaluation -Evaluation of the impact of the training on the providers' competence in culturally attuned care for homeless patients, and comfort with implementing the proposed practice adaptations (Stevens, 2013). In accordance with the first point of the ACE Star Model, this project began with an extensive review of the literature that currently exists.

### **Synthesis of the Evidence**

#### **Evidence Search**

The databases PubMed and Cumulative Index to Nursing and Allied Health Literature (CINAHL) were utilized to conduct the literature search for this DNP project. Search terms included but were not limited to *homelessness, stigma, Hawai'i, homeless persons, practice adaptations, emergency department utilization, chronic illness, mortality, homeless healthcare, and access to care*. These terms were combined using Boolean operators (AND/OR) to narrow the results to studies most relevant to this project. No filters on inclusion or exclusion criteria were applied to the searches. The initial literature search yielded a total of 35 articles published between 2004 and 2021. Abstracts from these articles were reviewed for relevance to this DNP project. After reviewing the articles for quality, strength of the research, and relevance, 15 articles were selected for inclusion in the literature synthesis. These articles were critiqued and organized using MeInkys Level and Quality of Evidence rating system (Appendix B). This rating system grades levels of evidence from I to VII, with the highest level of evidence being Level I and the lowest level of evidence being Level VII (MeInyk & Fineoiut-Overholt, 2015). The

studies reviewed were from multiple jurisdictions, including Canada, Japan, Australia, Sweden, and the United Kingdom. In addition, the selected articles included four systematic reviews, three case-controlled or longitudinal studies, six systematic reviews of descriptive studies, and clinical practice guidelines from the American Academy of Family Physicians (AAFP) and the Center for Health Care Strategies (CHCS) were also assessed. A graphic representation of the literature reviewed, and the pertinent information analyzed is provided (Appendix C).

## **Synthesis**

Common themes identified in the literature included discussions on the common cause of homelessness, the barriers to seeking care while experiencing homelessness, and the practice adaptations that can be implemented to ensure that homeless patients receive quality healthcare tailored to their unique challenges.

**Causes of Homelessness.** Among the research presented in the articles, there was a consensus that homelessness is a more complex problem than just the absence of shelter. It is not solely caused by a lack of financial means to afford housing (Mabhala et al., 2017; Nishio et al., 2017). Instead, it is often caused by a combination of factors such as mental illness and cognitive disability, poor physical health, drug or alcohol abuse, lack of employment, criminal history, low education levels, and living environment (Mabhala et al., 2017; Nishio et al., 2017). Adverse experiences of poverty and trauma in childhood are associated with a higher likelihood of adverse outcomes in adulthood. Research shows that individuals who have experienced social disadvantage and traumatic experiences during childhood, such as lack of social support, lack of psychological support, abuse – physical, emotional, or sexual, poverty, disruption in education, and unstructured or dysfunctional family environments are at an increased risk of experiencing homelessness (Mabhala et al., 2017).

**Barriers to seeking care and the social determinants of health.** Though homeless individuals are considered a vulnerable population, and there have been practice changes aimed toward increasing available community health care for the homeless, significant barriers still exist.

When we consider Maslow's hierarchy of needs, having unmet basic needs such as food, water, shelter, and security are often barriers to accessing health care (Davies & Wood, 2018; White & Newman, 2015; Campbell et al., 2015; Omerov et al., 2019; Watson & Kane, 2015). In addition, prioritizing basic human necessities often leaves little time and finances to seek healthcare.

Another well-researched barrier to accessing care is the stigma and discrimination that homeless individuals report experiencing in the healthcare setting (Campbell et al., 2015). Experiences of judgment, feeling powerless over their care, discrimination, and being stereotyped as dirty, substance-addicted, or lazy are commonly reported reasons to avoid healthcare professionals (Nam et al., 2020; Campbell et al., 2015; Davies & Wood, 2018; Purkey & MacKenzie, 2019; Omerov et al., 2019; Argintaru et al., 2013; Hwang & Burns, 2010; Watson & Kane, 2015).

Lastly, physical barriers such as lack of transportation, lack of insurance coverage, and long wait times in walk-in clinics contribute to the decision not to seek care (Omerov et al., 2019; Argintaru et al., 2013; Davies & Wood, 2018; Hwang & Burns, 2010; White & Newman, 2015).

**Practice Adaptations.** Having identified significant and pervasive barriers to accessing care, research has been done to identify adaptations that can be made to serve this vulnerable population best. As stigma and interpersonal concerns continue to discourage seeking care, providers must maintain awareness of the power differential and differences in their social status (Davies & Wood, 2018). It is recommended that providers endeavor to be caring and empathetic in their interactions with homeless patients and adopt a non-stigmatizing attitude (Hwang & Burns, 2010; Klein & Reddy, 2015; Omerov et al., 2019; Watson & Kane, 2015). By building mutual trust and upholding

the individual's dignity and autonomy, providers may avoid being perceived as judgmental or discriminatory, thus fostering positive interpersonal relationships (Hwang & Burns, 2010; Omerov et al., 2019; Montauk, 2006). In conjunction with empathetic and culturally attuned care, providers should adopt a person-centered and trauma-informed care delivery method (Menschner & Maul, 2016; Purkey & Mackenzie, 2019; Watson & Kane, 2015). In addition to adaptations to address interpersonal social barriers, the research also discusses adaptations in medication prescribing history taking, physical examination, patient teaching technique, and increased familiarity with available community resources (Davies & Wood, 2018; Hwang & Burns, 2010; Klein & Reddy, 2015; Maness & Khan, 2014; Montauk, 2006). Unfortunately, these practice adaptations are not frequently addressed in the standard education system, and providers are forced to learn them in the field. This DNP project will attempt to educate providers on adaptations that will improve the quality of care provided to homeless individuals.

## **Methods**

### **Project Design**

This evidence-based quality improvement project (QIP) sought to improve the healthcare afforded to homeless patients by increasing the knowledge base of providers serving homeless patients and providing education on the adaptations to practice that can be implemented to improve patient outcomes. Before beginning the project, the author completed the Collaborative Institutional Training Initiative (CITI) Training for research and ethics compliance and Health Insurance Portability and Accountability Act (HIPAA) Training on privacy practice protections. The overarching goal of this project is to evaluate the effectiveness and future implementation of a culturally attuned education module for providers caring for homeless patients at IHS for purposes of quality improvement. These findings will not produce generalizable knowledge, and therefore, this project will not require IRB application and review (Appendix D).

**Setting**

This project was conducted at the Institute for Humans Services medical clinic, located at the Sumner Men's Shelter. The facility has a nursing staff of 6 registered nurses, two medical assistants, five rotating medical providers, and four psychiatry providers. The IHS medical clinic offers comprehensive health services on a walk-in basis to anyone regardless of their insurance status or ability to pay. Individuals seeking care at the IHS medical clinic are often either unsheltered or sheltered homeless (i.e., living in an emergency shelter or transitional housing). They are regularly uninsured or underinsured and may not be eligible for Medicaid from the state. The IHS medical clinic provides services Monday – Saturday and is staffed by 1-2 registered nurses and at least one medical assistant for the entirety of the business day. The providers see patients in person from 8:00 am – 12:00 pm and via telehealth facilitated by the nurse from 1:00 pm- 4:00 pm.

**Participants**

The participants in this project were the core staff of the IHS medical clinic, which includes registered nurses and medical assistants. Full or part-time employment status was not considered an inclusion or exclusion criterion. All staff were encouraged to participate in the training as they interface with homeless patients throughout the day, and it is vital that everyone be culturally competent and abreast of the practice adaptations available to improve the quality of care delivered.

**Intervention**

In order to facilitate a greater understanding of the need for cultural awareness and trauma-informed care and to educate on the practice adaptations that can be made when serving homeless patients, the DNP student delivered a live presentation to the nursing staff at IHS. The PowerPoint used for the presentation consisted of statistics about the prevalence of homelessness, principles for adopting a trauma-informed approach, and specific considerations

for adapting provider practice to account for the challenges of homelessness. Additionally, narrated presentations of the PowerPoint were dispersed to the staff for independent review.

### **Data Collection**

The evaluation was conducted using anonymous pre-and post-test, as well as a follow-up post-test three months after implementation. In addition, patient satisfaction surveys were dispersed to patients in the clinic post-project implantation. This was done in alignment with the ACE Star model, which encourages process and outcome evaluation, and assesses provider competency on adaptations for improving the healthcare provided to homeless patients – before and after project implementation (Stevens, 2004). The author of this project developed nine-question surveys consisting of Likert scale ratings and a free response question and dispersed them to the nursing staff. This instrument has not been used before and is not validated. The surveys required the participants to rate their confidence and knowledge of practice adaptations, trauma-informed care delivery, and cultural considerations before and after partaking in training. The rating scale for the majority of the questions allowed selections from a seven-answer range: strongly agree to strongly disagree, and a five-answer range: always to never. This difference in range was made intentionally to allow for answers that corresponded with how the question was asked. Examples of questionnaire items include: "I am knowledgeable about the concept of trauma-informed care," "I can identify practice adaptations that may improve the care of the homeless patient," and "I am confident about my skills in caring for patients experiencing homelessness." Surveys were delivered electronically via email to identify staff that agreed to participate in the training. Responses were collected anonymously and then compiled into an Excel document. Subsequently, the data from the spreadsheet was organized into graphical examples. The free-response and individualized feedback from a participant was analyzed for common themes using a word cloud.

In order to assess patient satisfaction with care provided by IHS medical service team, an abbreviated survey instrument adapted from the Homeless Satisfaction with Care Scale was given to patients toward the conclusion of their visit to the clinic (Macnee & McCabe, 2004). For two weeks, the medical assistant staff offered each patient the opportunity to voluntarily complete an 8-question survey regarding their satisfaction with the care received at the IHS clinic. One to two questions from each of the themes of the five identified in the original survey conducted by Macnee & McCabe (2004) were included in the survey. In order to ensure readability, just as in the original implementation, a Likert-style survey was used, and participants were instructed to rate from 0 to 2, 0 being never true and two being always true (Macnee & McCabe, 2004). In addition, to assess the demographic data of the patients served in the IHS clinic, patients were given the option to report their age, identified sex, and identified race. Completed satisfaction surveys were organized in an Excel spreadsheet and subsequently converted into graphical representations of the data.

### **Data Analysis & Results**

#### **Demographics**

A total of seven IHS staff participated in the pre-test survey that was sent to them via email prior to participating in the training. Seventy-one percent of the participants identified as female (n=5), and 29% identified as male (n=2). Participants ranged in age from 23 to 65+. Regarding ethnicity, 57% of the participants (n=4) identified as Asian and 43% as Caucasian (n=3). Six of the seven participants who completed the pre-test survey participated in the live training session.

#### **Analysis**

Using Survey Monkey and Excel software, responses from the pre-test, post-test, and 3-month follow-up post-test were compiled and analyzed. These results were then reviewed to



identify whether there was an increase, decrease, or no change in the knowledge and self-reported confidence of the participants' post-project implementation.

**Pre-test.** A total of 7 responses were submitted responses to the pre-test. Using the concepts discussed in training, a 9-question survey was developed to assess the participant's confidence and knowledge base (Appendix E). Before project implantation, 14.29% of participants "strongly agreed" that they were confident in their skills and ability to care for patients experiencing homelessness. Additionally, 57.14% "agreed" and 28.57% "somewhat agreed that they were confident, with a mean response score of 2.14. In response to the question posed about having knowledge of trauma-informed care, the majority of participants, 42.86% "neither agreed nor disagreed," 14.29% "agreed," 28.57% "somewhat agreed," and 14.29% "disagreed. The average response was 3.71, with a median score of four. As the training module focused heavily on increasing awareness of practice adaptations and considerations for caring for homeless patients, the remaining six survey items questioned whether the participants considered things like tone of voice and posture during patient interaction, medication storage, and side effects, the ability for the patient understand and follow the treatment plan. Roughly 42.86% of participants "agreed" that they could identify beneficial ways to adapt their practice, and 42.86% of participants "somewhat agreed." While 57.14% "agreed" that they were attentive to tone and posturing when engaging with patients.

Similarly, 57.14% of participants reported that they "usually" take time to make sure that patients both understand and can follow the identified treatment plan. The final item of the pre-test survey asked patients to identify three words or phrases that they would use to describe trauma-informed care. The participants identified significant themes: empathetic care, consideration, and sensitivity. A word cloud was created to depict this data (Appendix F) visually.

**Post-test.** Following completion of the live training, participants were sent a link to a post-test survey. Similarly to the pre-test, the post-test survey consisted of 8-Likert style items and one free response (Appendix H). In addition, email reminders were sent to all participants who completed the pre-test survey. However, only 71% of the participants (n=5) completed the post-test. Analysis of the post-test data revealed that there was a clinically significant trend in which there was an increase in reported “strong agreement” in four of the training target areas; participant's self-rated confidence, the ability to identify practice adaptations, consideration of tone and posture, and knowledge of community resources (Appendix I). There was a 26% increase in the number of participants who "strongly agreed" that they were confident in their skill in abilities in providing care for the homeless patient, and there was a 3% increase in the number of participants who “agreed” to this statement.

Similarly, there was a 26% increase in the number of participants who “strongly agreed” that they would consider non-verbal cues such as tone and posture when engaging with patients. In addition, there was a 3% increase in the number of participants who "agreed." Regarding the ability to identify practice adaptations that may improve the care of homeless patients, there was a 6% increase in participants who “strongly agreed” and a 37% increase in those who “agreed.” Finally, 51% of those "agreed" that they knew of community resources, and a 6% increase in participants who “somewhat agreed.” In consensus with this noticeable trend of increased knowledge and confidence, analysis of the mean response of 6 survey questions that reviewed the same themes and were worded similarly revealed that the increase in participants' confidence and knowledge post-training completion was statistically significant with controlled error (T-test,  $t= 3.01, p=.006$ ). T-test determined the mean response to these six pre-test questions to be 2.71 (n=7), and the corresponding six post-test response mean was 1.87 (n=5).

	Pre-test	Post-test
Mean	2.71333333	1.86666667
Variance	0.39886667	0.07466667
Observations	6	6
Pooled Variance	0.23676667	
Hypothesized Mean Difference	0	
df	10	
t Stat	3.01378876	
P(T<=t) one-tail	0.0065165	
t Critical one-tail	1.81246112	
P(T<=t) two-tail	0.01303299	
t Critical two-tail	2.22813885	

**Table 1: t-Test: Two-Sample Assuming Equal Variances**

Post-test analysis of the survey item that asked participants to identify if they know trauma-informed care concepts identified a 14% decrease in participants who "strongly agreed." Following the training, 80% of participants "agreed," and 20% of participants "somewhat agreed" that they knew trauma-informed concepts. No longer did participants select that they "neither agreed nor disagreed" or "disagreed" with this statement. At the end of the survey, participants were given a free response option. The prompt asked participants to share their key takeaways from the presented training.

Examples of the written response included:

*“ It is important to consider various factors in regards to trauma-informed care.”*

*“Trauma-informed care is a shift from wondering what is wrong with a patient that would have made them act the way they do VS. what happened to a patient that would have them react the way that they do.”*

*“Access to care is so important for this at-risk population. They are at increased risk for so many health issues that they really need understanding individuals to work with them. They need to feel safe, not judged for who they are, and treated with respect just like any other person.”*

**Three-month follow-up post-test.** The follow-up post-test was administered three months after the training to the same participants who completed the initial post-test. This survey was sent to the participants with instructions to refrain from using notes or other resources in completing the survey. This assessment aimed to determine if the participants still felt confident in implementing the principles addressed in the training, and to assess what they retained. The mean of the responses to each survey item was analyzed using a T-test. Despite the observed trend of a more significant percentage of participants selecting that they "strongly agreed," that they were more conscious of tone and posture, and free response feedback that proved retention of the information presented, the T-test analysis found that difference in self-reported confidence and knowledge at the initial post and the 3-month follow-up post was not significantly different (T-test,  $t=7.34$ ,  $p= 0.50$ ).

	Post-test	3-month post-test
Mean	1.875	1.875
Variance	0.07928571	0.170714286
Observations	8	8
Pearson Correlation	0.63237805	
Hypothesized Mean Difference	0	
df	7	
t Stat	7.3434E-16	
P(T<=t) one-tail	0.5	
t Critical one-tail	1.89457861	
P(T<=t) two-tail	1	
t Critical two-tail	2.36462425	

*Table 2: t-Test: Paired Two Sample for Means*

**Patient Satisfaction.** To assess the patient's

satisfaction with the care received from the IHS clinic staff, all of whom had received the training, patients were provided the opportunity to complete a short survey rating their experience (Appendix J). Over a two-week period, patients were asked to complete a brief survey which was then collected by the medical assistant at the end of the patient's visit. There were 22 surveys completed. However, three surveys were not included due to being incomplete. These completed surveys were analyzed in Excel and are represented graphically in Appendix K.

Regarding patient demographics, 37% of patients (n=7) did not disclose their age, 26% did not disclose their sex (n=5), and 26% did not disclose their race (n=5). Approximately 42% of the patients (n=8) were 55 or over, 58% identified as male (n=11), and 16% identified as female (n=3). The majority of the patients who disclosed their race identified as Caucasian 32% (n=6), 16% as Native Hawaiian/Pacific Islander (n=3), 16% as Asian (n=3), and 11% as African American (n=2).

The participant's responses generally indicated overall satisfaction with the care received at the IHS clinic. With regards to whether they were treated with respect, 89% of patients (n=17) identified that this was "always true," and 10.5% of patients (n=2) selected that it was "sometimes true." Additionally, in response to if they felt they were treated like a real person, 95% of patients (n=18) reported that this was "always true," and 5% reported this as "never true." In the statement regarding whether the clinic failed to include the patient in the treatment process, 74% of patients reported that this was "never true," 16% said it was "sometimes true," and 10% said it was always true." Ninety-five percent selected "always true" and 5% reported "sometimes true" to the statement that IHS clinic leaves them sure that they got correct diagnosis. To the statement that the IHS clinic helps them to understand what is wrong 89% responded "always true" and 11% responded "sometimes true." The survey item from the commitment subscale saw that 90% of patient reported it "always true" that the IHS clinic was there for them even if they could not follow all the directions for their health, 5% reported this as "sometimes true," and 5% as "never true". The final two items sought to examine the judgment subscale. Eighty-four percent of patients reports that it was "never true" that IHS clinic judges homeless person. However, 11% of patient agreed with the statement, reporting that it was "always true" and 5% reported it was "sometimes true." Last the statement that asserted the IHS

clinic may assume things about the patient due to them being homeless received 79% of patients (n=15) who reported it was “never true,” 5% reported “sometimes true,” and 16% reported it “always true.” (Appendix ).

### **Discussion**

The general education system provides healthcare providers with an expansive knowledge of many subject areas. However, there is an identifiable gap in the literature and training available on healthcare for people without housing and adaptations to practice that can afford an improved healthcare experience for those experiencing homelessness. This quality improvement project sought to begin bridging this gap and improving the care provided to homeless patients by training medical professionals on the culture of homelessness, trauma-informed care, and practice adaptations they can implement. This was achieved through the development of a presentation that discussed challenges faced by those experiencing homelessness and tools that practicing providers to implement to account for these challenges. Additionally, pre-and post-tests were administered to the participants to gauge their confidence on these topics before and after the training and assess retention of the information presented.

### **Implications**

Before the implementation of this project, IHS did not provide its medical staff with any separate orientation to the unique medical needs of homeless patients. Like many institutions, IHS relied upon the general education system to provide the foundational and population-specific knowledge that the medical staff would need to achieve success. This project demonstrated the need for further attention and increased education on the nuances of caring for homeless patients. The result of the pre-and post-test signified that additional training on this subject matter improves provider confidence and encourages the consideration of adaptations that improve the

quality of care they provide to homeless patients. Additionally, routine use of a patient satisfaction survey in the IHS clinic has yet to occur. The patient responses collected during this project will allow the IHS clinic to analyze its current service delivery and identify areas for growth.

### **Strengths and Limitations**

**Limitations.** This project had many limitations, including the small sample size of participants. Of the seven participants who completed the initial pre-test, six participated in the training, and of those six, only five completed the post-test. This small sample makes this data less likely to be generalizable to larger samples. Additional limitations include the developer's inability to address the numerous factors that impact the quality of healthcare received by homeless patients and the lack of pre-implementation patient satisfaction surveys as qualitative means of assessing patient self-reported satisfaction before staff received additional training.

**Strengths.** A strength of this quality improvement project was that it provided the IHS clinic staff with a new training module that can be further developed and improved to meet the organization's mission of "nurturing homeless people toward greater self-direction and responsibility" (IHS, 2021). This pilot project also provided IHS with a patient satisfaction survey tool that can be used for ongoing assessment. This tool was adapted from the authors Macnee and McCabe (2004), who, in their research, found the tool to be both valid and reliable in measuring homeless patients' satisfaction with the care received. Additionally, this project was done in collaboration with a medical team from the IHS clinic and provided an opportunity to address gaps that the staff identified in their personal knowledge. This collaboration resulted in a strong commitment from the staff to participate in the various aspects of this project implementation resulting in the ultimate success of this pilot project.

### **Sustainability**

The IHS staff will likely continue to utilize this DNP project with revisions in the material presented, such as breaking the topics down into smaller individual training modules. The IHS executive director expressed interest in providing the training to future RN students who seek clinical experiences at the IHS clinic and new RNs onboarding with the organization but may lack awareness or experience implementing practice adaptations for homeless patients and trauma-informed care. Additionally, this project created a discussion-surrounding implementation of the patient satisfaction survey annually to assess strengths and areas for growth and gauge patient experience in the clinic.

### **DNP Essentials**

Through this quality improvement project implementation, the DNP student achieved the DNP essentials stated by the American Association of Colleges of Nursing (AACN, 2006). The activities executed by the DNP student to meet the DNP essentials are as follows:

Essential I: Scientific Underpinnings for Practice – The DNP student demonstrated this essential through the completion of a needs assessment which identified current practice gaps. Additionally, this evidence-based practice project was supported by a literature review and synthesis performed by the DNP student.

Essential II: Organizational and Systems Leadership for Quality Improvement – In collaboration with the executive director and medical director of IHS, the DNP student facilitated the implementation of an evidence-based intervention that met the organization's needs and can be used to support ongoing quality improvement measures.

Essential III: Clinical Scholarship and Analytical Methods for Evidenced-Based Practice – The literature review that was conducted provided the foundational literature necessary for the DNP student to design this quality improvement project. This information informed the creation



of the training module and survey tools. The DNP student then collected and analyzed the qualitative data that resulted.

Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care – Databases such as PubMed MEDLINE and CINAHL were utilized during the literature review and the process of creating the training module. In addition, the DNP student used Survey Monkey Software and Excel to collect and analyze the survey results.

Essential V: Health Care Policy for Advocacy in Health Care – The DNP student advocated for a change in practice and further attention to the healthcare disparities experienced by individuals experiencing homelessness.

Essential VI: Inter-Professional Collaboration for Improving Patient and Population Health Outcomes – Collaboration facilitated by the DNP student occurred between the IHS executive director, IHS medical staff, and NAWSON faculty and was vital to the success of this project implementation.

Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health – The DNP student implemented this project to address the paucity of information provided in the general education system on the practice adaptations that can be made to improve care for homeless patients.

Essential VIII: Advance Nursing Practice – The DNP student successfully developed, implemented and evaluated a sustainable quality improvement intervention.

Interpret the meaning and implications of the results.

### **Conclusion**

According to Maness and Khan (2014), the average life span for an individual who is homeless is between 42 and 52 years old. Homeless people suffer numerous serious health threats and have

unmet health needs due to a variety of factors, including unmet basic needs and the experience of stigmatization and judgment from healthcare professionals. This project highlights the complex care needs of homeless patients and illuminates the need for additional education and training on ways to adapt care to address these needs. Improved cultural competence, education, practice adaptations, and implementation of trauma-informed interventions are just a few of the actions that can be taken to improve the care of homeless patients. Continued implementation of training specific to the care needs of homeless patients and the use of brief patient satisfaction surveys are just a few sustainable ways in which the project can continue to be utilized by the organization to aid in its mission.

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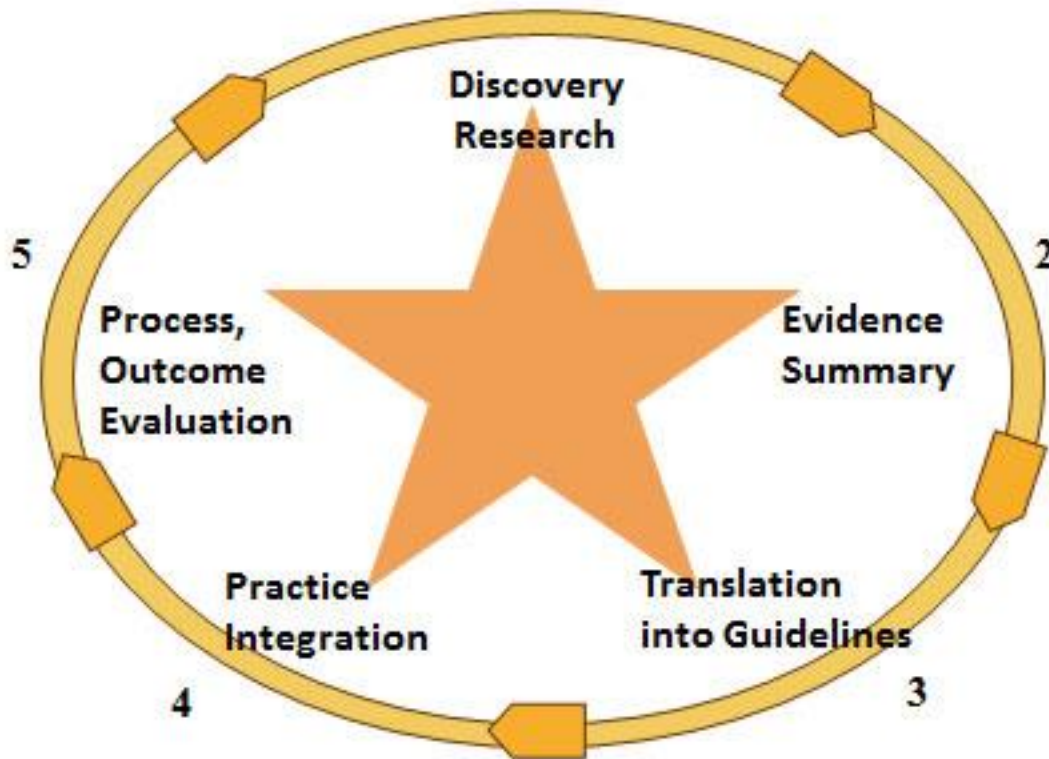
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## Appendix A

### The ACE Star Model of Knowledge Transformation



**Appendix A.** *The ACE Star Model of Knowledge Transformation. Retrieved from the Academic Center for Evidence-Based Practice, University of Texas Health Science Center at San Antonio.*



## Appendix B

### MeInky's Level and Quality of Evidence and Number of Relevant Articles

<b>MeInky's Level of Evidence</b>	<b>Number of Articles (Total of 15)</b>
<b>Level I:</b> Systematic review or Meta-analysis of RCT	4
<b>Level II:</b> Experimental research design (randomized controlled trials) RCT	0
<b>Level III:</b> Quasi-experimental design	0
<b>Level IV:</b> Case-controlled, cohort, longitudinal studies	3
<b>Level V:</b> Systematic reviews of descriptive and qualitative studies	6
<b>Level VI:</b> Descriptive (qualitative) studies	2
<b>Level VII:</b> Authority opinion or expert committee reports	0
<b>Other:</b> Performance improvement, case reports, literature reviews, etc.	0

**Appendix B.** Adapted from MeInky, B.M. & Fienout-Overholt, E. (2015). "Box 1.3: Rating system for the hierarchy of evidence for intervention/treatment questions" in *Evidence-based practice in nursing & healthcare: A guide to best practice (3<sup>rd</sup> ed)*. (p.11) Philadelphia, PA: Wolters Kluwer Health.

## Appendix C

### Literature Review Summary Table 1.1

Literature Matrix Author(s), Title	Year Published	Purpose	Level of Evidence #	Study Design	Conclusion	Theme
White et al., Access to primary care services among the homeless: A synthesis of the literature using the equity of access to care framework	2015	To identify barriers and facilitators to accessing primary care among the homeless and provide recommendations for improvement of health services for the population.	5	Quasi-systematic review of the literature	Barriers to primary care access: lack of insurance, competing priorities, perceived judgement or discrimination by providers, chronic homelessness, 1+ comorbid conditions. Facilitators to primary care access: Tailored primary care, fewer years being homeless, health insurance coverage, access to transportation, engaging and empathetic providers	Barriers to receiving primary
Wen et al., Homeless People's Perceptions of Welcomeness and Unwelcomeness in Healthcare Encounters	2007	To examine homeless people's experience of welcomeness vs unwelcomeness in past encounters with healthcare providers	6	Qualitative content analysis of 17 interviews	Conveying welcomeness is an important aspect for providing health care to the homeless. Providers should guard against stereotyping and approach each patient interaction with openness, humility, and receptivity.	Stigma and judgements as a barrier to receiving primary care
Montauk, The homeless in America: Adapting your practice	2006	To provide clinical recommendations and guidelines for adapting primary care practice for homeless patients.	1	Clinical guideline	Providers should practice trust building, emphasize the patient's strength, consider access to food, water, and proper storage when prescribing medications. Ensure to consider side effect profiles (GI distress, diuresis) when prescribing meds, and provide patient education that is appropriate for the patient's level of health literacy.	Practice adaptations. Patient trust and engagement must be achieved first. Medication prescribing adaptations, ensure patient understanding before ending visit.
Menschner & Maul, Key ingredients for successful trauma informed care implementation	2016	To provide clinical recommendations on facilitating trauma informed care that may improve patient engagement, health outcomes and decrease unnecessary utilization.	1	Clinical guideline	Clinical practices critical to advancing the trauma informed approach: Involving patients in the treatment process, screening for trauma, training staff on trauma specific treatment approaches, engage referral sources and partner organizations	Practice adaptation: Implementing trauma informed care to address trauma benefits patients
Maness et al., Care of the homeless: An overview	2014	To provide clinical recommendations and guidelines for primary care of homeless patients.	1	Clinical guideline	Providers should practice empathetic communication and focus initially on building rapport. Therapy for treatment of clinical and medical conditions should be tailored to the patient's needs, consider using a trauma informed approach due to the high likelihood that some form of violence has been experienced. The best model for care is that which involves an integrated multidisciplinary team approach.	Mortality rates of homeless, trust building should be a focus in initial encounters, and using trauma informed approach promotes healing.

**Literature Review Table 1.2**

Watson et al., Social exclusion, health, and hidden homelessness	2015	To explore and expand the concept of social exclusion, to understand how health behaviors and health statuses are associated with material and social deprivation.	6	Fundamental qualitative study	Lack of social support and quality social interactions exacerbate material, social, and psychological deprivation. Shelter is a prerequisite of health and a human rights. Practice should be holistic in manner and interventions should "user-led" or patient centered.	Health behaviors are influenced by lack of social support. Holistic assessments and interventions, person centered care is more effective.
Nishio et al., Causes of homeless prevalence: Relationship between homelessnes and disability	2017	To compare causes of homelessness, barriers to escaping homelessness for those w/without mental illness, evaluate Japans policy towards homeless, and propose an effective support system.	4	Cohort Study	Most homeless perosn consider economic problems to be the cause for their homelessness, when in fact, difficulties with human relationship was just as prevalent a cause, especially for those with mental illness.	relationship between homelessness and disability (mental illness and cognitive diability)
Hwang et al., Universal health insurace and health care access for homeless persons	2010	To examine the extenet of unmet needs and barriers to accessing care among homeless people with access to a unviersal health insurance system.	4	Cohort Study	Even in place where universal healthcare exists, accessing healthcare can still be a challenge. Likely due to general mistrust of providers and fears, this makes it important that providers take on nonstigmatizing attitudes and supports the creation of special programs to primary care to homeless patients	Stigma and mistrust as barrier to accessing care
Argintaru et al., A cross sectional observational study of unmet health needs among homeless and vulnerably housed adults in three Canadian cities	2013	To examine the prevalence and factors associated with unmet healthcare needs un homeless and vulnerably housed adults in 3 major cities where universal healthcare exists.	4	Cross-sectional observational Study	Even in place where universal healthcare exists, barriers to accessing healthcare still exist. Barriers may be related to lack of knowledge about where to ger care, where to get transportation, lack of childcare, long waits, perceived discrimination, and competing priorities	Barriers to accessing care
Purkey & MacKenzie, Experience of healthcare among the homelss and vulnerably housed a qualititative study: opportunities for equity oreinted healthcare	2019	To examine the experience homeless and vulnerably housed individuals in SE Ontarios attempting to access hospital based services, and consider equity oriented healthcare as an an approach to improve care	5	Qualitative study	The current standard of healthcare received by homeless and vulnerably housed individuals is insufficient and does not meet the standard of what is accepted universally. EOHC could provide a framework by which to change the system	Barriers to accessing care- stigma / Practice adptation - TVIC (traum informed)

**Literature Review Table 1.3**

Klein & Reddy, Care of the homeless patient	2015	To provide clinical recommendations and guidelines for primary care of homeless patients.	1	Clinical guideline	Many practice adaptations can be made to be care for homeless patients; Interpersonal relationship, medication management, condition specific treatment, harm reduction	Practice adaptations
Campbell et al., Primary healthcare needs and barriers to care among Calgary's homeless population	2015	To explore the perceived healthcare needs and barriers among homeless individuals in Calgary, Alberta.	5	qualitative descriptive study	Despite the presence of universal healthcare, homeless persons in Calgary still experience barriers to accessing care i.e fear of the provider, feelings of shame or judgement, lack of health literacy, lack of transportation	Barriers to accessing care
Mabhala et al., Social conditions of becoming homelessness: qualitative analysis of life stories of homeless people	2017	To examine the stories of homeless people to obtain a better understanding of the social conditions under which homelessness occurs.	5	Qualitative analysis	Homelessness is caused by a combination of behavioral causes and social and economic conditions. Amongst those interviewed the social conditions in which they grew up i.e. poverty, abuse, lack of education and lived reduced available life opportunities	Exploring causes of homelessness
Omerov et al., Homeless persons' experience of health and social care: A systematic integrative review	2019	To explore the experiences and needs of health and social care for individuals experiencing homelessness	5	Systematic review	Unmet basic needs (food, water, shelter), interpersonal dimensions (stigma and discrimination), and structural and organizational aspects (rigid hours/ bureaucracy) hinder access to healthcare	Barriers to accessing care
Davies & Wood, Homeless health care: meeting the challenges of providing primary care	2019	To propose a best practice model for improving the health outcomes for those experiencing homelessness in Australia.	5	Systematic review	Barriers to primary care access: competing needs and priorities, illness and poor health, medication security, perception of being judged, physical access to services	Barriers to accessing care

## Appendix D

### Memorandum related IRB and Human Studies



UNIVERSITY  
of HAWAII  
SYSTEM

Office of Research Compliance  
Human Studies Program

August 6, 2021

#### MEMORANDUM

TO: Rick Ramirez, DNP, APRN-Rx, AG-ACNP-BC, FNP-BC, ENP-C, CEN, CPEN  
Doctor of Nursing Practice Program Director and Assistant Professor  
AG-PCNP Specialty Coordinator  
APRN Clinical Course Series Faculty Coordinator  
University of Hawai'i at Mānoa  
School of Nursing and Dental Hygiene

FROM: Victoria Rivera   
Director, Office of Research Compliance, Human Studies Program  
University of Hawaii

SUBJECT: Doctor of Nursing Practice Program

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This memorandum intends to clarify the University of Hawaii (UH), Human Studies Program (HSP) position regarding the quality improvement (QI) project required by the UH School of Nursing and Dental Hygiene's Doctor of Nursing (DNP) Program.

Based on our discussions, students enrolled in the DNP Program are required to complete a QI project in order to meet the *AACN Essentials of Doctoral Education for Advanced Nursing Practice* for this professional degree. According to the AACN guidelines, since this is a practice doctorate, "requiring a dissertation or other original research is contrary to the intent of the DNP. The DNP primarily involves mastery of an advanced speciality within nursing practice."

Therefore, by definition, the DNP quality improvement project required by the UH School of Nursing is not considered human subjects research as defined under federal regulations at 45 CFR 46. To very briefly summarize, *research* is a systematic investigation designed to contribute to generalizable knowledge, and *human subject* means a living individual about whom an investigator conducting research obtains 1) data through intervention or interaction with the individual or 2) identifiable private information. Quality improvement/program evaluation focuses on making judgements about the program, to improve or further develop program effectiveness, and inform decisions about future programming. As part of the DNP program, students are familiarized with the difference between conducting a QI project and a research project.

Given the purpose of the DNP quality improvement project, it is the position of the UH Human Studies Program that these projects are considered "NOT human subjects research" (NHSR) and as such, does not require IRB review. To be clear, this is not a determination of "Exempt" status under 46.101, as these are categories of *research* considered to be exempt from IRB review. Please ensure that DNP students understand that the results of these types of QI projects may be presented or published, but must not be labeled as human subjects research.

Please feel free to contact our office for any questions.

cc: Alice Tse, SODNH Department Chair and Graduate Chair

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## Appendix E

### Pre-test Survey

<b>Instructions: Read the statement and select the answer that is most true to you.</b>	
<b>Statement</b>	<b>Response</b>
I am confident in my skills to care for patients experiencing homelessness.	1 (strongly agree) to 7 (strongly disagree)
I am knowledgeable about the concept of trauma informed care.	
I can identify practice adaptations that may improve care of the homeless patient.	
I am conscious of my tone and posture when engaging with patients.	
I am knowledgeable of community resources and can provide relevant information to my patient.	
When ordering or prescribing medications I always consider storage needs, side effect profiles, and abuse potential.	
I ensure that my patient understands and is able to follow the treatment plan.	1 (always) to 5 (never)
I consider education level when interviewing and educating my patient.	
Please provide 3 words or phrases that you would use to describe trauma informed care.	

## Appendix F

Word Cloud formed from common themes identified in pre-test survey free response item.



**Appendix F.** *Word cloud generated using WordItOut! Software developed by Enideo, 2023. Prompt: Please provide 3 words or phrases that you would use to describe trauma informed care.*

## Appendix G

### Pre-test Survey Results

Item#	Statement	Response# (Mean)
1	I am confident in my skills to care for patients experiencing homelessness.	2.14
2	I am knowledgeable about the concept of trauma informed care.	3.71
3	I can identify practice adaptations that may improve care of the homeless patient.	2.29
4	I am conscious of my tone and posture when engaging with patients.	2.14
5	I am knowledgeable of community resources and can provide relevant information to my patient.	3
6	When ordering or prescribing medications I always consider storage needs, side effect profiles, and abuse.	3

\*Response Scale: Strongly Agree=1; Agree=2; Somewhat Agree=3; Neither Agree nor Disagree=4; Somewhat Disagree=5; Disagree=6; Strongly Disagree=7

7	I ensure that my patient understands and is able to follow the treatment plan.	1.57
8	I consider education level when interviewing and educating my patient.	2.29

\*Response Scale: Always=1; Usually=2; Sometimes=3; Rarely=4; Never=5



## Appendix H

### Post-test Survey

<b>Instructions: Read the statement and select the answer that is most true to you.</b>	
<b>Statement</b>	<b>Response</b>
I am confident in my skills to care for patients experiencing homelessness.	1 (strongly agree) to 7 (strongly disagree)
I am knowledgeable about the concept of trauma informed care.	
I would feel comfortable utilizing a trauma informed approach when interacting with patients.	
I can identify and implement the 6 guiding principles of trauma informed care.	
I am more likely to consider storage needs, side effect profiles, and abuse potential when ordering or prescribing medications.	
I am knowledgeable of community resources and can provide relevant information to my patient.	
I can identify practice adaptations that may improve care of the homeless patient.	
I am more likely to consider tone of voice, posture, and health literacy status when engaging with patients.	
What is something you recall learning from the education module?	

## Appendix I

### Post-test Survey Results

Statement	Response* (Mean)
I am confident in my skills to care for patients experiencing homelessness.	2.2
I am knowledgeable about the concept of trauma informed care.	1.8
I would feel comfortable utilizing a trauma informed approach when interacting with patients.	1.6
I can identify and implement the guiding principles of trauma informed care.	2.2
I am more likely to consider storage needs, side effect profiles, and abuse potential when ordering Dr.	1.8
I am knowledgeable of community resources and can provide relevant information to my patient.	2.2
I can identify practice adaptations that may improve care of the homeless patient.	1.6
I am more likely to consider tone of voice, posturing, and health literacy status when engaging with	1.6

\*Response Scale: Strongly Agree=1; Agree=2; Somewhat Agree=3; Neither Agree nor Disagree=4; Somewhat Disagree=5; Disagree=6; Strongly Disagree=7

## Appendix J

### Patient Satisfaction Survey

General Information (optional) [L] [SEP]

**Age:**

**Gender:**

**Race:**

Read the statement and check one box that is most true to you.

Item #	Subscale	Statement	Response
1	<b>Respect</b>	This clinic treats me with respect.	0 (Never True), 1(Sometimes True), 2 (Always True)
2		This clinic treats me like a real person.	
3	<b>Inclusionary</b>	This clinic does not give me much choice about what I am going to do about my health.	
4	<b>Trust</b>	This clinic leaves me feeling sure that I have gotten the right diagnosis and treatment.	
5		This clinic helps me understand what is wrong with me.	
6	<b>Committed</b>	This clinic is there for me even if I cannot follow all the directions for my health.	
7	<b>Assumption Free</b>	This clinic assumes things about me just because I am homeless.	
8		This clinic judges people who are homeless.	

**Appendix F.** *Adapted survey instrument using questions from the Homeless Satisfaction with Care Scale (Macnee & McCabe, 2004).*

## Appendix K

### Patient Satisfaction Survey Results

Statement	Never True	Sometimes True	Always True
This clinic treats me with respect.	0	2	17
This clinic treats me like a real person	1	0	18
This clinic does not give me much choice about what I am going to do about my health.	14	3	2
This clinic leaves me feeling sure I've got the right diagnosis and treatment.	0	1	18
This clinic helps me understand what is wrong with me.	0	2	17
This clinic assumes things about me just because I am homeless.	15	1	3
This clinic is there for me even if I cannot follow all the directions for my health.	1	1	17
This clinic judges people who are homeless.	16	1	2

