ABSTRACT

HOMELESS HEALTHCARE NEEDS: PRE AND POST WPC PILOT STUDY COMPARISON

Evidence of the rapidly increasing prevalence of homelessness in America can be observed by the large numbers of people living on our Nation's streets. The State of California in 2015 approved the Whole Person Care (WPC) Pilot Program. This 5-year program aimed to coordinate health services for California Medicaid recipients. This Qualitative Phenomenological study was based on Attachment Theory as a framework. Data collection through semi-structured interviews addressed the effect of WPC on the people experiencing homelessness (PEH) population. This study consisted of three stages: first, conducting a close examination of the problem of homelessness within the San Francisco Bay Area through policy and literature review. The second phase was to collect information in 2016 and 2020 from homeless care providers within the representative county setting regarding providers' perceptions of the social, economic, physical, behavioral, and psychological problems associated with their role as members in the WPC Pilot Program in addressing the problem. The third, comparing 2020 interview finding to the same participant group from the 2016 findings.

Key Terms: Attachment Theory, Homeless provider perceptions, People Experiencing Homelessness (PEH), Phenomenology, Whole Person Care (WPC) Pilot Program.

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HOMELESS HEALTHCARE NEEDS: PRE AND POST WPC PILOT STUDY COMPARISON

by

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CHAPTER 1: INTRODUCTION

This chapter identifies the health care needs of People Experiencing Homelessness (PEH). Currently, the PEH community has numerous health care issues that need to be addressed. The National Healthcare for the Homeless Council conducted research to identify systemic problems leading to chronic homelessness (NHCHC, 2021). California also identified several congruent health issues creating a bidirectional challenge (Baggett et al 2018). In 2015, the California state Department of Healthcare Service (DHCS) (2020) initiated the Whole Person Care (WPC) pilot program due to the new evidence of holistic healthcare approach success. From 2016 to 2020, many events have influenced the PEH community health experts' mindset and perspective. A pandemic, COVID-19, has changed the world in a socioeconomic, spiritual, medical, behavioral, and psychological way. These have had the most influence on a holistic perspective in general and, more specifically to the PEH community. These have had the most impact on a holistic perspective in general and, more specifically to the PEH community. Other events such as the Affordable Care Act (ACA) changes, the death of African Americans in direct relation to law enforcement, and in general, an additional five years of experience. This project focused on the homelessness issues and the rationale for healthcare practice standards from the providers' perception of the PEH health care needs. Therefore, the goal was to determine if WPC providers' perceptions of homeless healthcare needs have changed from the 2016 study compared to this 2020 study.

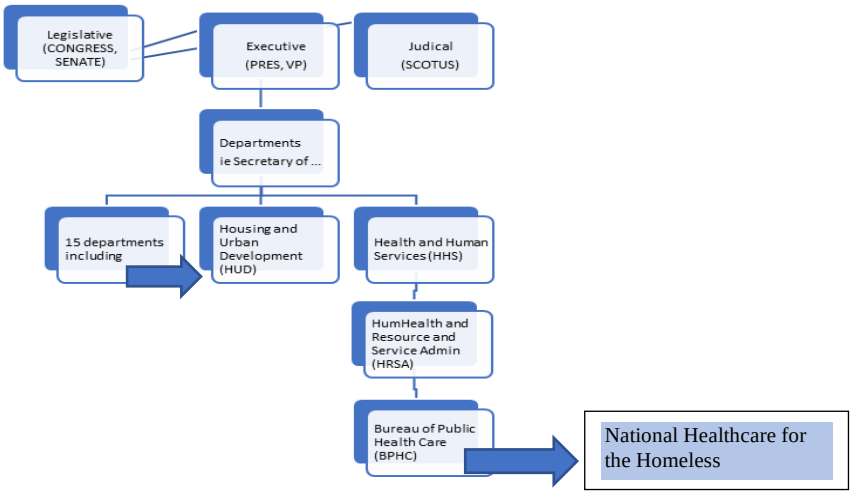
The PEH community has become a visible concern in the United States. There are two federal definitions of homelessness. Housing and Urban Development (HUD) define homeless as one of the four categories; "(a) literally

homeless; (b) imminent risk of homelessness; (c) homeless under other Federal statutes; or (d) fleeing or attempting to flee domestic violence" (HUD, 2020). Health and Human Services (HHS) definition was "A homeless individual was defined in section 330(h)(5)(A) as "an individual who lacks housing (without regard to whether the individual was a member of a family), including an individual whose primary residence during the night was a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who was a resident in transitional housing" (HRSA, unknown).

Homeless health care, funded by governmental agencies, provide services PEH community. Health Resources and Service Administration's (HRSA) Bureaus Department, Bureau of Public Health Care (BPHC) monitors and provides discretionary funding to the National Health Care for the Homeless (NHCHC), as noted in Figure 1. The NHCHC helps support regional and county medical and housing care for the homeless (NHCHC, 2021).

Figure 1

Federal Organizational Chart



The National Healthcare for the Homeless (2017) has the mantra that ‘housing is healthcare’. Evidence demonstrates the devastating effects of homelessness on physical health (Baggett et al., 2018). However, obtaining stable housing was the initial step. The PEH community continues to require proper healthcare services to receive the care they need and to maintain healthy habits. Many specialists who offer collaborative services are aware of the PEH community’s specialty needs (Baggett et al., 2018). Attending to the needs of the PEH community requires a multi-discipline, interprofessional team of health care providers.

California’s WPC pilot project was initiated in 2015. In 2016, a qualitative study focused on the holistic healthcare needs of the PEH community, which lead to the identification of a potential action plan and intervention (Johnson, 2019). The semi-structured interview data collection was conducted with a purposive group of California Medicaid (Medi-Cal) healthcare providers. The providers were invited to participate as they identified as having expertise and knowledge of the PEH community. The data collected offered information regarding the specific healthcare assessment, practices, and the PEH community’s well-being.

Corona Virus Infection Disease of 2019 (COVID-19) has affected the global population leading to regulatory changes within the state of California. Many healthcare delivery models and regulatory limitations have changed at the local, state, and federal levels about funding, housing, and healthcare for the community (DCA, 2020;Corona Relief Act of 2020). Due to the COVID-19 related shelter-in-place orders, the PEH community were provided additional temporary shelter spaces. The Coronavirus Aid, Relief, and Economic Security (CARES) Act was a $2.2 trillion bill passed by the 116th U.S. Congress (USCongress, 2020). This Act included $12 billion for rent, mortgage, and

homelessness resources (Corona Relief Act of 2020). The motivation for this DNP project stems from the above-mentioned regulatory changes and the WPC pilot program. The WPC pilot program was projected to be completed on December 31, 2020. This DNP project aims to compare WPC providers' 2020 perceptions of homeless healthcare needs to the initial 2016 study findings.

Problem Statement

Evidence of the rapidly increasing prevalence of homelessness in America can be easily observed by the large numbers of people currently living on our nation's streets. The 2019 Annual Homeless Assessment Report (AHAR) to Congress stated that in the United States of America, 568,000 people were dealing with homelessness. This AHAR data indicates a 2.6% population increase in comparison to the 2018 report. (HUD, 2020). Health maintenance has been a challenge for the PEH community. This community has high utilization of emergency departments for less than emergent healthcare needs (Kraus, 2020)

A lack of stable domicile was linked to financial, physical, behavioral, and social health strain (NHCHC, 2021). Tsai, et al (2017) cited that the community often attributes unstable housing to an untreated psychological situation or substance abuse issues. However, socioeconomic concerns leading to housing instability create prolonged stressors with correlated and reciprocal health effects (Baggett et al., 2018). Health improvements are noted in people when adequate housing was established (NHCHC, 2021). This reciprocal condition noted creates a cycle rooted in chronic homelessness. PEH community healthcare providers hold a unique set of skills. These providers have generated a distinctive set of assessment, treatment, and evaluation skills that demonstrates a keen understanding of the care needed to support the homeless population. The future

challenge was a culmination of standardized care that meets this prominence of care.

Healthcare needs are complex in the general population. The various categories, such as Social Determinants of Health (SDOH), family history, health literacy, and other demographic information, assist the provider in patient-provider health planning. Each type requires focus, prioritization, and logical planning. However, inadequate rest, sleep, and other care needs to diminish the possibility of logic and planning. The planning and scheduling practice needed for healthcare maintenance concerns are problematic in this population (Kraus, 2020).

Systemic stability was complicated in a “normal” environment. Socio-economic challenges, unstable domicile, and environmental changes cause emotional and physical stress, directly affecting the cardiovascular system (Baggett, et al 2018). These cardiovascular problems lead to microvascular changes affecting all major organs and normal physiologic activity. These pathophysiologic changes require expert knowledge and a standardized approach (Baggett, et al 2018).

The 2016 and 2020 studies obtained data from one of California’s nine San Francisco Bay Area counties. The themes and codes that emerged from the analysis of interview responses suggested a strong link between the providers’ perceptions of healthcare needs and how they exercised their professional skills. In 2016 assessment tools, which are topic-specific scored questionnaires, help the provider measure a given condition’s risk were identified as significant. These assessment tools are valid, reliable, and qualitative instruments to gauge specific health concerns’ severity. Surprisingly, these questionnaires, although well-known to providers, were inconsistently used across the institutions.

Healthcare, in general, was not the highest priority until it becomes a necessity. This concern was intensified in the PEH community. Prioritizing healthcare needs requires coordinated support from all healthcare disciplines. A standardized approach to meet the homeless healthcare needs may assist the PEH population. With our newly acquired understanding of the homeless providers' perceptions, it was easier to plan and implement a standardized healthcare system for the PEH community.

Purpose

This DNP project was intended to contribute to our knowledge of additional SDOH from the providers' view of PEH healthcare. According to the Center for Disease Control and Prevention (CDC), SDOH are the conditions in which a person lives, learns, and works that may have a wide range of health consequences (CDC, 2018). The areas of health that require special attention are physical, mental, emotional, and spiritual. Environmental effects such as stress, inappropriate dietary intake, interrupted sleep patterns, and persistent 'fight or flight' mechanisms require medical attention. An all-inclusive standardized approach may be the solution to these issues.

Homeless healthcare specialty services are undoubtedly needed with the growing number of California homeless patients. Morbidity and mortality are higher in the PEH community than in the rest of the population. According to the Council of Economic Advisers, (CEA) life expectancy in the general population was 78.8 years, compared to approximately 50 years in the PEH community (Murphy, et al. 2021; Council of economic advisors, 2019). The California Endowment Center recognizes the need for health equity within underserved communities. As the PEH community's living conditions produce systemic health

care problems, proper health care services are necessary (California Endowment Center, 2020). Studies have shown a multi-disciplinary approach may be the solution to this problem (DHCS, 2020). The premise for this information was that primary healthcare was complicated in the general population. This theory asserts that primary healthcare maintenance was more complex for individuals in an unstable housing environment.

One healthcare solution theory was the use of a one-stop-shop medical center. Having a one-stop-shop makes it easier for the individual to obtain care from a multi-disciplinary team. Medical centers' inaccessible locations may reduce wait times, shorten the distance from medical providers to the various healthcare departments, and make it easier for patients to follow through. A local medical center would allow patients to access medical, dietary, laboratory, and mental health services more conveniently.

Many providers agree that there was a need to improve PEH community healthcare support. Several constraints make it challenging to provide excellent care, including staff productivity, reduced in-person office visits, and COVID-19 precautions. As stated, the PEH community requires coordination of physical, mental, behavioral, social, spiritual, and rehabilitative healthcare.

Rehabilitation and substance abuse care are essential components of PEH healthcare, as approximately 10% of the homeless population reports having substance abuse issues. Substance Abuse and Mental Health Services Administration (SAMHSA) (2020) states that substance use, as self-medicating treatment, may lead to unhealthy habits (SAMHSA, 2020). These habits, if gone unimpeded, may then lead to abuse. Psychiatric and behavioral health concerns, such as depression, anxiety, post-traumatic stress disorder (PTSD), and domestic violence, are frequently treated. Self-medicating or independent therapy may be in

the form of consuming alcohol, drug, or other addictive substances or activities (SAMHSA, 2020). These concerns demonstrate the depth and breadth of specialty homeless health care needs.

Background

WPC was designed to assess and plan with each of the underserved populations. A WPC approach was a model of care that incorporates all areas of an individual's social, physical, mental, psychological, and behavioral health. The holistic approach originated, designed, evolved, and researched by many nursing theorists, such as Martha Rogers, Margaret Newman, and Jean Watson. This approach is rooted in the theory of interconnectedness. It then invites providers and others to work towards discovering new ways for multidisciplinary teams to collaborate in providing healthcare for homelessness among and the nation's underserved populations. The PEH community was diverse and incorporated in many aspects of the underserved and general population. Several healthcare limitations can be taken from this study. Other health issues have been identified. However, due to the goal of this study, it was imperative to clearly state that the depth of these issues will not be fully discussed within this study. Topics such as equitability, social determinants of health, psychiatric concerns, rehabilitative services, spiritual concerns, safe sex practices, food insecurities, economic insecurities, to name just a few, might be addressed in future research.

California law was divided into multiple Divisions. The Welfare and Institutions Code (WIC) was enacted in 1937. Of the 20 Divisions within the WIC, number nine was concerning public social services. Chapter 7 of WIC Division 9 - Part three represents essential healthcare in California. These sections and

subdivisions lead to the WPC pilot program, one of four Medi-Cal 2020 programs. California's 1115 Medicaid waiver consists of four program options:

- Public hospital redesign and Medi-Cal incentives (PRIME)
- Global payment program (GPP). The purpose was to assess California's uninsured in the public healthcare system.
- Dental transformation initiative. This program was an incentive to increase the frequency and quality of dental care for children.
- WPC was designed to support the most vulnerable patients in local communities, such as the PEH community. (California law, 2018)

The whole person care (WPC) pilot program in California was a 5-year program approved as part of the Medi-Cal 2020 waiver in December 2015. Matching funds of $1.5 billion of federal Medicaid monies with the local funds allowed inter-governmental transfers (Harbage, 2018). The services are for those beneficiaries identified as 'high-utilizers,' defined as patients frequently seen in emergency rooms, mental health facilities, and substance abuse departments (Salhi et al., 2017). Other patients in this category include those recently released from correctional facilities, high-risk pregnant mothers, individuals with cognitive impairments, and homeless individuals. The majority of the approved pilot projects were planned for the PEH population (California Department of Public Health, 2017).

The WPC project recognizes interprofessional care models. Although several care systems, such as dental, vision, and substance abuse interventions, matched the criteria requirements, 36% of the approved projects helped support the homeless population (California Department of Public Health, 2017). California state has applied the term 'silo-mentality' to describe resistance to collaboration among those agencies and organizations who provide primary,

secondary, and tertiary care for the homeless. According to the California Department of Healthcare Services (DHCS) (2016), the WPC 5-year pilot program explicitly includes the coordination of medical and behavioral health, social services, data sharing, and comprehensive coordination of care among institutions.

Historically, the PEH community's health and well-being became a national concern in the 1870s (Committee on evaluation of permanent housing for the homeless, 2018). This concern was a multifaceted problem that harms those afflicted with it as well as the larger community. Living on the street, consuming an unhealthy diet, social stressors, and environmental factors create many concerns.

Poor medical health and homelessness have a reciprocal relationship. Factors such as the effect of environmental conditions on the skin as the first line of defense can lead to various local and systemic health disorders. The harshness of temperature changes allows for expansion and contraction of the epidermis affecting the dermal layer and underlying structures (Weisshaar, 2016). Skin irritations are common disturbances in the PEH community, which can lead to detrimental health consequences. The first line-of-defense breakdown can affect the cardiac, respiratory, and musculoskeletal systems with additional physical and emotional stressors (Coates et al., 2020).

Well documented are the Cardiovascular disturbances and risk factors of the PEH community. Studies have demonstrated that stress and constant "fight or flight "conditions have a chronic effect on vascularity and cardiac function. Inadequate venous return may cause vascular congestion, leading to a bidirectional disturbance between the skin and the vascular circulation. As several of these undiagnosed or poorly controlled conditions persist, the condition's chronicity often leads to further systemic damage (Baggett et al., 2018).

Disturbances within the vascular system, especially the micro vascularity, can affect the neurological system. A stroke or cerebrovascular accident (CVA) may affect the patient's speech, dietary intake, urinary function, mobility function, cognition, and neurological stability resulting in additional stress. An individual may feel more vulnerable in an otherwise potential intimidating environment (Baggett et al., 2018).

Attempts to acquire medications may be difficult in a general setting. Research has demonstrated that patients may have difficulty obtaining the prescribed medications, therefore delaying treatment initiation (SAMHSA, 2020). Problems such as lack of transportation, high prescription costs, lack of motivation, and limited insurance coverage may postpone the therapy process. The PEH community often shares medications and illicit drugs, such as treating and managing pain and chronic diseases (Landefeld et al., 2017).

The PEH community was initially ascribed Substance abuse as the primary challenge requiring a significant number of rehabilitation programs. However, on further examination, multiple concerns have been raised. Substance abuse may be amplified by the stress of chronic homelessness (SAMHSA, 2020). Although this appears daunting, several programs have been made available, and patients have utilized the substance abuse programs set forth by Healthy People 2020 (Office of Disease Prevention and Health Promotion, 2016).

Over the years, it has been well documented that multiple risk factors lead to an unstable domicile, such as behavioral or mental health instability. Researchers have also identified common characteristics among populations at risk for homelessness, including Adverse Childhood Experiences (ACEs). ACEs affect people in their adult life, leading to common risk factors for homelessness. Demographic components alone do not provide sufficient insight into a person's

health and social history (Dowd, 2014). For this reason, an examination of the WPC approach could more readily provide insights into the homeless health care problem. Dowd (2014) also stated that acquiring a comprehensive perspective of how ACEs affect people during their adult life was necessary since these early experiences harm brain development. These effects result in molecular changes that generate physiological alterations directly correlated to WPC Pilot program components of physical, behavioral, and social health (Dowd, 2014).

The previous qualitative study evaluated WPC provider perceptions of homeless healthcare needs (Johnson, 2019). This study was initiated at the outset of the WPC pilot program in 2016. The study findings showed that the participants were knowledgeable and focused on their respective roles to provide aid to the homeless. However, the results also demonstrated a need for an expanded inter-organizational cohesive approach. The participants were somewhat unfamiliar with other members enrolled in the WPC Pilot Program. The analysis of Health care providers' expectations, knowledge, tools, and experiences were useful in the conclusion. The conclusion also acknowledges recommendations for further research and consistent use of available validated assessment tools.

Regarding the socio-economic effects of a WPC approach to homelessness, it was necessary to identify stakeholders and groups providing WPC services to the PEH community. Stakeholders currently working with these populations in the San Francisco Bay Area include a full spectrum of medical, dental, behavioral health personnel, social workers, dieticians, and housing advocates. Stakeholder organizations include hospitals, clinics, drug, and alcohol rehabilitation services, housing and social support organizations, managed care providers, and criminal justice organizations (Whole Person Care, 2017). In the most recent Annual Homeless Assessment Report (AHAR), Congress stated that 567,715 people living

in the United States had been classified as homeless, with 68% residing in shelters and 32% residing in street tents (HUD, 2020). Homelessness in California increased by 16.4% equaling 21,306 in 2018 (HUD, 2020). In addition to a strained economy and housing shortage, these statistics place an extra financial burden on states, cities, and counties throughout the United States (Leamer, 2015; Weiner, 2014). For example, the economic impact noted in one San Francisco Bay Area city was identified in a thorough assessment of the housing, shelter, rehabilitation, social, and support programs, which yielded an annual budget of $500,000 in operational costs (Berkeley, 2019).

Theoretical Framework

Collectively the framework and theory are the roots of the research structure. Abend (2013) defined a Theoretical framework as "…the structure that can hold or support a theory of a research study." The theoretical framework describes the existence of the research problem (Abend, 2013). Five Qualitative theoretical frameworks were found; Phenomenology, Ethnography, Grounded theory, Case Study, and Narrative Inquiry. Phenomenology originated in philosophy to describe one's experience (Neubauer et al., 2019).

Attachment Theory as a Behavioral Science deals with the various stages of an individual's developmental experience regarding the need for close interpersonal relationships from infancy through adulthood. Attachment Theory was a psychological theoretical model highlighting specific child-parent relationship development, as shown in Figure 2 As compared in Figure 3 this theory also correlates with adult social health, such as adult interpersonal relationships (Curry, 2017).

Figure 2

Mother-Child Attachment

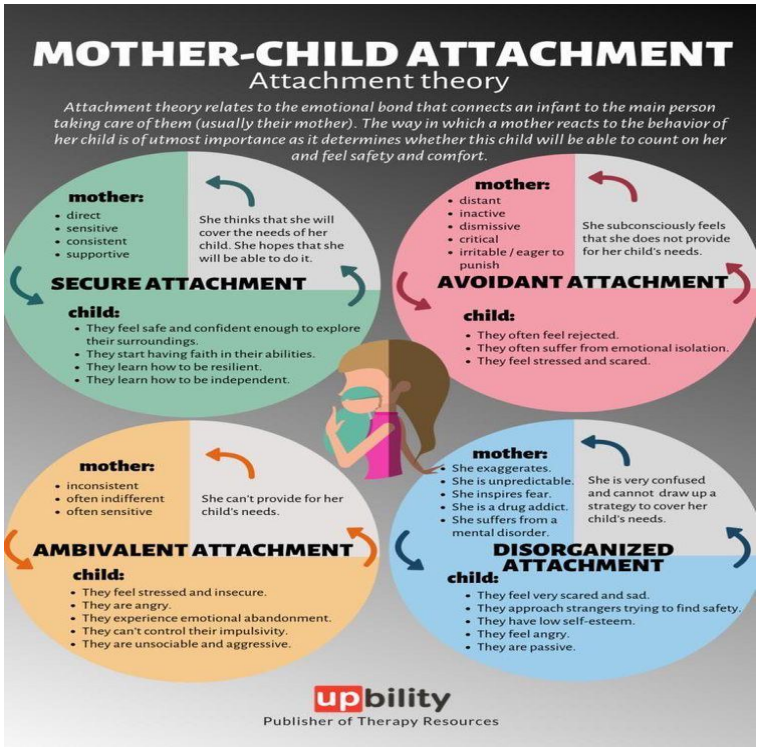
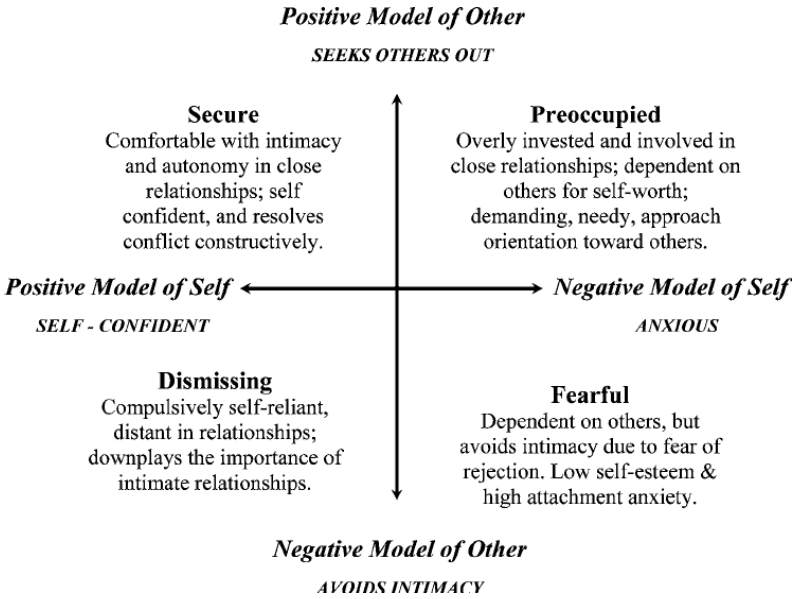


Figure 3

Attachment Adult Behaviors



The basic principles and assumptions of Attachment Theory were outlined in Bowlby's foundational seminal work in 1988. According to the author, some fundamental principles include the infant and child's need for a secure, warm, and loving relationship. In addition, the importance of the parental role as caregiver and nurturer and the presence of a stable home to produce an adolescent or young adult capable of engaging in healthy relationships was emphasized by Bowlby (1988). Assumptions connected with the theory specify that human beings bond on physical, psychological, emotional, and intellectual levels, which result in certain 'attachment-driven' behaviors (Bowlby, 1988).

Attachment Theory as a Behavioral Science

Homelessness studies have employed the Attachment theory. This theory deals with the various stages of an individual's development regarding the need for close interpersonal relationships from infancy through adulthood. Attachment Theory belongs to the family of behavioral sciences whose function was to investigate behavior in terms of an individual's ability. These include decision-making abilities that exist within a particular environment that help develop relationships with others. Slater (2007) was preeminent in identifying Attachment Theory as a Behavioral Science. He stated that although attachment behaviors may change significantly throughout a person's development, there remains a constant need for security. The Attachment Theory's greatest strength was its interdisciplinary character connecting it to other fields, such as developmental psychology, neuroscience, anthropology, and cognitive psychology (Slater, 2007).

Attachment theoretical models throughout literature have been generally utilized in the setting of adult adverse outcomes. When it comes to Attachment theory in the general population, it was important to recognize the effects of an

individual's relationship with their parental figures (Curry, 2017). The Attachment Theory was commonly used by social workers when working with children; however, it may be applied to people of all ages. Hardy (2016) explained how an adult who was abused as a child might have difficulty regulating emotions within relationships, leaving them more vulnerable to abuse. Hence, ACEs may be primarily responsible for placing individuals at a higher risk for homelessness (Hardy, 2016).

Attachment Theory belongs to the family of behavioral sciences whose function was to investigate behavior in terms of one's ability to make decisions, exist within a particular environment, and form relationships with others. The framework was focused on attachment behaviors developed in childhood that extend into one's adult life. Daniel and Wassell (2017) pointed out that attachment theorists' work has shed light on crucial social development areas and the study of subsequent adult human relationships. As it relates to healthcare providers, Grady et al (2017) stated that although attachment behaviors may change significantly throughout a person's development, there may remain a constant need to seek security and affection from others.

This qualitative methodology best guides the participating providers' perceptions of the WPC pilot program. The principles and assumptions of Attachment Theory will be applied to the qualitative thematic analysis of the providers' responses to the 12-question interview tool. This tool will be used as a guide in making recommendations for future evidence-based studies dealing with a WPC approach to homelessness.

Summary

In summary, there was evidence of the multiple health factors and specific care requirements for people experiencing homelessness. It was also recognized that there was inadequate planning and scheduling for healthcare needs. The purpose of this qualitative DNP project was to illustrate the changes that have occurred with a holistic approach to homeless health care needs. This was done by comparing the health care needs of the homeless population through the WPC pilot program. California initiated this program in 2015, which was completed on December 31, 2020. WPC program providers with the use of attachment theory participated in a semi-structured interview. As the attachment theory methodology was helpful in understanding providers who participated in this WPC program, it can also help shed light on other adult risks, decisions, and behaviors.

The participants are associated with various disciplines and agencies as there are multiple variables related to health care needs for the PEH community. A lack of housing and health are inversely related to one another. Therefore, alliances of many governmental and community levels help in offering a solution. Funding and support platforms are possible by collaborating with multiple agencies, such as HHS, HUD, NHCHC, and others. The importance of local WPC providers' holistic knowledge and experience may improve evidence-based health care practices.

CHAPTER 2: LITERATURE REVIEW

This chapter examines the relevant literature regarding evidence-based health care providers' perception of the PEH community health care needs. This comparison project will evaluate provider perception changes at the completion of California's WPC pilot project. The findings of foundational seminal studies, which were older than 5-years were expressly included for their contribution to a broader range of ideas, strategies, and evolution of attitudes towards homelessness.

Homelessness

The 2018 Housing and Urban Development (HUD) Annual Homeless Assessment Report (AHAR) to Congress stated that 567,715 people were dealing with homelessness in the United States. Statistical estimates the PEH community housed in emergency shelters or transitional housing represents 68%, and 32% remained unsheltered. Of these numbers, over 25% were children.

Reporting on the demographic characteristics, the researchers found that nine out of every ten homeless children are in temporary shelters and that 48% of homeless were Caucasian, 39% African American, 22% Hispanic, 7% multiethnic, 3% Native American, 2% Pacific Islander, and 1% Asian. California had the highest number of homeless children, 66% of whom were unsheltered. California, again, had the highest number totaling one in four or 26%. Out of 9,612 veterans, 5,600 remained unsheltered (HUD, 2020).

In a landmark, qualitative research study, recently reprinted, on the connection between home environments and human behavior, Dovey (1985) provided an alternative view of both home and what it means to be homeless apart from the traditional idea of being impoverished and unsheltered. The author

associated the concept of home with order's properties, suggesting that a person was orientated within a spatial, temporal, and socio-cultural order that one readily understands. With the term "spatial," Dovey (1985) referred to the concept that the underlying domicile structure provided secure boundaries. These limitations help establish a grounded, familiar building where the inhabitants can exert control over their behavior.

The home's temporal orientation means that it can be a place where one returns surrounded by the familiarity of past experiences and where time measurement was according to one's daily routines and cycles. It was precisely the nature of a person's habits, such as meal preparation, child-raising, family traditions, and ceremonies, that create the home's socio-cultural ordering. The "home" signifies a sophisticated system of ordered relationships, where there exists an integral connectedness between the place and its inhabitants, collectively and individually (Dovey, 1985).

Dovey (1985) also pointed out homelessness's characteristics, unrelated to being impoverished or unsheltered, including conditions that work against a traditional sense of home. For example, an over-emphasis on material objects requiring excessive time and emotional commitment. Another characteristic involves an authoritarian approach to organization that overlooks the needs of the inhabitants. Although Dovey's (1985) discussion of home and homelessness focused on abstract notions rather than physical realities, they are essential concepts to consider from the standpoint of the risk factors that contribute to family disunity and actual homelessness.

The problem of homelessness is, by no means, confined to any one country but was widespread throughout the world. Busch-Geertsema et al (2016) explained that homeless was historical as a global phenomenon experienced by underserved

populations regardless of a country's socio-economic development. The authors clarify insufficient data from several European countries, such as Belgium, Denmark, Finland, Latvia, Norway, Slovenia, Spain, and Switzerland, as they had not collected census data. Nonetheless, there are homeless people in these countries. Italy had the highest number of 34,653 unsheltered citizens, followed by Slovakia, France, and the Czech Republic with 23,483, 16,339, and 11,496, respectively (Busch-Geertsema et al., 2016).

To build a global framework for conceptualizing and measuring homelessness, Busch-Geertsema et al (2016) divided their research into three principal sections, a security domain, a physical domain, and a social domain. According to the proposed framework utilizing Attachment Theory, the security domain determines the extent to which a household constitutes a stable home for a reasonable period. The physical domain deals with the home's adequacy in terms of its capacity to protect the inhabitants from weather, supply the necessary amenities, be free from pests, pollutants, overcrowding, and unwanted outside intrusions. Third, the social domain constitutes the degree to which the inhabitants can engage in positive, culturally appropriate social relations, safe from internal threats to their person or possessions from other household members (Busch-Geertsema et al., 2016).

Using the criteria in each of these domains, the researcher determined that the distinction between inadequate housing and actual homelessness depended on the category's deprivation level. However, Busch-Geertsema et al. (2016) maintained that a single definition could not justify homelessness on a global scale. Descriptions and definitions may reflect the norms of a particular society's housing standard. Based on this rationale, not all countries may agree with the concepts that make up each domain due to inherent cultural differences. They then

recommended a tremendous effort to formulate a “clear and consistent” definition that would foster a global initiative aimed at relieving severe deprivation (Busch-Geertsema et al., p. 126). Furthermore, the authors added that concerning a concrete approach to homelessness, it was essential to focus on those who are entirely homeless and unsheltered than those at risk for homelessness. Overall, Busch-Geertsema et al. (2016) pointed out that their research intended to generate discussion on the best way to conceptualize and measure homelessness from a global perspective, especially in its most extreme forms.

Homeless Health Needs

As stated, poor health can be a crucial cause of homelessness. Reciprocally, homelessness may be the primary cause of poor health (NHCHC, 2021). Considerations such as the environmental and ambient temperature effect on the first line of defense of the integumentary system. The harshness of any temperature changes allows for expansion and contraction of the epidermis affecting the dermal layer and underlying structures, leading to irritation and other breakdown sources. Other breakdown sources include infestation, inflammatory responses, intertriginous irritation, and other such dermatological disturbances. With additional stressors, this first line of defense can affect the systemic order (Coates et al., 2020).

Baggett et al (2018) pointed out the components affecting the homeless population. Systemic problems, as mentioned above, facilitates further end-organ damage. The primary cardiac function is to supply of oxygenation via circulation to promote systemic, and other major organ viability. When one is affected by significant stressors, such as inadequate dietary intake, questionable living situation, environmental ~~a~~mbient temperature variations combined with chronic

conditions, good health is modified (Baggett et al., 2018). This cascade of disturbances can be seen in the environmental changes that affect the integumentary system. With skin changes, microvascular alterations occur to the immune system and the other vital organs. Vital organs that rely on microvascular circulation by the cardiac, respiratory, gastrointestinal. tract, and renal system may fail. For example, the geriatric PEH population may experience chronic conditions, such as hypertension. Hypertension was worsened by inadequate oxygenation to the myocardium. Low oxygen flow to the cardiac muscle leads to pumping, affecting other organs, especially the renal function, secondary to inadequate oxygenation and increase filtration requirements.

Cardiovascular disturbances have demonstrated that stress and constant "fight or flight "conditions have a chronic effect on vascularity and cardiac function (Baggett et al., 2018). The inability to obtain adequate venous return may cause congestion. Therefore, a common disturbance between the skin and the vascular bed further effecting skin integrity.

Disturbances within the vascular system, especially the micro vascularity, can affect the neurological status. Health management through medical follow up may alleviate these vascular changes. Vascular changes that lead to stroke or uncontrolled Diabetes Mellitus (Baggett et al., 2018). The cascade-effect result in neurological instability lead to poor speech ability, altered independent dietary intake, uncontrolled urinary function, and dependent mobility function. A more vulnerable physical state in an otherwise potential intimidating community environment may be detrimental.

Medication sharing was a common occurrence in the PEH community. The researchers also noted medication sharing may be prescribed or illicit medication. Substance abuse, forms of pain management, and depression management are

common. Systemic and or chronic disease management may also be treated through medication sharing (Baggett et al., 2018).

Baggett et al (2018) cited additional concerns in the PEH community. The benefit of maintaining contact with primary care, medications delivery, and pick up may be altered. As often noted, there are independent medication dosing adjustments done due to delayed Prescription acquisition (Baggett et al., 2018). Attempts to acquire medications may be difficult in a general setting. Research has demonstrated that patients receiving prescriptions may lack the ability to initiate therapy (Healthcare for the Homeless Clinicians Network, 2004). Difficulties such as transportation, costs, motivation, insurance coverage, and errands' prioritizing may prevent starting treatment.

Whole Person Care (WPC) Approach to Homelessness

The Whole Person Care (WPC) pilot program was developed from an assessment of Medi-Cal recipient healthcare utilization. Several issues were recognized requiring interventions. Emergency room utilization from 2005 to 2010 increased 44% in the PEH community compared to 7.4% of the general housed population (Kraus, 2020; Salhi et al., 2018). The California committee also observed a 'silo-mentality' among the organizations providing care to this vulnerable population (McCartney, 2016). These issues were incorporated in the formative evaluation as program requirements to support the underserved population.

Although the term WPC has recently become a popular term, the underlying basis of this approach to care can be traced as far back as the writing of Florence Nightingale. In *Notes on Nursing*, Nightingale (1969) consistently emphasized the need to focus on the person as an individual. According to Jasemi

et al., (2017), Nightingale “was the first nurse to emphasize the significance of holistic care” (p. 71). Nursing theorist, Jean Watson, created the functional patient-centered, holistic care approach (Butts & Rich, 2018). Although this type of care has been identified using various terms, such as patient-centered care, the underpinning philosophy emphasizes the individual’s humanity remains the same. Jasemi et al. (2017) pointed out that a holistic approach to healthcare necessarily involves the patient’s physical, mental, emotional, and spiritual needs.

In a study of how general practitioners (GPs) applied evidence-based clinical practice guidelines (CPGs) to their practice, Hansen et al (2016) found that G.P.s were not always able to adhere to CPGs and still retain their focus on a WPC approach. This was because the CPGs did not always address the individual patient’s needs and priorities. As a result, the dichotomy created by this circumstance was reported as a source of tension for the G.P.s since the emphasis placed on patient-centered WPC could generate operational challenges (Hansen et al., 2016). Despite these findings, however, the value of WPC was not in any way diminished.

Providers’ Perception

Provider perceptions are generally personal insight based on one’s life and professional experience and intimate relationship attachments. Just as homeless persons have been perceived as mistrustful of providers, the providers themselves can be affected, sometimes unconsciously, by the appearances of those they treat. Gombeski (2016) stated that many studies of providers’ perceptions of patients were based on several characteristics such as ethnicity, gender, and education level. Subsequently, provider behaviors are influenced by the patient’s appearance. These studies’ findings revealed that the quality of provider service was affected

by whether the patient was perceived as more or less attractive. Consequently, these types of perceptions were also found to impact the quality of patient and provider communication. Gombeski (2016) recommended that all patients, regardless of appearance, should be treated with high-quality care and that provider training should include an ongoing, introspective examination of provider perception towards patients.

Homeless Healthcare Providers

Attachment theory was a theoretical model based on the child/infant and parental role. Generally, this theory was used about the patient's relationship with others. However, this literature opens the discussion from the perspective of the Attachment Theory effect on the provider (Yazdani et al., 2018). These attachments help to develop the personality of an individual throughout their life span.

Provider perceptions are essential in understanding the care needs of the homeless population. Providers that choose homeless care do so, whether unintentionally or intentionally. Yazdani et al (2018) defined specific healthcare providers' specific methodologies and career choices. Nine theories were evaluated. The aim was to evaluate the theories related to career choice. one of the nine theories discussed includes Attachment Theory. This article's attachment styles state that the relationship between patients and healthcare professionals was generally securely attached. Citing that "researchers have proven the attachment styles of healthcare providers can affect their career satisfaction" (Yazdani et al., 2018).

Comparative Studies

Several resources site typical evaluation methods. The Centers for Disease Control and Prevention (CDC) defines each of these in various situations, such as program, clinical competencies, and community projects. Comparative evaluation studies are one of four types, summation, outcome, process, or impact. Each of the evaluation types was similar to the respective titles. The most suitable evaluation methodology for this study was impact evaluation. The process evaluation was to determine if the goals of implementation have been met. The outcome evaluation helps to determine whether the program met the intended purpose. (CDC, n.d.)

Similarly, other authors site evaluation types that occur before the implementation of the program. This type of evaluation, formative, was used when reformatting a particular program, project, or process. Many disciplines utilize impact evaluation. As the name implies, this type was to offer a standard, valid, and reliable tool application in its effectiveness, achievement of the programs ultimate goal, and whether the target population was impacted in a meaningful way (Peterson et al., 2020)

Comparative studies are used in research to assess which formation, project, or process was most appropriate for a group, community, or other distinct population. Of the various types of comparative studies, the quantitative versus qualitative differ in the data collected. Lau and Holbrook (2017) described the comparison methods utilized for this particular study a qualitative non-randomized research best corresponds. Generally, in a quantitative ANOVA study, there was a pretest and post-test. Similarly, the 2016 study may be likened to the pretest compared to the post-test of 2020.

Although comparing possible 4-year expert perception changes of PEH healthcare was from the inception of the study, this DNP project sought to

understand the change in practice and the benefits to the PEH community. Hatzl et al. (2016) conducted a comparison of market-based participation versus grassroots citizen participation. The intent of this particular study to determine which group would be most effective in renewable energy plans. The study was of another discipline's efforts. It was similar to the DNP project aspect of impact evaluation of traditional healthcare versus WPC healthcare. The results were consistent, providing power to citizens. The two comparative units had similar characteristics leading to reliable evaluation completion.

The qualitative method uses by Hatzl et al. (2016) included semi-structured interviews were carried out with each group. The comparison was made based on the interviews to classify the citizen-participation initiative (CPI) progressed to the coding and identification of development analytical phases. Subsequently, in the evaluation of the CPI regimen, the influence was discussed. Participants admitted influence more directly by "Financial rather than idealistic." Grassroots, versus the market-based initiatives, were more successful.

The knowledge of those directly affected by an initiative or process was essential as in the semi-structured interview focus on the WPC pilot program. Hatzl et al. (2016) also pointed out other influencing factors included the participation of citizens within the decision-making. Local input allows the community to "speak the same language." Whether market-based or a grassroots language was spoken, there was a clear understanding by all participants.

This style of comparative study offers a view from validated methods. It was ideal to describe what was being compared. With the focus on WPC providers' experience and perception, phenomenology was the best qualitative study approach. Neubauer et al. (2019) discussed the various types of qualitative

study and offered a prime definition of phenomenology as it compares multiple participants' experiences (Neubauer et al., 2019).

With the comparison study, it must be recognized that the phenomenological framework helps understand the various phases of the participants' consciousness and experience. Neubauer and his team (2017) described the stages as, 'series of reductions.' The first reduction was transcendental, defined as the researcher categorizes experiences. The second reduction was the transcendental-phenomenological reduction, in which a description and definition were constructed of the phenomena. The third and final reduction was the imaginative variation. In this phase, the participant's perception and life experience are given to wait to describe the variations. Therefore, the phenomenological approach and methodology allow us to learn from the participants' experiences (Neubauer et al., 2019).

The DNP project, at its inception, identified the need to change from standard medical healthcare practice to holistic, WPC healthcare. WPC core competencies, comparative evaluation has several areas in common. Areas such as knowledge, skill, patient care, evidence-based practice, attitude, and communication skills are familiar. Nelson et al. (2019) comparative article was an example of this type of evaluation from the *British Journal of General Practice* provided information regarding the strengths and limitations of general practitioners. The research question was "Was there same, similar, or different Primary Care given dependent on the credentialing and core competency requirements?" An overview and semi-structured interviews of those within each healthcare practice area offered a summary. The data collection, similar to the DNP project, utilized qualitative method semi-structured interviews. The use of transcripts also provided the identification of codes and themes. The

transformation of quantitative information, such as frequencies and duration of discussion, helped identify each discipline's relevance, expectation, and perception. It was stated that physician assistance with less equipped to substitute in general practice. The authors admitted this was the "first to offer a glimpse into how APs may work differently." The need for further study, research, and practice projects was recommended to incorporate as evidence-based practice standards.

Summary

Relevant research supports this DNP project. There were no studies, to date, investigating the Whole Person Care (WPC) Pilot Program. The researcher was able to locate relevant literature dealing with the present study's more prominent themes. Public perceptions of the PEH community have changed in the last decade (Rae & Rees, 2015). Recent literature offers minimal research of provider's perceptions of PEH health care needs. Comparing information separated by many years may be a bit difficult. There were confounding and influencing factors to change the perspective of the participant over time. Therefore, the questions may remain the same. The view of the clinician and non-clinician may vary due to spatial changes, time differences, and more significant experiences. In a study by Ryan et al. (2017), there was a discussion of the life circumstances changes that may elicit various responses to any particular question. Perspective and perceptions change with these life circumstances.

The first study in 2016 sought to answer, 'What are the homeless provider's perceptions of homeless healthcare needs at the end of the WPC pilot program?'. The 2020 comparison study plan was to make a note of any changes in perception. These included the social, economic, physical, behavioral, and psychological problems connected with homelessness and those at risk for homelessness.

Dovey's (1985) article was beneficial in this regard since it added a unique perspective. The author explained certain conditions, such as an over-emphasis on material objects requiring an excessive commitment of time and emotion and an authoritarian approach to organization that overlooks the inhabitants' needs, all of which militate against a traditional sense of home. These concepts serve as critical points that can apply equally to providers and household members since they provoke close examination of one's motives and intentions and direct actions.

Key points relevant to the second part of the research question addressing, 'Did the WPC provider's perception of homeless healthcare needs change?' According to Curry (2017), maltreatment of a child, in any form, may not only lead to homelessness as an adult but may ingrain personal characteristics in the choice of health care practice choice. These are essential points for providers to consider when helping formulate healthcare maintenance plans for those at risk for homelessness and the homeless.

CHAPTER 3: METHODS

Research Design

This chapter provides a detailed description of the researcher's steps to plan the project. A qualitative phenomenological research design chosen for this study is most appropriate to understand the effectiveness of the WPC pilot program through the experiences of those delivering care to the homeless. Consent forms were given to each participant upon schedule confirmation of each interview. In both 2016 and 2020 studies, the data collection method was a series of semi-structured interviews using a ten and 12-question survey, respectively. The DNP project committee approved these questions. The researcher compiled the codes based on the 2016 code list, following the latter interview endeavor for effortless participants' answers coding. The open-ended interview questions were related to the research question. The researcher allowed each participant ample opportunity to elaborate on the responses, ask questions, and contribute alternate viewpoints.

The qualitative phenomenological research method generally explores why or how a circumstance is experienced (Jamshed, 2014). Overall, the effectiveness of any approach when working with underserved populations, no matter how well a program is organized or how much funding is provided, will ultimately depend on the character of the individuals' perceptions, attitudes, efficiency, and actions directly involved. Studies that are inclusive of multidisciplinary teams may examine how the collaborative process can improve efficiency, formulate solutions to overcome barriers and shape future policies. This study uses the perception of various PEH provider disciplines. An overall objective is to improve health outcomes for homeless and underserved populations by identifying some of

the differences between the providers' perceptions and how those differences could affect their collective approach to the problem.

As the name implies, this comparative research method compares two or more items, events, or components to each other. Comparative research, such as longitudinal studies, are familiar comparison methods. Longitudinal research seeks to compare pre and post-intervention data and information over a specific time. These things will be known similarly or adversely. In a comparative analysis, it is vital that the researcher 'dig deeper' to understand the why and how these factors compare positively or negatively (Esser & Vliegenthart, 2017). Other comparison studies evaluate the therapeutic or modifying effect that may occur to a subject or other entity. Likewise, in the evaluation type of comparison, the study design compares and contrasts the intervention effectiveness. Several methodologies for this comparison study were considered. The 2016 and 2020 providers' interviews were evaluated to determine whether changes in perception occurred in the interim period.

Informed consent documents were reviewed and signed. Each participant was informed of the interview recording process. These iPhone® interview recordings were then transcribed for ease of review and stored in a secure location to preserve privacy per Tigerfish™. The researcher employed a Computer Assisted Qualitative Data Analysis (CAQDAS) software system, which allows visualization and identification of the codes and themes from transcribed documents.

Sample

The target population consisted of multidisciplinary providers actively engaged in the WPC Pilot Program. Phenomenological qualitative sample size

requirements, 5 to 25 participants, are noted in the literature as sufficient to describe “the essence of an activity” (Englander, 2016). The providers’ responses to the interview questions were used to ascertain the providers’ perceptions of the WPC approach to homelessness health.

A variety of studies use Semi-structured interview techniques. The use of phenomenological qualitative studies was to describe the intrinsic nature of a given activity (Englander, 2016). Before selecting the participants, the researcher investigated the requirements for active participation within the WPC Pilot Program. The second step involved identifying the previous study participants. Previous and current qualifications include PEH community providers who worked directly with this population.

Recruitment of prior study participants was carried out through email with attached flyers explaining the purpose of the study and inviting the providers to participate in a face-to-face or Zoom® interview with the researcher. As the target sample, comprised of providers occupying administrative and advisory positions, including those in hands-on service positions, the researcher addressed each potential participant by name, using the appropriate title and department designation. Although communication transparency within the interview is imperative, each participant was informed that a numeric identification and fictitious names assignment is inherent to ensure their privacy, descriptions of their position, and responsibilities within their respective organizations.

Multiple providers who care for the homeless and underserved of various disciplines as part of the WPC Pilot Program, whether paid as employees or as volunteers. This requires professional skills in their respective fields. The roles included in these studies are administrators and service personnel. The specific career occupations include physicians, nurses, social workers, dieticians, housing

specialists, legal advisors, financial consultants, educators, psychologists, mobile health clinicians, and communication and technology specialists.

The primary feature of the study sample is to reflect the larger provider population. This population consists of those who work with the PEH community, including imminent loss of domicile risk, shelter residents, unsheltered and encampment residents. Providers must be cognizant of task performance compatible with the practice standards and guidelines required of all licensed medical and service personnel throughout the State of California. In addition to the specific skills associated with each profession, features common to all the participant members include standards of conduct and professional competence. Examples of these features are respect for all individuals' dignity, including one's colleagues, commitment to safe practices, respect for privacy, cultural competency, engagement in continuing education, and multidisciplinary collaboration.

The purposive sampling qualifications consisted of an age greater than eighteen years, a homeless healthcare provider, knowledge of health variables, healthcare barriers, support characteristics, and the capacity to discuss comprehensive homeless health care approach suggestions. The rationale for invited participants is based on a decision to conduct an in-depth, semi-structured interview focused on their leadership roles as providers working with the homeless and those at risk for homelessness within the WPC Pilot Program.

Of the purposive sampling categories, expert sampling is most appropriate for this study. Guetterman's (2015) study results revealed Ph.D. dissertations project sample size are in multiples of ten, with a mean value of 31 participants. A small sample plan from the outset of the study may allow time for the participants to become familiar with the interviewer and for the interviewer to acquire a more

in-depth understanding of each participant's unique perspective. Dworkin (2012) pointed out that elements to consider when deciding on sample size include the quality of data, scope of the study, nature of the topic, and the amount of useful information gained from the participants. Similarly, Malterud et al. (2016) explained that participants are selected to gather information; yet the information does not exist in isolation but "is elaborated on by the researcher" (p. 1757). In other words, the authors inferred that the quality of the data would depend on how well the researcher has designed the interview questions and interrelates with the participants. Another advantage to choosing a small sample, as defined by phenomenological recommendation; for the present study, the small size tends to allow one to more easily specify the inclusion and exclusion criteria (Englander, 2016). Purposive sampling is used to select qualified participants with homeless care experience and included measures such as knowledge of financial considerations, medical and mental health concerns, resource structure, and community planning (Gentles et al., 2015). Excluded from the sample are providers who are not actively participating in the county's WPC Pilot Program.

Potential candidates invited to participate in the study are assigned a numeric identifier and fictitious name in place of their names. Every effort is taken to ensure their anonymity throughout the survey and afterward. The interview process, which included recording the participants' responses, must be fully explained in the email invitation. Potential candidates are also informed that web-based information would be password protected and encrypted. All recordings, transcriptions, email correspondences, consent forms, and any other identifying notation would be deleted and destroyed once the research project is completed.

Ethical Considerations

Ethical review sanctions for this project were obtained from California State University, Fresno Institutional Review Board (IRB), after which permissions to initiate the project were given. Due to the sensitive nature of the collected data and the positions held by the providers engaged in the WPC Pilot Program, every precaution must be taken to protect the participants' privacy and adhere to ethical standards of research. At the start of the interview, each participant is briefed on the signed consent form's information and reminded that the interview would be recorded. All documents containing data gathered from the interviews are numerically labeled, and the participant's name and any other identifying information are kept strictly confidential. Following the discussions, all identifying information, including the interview site location, is stored in a secure area, either a locked box or secured by encryption and password.

Semi-structured Interview Questions

Each interview was recorded following signed consent permission from each participant. In 2016 the participants were asked 10 open-ended questions. In 2020, due to the global health concerns of the COVID-19 pandemic effect on the PEH community, two interview questions were added, questions 10 and 11. Also, due to the worldwide health concerns, each participant incorporated COVID-19 impact on the ability to provide care services upon elaboration.

1. What was your current position within the organization?
2. Describe what type of medical health support was available in your program.
3. What type of medical questionnaire format was used?
4. What type of demographic data was collected?
5. What social health support was available in your program?

6. What type of behavioral health support was available in your program?
7. Which behavioral questionnaires are used to assess for adverse childhood experiences (ACE), patient health such as the (PHQ-9), and post-traumatic stress syndrome (PTSD) or resilience scoring?
8. From the current knowledge of medical, psychological, and socioeconomic healthcare, which of these areas was more prominent in your program?
9. Of these three areas, which one do you feel needs expansion? Why?
10. What impact has COVID-19 had on WPC?
11. What was the future of Homeless Whole Person Care?
12. With any specific homeless person in mind, what do you feel was the most helpful characteristic of that individual?

The purpose of the first question was to identify the provider's position within the organization. Questions 2 and 3 were designed to request information about each organization's type of medical services and the type of format used to collect the clients' medical information. The fourth question addressed the collection of demographic data—question 5 asked which types of social health support services were offered. Question 6 was regarding behavioral health support services. Question 7 included an emphasis on whether the behavioral assessment included features such as adverse childhood experiences (ACEs), depression symptoms through the use of a Patient Health Questionnaire (PHQ-9), and an assessment for post-traumatic stress syndrome (PTSD).

The last three questions were directed towards evaluating the effectiveness of the WPC approach to the health concerns of homelessness. For example, question 8 asked the providers to offer their professional opinion regarding the

three areas: medical, psychological, or social/economic support received the most focus within their organization. Question 9 asked the providers to address which one of the three areas required expansion and why. Questions 10 and 11, not part of the original study by Johnson (2019), were designed to note the effects of social, economic, and physical health changes due to the COVID-19 pandemic. Lastly, question 12 was intended to focus the providers' attention on a specific homeless individual served by their organization and relate what they believed to be that particular individual's most helpful characteristic.

Setting

Participant comfort was conducive to the interview process. Important environmental concerns regarding the settings consisted of ambient temperature control, adequate illumination, and, most importantly, each interview's privacy. Due to the current pandemic location, alternatives must be considered. Electronic meeting sources, such as Zoom ®, were considered. Meeting areas was mutually agreed upon by interviewer and participant, such as but not limited to physical distancing in the behavioral health counseling office, administrator's office, or hospital conference room. Location setting was confirmed 24 hours before each appointed meeting time. Communication, completed by telephone contact, was part of the design to answer any questions regarding the informed consent document. These documents were collected before each interview.

Instruments

The guided interview technique was the main instruments to collect data. The researcher and the 12-question interview tool, pen and paper, and an iPhone® were instruments for recording the participants' responses. In preparation for the study, the researcher described each device and item on the consent form and

explained how it would be used. The researcher was present at each interview to record the interviewees' responses. A pen and paper were used, as needed, to document critical points or address a reply that required a broader explanation. The iPhone® was chosen as a recording device for two reasons. An iPhone® has an advanced, user-friendly recording application that allows the audio session to be easily replayed and the data transferred to another device later. Moreover, the iPhone® may be placed on a nearby surface to enable the researcher to take notes and is less cumbersome and distracting than a hand-held microphone.

The semi-structured interviews will take place in an orderly, professional manner. Each participant's time and expertise were necessary to compile a variety of professional expert perceptions. The interviewer was an advanced practice nurse (APN), nurse practitioner (NP), certified wound, ostomy, and continence care specialist (CWOCN). The clinical skills required to comprehend the weight of each response were essential qualities. With a background in medical center study design, direct patient planning, teaching, mentoring, nursing management, pharmacology, and public health working directly with the PEH and other diverse communities, possessed the social qualifications needed to design and carry out the present study. The background was also a skill needed in the creation of an interview tool aimed at data collection specifically related to the project.

Attention to cultural competency and cultural humility is another critical feature of the researcher's preparation. To this end, it is essential to focus closely on the person being interviewed, show sensitivity, pay attention to body language and vocabulary, and allow enough time for open-ended discussion and clarification of points in between asking questions. Homelessness is a compassionate issue, and not everyone is comfortable discussing this growing global phenomenon. Depending on a person's background and cultural beliefs, the

person may have opinions and biases that are not immediately apparent. It may take a little extra time for the interviewee to open up and speak freely with strangers. The researcher identified this to be the case among providers who worked with the homeless in their professional capacity as members of the WPC Pilot Program.

Procedures

From the onset, careful consideration must be given to this study's feasibility since it is wholly dependent on the participants' availability and willingness to be interviewed regarding their work with the homeless and underserved populations. Providers who work in administrative positions have busy schedules and may not always spare the time or inclination to engage in an in-depth interview with a dissertation student. Other considerations regarding the project and the steps necessary to carry out the methodology involved whether an adequate number of qualified participants could be recruited within the specified timeframe and an appropriate interview instrument be designed and approved. For these reasons, the researcher made a clear outline of each step of the study, including identifying possible barriers that could delay progress or frustrate the outcome. After finalizing the plan under the California State University's supervision, Fresno Institutional Review Board (IRB) and Dissertation Mentor committees' support is maintained throughout the project.

Data Collection

Semi-structured interviews are carried out to facilitate the interview to obtain information. The homeless care provider can divulge additional information concerning their specific position within the WPC pilot program through the use of open-ended questions. Interview style adherence is imperative in avoiding

responses that lead the participant toward particular outcomes. Familiar terms may be utilized to be conducive to administrators, medical, social, and behavioral health providers' professional communication. The questions must be concise. Questions number 1 through 4 are noted to establish demographic information and provide a foundation for interview participation. Kallio et al (2016) indicated in the procedure for semi-structured interviews, it is essential to begin with the necessary information, simple topics, factual information, and less sensitive information. Following crucial details, the interview may segue into the most recent information, complex and compound information, and the more sensitive information after the interview.

Data are collected through a semi-structured 60 to a 90-minute face-to-face recorded interview with each qualified participant. Additional data are collected, as needed for clarification of key points, using pen and paper. Interviews are conducted in the participant's office or other on-site setting chosen by the participant. This arrangement involved careful scheduling, flexibility, time management, and extended travel time for the researcher.

Data Analysis

A qualitative analysis of the data performed using a thematic approach reveals specific patterns in the participants' responses. After transcribing the recordings into a Word document, the researcher assigned codes that are sorted thematically. Relevant themes included topics related to behavioral, psychological, socioeconomic, and spiritual healthcare. The themes are then reviewed, and overlapping data and similarities are identified to clear distinctions between each section.

The recorded interviews are reviewed for accuracy or malfunctioning in the recording process directly following each of the interviews. The interview file, once downloaded to an encrypted flash drive, is then transcribed. Transcription completed, with the help of Tigerfish®, a professional transcription company, verbatim. The document, time-stamped transcriptions may be formatted into Microsoft word documents. The transcriptions are reviewed concurrently with the audio recording for accuracy. Notetaking in this review is required to complete the encoding process of re-reading the transcript line by line.

The coding methods helped to frame categorical themes. An overview review of the transcript themes may be recognized. Initial coding is the notetaking of the raw qualitative data from the transcription. The data excerpts are correlated and labeled during this level. The codes are re-examined for accuracy and continuity. Once re-examined and filtered, codes may allow the most prominent with relation to the providers' perspective. The next cycle of coding segues into themes and axial coding.

Summary

All of the steps taken in chapter 3 about the research design, target population and sample, selection of participants, and the procedures and instruments used to collect the data are carried out respective of the research question: How do providers' perceptions of the social, economic, physical, behavioral, and psychological problems associated with homelessness, and those at risk for homelessness, affect their role as members of the Whole Person Care (WPC) Pilot Program in addressing the problem of homelessness as well as serving as determinants for future research? The 12-question interview tool is specially designed to ask questions that directly addressed the providers'

perceptions of homelessness. Subsequently, the data may be analyzed using a thematic approach to assign codes and identify patterns in the responses. The findings from the analysis of the collected data are discussed in chapter 4.

CHAPTER 4: RESULTS

Introduction

California's WPC pilot program was initiated in 2015 and has come to an end as of December 31, 2020. This DNP project compares PEH community providers' observations of the WPC holistic approach from 2016 to 2020. This section explains the qualitative analysis, phenomenological theoretical framework, and Attachment Theory application that helped guide this analysis. To eliminate bias, previous results were not reviewed before the analysis of the 2020 interview answers. However, this information was needed in the final step of comparison.

A phenomenological comparison study seeks to answer any change that may have occurred over a specific period as experienced by an individual. The interim confounding occurrences are noted due to state wildfires, economic shifts, changes in weather patterns, and especially the Corona Virus Disease of 2019 (COVID-19) pandemic. COVID-19 has impacted the world socioeconomically, spiritually, medically, behaviorally, and psychologically. These factors were considered when employing a holistic perspective, especially when it comes to an understanding the health care needs of the PEH community. Other events such as the Affordable Care Act (ACA) changes, the prevalence of African American citizens' death by law enforcement, and an additional 5-years of experience have adjusted the vantage point of society (Weine et al., 2020).

Site Description

Research project locations should be comfortable and conducive for data collection. The 2016 interviews were conducted in person. However, the 2020 interviews were performed via Zoom sessions due to COVID-19 social distancing

measures. The requirements for each site in this project were to offer privacy, adequate lighting, comfortable seating, and ambient temperature.

Description of the Sample

A representative California county was selected in which a representative group of qualified providers was chosen. Examining their perceptions regarding the WPC approach to the social, economic, physical, behavioral, and psychological problems associated with the PEH community helped fulfill the research question. The 2016 interview of 10 participants showed that they were acknowledged, knowledgeable, and focused on their respective roles to provide aid to the homeless. The 2020 invitations sought to reinterview participants of the initial WPC provider perception study.

Measures were taken to be certain these interviews were carried out ethically. The 2020 sample size of eight participants reflected 80% of the original ten participants. Participant demographics included gender identification, years of PEH community experience, clinician status, title, and agency position. The participating WPC providers held the following positions:

- Registered Dietitian (RD)
- Licensed Clinical Social Worker (LCSW)
- Project Manager
- Registered Nurse (RN)
- Emergency Medical Technician (EMT)
- Community Health Outreach Worker (CHOW)
- Grant Writer
- Business Administrator (MBA)
- Physician. Doctor of Osteopathy (DO) and Medical Doctor (MD)

Participants were assigned numeric identification and fictitious names to ensure their privacy. Descriptions of their position and responsibilities have been retained. Two participants did not respond to requests for 2020 follow-up interviews.

Participant Descriptions

In this comparison study, 20% of the initial participants were unable to return. As noted below, Andy and Elly only participated in 2016. The remaining descriptions were the participants of both the 2016 and 2020 interviews.

ANDY (2016)

He was an MD physician who provides medical care to the homeless at a local community health center funded by a grant program. He also provides ‘street medicine’ services as the mobile clinic director for a San Francisco Bay Area county.

ELLY (2016)

She holds a Doctor of Public Health (DrPH) and was a practicing Licensed Clinical Social Worker (LCSW) with twenty years of experience. She was currently the program director of a ninety-day, co-occurring, residential, and rehabilitation facility serving both men and women. The facility can accommodate 30 residents, of which an estimated 85% are deemed homeless.

BILL (2016 and 2020)

He was the chief medical officer of a national healthcare organization. The organization connects low-income and homeless patients with essential resources. He was the interim medical director of another healthcare for the homeless care

program while providing patient care at an urgent care clinic. Currently, he was the medical center's homeless program director.

CARL (2016 and 2020)

He was a physician who also holds three medical director titles of a large medical center. He was directing a mobile healthcare for the homeless clinic in 2016, and he has taken on an ambulatory care administrative role in 2020. His responsibilities also include directing an urgent care clinic and an employee occupational health group while providing direct patient care.

DEENA (2016 and 2020)

She was a registered dietician and certified diabetes educator with eleven years of knowledge-based experience at a large multi-service Federally Qualified Healthcare (FQHC) medical center. Her expertise includes providing Intensive Care Unit (ICU) inpatient and outpatient services for a diverse demographic population in various primary and specialty clinics. Her healthcare services also include individuals experiencing street-level and encampment homelessness.

FRAN (2016 and 2020)

She was a health services manager at a medical center who works with two primary sectors: as manager of a Homeless Coordination Office for all patients experiencing homelessness seen within the ambulatory system and as a coordinator at a FQHC. Her expertise generates insights regarding the reporting of information to the federal government and how care was provided to ambulatory patients experiencing homelessness.

GAY (2016 and 2020)

She was a registered nurse and manager at a county medical center. She oversees a complex care management program combining a homeless coordination program, a Homeless Action Program (HAP) team, and a care transitions team. These programs utilized RN, LCSW, and Community Health Outreach Worker (CHOW) services to offer interventions through a primary care setting. The office identifies and provides care for homeless patients not otherwise noted in non-homeless programs and care management. In the 2020 interview, she was Care Coordinator Director with another agency that provides care to the underserved Geriatric population.

HANK (2016 and 2020)

He was a program coordinator for a care management program at a county medical facility with six affiliated medical clinics. His perspective offers a vantage point from the allied support branch that serves medically vulnerable patients experiencing varying health care needs. His Community Health Outreach Worker (CHOW) staff's role was health education and the removal of barriers to accessing care.

IRVIN (2016 and 2020)

He was a grant manager, special-projects manager, and management analyst for one of the San Francisco Bay Area counties. He has experience as a CHOW working at a Healthcare for the Homeless facility. Currently, he evaluates dental services, public health outreach programs, and street medicine service programs for the Health Resources and Services Administration (HRSA) regarding grant compliance. He was a National Healthcare for the Homeless Council (NHCHC) board member involved in advocacy and policy development.

JANE (2016 and 2020)

She was an executive director and chief executive officer for a 64-year-old nonprofit behavioral health and social service organization for underserved and mentally unstable individuals experiencing or at risk for homelessness. The organization started when a group of churches collaborated to serve the community's growing need to focus on older adults with mental illness. The current population has expanded to include mentally ill adults of all ages living in an unstable housing situation.

Data Preparation and Analysis Procedure

In comparing both studies, the design, data collection, and analysis remained the same. The recorded semi-structured interviews were transcribed into Microsoft Word documents by Tigerfish® Transcribing Company. The documents were then stored on a secure, encrypted Scan Disk® flash drive and downloaded to Dedoose™, a computer-assisted qualitative data analysis system (CAQDAS) web-based encrypted software. Further preparation of each set of data involved thematic evaluation of the transcripts and subsequent data coding, with careful consideration of WPC pilot program goals. The coding and reevaluation of the themes allowed succinct and accurate handling of data.

Each study identified several codes and sub-codes in a variety of ways. These were identified through cycles of transcript reviews. Reviewing the numerical count of the codes was used to help determine change. The time the participants spent responding to interview questions was considered during data analysis. Several codes, such as provider profession, rehabilitation, and shelter, were predicted due to the semi-structured interview's structural portion. As the participants continued elaborating on the questions, the most frequently mentioned codes were identified.

Themes

Themes are the participant's account characterizing experiences. The researcher, in both analysis procedures, was able to extract relevant information concerning the research question. The codes were subsequently compiled according to the various theme categories (Kuckartz, 2014). Although there were anticipated codes as deemed by the interview questions, the dominant codes that emerged from each interview enabled the formation of a set of similar codes. In an attempt to include pandemic effect information, questions 10 and 11 were added. However, Qualitative analysis of the data demonstrated these two questions, due to global discussion, offered similar information as discussed throughout each interview. Due to topic questions, the WPC themes identified through the analysis included: health literacy, medical, socioeconomic health, behavioral health, and resilience. No matter the differences in participants' occupations or disciplines, their respective organizations' vision and mission were indistinguishable.

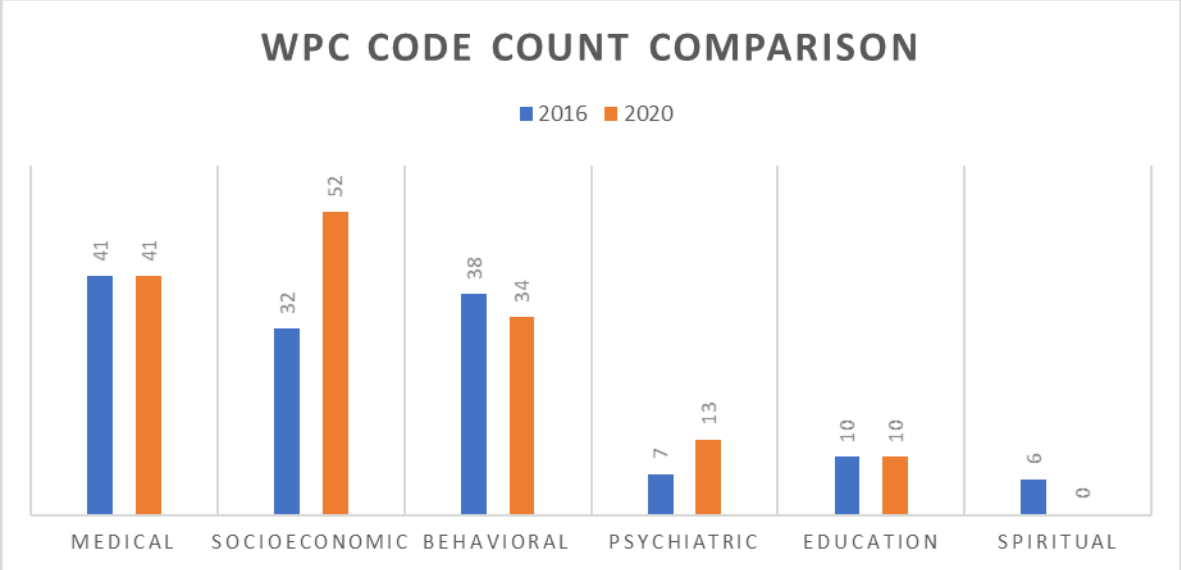
Code Categories

Code categories were generated using the WPC Pilot Program goals, including the coordination of medical, behavioral, and social health services. Sub-codes were also used to express universal themes, such as personal skills and population characteristics. Text code comparison revealed axial code patterns, as noted in Figure 4.

The codes were synthesized as part of the analysis process. Data excerpted from the transcripts were used to compile the relevant information. Examples, as noted in Appendix A of the elicited questionnaires, are history and physical (H &P), Montreal Cognitive Assessment (MoCA), Nine question Personal History Questionnaire (PHQ9), as well as Vulnerability Issues- Service Prioritization Decision Assessment Tool (VI-SPDAT). In comparison to the 2020 findings,

Figure 4

WPC Pilot Program Codes



these screening tools were incorporated into the new evidenced-base patient interview technique. (Souders, 2021)

In both studies, transcripts were carefully reviewed multiple times to categorize the participants' perceptions. The iterative process, patterning, and sequencing identified several codes whose frequencies were listed in table 1. Codes also consisted of concurrent sub-codes within the transcription text, which allowed the identification of dual codes within a single response. Each code type was significant in the analytical process. The code count and the duration of topic discussions were incorporated into this objective process. The researcher identified this information as valuable in the providers' perceptions.

The numerical count of codes supported the initial process. For example, in the 2016 assessment, screening tools were identified 33 times within the transcription document, less than the 41 notations in the 2020 study. Additionally,

Table 1

Code Frequency

Axial code	Code Frequency 2016	2020
Housing	9	15
Survival	16	15
Medical Health	41	41
Education	10	10
Assessment tool	33	41
Whole Person Care	13	45
Social Health	52	32
Spiritual Health	6	0
Behavioral Health	38	34
Psychiatric Support	7	13

behavioral health and counseling were identified on four occasions within these transcriptions. Nevertheless, each was assigned as codes to compare the significant value within the documentation and transcription.

All participants mentioned a variety of screening assessment tools. There were a number of screening questionnaires that were used in varying degrees within individual organizations. During the 2016 qualitative data analysis, some codes were unexpectedly found to be significant, such as the Vi-SPDAT screening tool. Likewise, these codes were evident in the 2020 study. For example, a standard practice shift occurred from a H & P to intake discussion. The screening queries were incorporated within the evidence-based practice of intake interviewing. They were incorporating the previous screening tools in the 2020 intake process responses improved processing and communication.

Presentation of Data and Results of Analysis

The data were prepared for presentation with a CAQDAS to compare the participants' responses and support code development. The data acquired from the providers as a diverse group of multidisciplinary, multi-professional stakeholders combined to offer a broad framework for analysis. Charts and graphs depicting the range of the participants' occupations, disciplines, and perceptions of resilience characteristics among the homeless have also been included as visual aids. The following are the questions the participants were asked in the interview process. Each section consists of the interview question, identified themes, and the researcher's summation of the participants' responses.

1. What was your current position within the organization?

The first question's responses showed a significant variation in the types of organizations and professional positions held by the participants. The gender assigned at birth and using the pronouns[2] he/him and she/her remained the same in both studies, as in Figure 5.

Andy and Elly, two participants from the original study, were not available to complete the interview process. Other changes included employment adjustments such as those noted regarding Bill, who was previously the Medical Director of a county facility. He has subsequently resumed a clinician role coupled with administrative tasks within another WPC organization. His employment and roles remain related to the PEH community. His perspective was affected by his new role. The primary roles of the participants are noted in Figure 6. The number of Clinicians remained the same in both studies due to the dual roles of several licensed professionals.

Figure 5

Percent Gender Participation

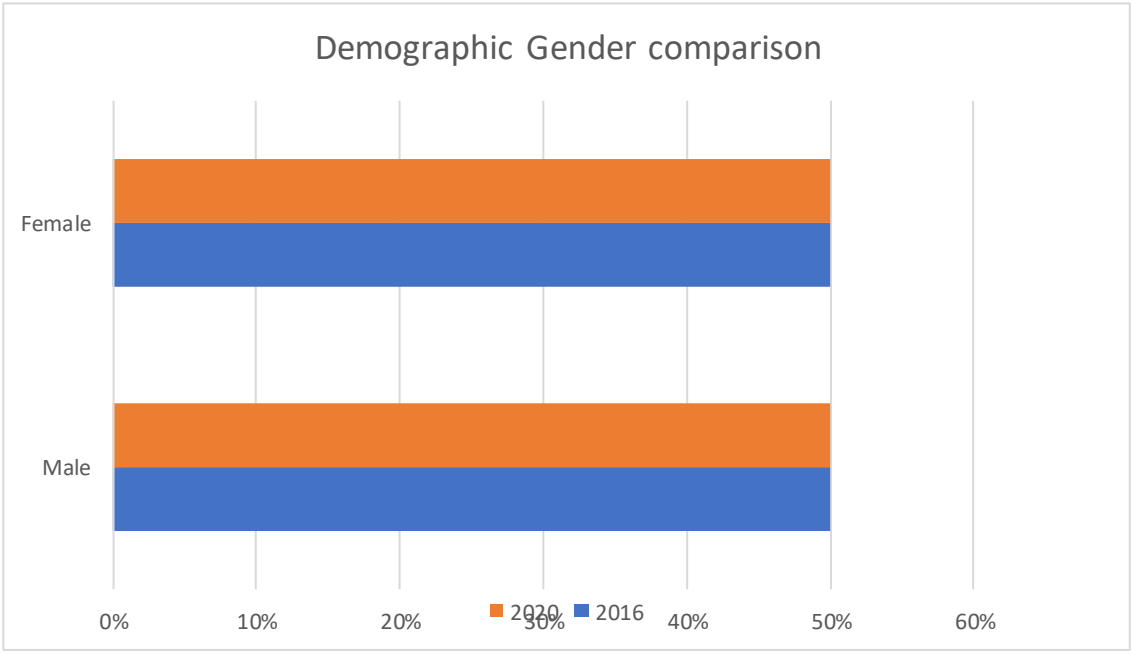
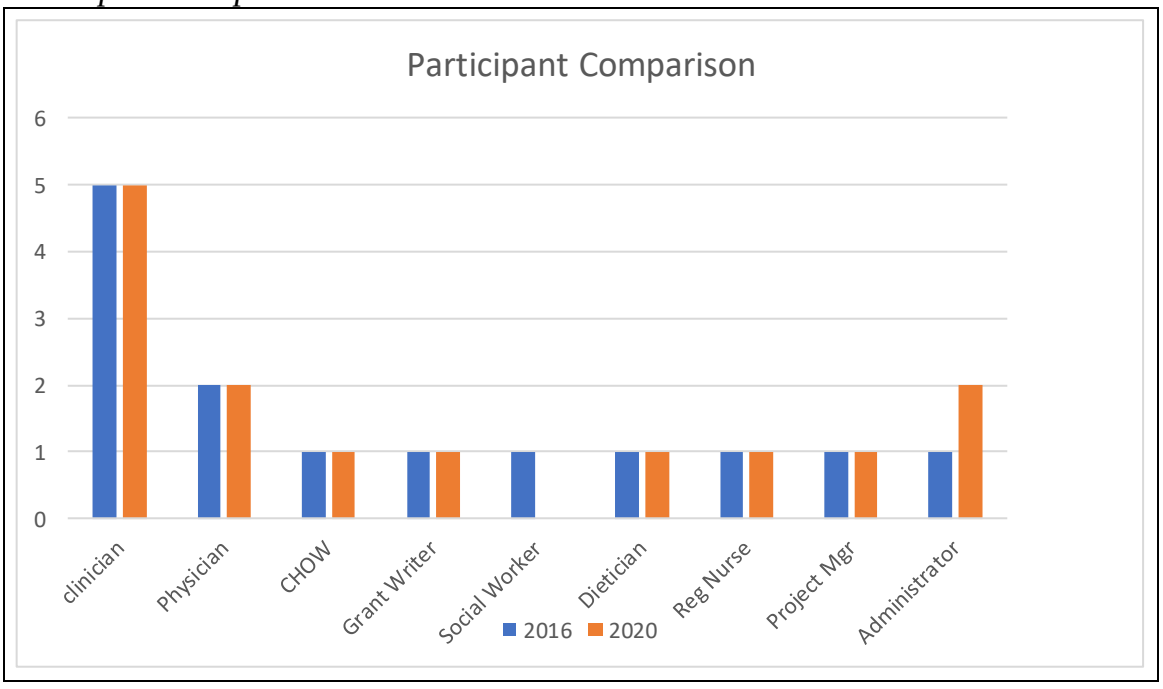


Figure 6

Participant Comparison



2. Describe what type of medical health support was available in your program.

Health literacy was identified from the responses to question 2. Health literacy, initially defined by the Institute of Medicine (IOM) report, requires a complex set of skills within a cultural and societal context involving the individual, the healthcare system, and the education system (IOM, 2004). In other words, health literacy was demonstrated by persons who had comprehensive knowledge of the appropriate terminology when discussing matters related to medical healthcare.

In the initial study, one interviewee stated, “In our large homeless senior program, we have a full-time nurse. We have a part-time doctor who was dual board certified as a psychiatrist and a primary care physician . . .” (Carl, 2016). In contrast, another explained, “So there was not comprehensive availability necessarily, but there was a pretty comprehensive array of services that we at least touched and offered to segments of the population. So the core was primary care with integrated behavioral health services . . .” (Bill, 2016).

Most participants likewise in both studies offered an overview of the staff and services rather than provide a more comprehensive description from a medical perspective. For example, Jane stated in the 2020 interview, “ in our residential programs, we do medical care management, so we have nurse coordinators. We liaise with primary care providers and then certainly our psychiatric support system. But we’re doing basic medical case management and care management for our populations.” (Jane, 2020)

3. What type of medical questionnaire format was used?

Comparison of the two studies demonstrated there was an overwhelming consensus in response to question 3. The routine history and physical (H&P) were performed in the intake assessment phase with each new patient. As an

administrator, Jane stated, ". . . a standard psychiatric evaluation, a nursing assessment, and then a biopsychosocial assessment and evaluation [is performed] for everyone on intake. And then, depending on the domains, we kind of branch out. And we do have an electronic health record system where we capture this . . ." (Jane, 2016).

Similarly, although terminology changed moderately, in the 2020 interview, Jane says, "So, we do a medical screen (H&P) assessment at intake. So anytime someone comes into one of our programs, as part of their assessment and evaluation, we do basically a medical health screen that goes through all kind of basic elements of care management for the individual. We also get reports from their primary care doctor" (Jane 2020). Although the participants stated that they used a general format to record patient health information,

4. What type of demographic data was collected?

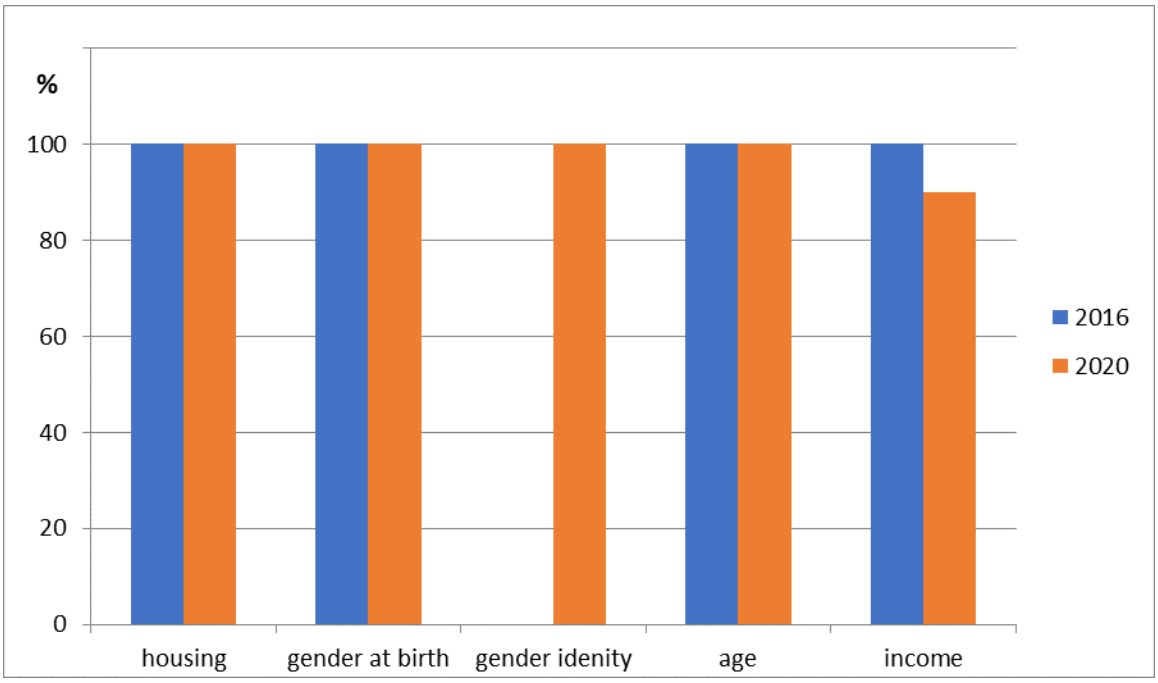
Question 4 responses regarding the collection of demographic data correlated with overall responses to question 3. In both 2016 and 2020, each participant relied on routine medical record documentation, including the name, date of birth, gender, address, living situation, religion, marital status, and emergency contact. It was also mentioned that grant funding was essential to maintain the provision of services. In the 2020 interview, additional demographic data, such as gender identity, has been incorporated. A comparison of the demographic data has been presented in Figure 7.

5. What social health support was available in your program?

In both 2016 and 2020, most responses indicated the availability of social health support was dependent on the availability of grants and other funding

Figure 7

Demographic Data



streams. Social services' primary focus was transitioning individuals from one housing situation to another to improve their living circumstances.

Programs rooted in social health support were said to be associated with a more extensive network and offered rehabilitative services and residential advocacy support. Carl (2020) stated there were pre- and post-COVID styles of social support. He continued with comments regarding social events affecting the African American community, saying, "…In addition to that, there are a couple of other programs that will be -- they're (they are) in various states of startup. The Black Centering was coming... originally it was, I think, meant for African American mothers sort of with higher-risk pregnancy, but I understand that they've just expanded it basically to African American mothers, expecting mothers. And within Centering, there are psychosocial components" (Carl, 2020)

6. What type of behavioral health support was available in your program?

There was a correlation in the overall response to question 6 regarding the type and availability of behavioral support and the answer to question 5. Similarly, the consensus was that programs rooted in behavioral health support were associated with multiple services and offered residential rehabilitation support. Programs and shelters have integrated behavioral health support in the respective programs. For example, in 2016, one participant stated, "We have structured support just by the structure that we have in our program, and then we have classes, we have groups…" (Elly, 2016). Likewise, in 2020 Jane stated, "we remain kind of the intersection of social service and behavioral health and housing and homelessness and older adult services for the Bay Area" (Jane, 2020).

7. Which behavioral questionnaires are used to assess for adverse childhood experiences (ACEs), patient health such as the (PHQ-9), and post-traumatic stress syndrome (PTSD) or resilience scoring?

Responses to question 7 regarding the providers' use of behavioral questionnaires showed variations in the types utilized in their practice. Overall, the consensus was that these assessment tools were used only sporadically and not regarded as a mandatory component of homeless care. These questionnaires were well known to specific disciplines, including medical, behavioral, social service, administrative, nursing, and grant writing. In the 2016 study, findings showed that, despite their knowledge regarding assessment tool function, 80% of the participants did not use the validated tools consistently in their program. This demonstrated 20% of the participants involved in rehabilitation programs always used various tools such as the Vulnerability Index (VI–SPDAT) and Adults Needs and Strength Assessment (ANSA) during an initial assessment of homeless clients.

In contrast, 12.5% of the 2020 participants utilized these assessment tools consistently in the previous format.

8. From the current knowledge of medical, psychological, and social healthcare, which of these areas was more prominent in your program?

Regarding question 8, the most prominent health concerns addressed by the providers' programs demonstrated a variety of combinations. In comparison, participants stated that although one area was more weighted, all services would be ideal. In both studies, participants noted the psychological support was the health specialty service most needed by the homeless population and the least incorporated in the various programs. The overall response in both 2016 and 2020 interviews confirmed the importance of WPC through the intersection of social, psychological, medical, and behavioral health. Group sessions and general assistance (GA) were consistently mentioned as integral aspects of rehabilitation and shelter programs, including social and psychological support services, in both studies.

Providers who offered medical services stated that the other components were made available in accordance with the patient's need. Although both studies demonstrate a necessity for various service organizations, they could not provide all services directly. There was a moderate shift noted in comparison. As indicated in Figures 8 and 9, the prominent health care type shifted due to increased medical support, socioeconomic health moderately, and a decrease in psychiatric care.

9. Of these three areas, which one do you feel needs expansion? Why?

In response to question 9, there was a variation regarding the participants' perceptions of which of the three areas within their respective organizations serving the homeless needed expansion. This was also a high priority among

Figure 8

Prominent health care type, 2016

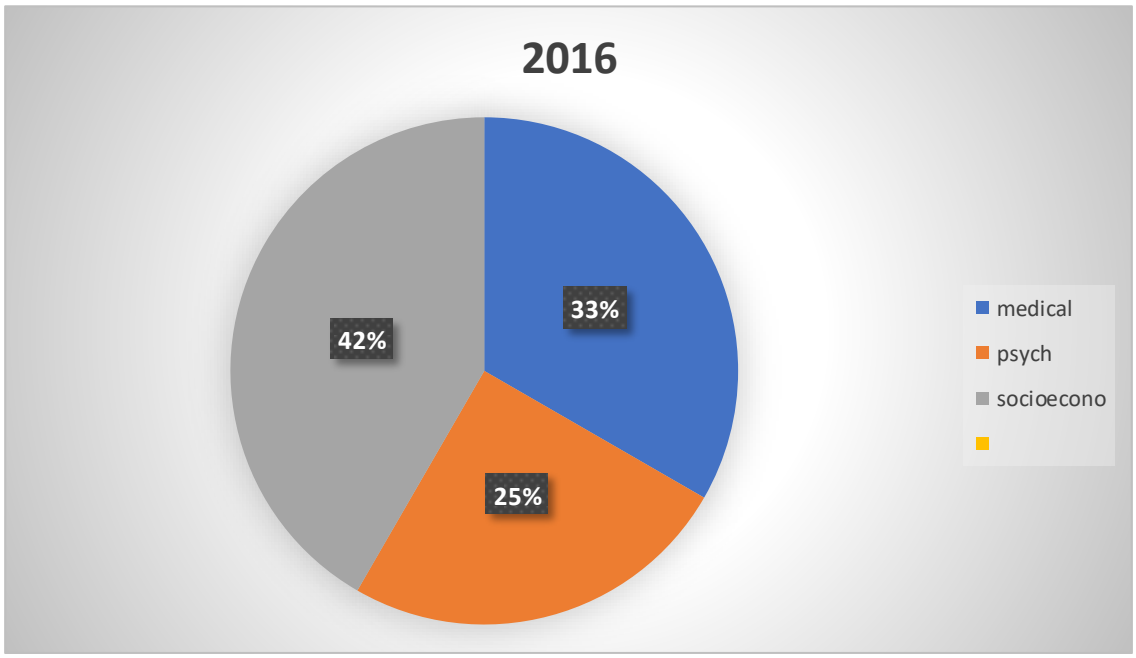
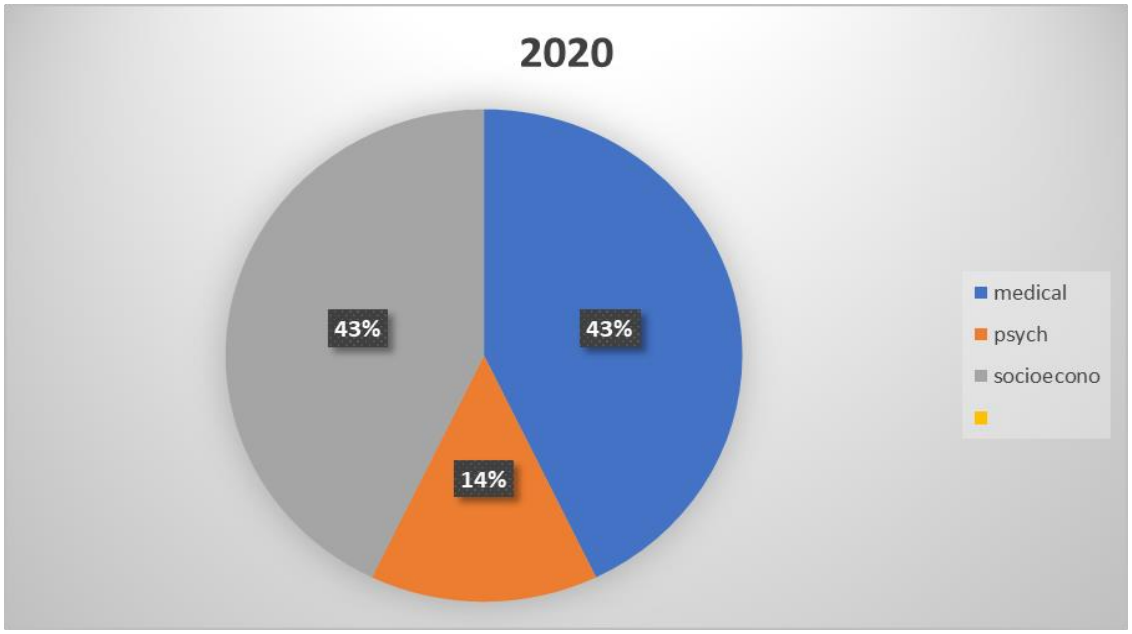


Figure 9

Prominent Health care type, 2020



the participants who provided medical services. Consistently, each interviewee cited the need to have an equal weight between all of the components. An increase in health literacy was cited by all the participants as a required component within the various homeless care programs.

Mental health program integration was successful comparatively. Psychiatric concerns were stated as a probable cause of chronic homelessness and vulnerability. In 2016, 70% of the participants recommended an increase in the psychiatric support of the respective programs. In the 2020 study, 57% identified the need to improve, increase, or incorporate psychiatric, behavioral, and mental health care services.

10. With any specific homeless person in mind, what do you feel is the most helpful characteristic for that individual?

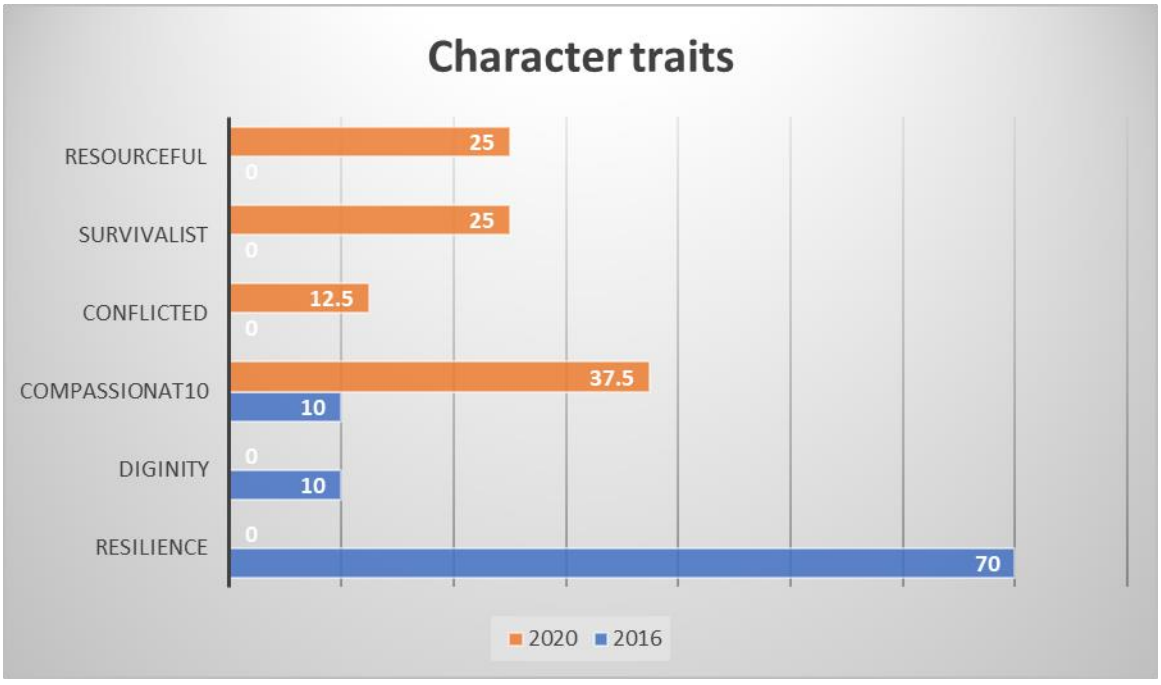
In the 2016 study, 90% of the participants responded to this question. 70% of the participants stated fortitude and resilience was an admirable character trait. One participant described her inability to provide adequate information as "Believe it or not, despite all of my work, I'm so administrative and not very specific with any patients . . . I don't have the opportunity to know any patients well enough to really feel like I'd be able to answer that question." (Fran, 2016). However, in 2020, Fran stated an increased opportunity to communicate directly with PEH community members. With this change, perseverance was noted as an individual's character asset.

Figure 10 indicates the percent range of responses resourcefulness and survival skills as the most beneficial traits. Although dignity was not stated in the 2020 interview, other terms summarized the vast number of character traits that offer independent support. Other terms leading to resilience were noted, as in

figure 10, such as reciprocity, self-reflectiveness, perseverance and trust were noteworthy terms.

Figure 10

Character traits



Summary of the Results

An analysis of the data found minimal differences between the first and second study. There was minimal change in participant demographics. Although there was 80% participant retention between 2016 and 2020, the demographic percentages remained constant. Within the participant data set, the percentage of clinicians and administrative personnel remained the same. The familiarity of each participant was significantly improved over the four years. The time between studies created a moderate knowledge shift in the elements of comparison.

An analysis of the data found minimal differences between the first and second study. There was minimal change in participant demographics. Although there was 80% participant retention between 2016 and 2020, the demographic percentages remained constant. Within the information, that clinician versus administrative participants remained steady. The familiarity of each participant was significantly improved over the 4-years. The time between studies created a moderate knowledge shift in the elements of comparison, as noted in Appendix B.

Medical care was an essential factor of the WPC pilot program. The WPC pilot program's integration of medical, mental, social, and psychiatric health support showed improvement. Participants in both 2016 and 2020 recognized the importance of the medical aspect and evaluation availability related to all areas of good health and healthcare. Whether integrated within the program or contracted through another medical facility, it was deemed imperative to adequately care for the community. For example, although in 2016 various forms and screening tools were cited as necessary, in 2020, it was apparent that several of the screening tool questions were integrated into an evidence-based style of H&P interviewing. Code categories for comparison were noted as in Table 2.

Overall, both the 2016 and 2020 semi-structured interviews elicited information that showed a minor shift in aspects of WPC pilot program participants' experiences. In moderate contrast, the main focus of the WPC pilot program remained constant. The support for medical, social, psychiatric, spiritual, and mental health were significant and important aspects of both the 2016 and 2020 analyses.

Table 2

Categories for Comparison

Code	2016	2020
Medical Health: Medical care was a primary concern regarding good health.	Comparatively, this area of health equal with a code count of 42 in 2016	43 code counts noted in 2020
Mental Health: Behavioral and Mental health was a significant component of the WPC pilot program	Approximately 25% of the participants agreed with the importance of behavioral health in their programs;	However, in contrast, 14% were noted
Socioeconomic: this area remained significantly important in both studies	Code count comparison 52	Increasing importance noted in a code count of 32
Housing: Potential reciprocal effect as "poor health may lead to loss of housing and loss of housing contributes to poor health."	Although mentioned in 2016, plans were not as well or as viable as in 2020 to obtain permanent housing.	In contrast, there was increased support from the federal and state government. 'Operation room key' created hotel temporary housing in the PEH community.
Spiritual: An aspect of good health within the holistic health realm of care.	Minimal discussion in the 2016 study	There was no comment and concern regarding the PEH community's spiritual health.
Unexpected findings: In data collection, several codes are evident due to the discussion topics. Other findings may be discussed during elaboration	In 2016 multiple screening questionnaire tools with a frequency of 33 counts	The 2020 study showed that multiple influencing factors were identified

CHAPTER 5: CONCLUSION

Introduction

This chapter discusses how the findings regarding a comparison of providers' perceptions of the WPC approach to homelessness can serve as determinants for future research. A WPC approach was a care model that incorporates all areas of an individual's social, physical, mental, psychological, and behavioral health. This approach encourages providers and others to work towards uncovering collaborative multidisciplinary healthcare teams for the PEH community.

This study aimed to contribute new knowledge regarding the WPC healthcare approach's effectiveness to the PEH community. As the PEH community and participant group were diverse and incorporated in many aspects of the general and underserved populations, several healthcare caveats can be taken from this study. Other health issues have been identified. However, due to the goal of this study, it was imperative to clearly state that the depth of these issues will not be fully discussed within this study. To name just a few, topics such as racial equitability, social determinants of health, psychiatric concerns, spiritual concerns, safe sex practices, food insecurities, economic insecurities may be incorporated in future research.

Recommendations may be made for future research based on the comparative analysis of the providers' perceptions. The information collected from the semi-structured interviews of the providers' perceptions regarding their role in addressing the problem will help inform future practice standards. First, identify components of homeless health care needs at the start versus the end of the WPC pilot program. In comparison, this study sought to determine if WPC

providers' perceptions of homeless healthcare needs have changed from the 2016 study compared to the 2020 study.

Diverse professional and cultural backgrounds were needed for the semi-structured interview. Eight of the original 2016 PEH providers returned to participate in the 2020 interviews. The interview questions were specifically designed to allow the participants to elaborate on their responses and request additional information as needed. The participants' professional background and role in the WPC Pilot Program have been retained; however, every precaution was taken throughout the study to preserve the participants' anonymity.

The ideal population of participants for a given study was those directly affected by homelessness circumstances. Research efforts to work directly with the PEH community are challenging due to various research ethics concerns. Therefore, to understand WPC programs' effectiveness, the participant group selected experts that directly or supportively provide care to the PEH population. This study relied on the ever-expanding role of Attachment Theory. It served as an aid to better understand the psychological and sociocultural impact of interpersonal relationships across the span of human development (Sochos, 2015). It was essential to recognize the implications for providers and others who may adopt this framework to enhance a WPC approach to the problem of homelessness.

Whether the cause of a person's homeless condition was due to poverty, addiction, trauma, or another factor, the road to recovery and subsequent stability has been reported by researchers, such as Hardy (2016), David et al. (2012), and Slater (2007) to be strongly related to the quality of the relationship. The differences in the participants' perceptions, such as the resilience character traits discussed in question 12, may demonstrate the effects of COVID-19 changes,

socioeconomic changes, diversity of aptitudes, community background changes, and causes of homelessness within the PEH population. Although noted as positive attributes, the normalization of these conditions and changes may lead to persistent and chronic homelessness.

Discussion of the Results

The result of these comparison findings included the information presented, the changes within the state's pilot program, and regional, national, and international community influencing factors. Gaps in healthcare are generally identified from the perspective of the provider. The initial step of discovering the need brings about the compilation of data and metrics. Historical background of attempted solutions and resolution as well as policies and funding are needed. The impetus in which the study was rooted was imperative; as well, the foundation for good dissemination was evident.

The foundation, framework, and modeling defined the WPC, holistic approach to caring for the PEH community. With this approach, perceiving, acknowledging, and understanding the provider's perspective was imperative. Utilizing the expert providers' evidence may offer sufficient and reliable information for a standardized template for physical, mental, and socioeconomic support in this community.

The California state-approved 5-year pilot program supported this community. PEH community members have a challenge within the healthcare system. Understanding those challenges through providers' perspectives helps identify learning points in an empathetic approach for nursing, advanced practice nurses, and medical providers. The WPC approach serves as the underpinning rationale for changes in PEH community healthcare.

The social determinants of health (SDOH) from the providers' view of PEH healthcare were significant points of discussion. The CDC defines SDOH as the conditions in which a person lives, learns, and works that may have a wide range of health consequences (CDC, 2018). The areas of health that require special attention are physical, mental, emotional, and spiritual. Participants described financial and social stressors as affecting inappropriate dietary intake, interrupted sleep patterns, and persistent 'fight-or-flight' mechanisms. 'Fight-or-flight' was an autonomic neurological mechanism when confronted with a dangerous situation.

The WPC program was designed to coordinate health, behavioral health, and social services to improve Medi-Cal beneficiaries' health outcomes. There can be no doubt that an increased knowledge level among all the stakeholders regarding one another's role could result in greater program efficiency. Whereas the providers interviewed for the study were mainly from the healthcare field, it was unknown how other stakeholders' perceptions might have influenced the study outcome. Other WPC Pilot Program members may have responded similarly regarding their awareness of one another's role in the program, such as persons with religious affiliations, educators, politicians, real estate developers, law enforcement, and philanthropists, and community volunteers,

As defined by the State of California, a 'silo-mentality' refers to a resistance of inter-organization information sharing among those agencies and organizations who care for the homeless (DHCS, 2016). Concerning both sets of data collection, whether the apparent lack of shared knowledge among the participants was deliberate or due to organizational inefficiency was unknown since none of the interview questions dealt directly with the silo-mentality phenomenon. It should be noted that the lack of shared knowledge, whether deliberate or not, creates an almost insurmountable barrier to discovering a robust

solution to the problem of homelessness. One way to articulate the difficulty caused by this type of barrier was to envision the link between one specialty service and another as competition versus collaboration.

Notwithstanding the researcher's impressions regarding the providers' level of shared knowledge beyond their respective roles and organizations within the WPC Pilot Program, the research question was addressed to examine the participants' perceptions of a WPC approach to the problem of homelessness. Though the subject of homelessness was not easy to discuss, the participants were open and candid in their responses to the ten interview questions. Moreover, there are many facets to the problem ranging from politics, financing, housing, and healthcare to addiction, unemployment, and mental illness. The saying that "everyone was only one paycheck away from being homeless" demonstrates this topic's breadth and depth. In a sense, the idea of homelessness hits us all too close to home. In addition to answering the research question, there was no doubt that the findings regarding the providers' perceptions served very well as determinants for future research.

Review of Research Problem and Purpose

This qualitative research project was conducted through semi-structured interviews with ten homeless care providers. The results of the present study, through comparative methods, exposed that the participants, as providers, working in "satellite" or "street medicine" clinics, shelters, residential, or drop-in facilities. As characterized by their various roles within their respective organizations, they have contributed significantly to the WPC support of diverse individuals experiencing homelessness.

As discussed in chapter 2, providers who work with the homeless are in a unique position to share their perceptions from a particular vantage point. Homeless individuals are frequently the victims of a wide range of unhappy circumstances such as substance abuse, eviction, foreclosure, unemployment, the absence of a living wage, and mental illness (SAMHSA, 2020). As stakeholders working for the cause of humanity, their perspectives can help others better understand and respond to the social injustices and complex realities currently afflicting a growing number of Americans and the citizens of other nations.

The interview findings provided credible support for applying the Attachment Theory framework and the previous literature concerning the theoretical framework. Of all the issues surrounding the subject of homelessness, ACEs frequently played a significant role. However, a complete diagnosis, plan, and ACEs intervention standard was necessary but not yet available. Although the interview questions did not specifically address this phenomenon, the issue surfaced as a regular feature of the previous literature.

It may also be presumed that there was a strong link between ACEs and the Attachment Theory framework. For example, David et al (2012) pointed out that the role of Attachment Theory can serve as a guide to understanding the sociocultural phenomena and individual circumstances, such as provider to patient relationship, ACEs, substance abuse, and mental health issues that influence people's attitudes towards homelessness. Likewise, Patterson et al (2014) stated that ACEs in the form of abuse, neglect, and family dysfunction had been reported to be disproportionately present among homeless adults. The various types of child abuse and low-income family attachments can have a cumulative effect, putting individuals at risk for future homelessness.

Analysis, Synthesis, and Evaluation

Providers' perceptions, as shown by the results of the study, have a significant effect on their approach to working with the disadvantaged. The codes that emerged from the interview responses analysis suggested a strong link between the providers' perceptions and how they exercised their professional skills and utilized the WPC Pilot Program resources.

The common thread throughout this qualitative study was addressing phenomenology as the primary framework. In using the phenomenological framework and behavioral sciences, the methodology collectively allows analysis from multiple perspectives. The comprehensiveness of the analysis was enhanced by applying the Attachment Theory framework at each research project stage. In the 2016 study patterns associated with the providers' perceptions of the WPC approach to working with the homeless, the framework helped consolidate the social, economic, physical, behavioral, and psychological domains. The patterns identified from the providers' responses to the interview questions revealed a quality of relationship with their clients. In cases where the provider did not directly contact the homeless, some indicators showed characteristics of attachment-driven behaviors such as expressions of empathy and compassion.

The 2016 interview of 10 participants showed that the participants, as stakeholders, were acknowledged, knowledgeable, and focused on their respective roles to provide aid to the homeless. However, the results also demonstrated a need for increased collaboration since it was recognized that participants were somewhat unfamiliar with each other's organizational work as collective members in rolled-in the WPC pilot program. For example, the unexpected codes noted in the 2016 study were not as evident in 2020. Surprisingly, in 2016 assessment screening tools were mentioned by all participants in varying amounts with much

elaboration. However, it was noted that none of these organizations were using them consistently and comprehensively. The use of a standardized template or algorithm would be built into the intake, H&P process. This demonstration of the interconnectedness, standardized communication, and collaboration of the PEH service community would initiate specialty care referrals.

Time gives rise to growth, knowledge, and more experience in any field of study. Much has happened in the interim period, socioeconomically, changes in health advocacy, research, and new evidence. History and physical interviews in 2020 were generally made over a computerized system, as opposed to 2016 assessments in which computer prompted referrals and conversations among different community organizations were limited. However, the PEH community providers had found it necessary to utilize privacy-protected technological equipment in patient interviewing. Several aspects of the aforementioned assessment tools in 2020 were used in a more significant conversation and information gathering format such as motivational interviewing style conversation (Souders, 2021)

Influencing Factors

This phenomenological comparison study sought to answer perception changes that may have occurred over a specific period as experienced by an individual. Much had happened socially, economically, health advocacy, research, and new evidence between 2016 through 2020. Also, within that extended period of time, multiple events have occurred that changed the tenor of healthcare policy and practice. The interim confounding occurrences were state wildfires, economic shifts, changes in weather patterns, social justice incidents, and especially the Corona Virus Disease of 2019 (COVID-19) pandemic.

COVID-19 pandemic safety requirements include social distancing, virtual school, reduced exposure to environments, other socioeconomic changes, racially motivated activities, and political conflicts. The global pandemic has created unforeseen economic changes. As it has affected the world, it has indisputably affected the PEH community. COVID-19 has required society to social distance, increase droplet and airborne precautions, stay at home, limit excursions, and maintain daily living activities. For individuals who lack housing, these "normal" activities are challenging to incorporate.

Providers' perceptions are included from the pandemic-affected vantage point. Due to systemic, regional, and international events, economic changes required the government to support individuals, families, and communities. The PEH community needed specific support. COVID-19 affected the WPC pilot program. Unhoused individuals and others define through HHS or HUD could benefit from some of these federal funding changes.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, a Federal bill that offered financing and funding to the state, is another 2020 study influencing factor. (USCongress, 2020). This funding supported a safe domicile for un-housed individuals, such as Operation Room-key. Operation room key was designed by California Department of Social Services (CDSS) in response to support and protect vulnerable homeless citizens (California Department of Social Services, 2020). The state-funded WPC pilot program collaborative information sharing offered a good holistic vantage point to accept COVID-19 effects. In other words, this influenced the overall support and stance in helping the unhoused. The pandemic affected the PEH community in which more accessible residences, shelters or hotels, winter shelters, and permanent housing were made available through county and state funding.

In 2016 each discipline utilized a tool familiar to their domain. However, in 2020 it was recognized that these are general intake tools questionnaires and screening. It was currently customary for a multidiscipline, administration, or clinicians to utilize an intake process. This does not forgo the screening tools as they are now incorporated within that process. In comparison, in 2020, a standard practice shift concerning screening tools occurred. These screening queries were included within the evidence-based practice of motivational interviewing (Souders, 2021). In this practice, patient screening tool responses were incorporated in 2020, were incorporated in an intake process.

Over the 5-year timeframe, there was more significant knowledge through more experience. History and physical data gathering, and interviews were commonly made using a computerized system. However, the PEH community providers have found it necessary to utilize laptops, smartphones, or other devices while interviewing patients. Therefore, several aspects of the aforementioned assessment tools were used in a more meaningful conversation and information gathering format in motivational interviewing style conversation (Souders, 2021).

The participant group has been impacted by several world events from 2016 to 2020. There have also been, as noted, adjustments within employment positions that occurred. These influencing factors may have led to a different perspective than the 2016 interview data. Other events such as the Affordable Care Act (ACA) changes, the prevalence of African American citizens' death by law enforcement, and an additional five years of experience have adjusted society's vantage point.

As previously discussed, each question was significant concerning WPC pilot program. The expert providers' perceptions were documented and analyzed. Below are the results of that comparison in the analytical process of codes.

However, the depth of the respondent's answers was moderately different. Influencing factors and confounding events help change the perspective and vantage point of a specific topic, content, concern, or event.

Five years of experience offer a significant change in individual maturation. A personal 5-year plan was often set out by many to adjust life strategy in the literature review. Theorists, such as Maslow and Erickson, consider physiologic and cognitive brain growth and development. Maslow's hierarchy or Erickson's maturity stages supports cognitive advancement over an extended period (Butts & Rich, 2018). This change was anticipated and expected on a routine basis. As all adults generally budget their time management, this 5-year plan was for growth, maturity, and enlightenment. Many five-year plans include changes such as other milestones of education and or employment.

The maintenance of the health and well-being of the PEH community and the general population was imperative. Adjustment of the affordable care act (ACA) made it possible for unemployed people to access Medicaid insurance. However, the Trump administration would not allow Medicaid monies to be spent on those that could not document any work for a specified number of hours per month. The Medicaid waiver 1115 allowed work requirements to be adjusted (DHCS, 2020). Several states attempted to reinstate the work requirements, therefore, leaving approximately 18,000 insurance beneficiaries without coverage in 2018. Although California was not among the states that requested a halted policy, this has affected the PEH community overall (USA.gov, 2020).

Another influencing factor in the last five years was the global support for the Black Lives Matter illustrations. This factor was fueled in part by COVID-19 shelter-in-place and a global audience of a racially charged incident. Other devastating stories encouraged many races, ethnic backgrounds, socioeconomic

backgrounds, religious and spiritual denominations to recognize these anomalies inflicted by the black community.

The news was witnessed by the world of an African American man's death while calling for help. The information was observed by so many during a fragile emotional time of sheltering in place. This incident, coupled with COVID-19 networking and social distancing requirements, affected racial concerns' lives and knowledge level. In the summer of 2020, people demonstrated against racism in Australia, Switzerland, London, the Middle East, Belgium, Portugal, the Netherland, Berlin, Portugal, the Netherlands, Hong Kong, Rio de Janeiro, Brazil, Rome, South Korea, South Africa, and Scotland to name a few (Weine et al., 2020).

The national news and enlightenment occurred as information trickled down to the PEH community and those who care for their health and well-being. In particular, it affects the PEH community. It has been recognized that in the point-in-time (PIT) count, there was a significant racial disparity of African American males in this chronic homeless population in the point-in-time (PIT) count. Also demonstrated in Congress' PIT report was that they are generally of a senior age with difficulty locating employment. Federal funding was dependent on this summation of the PEH community (HUD, 2020).

Findings in Relation to Reality

Although the project was limited to a small sample as defined in relation to phenomenological qualitative research, the results yielded helpful information for future studies. Despite the outcome, however, the study may have benefited from a more widely dispersed sample of qualified participants from professions other than

healthcare. Additional disciplines might have contributed to the rigor of the research.

Moreover, the quality of provider responses may have enhanced by using open-ended, semi-structured interview questions to elicit a more personal response to a WPC approach to working with the homeless. On the other hand, persons who hold public positions of trust and who work with vulnerable populations may be reticent about sharing personal opinions no matter how the question was posed.

It is unclear how the participants for the present study would have reacted to a more personal inquiry; however, the interview questions seemed to put them at ease and allowed them enough room to expand on their responses without any pressure or coercion. Lastly, an obvious limitation was the purposive but necessary choice of a single county out of the nine San Francisco Bay Area counties. As in the case of the study benefiting from a more widely dispersed sample of participants, the study might also have benefited from the compared results from more than one county.

Implications of the Study

Based on the present study's findings, including the information drawn from the relevant literature, it was clear that homelessness was not just the province of providers, policymakers, and charitable institutions but remained an everyday reality that touches society's whole. The implications of the comparison research of WPC provider experience in working with the homeless are significant for organizations and their members.

In today's world, organizations of all types, including healthcare, are organic or mechanistic. This means that they function according to a particular management structure. An organic type of management allows for increased

specialist collaboration, decentralization of the authority, less formality, and ongoing communication. In contrast, a mechanical structure relies more on a hierarchical, top-down form of management, standardization of rules and operating procedures, and fixed positions corresponding to specific tasks (Lunenburg, 2012).

To describe the implications of the present research, it suffices to say that no matter what type of management structure was employed by the organizations enrolled in it, the WPC Pilot Program was accelerated by the COVID-19 pandemic. They must include in their vision and mission how they will share information among all the other member organizations.

Without inter-organizational sharing of information, the concept of the interconnectedness of the WPC program would remain only a phrase on a page. The physician, social worker, or nutritionist may be good at the practice of their profession. Still, suppose they cannot appropriately refer patients who have other needs due to their lack of inter-organizational knowledge. The WPC and funding for such a program would not be utilized as fully as intended. As mentioned earlier, the WPC Pilot Program organizations may not be deliberately withholding information from each other in the form of a "silo mentality." However, there needs to be a precise evaluation of what was meant by WPC and how organizations that apply to a WPC program can demonstrate, regardless of their type of management structure, that they have the means to share information and can refer clients appropriately as needed.

Discussion of Conclusion in Relation to the Field

The Nursing discipline initiated the holistic patient care approach. The incorporation of this nursing theory in healthcare, in general, was a crucial phase.

They recognized that the medical aspects and information technology, data, and planning are needed for individuals. Each individual was comprised of many aspects of well-being. These aspects include genetic, physical, mental, social, and spiritual health. Recognizing and incorporating these aspects in healthcare maintenance was ideal.

Nursing theorists have long recognized the need to treat the total person. Therefore, the whole person care project was in alignment with nursing practice. Obtaining the perspective from other disciplines in relation to comprehensive care, including financial, socioeconomic, spiritual, medical, will foster the concept of individualizing patient care.

Regarding the individual providers, the study's implications also show a need for inter-organizational in-service meetings for the members of the WPC Pilot Program to find out who's who and what resources are available to clients outside their specialty area. For instance, a nurse practitioner who was a member of a WPC Pilot Program organization should refer a homeless client immediately to another WPC Pilot Program member organization without unnecessary delays.

Moreover, there needs to be a follow-up protocol to avoid "losing patients in the bureaucracy." A nurse practitioner who was a member of a WPC Pilot Program organization and purported to have a WPC approach to working with the homeless does not have to be a carpenter or an electrician to know where and refer a homeless client in need of housing. The WPC Pilot Program and similar program applications need to specify that a condition for members in the program includes a willingness to engage in inter-organizational sharing of information and collaboration.

As the common thread in comparison, the implications for policy and current practices locally, statewide, and nationally involve the perception of the

various regional providers in the repeated study. This study obtained data from one county of the nine San Francisco Bay Area counties in California. Considering the ‘economies of scale’ concept, further use of these findings can offer economical, community, health care, and homeless care solutions. A standardized, holistic, WPC concept approach to homelessness, adjusted regionally based on provider perceptions, may allow an explicit municipal form of WPC within each national region to exist.

The evaluation of a program was done through an ‘impact evaluation’ of a given program or intervention. As in all aspects of programs and interventions, plans must be made to coordinate, facilitate, communicate, and validate the program’s need in the community it serves. The impact evaluation offers five significant areas; The first was ‘did the project meet the goal?’ The formative evaluation process identifies the program goals. The second aspect was ‘what are the resources and sources to be included such as data and stakeholders?’ The third component of impact evaluation was ‘what was the most appropriate method to utilize as a framework?’ The methodology may be mix-method, qualitative, or quantitative methodology. The fourth aspect was the viability of the program, ‘was it realistic?’ Were the questions, data, and sources appropriate and relevant for the program?’ The fifth and final component of impact evaluation was ‘how will the information be disseminated?’ Pedagogy or andragogy considerations may be utilized to disseminate this information to stakeholders and the larger community. In conjunction, another plan must be developed to repeat the study and determine how the program can help the community. The California state WPC pilot program impact evaluation was pending at this time. Once completed, this aspect will better support future research.

Recommendations for Further Research

As determinants for future research, the providers' perceptions of a WPC approach to homelessness suggested two possible study areas. The first recommendation for further research involves a post-WPC pilot program repeat phenomenological study. Repeating the present study with the added feature of assessing the providers' knowledge of the work and resources available through partner WPC-oriented organizations, especially those inclusive of disciplines other than healthcare.

Overall, The WPC pilot program and this DNP project focused on assisting the underserved population. It was well understood that the PEH community was less fortunate compared to the general population. More specifically, the PEH community and their healthcare needs were the focus of these programs. The WPC pilot program identified areas that would help support community well-being. As this DNP project focuses on holistic WPC healthcare, the richness of a semi-structured interview helps identify additional areas that will help guide us in a more holistic approach. Appendix C helps to define the themes identified in each study and any recommended action.

Future studies could be carried out through interviews or written surveys distributed to other disciplines. These disciplines may include politicians, teachers, spiritual leaders, law enforcement, and others who encounter PEH in the practice of their professions and the management heads of organizations claimed to be WPC entities. Moreover, the qualitative study may include fictional case studies featuring homeless clients or those at risk for homelessness who will require the participants to demonstrate how each need would be addressed through timely inter-organizational collaboration.

A second recommendation for a research project could involve repeating the present study focusing on more than one county in the state of California post-WPC pilot program. The application of an intercounty intake algorithm tool used to compare and measure the effectiveness of more than one county's WPC approach to the problem of homelessness could yield valuable information concerning future program design, the allocation of funds and resources, membership requirements, and provider training. These findings, then, demonstrate the validity of interdisciplinary collaboration healthcare among the various providers, continued research to improve services, and cost-effective availability of resources, all of which can reduce the incidence of chronic homelessness and improve the quality of life for all.

Summary

The comparison study rationale was demarcated by the growing prevalence of homelessness throughout the United States. Also, programs such as the WPC Pilot Program in the State of California contribute sufficient evidence to support investigative research into the lack of shelter and the perceptions and attitudes of those whose role and responsibility are to address the issue.

In comparison to the two studies, several consistencies were noted. There was a unanimous agreement of the holistic, collaborative coordination of PEH community health care. As previous studies have shown, homeless individuals are found in poor neighborhoods and can be observed wherever human beings are grouped in every society segment. According to Har (2017), advocates for the homeless reported that the situation would only worsen unless affordable housing were constructed.

Of all the circumstances that put human beings at a disadvantage, such as old age, disability, and disease, no one of these things seems to have as crippling a stigma attached to homelessness. The tendency not to see or respond to people in this situation appears to be a common trait shared by many Americans, even among those who may themselves be economically disadvantaged.

It has been said that Adverse Childhood Experiences (ACEs) can put individuals at high risk for future homelessness. So, if the seeds of homelessness begin with childhood, one might even say that homelessness begins at home. Each interviewed provider for this research project plays a specialized role in the care of the homeless across the lifespan. As such, they had much to contribute, both by way of their perceptions and experience. These professionals are stationed at the forefront of the war against poverty and disease. What many people choose not to see or confront, they deal with daily.

In 1952, African American writer Ralph Ellison published the *Invisible Man*, the story of a black man who struggled, in the author's words, against the "national tendency to deny the common humanity" (Ellison, 1953, p. xxii) shared by his character and those who might read of his experience. In 1953, he won the National Book Award (National Book Award Foundation, 2018). In 1998, Modern Library ranked the work as one of the best 100 English language novels of the 20th Century (Modern Library, 2018). "I am an invisible man," (p. 3) says Ellison's character, who throughout the novel remains nameless. "I am invisible, understand, simply because people refuse to see me" (p. 3). He explains that the kind of invisibility he speaks of was a peculiar disposition of the *inner* eyes, those lenses through which people view the world around them. What Ellison's book had to say about racial inequality can be equally applied to the problem of today's

homelessness, and especially to the nation's youngest victims. The latter, like Ellison's nameless character, remain largely unseen.

This DNP project was intended to contribute new knowledge regarding WPC healthcare approach effectiveness and make recommendations for future research. The study also serves as a testament to the problem's scope, the work being done to reduce the incidence, the persistent perception of care needs, and the people. The providers and organizations bold enough to break through the barrier of invisibility and give assistance where, when, and more specifically, how assistance was most desperately needed.

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APPENDICES

APPENDIX A: CODES AND EXCERPTS

Codes	Meaning	Theme: Excerpt example
Behavioral Health	An interpretation and resultant interaction within a situation	Psychiatry. "…there're a lot of services in this area doing right by people, in connecting people to the things that they need. The one thing that we saw, working with the various community partners, was the lacking of mental health services…" (Hank, 2016) "And then we have our social workers who can intervene and deal with behavioral health referrals and things of that nature." (Hank, 2020)
Health Literacy	An understanding of the interaction of preventative, iterative, and health therapies	Whole Person Care. "…proposals that, I think, would be really critical to your research. Because how they structure the programs that they're going to implement through whole-person care kind of validate a lot of what you're looking at. And they're -- really, the concept was to create a homeless system of care in a hub model through the whole-person care. So it's right in line with it…" (Jane, 2016) So we do employ nurses, psychiatrists, social workers, therapists, and then a host of paraprofessional care-coordinating staff throughout all of our programs… Yeah. So in our residential programs, we do medical care management. So we have nurse coordinators. We liaise with primary care providers and then certainly our psychiatric support system. But we're doing basic medical case management and care management for our populations. (Jane, 2020)
Resilience	An ability to maintain health in challenging situations	Survival. "…self-advocacy. He's still in the game. He did all of it. Not easy for anybody, let alone somebody who's schizophrenic and homeless, but he

		knocked it all out…' (Carl, 2016) "… remarkably resilient. I don't want to paint the wrong picture, but the gentleman -- I think he was over . . . I can't think of any great way to say this without -- I don't want it to sound be patronizing or disparaging. He accepted where he was in life. And please, believe me, I am not making an argument that anybody should accept like, "Homeless was my lot in life." (Carl, 2020)
Social Health	An interaction with the community and social setting	Family support. "…structured support just by the structure that we have in our pogrom, and then we have classes, we have groups, we have a process, we have individual counseling, and we have family counseling. We have family and friends visit on Sundays. … We have phone privileges. But when someone first comes in, we don't allow them to use the phone alone for 21 days, so they use it in facilitation with their counselor…" (Elly, 2016) You know, we have a couple of people, you know, most people, "Oh, you know, I don't need that. I've got family I can call." But for that small subset of people who may be older, don't leave the house, don't have family around, you know, we found that some of our patients who we will call and keep us on the phone for 30 minutes or an hour talking about -- you know, we've got other patients to call. We're like, "If you need someone to talk to, we have other people for you to just kind of shoot the breeze with. No one with a real aim, they're not trying to diagnose you or do any of that." (Hank, 2020)

APPENDIX B: COMPARISON ELEMENTS

	2016	2020
Purpose	The study purpose was to obtain the providers' perceptions at the outset of the WPC pilot program in the state of California examine the homeless population	The purpose of this study was two-fold. First, to reinterview PEH provider experts to obtain their perceptions regarding the WPC pilot program at the end of this study. The second step was to compare these findings to the 2016 findings
Background	Congress point in time (PIT) count was exceeding 500,000 people throughout the United States	there was an overall 2.6% increase in homelessness
Literature Review	The initial WPC information leading up to the pilot program was well documented. Adverse Childhood Experiences (ACEs) affect frequently identified in the literature. Theoretical and methodological concepts were also identified	WPC information impact evaluations are pending. Methodology, framework information remained credible. Comparison methodology was added to support the final phase of this project
Results	The themes and codes that emerged from the analysis of the interview responses suggested a strong link between the providers' perceptions and how they exercised their professional skills and utilized the WPC Pilot Program resources.	There was an increase in collaboration since it was recognized. Each health care area was discussed as imperative to support the PEH community-
Recommendations	1-Research involves repeating the present study 2-An ACE assessment tool to be used inter-organizationally 3- repeating the present study with a focus on more than one California state county	1- WPC pilot program repeat phenomenological study 2- involve repeating the present study with a focus on more than one California state county

APPENDIX C: SUMMARY AND RECOMMENDATIONS

Theme/Code	2016	2020	Recommendation
Medical Health: is a primary concern well documented historically the measure of good health	In both studies, participants stated this area as a reference point to define good versus poor health		Continue to use this area to help certify levels of health
Mental Health: Behavioral and Mental health was a significant component of the WPC pilot program	Participants agreed with the importance of behavioral health in their programs;	There was little direct on the mental health aspects. However, it was not integrated into medical and socioeconomic areas of health	Mental health maintenance will continue to help the PEH community cope with the various stressors of fragile domicile status
Socioeconomic: this area remained significantly important in both studies	Discuss as a function and risk factor of homelessness	Identified as a risk factor as well as chronic conditions in maintaining homelessness	Greater support to overhaul the judicial, economic, educational, and housing systems to promote equity (vs. equality)
Housing: Potential reciprocal effect as "poor health may lead to loss of housing and loss of housing contributes to poor health."	Definition of housing concerning homelessness. No significant plan of housing defined	In contrast, there was increased support from the federal and state government. 'Project room key' created hotel temporary housing in the PEH community.	Incorporate phases of housing to include respite care, 'Project Room-key' toward section 8 housing resources for chronically ill
Spiritual: This was an aspect of good health within the holistic health realm of care.	Discussed aspects of WPC and holistic care. Food and support programs sponsored by churches and other religious institutions	No comments and concerns were made regarding the PEH community's spiritual health throughout this set of interviews.	Consideration of racial and age demographic for historical community support religious-based programs may better support this community
Unexpected findings: In data collection, several codes are evident due to the discussion topics. Other findings may be discussed during elaboration	The use of the various screening tools was not used in a standardized manner	World, community, and regional events significantly impacted and influenced the community	A network and inter-organizational regionally prepared program to team with FEMA

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