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Improving Care for Homeless Young Adults: A Shelter Client and Health Service Provider Perspective

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Perspective

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Abstract

The purpose of this study was to determine if the healthcare needs of homeless young adults from the client, shelter staff, and shelter healthcare provider's perspectives. Data was collected via focus group with homeless unaccompanied young adults (n=4), and an online survey with shelter staff and healthcare staff (n=8) of The Night Ministry (TNM) and Ignite Promise. The focus group was recorded, and transcribed. Themes were derived utilizing grounded theory methods. Themes suggested a need for improving the quality of services provided. Based on the findings, recommendations include assessing the needs of homeless unaccompanied young adults from their perspective utilizing larger sample sizes, across multiple institutions to develop a framework for understanding the nature of the services that are required by this population.

Keywords: homeless youth, mobile healthcare bus, healthcare needs, quality, and evidence-based recommendations

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Background

Introduction

According to the National Association for the Education of Homeless Children and

Youth (NAEHCY), "Unaccompanied homeless youth, are youth experiencing homelessness

while not in the physical custody of a parent or guardian" (NAEHCY, 2017, p. 1). It is estimated

that 1.7 million youth experience homelessness annually (NAEHCY). Youth homelessness has

been consistently linked to conflict and disengagement within traditional settings such as home,

school, and other youth serving systems providing strength building experiences and resources

associated with development of positive personal and social assets in normative youth

populations (Heinze, Hernandez-Jozefowicz, & Toro, 2010). According to NAEHCY, "the

primary causes of homelessness amongst unaccompanied youth include physical, and sexual

abuse by a parent or guardian, neglect, parental substance abuse, and family conflict"(p.2).

Unaccompanied homeless youth experience healthcare needs which are different from

older adults and children (English, 2010). However, prior to the expansion of the Affordable

Care Act, (ACA), only about 50,000 homeless youth reported having access to healthcare

services (U.S. Department of Health & Human Services, (DHS). As a result, many

unaccompanied youth at risk for developing serious health, behavioral, and emotional problems

because they lack sufficient resources to obtain care.

Youth who become homeless often engage in risky subsistence behaviors

including drugs, crime, or sex trading for money or food (United States Interagency Council on

Homelessness, [USICH], 2010). These risky behaviors increase their risk for developing serious

health, behavioral, and emotional problems often resulting in higher rates of substance abuse and co-occurring mental health disorders than housed youth (USICH, 2010). These youth because of their age and situation are urgently in need of services that ensure safety, belonging, self-worth, independence, and closeness and other skills ensuring successful transition to adulthood (Family & Youth Services Bureau, [FYSB]).

To increase access to healthcare services, homeless youth need access to diverse health care sites where healthcare professionals are experienced to address their needs (English, 2010). Nurse Managed Health Clinics (NMHCs) are community health clinics run by advanced practice nurses to deliver comprehensive, primary care services to vulnerable populations (Hansen-Turton et al., 2011). Youth shelters, teen drop-in centers and the night health bus are all sites managed and run by nurse practitioners to provide opportunities to reach homeless, unaccompanied youth (USICH, 2010). These sites are usually the first point of contact for runaway and homeless youth seeking healthcare services including HIV and STI testing, family planning, treatment of chronic illness, mental health counseling, substance abuse, and case management services (USICH, 2010).

According to the National Health Care for the Homeless Council (NHCHC), all staff and healthcare providers seeking to build relationships with homeless youth should have the following attributes: "trust, safety, respect, and cultural humility" (2019, p, 4). These attributes are essential to engaging youth and building alliance with homeless unaccompanied young adults which helps to improve their health status, and minimize their risks for adverse health outcomes.

Lastly, culturally appropriate strategies for engaging homeless youth should be addressed on all levels throughout the agency to help eliminate the inherent imbalance of power (NHCHC, 15). Provider and staff encouragement of youth participation when developing and evaluating

programs, and/or creating policies or changing policies, helps to build self-efficacy and self-

esteem. The National Resource Center for Youth Services' and Positive Youth Development

(NRCYSPYD, 2008) suggests surveys, focus groups, peer mentoring, and other ways to

encourage youth participation in program development.

Clinical Site

The Night Ministry

The Night Ministry (TNM) is an organization dedicating to providing services to

homeless populations in the Chicagoland area. TNM's Health Outreach Bus is a mobile

healthcare unit which serves underserved populations in Chicago. TNM's Health Outreach Bus

is managed and run by Nurse Practitioners. The Night Ministry also operates two shelter

locations targeting homeless youth. Nurse Practitioners (NP) provide healthcare services on the

Health Outreach Bus and also at the shelter sites. Typical services include treatment of acute and

chronic diseases, immunizations for adults, health education, Human Immunodeficiency Virus

(HIV) and Sexually Transmitted Infections (STIs) testing, and treatment, hepatitis C testing,

tuberculosis testing, pregnancy testing, blood pressure screening, and health care referrals.

Research shows that nurse practitioners provide quality health care services and provide a cost-

effective option for improving access to healthcare while improving health outcomes for

homeless youth (Newhouse et al., 2011). An onsite clinic run by a single nurse practitioner

resulted in direct medical cost savings of nearly $2.18 million over a two-year period (Savage et

al., 2006).

Ignite Promise

Ignite Promise formerly Teen Living Programs (TLP) located in Chicago, operates four

youth housing programs, a drop-in center, an after-care program, street and outreach programs, a

24-hour crisis and referral hotline, and they provide supportive programs to assists with employment, education, and life skills training for greater than 500 young people year round (Ignite, 2019). Ignite Promise has a 4 bed shelter for minor youth ages 14-17 located in Bronzeville, manages Belfort House, a 24 bed transitional living program for young people ages 17-2, and lastly Ignite manages two independent living programs for youth ages 18-24, CaSSA or Clustered and Scattered Site Apartments, and the Next Gen Housing Program where young adults can living up to 3 years independently while receiving support for employment, and later effectively transitioning them to permanent housing Ignite, 2019). Ignite promise also provides supportive services similar to those provided by TNM such as employment, educational assistance, and outreach, however in addition to these services, Ignite also provides young adults access to a drop-in center where they can receive case management services, and also access to a 24 hour crisis and resource hotline (Ignite). Ignite has partnered previously with outside organizations which provided healthcare services by a Nurse Practitioner (NP); however, these services were discontinued in early 2016. As a result, the leadership team of Ignite Promise continue to search for the most cost-effective methods at addressing the healthcare needs of homeless youth and have partnered with outside organizations including TNM to help provide STI testing and treatment, and any urgent care needs via the healthcare bus which has regular visits on Fridays just near the Ignite Promise site on the near south side of Chicago.

Problem Statement

Little is known about the extent of the quality of health care services provided by TNM's Healthcare Bus and shelter for homeless unaccompanied youth or by the shelter or drop-in center of Ignite Promise. Moreover, no previous studies have examined whether the services currently provided by TNM's Healthcare Bus or Ignite Promise are meeting the needs of unaccompanied

youth, or if there is a need to add or improve upon the current services from the client, staff, and health care provider's perspectives.

Purpose of the Project

This project was developed to determine the need for establishing a comprehensive healthcare service clinic onsite of a youth shelter to benefit the homeless youth. Specifically, this project was initiated to determine the healthcare needs of homeless unaccompanied youth, to assess if current needs are being met by the services provided by TNM's Healthcare Bus or shelter and the shelters or drop-in center of Ignite Promise, to determine any gaps in healthcare services provided, and to determine if there is a need for improving or adding services to better address the healthcare needs of unaccompanied youth.

The aim of the DNP project was to engage homeless youth in providing their perspectives about the healthcare issues they experience and also to obtain the perspectives of TNM and Ignite Promise healthcare staff, and nurse practitioners. A secondary focus of the DNP project included examination of the effectiveness of nurse led clinics in meeting the healthcare needs of homeless youth at TNM youth shelters and how can the nurse led clinic model be improved.

Clinical Questions

1. Which healthcare services provided by TNM's Healthcare Bus or shelter, and the shelters and drop-in center of Ignite Promise effectively meet the needs of unaccompanied homeless youth residing at TNM's shelter for homeless youth or at Ignite Promise's drop-in program?

2. How can the healthcare services provided by TNM's Healthcare Bus or shelter, and the shelters and drop-in center of Ignite Promise be improved?

3. What barriers exist?

Theoretical Model

Conceptual Framework

The Donabedian Quality Framework (DQF), a framework which uses the concepts structure, process, and outcome to evaluate the quality of healthcare (Ayanian & Markel, 2016). According to Ayanian & Markel, Donabedian "defined structure as the settings, qualifications of providers, and administrative systems through which care takes place; process is defined as the components of care delivered; and outcome is defined as the recovery, restoration of function and survival state", (2016, p. 206). For the purposes of this study, structure includes the conditions under which care is provided. Process will include all healthcare activities such as diagnosis, treatment, patient education and other services provided to homeless youth. These activities can be carried out by healthcare providers, and staff. Lastly outcome will include the results of all healthcare activities. These may be either positive or negative. The use of the Donabedian Quality Framework will help identify structure and process which impact care. It is important when evaluating the quality of healthcare services to include a framework such as the DQF to separately address the elements outside of the control of the client or the service provider.

Table 1. Donabedian Framework Conceptual Model (Wolf & Edgar ,2007)

Structural Aspects	The Process of care	The Outcome of Services
Staffing levels	Cultural competence	Overall Quality of life
Staffing qualifications	Privacy and Confidentiality	User or client satisfaction
Service objectives	User involvement in planning	Employment status
Physical property	User involvement in evaluation	Housing Status

Review of Literature

Search Method

A multi-database search of the CINAHL complete, PsychINFO, and Business Source Complete databases was conducted to determine the level of evidence published surveying the needs of homeless unaccompanied youth, and the impact of healthcare services provided by the mobile healthcare bus. An additional search was conducted to determine if there is any level of evidence published within the last 5 years which discussed the benefit of establishing a direct service nurse led clinic for homeless youth populations located within a homeless youth shelter. The purpose of this search was to determine if a nurse led model has been shown to effectively meet the healthcare needs of homeless youth, however this search did not reveal any current or previous publications. The search was conducted years 2006 and 2018, with criteria for English language, using the medical subject headings (MeSH terms) *homeless youth, unaccompanied youth, health care services, client perspective, healthcare provider perspective, program impact, nurse led clinics, healthcare bus, youth shelters, nurse managed clinics, nurse practitioner clinics, and nurse managed centers.* This search resulted in 236 publications. This search was further narrowed with use of the MeSH term *underserved,* to further distinguish homeless youth, this resulted in 24 publications. The abstracts were read and all relevant articles were included. The focus of the review of these articles was to locate information on feasibility or practicality of establishing nurse led clinics with underserved populations, the secondary aim of the DNP project. A combination of original research on nurse led clinics, and homeless youth were included and an evidence-based research table was created listing strongest evidence first. (See Appendix A. Evidence-based Table on Nurse Led Clinics and Homeless Youth).

Health Status of Homeless Youth

Youth who become homeless often engage in risky subsistence behaviors including

selling drugs, stealing, or sex trading for money or food (USICH, 2010). They also experience

higher rates of substance abuse than housed youth, and most have co-occurring mental health

disorders (USICH, 2010). Most of the health conditions commonly experienced by homeless

youth include asthma, hypertension, arthritis, diabetes, sexually transmitted infections, hepatitis,

and tuberculosis (USICH, 2010).

"Risk factor assessments complement vital statistics data systems and morbidity data

systems by providing information on factors earlier in the causal chain leading to illness, injury

or death" (McGonigle & Mastrian, 2015, p. 304). The use of risk assessments determines if

programs are effective in reducing the risk of a specific illness or issue for a specific population

and according to McGonigle & Mastrian also influence public policy.

A specific risk assessment tool useful for the adolescent population included the Youth

Risk Behavior Surveillance System or (YRBSS). The YRBSS was developed in 1990 to

monitor priority health risk behaviors that contribute to the leading causes of death or injury for

youth and adults in the U.S. These include sexual behaviors, use of drugs and alcohol, and diet

and exercise. (Center for Disease Control & Prevention, 2016).

Cost of Homelessness

"Homeless individuals experience very high rates of behavioral health disorders, chronic

and acute physical conditions, and injuries related to assaults and accidents" (Lin et al., 2015,

p1). People experiencing homelessness are more likely to access the most costly health care

services" (National Association for the Education of Homeless Children and Youth, [NAEHCY],

n.d.). Thirty-three to Sixty-Six percent of homeless persons reported one or more emergency

department (ED) visits in one year and 25% to 33% of homeless people are hospitalized during a

year (Lin et al., 2015). Although homeless populations actively seek treatment less frequently than the general population, they have a rate of hospitalizations and use of the ED that is four times higher than the U.S. norm (Lin et al., 2015).

"The Patient Protection and Affordable Care Act of 2010, commonly referred to as the ACA, was signed into law on 2010 by President Barack Obama" (HHS.gov). "The four main objectives of the ACA are to improve consumer rights and protections, improve access to care, make coverage more affordable and improve Medicare coverage. " (HHS.gov). Its major provisions include: Increasing healthcare insurance coverage to most U.S. citizens; increasing consumer protections; improving quality and system performance; expanding the healthcare workforce; and decreasing the rising costs of healthcare.

The implementation of the ACA will has had major implications for vulnerable youth. These include the expansion of state Medicaid programs to help increase healthcare coverage. In addition to expanding healthcare coverage for homeless teens, the ACA also increased funding to support community health centers and establish teaching health centers within the community to help address the health needs of at risk youth (Paradise, Rosenbaum, Markus, Sharac, Tran, Reynolds, & Shin, 2017).

Under the ACA, Medicaid has been expanded to include all non-Medicare eligible individuals under age 65 with incomes less than 133% of Federal Poverty Line (FPL) (English, 2010). This includes many uninsured low-income young adults who are not pregnant or disabled or parents of dependent children. Also, under the ACA, former foster care children aging out of the foster care system are now mandated by the federal government to receive health insurance coverage up to age 26 regardless of what their state decides to do for Medicaid expansion

(English, 2010). The overall goals of the ACA are to expand health insurance coverage to all adolescents and young adults, and to improve access to comprehensive and preventative health care services for adolescents and young adults (English, 2010).

Prior to the expansion of the ACA in 2010, federal policies have focused primarily on improving the health for chronically homeless adult individuals (Bassuk, 2010). However, with the expansion of the ACA to include teen homeless populations, many organizations can establish programs to help address the needs of this growing population and ultimately prevent many adverse health conditions they may experience.

Role of Nurse Practitioner

According to Xue and Intrator (2016), the role of nurse practitioners as primary care providers is central to the care of vulnerable populations. Nurse practitioners bring a blend of nursing and medical care shown to be cost effective, with high patient satisfaction and positive patient outcomes (Seilter & Moss, 2012). With growing homeless populations, widening health inequalities, and the expansion of the ACA, advanced practice nurses are expected to help meet the growing demands of primary care services for vulnerable populations (Xue & Intrator, 2016).

In order to help increase access to healthcare services for homeless teens, the ACA has increased funding to support the addition of healthcare services provided by Advanced Practice Nurses (APN) at various community sites (English, 2010).

Research has shown that nurse practitioners provide care of equivalent quality to physicians at a lower cost, while achieving high levels of patient satisfaction and providing more disease prevention counseling, health education, and health promotion activities than physicians

(Newhouse et al., 2011). "Clinics run by nurse practitioners create cost savings associated with reduced use of emergency rooms, urgent care centers, hospitals, and emergency medical services "(Newhouse et al., 2011, p. 2).

Methods

Design

The research was qualitative, utilizing grounded theory methods to formulate patterns or themes related to healthcare quality. It addressed the clinical research questions on page 7 above. The purpose was to hear from the youth, and those providing services to the youth to help evaluate the effectiveness of healthcare services being provided to homeless youth today.

The methods included a semi structured focus group to interview homeless youth at TNM shelter and an online survey was administered to the staff, and nurse practitioners providing healthcare services for homeless youth at the shelters at TNM and Ignite Promise.

Setting

The project took place at The Night Ministry (TNM) and Ignite Promise, two non-profit organizations in Chicago, Illinois that provide housing, social services, and healthcare services to those struggling with poverty and homelessness regardless of their race, gender, sexuality, or religion. The services provided are free and are provided daily in the city of Chicago for youth between the ages 14 to 24 who struggle with homelessness.

Sample

The target population included approximately 60 homeless youth shelter clients (ages 18 and older) utilizing healthcare services at TNM, 120 shelter and healthcare bus staff (ages 18 and older) of TNM and Ignite Promise and lastly approximately 120 nurse practitioners (ages 18 and older) who provide healthcare services to shelter and healthcare bus clients of TNM and Ignite Promise. Homeless youth must be ages 18 and older and currently reside at the shelters of TNM, Staff and nurse practitioners must also be 18 years and older and must also provide healthcare services to unaccompanied homeless youth ages 18 and older.

Focus Group (Unaccompanied Youth) TNM

Homeless unaccompanied young adults (ages 18 and older) who live at the shelters at TNM were invited to participate in a focus group, which took place at the shelters at TNM. Recruitment flyers (see Appendix D) provided details regarding the upcoming research study. They were posted at the shelters on the community announcement board and handed out to the Homeless unaccompanied young adults (18 and older) who reside at the shelters of TNM.

A verbal script/announcement (see Appendix I) was made the day of the focus group inside the community room, where residents of the shelter congregate for group activities, workshops, socialization etc. To document consent for their participation, an informed consent form was signed by the Homeless unaccompanied young adults (18 and older) (Appendix B1). All participants were asked if they had any questions prior to the study, and anyone with questions was given the opportunity to ask privately.

A Focus Group Guide (see Appendix H) was utilized to help guide the focus group. The guide includes a brief introduction, the purpose for the study, the details of the study, the screening process to ensure all participants met the criteria. Consent was obtained 15 minutes prior to the start of the focus groups. The focus group was audio recorded. Light refreshments

were provided, and the research participants of the focus group received $20 cash incentive for their participation.

Additional demographic questions were asked to unaccompanied youth only as a request from TNM (see Appendix H). Data will not be discussed here however the data was tabulated and presented to the staff at TNM.

Qualtrics Survey (Ignite Promise)

The staff and healthcare providers at Ignite Promise who met the inclusion criteria received the link via their work email asking for their participation in the research study. All staff and healthcare providers were allowed to participate if they were age 18 and older and if they provided direct care to homeless unaccompanied young adults (18 and older). After reviewing the survey questions and determining the appropriateness for the staff and healthcare providers, Director Danielle Kendrick emailed the Qualtrics survey link to all staff and healthcare providers at Ignite Promise.

Consent was obtained after participants clicked the survey link on the first page just before starting the survey questions. Written signatures were unable to be obtained. A waiver of consent was submitted**.**

Qualtrics Survey (TNM)

The staff and healthcare providers at TNM who met the inclusion criteria received a link via their work email asking for their participation in the research study. All staff and healthcare providers were allowed to participate if they were ages 18 and older, and if they provided direct care to homeless unaccompanied young adults (18 and older). After reviewing the survey questions and determining the appropriateness for the staff and healthcare providers, Director

Gregory Gross provided instruction for emailing the Qualtrics survey link to all staff and healthcare providers at TNM.

Consent was obtained after participants clicked the survey link on the first page just before starting the survey questions. Written signatures were unable to be obtained. A waiver of consent was submitted**.**

<u>Recruitment</u>

Focus Group (Unaccompanied Youth) TNM

Convenience sampling was used to recruit youth at TNM Open Door Shelter in West town and The Crib. Homeless unaccompanied young adults (ages 18 and older) who reside at the shelters at TNM were invited to participate in a focus group, which took place onsite. Recruitment flyers (see Appendix D) were posted in the community rooms at TNM one week beforehand, and one hour prior to the start of the focus group. Verbal announcements (see Appendix I) were made to recruit participants also and the focus group took place 30 minutes after in a separate room.

Qualtrics Survey (Ignite Promise)

A Recruitment email (Appendix E) was sent to all staff and healthcare providers working at Ignite Promise asking for their participation in the research study. Dan'iel Kendricks of Ignite Promise emailed the Qualtrics link to all staff and healthcare providers who were eligible to participate.

Qualtrics Survey (TNM)

A Recruitment email (Appendix E) was sent to all staff and healthcare providers working at Ignite Promise asking for their participation in the research study. Gregory Gross of TNM provided the email groups for all staff and healthcare providers who were eligible to participate.

Measurement

Focus Group (Unaccompanied Youth) TNM

A focus group with 4 participants was conducted with homeless youth at TNM utilizing a

"semi structured interview guide (SSIG)" (see Appendix H) (Hudson, Myamathi, Greengold,

Slagle, Koniak-Griffin, Khalilifard, & Getzoff, 2010, p 213). The focus group guide (see

Appendix H) was adapted from a qualitative study examining the perspectives of homeless youth

on the barriers and facilitators of health seeking behaviors and their thoughts on improving the

existing programs for homeless youth (Hudson, Myamathi, Greengold, Slagle, Koniak-Griffin,

Khalilifard, & Getzoff, 2010).

Qualtrics Survey (Ignite Promise & TNM)

The staff and healthcare providers at Ignite Promise who met the inclusion criteria

received a Qualtrics link (see Appendix E) via their work email asking for their participation in

the research study. All staff and healthcare providers were allowed to participate if they were age

18 and older and if they provided direct care to homeless unaccompanied young adults (18 and

older).

Validity

To ensure the validity of the survey, survey questions were developed after reviewing the

literature of studies addressing the issues of homeless adults and assessing their needs from their

perspective. No specific survey tool could be identified relating to assessing the needs of

homeless youth, however after thorough discussion with academic faculty, survey questions

were designed to address the project goals.

Reliability

To ensure the survey was reliable, the survey questions were piloted to approximately 15 adults between ages 18-65 from various backgrounds, professions, and cultures to determine the consistency of response and to identify any issues related to either the survey questions or the design of the survey. Eleven of these completed the survey. A suggestion to include a definition for homeless unaccompanied young adults was made by one individual who did not work in the health care profession, however this suggestion was made with the assumption that the survey would be sent to individuals who are less familiar with this population, and therefore would possibly be unfamiliar with the terminology. However given the clinical setting, this change would not be necessary.

Data Collection

The project was coordinated by the PI with assistance from staff with announcements and sending email link to the staff. The focus group was audio recorded with the participants' consent and occasional notes were taken by the PI. All data from the focus group was transcribed and analyzed inductively using grounded theory to allow the themes to emerge without limitations. The online survey data was analyzed for comparison to youth responses and emerging themes.

Data from this study was collected in three phases: In phase one, a focus group was conducted with 4 unaccompanied homeless youth at TNM. In phase two, a Qualtrics online survey was conducted with the staff and healthcare providers at TNM. In phase three, a Qualtrics online survey was conducted with staff and healthcare providers at Ignite Promise.

Focus Group (Unaccompanied Youth) TNM

In phase one, homeless unaccompanied young adults (ages 18 and older) who currently reside at the shelters of TNM were recruited via a Recruitment Flyer (Appendix D) which was

placed 1 week before the scheduled Focus Group placed on community activity board and via a

Recruitment verbal script/announcement (Appendix I) announced 30 minutes before the

scheduled Focus Group took place. A semi structured focus group guide (Appendix H) was used

to conduct the focus group. After completion of the focus group, which lasted approximately 60

minutes, the data was transcribed, this included both audio, and written notes.

Qualtrics Survey (TNM)

In phase two, staff and healthcare providers who work at TNM shelters (ages 18 and older)

were sent a Recruitment Email (Appendix E) via their work email asking for their participation

in the research study. All staff and healthcare providers who met the criteria were eligible to

participate by accessing the Qualtrics survey link sent via their work email and by providing

their consent to participate. Gregory Gross of TNM provided access to the email groups which

included all shelter staff and healthcare providers who work at TNM. Shelter Staff and

Healthcare providers included: all healthcare providers i.e. physicians, nurse practitioners,

counselors, case managers, and other staff who provide care to the homeless unaccompanied

young adults (18 and older).

Qualtrics Survey (Ignite Promise)

In phase three, staff and healthcare providers who work at Ignite Promise (ages 18 and

older) were sent a Recruitment Email (Appendix E) via their work email asking for their

participation in the research study. All staff and healthcare providers who met the criteria were

eligible to participate by accessing the Qualtrics survey link sent via their work email and by

providing their consent to participate. Dan'iel Kendricks of Ignite Promise emailed the

recruitment email to all shelter staff and healthcare providers who work at Ignite Promise.

Shelter Staff and Healthcare providers included: all healthcare providers i.e. physicians, nurse

practitioners, counselors, case managers, and other staff who provide care to the homeless unaccompanied young adults (18 and older).

Data Analysis

The goals of the data analysis were to determine the healthcare needs of homeless unaccompanied youth, to assess if their healthcare needs are being met by the services provided by TNM or Ignite Promise, determine if there are any gaps in the healthcare services provided, and determine if there is a need for improving or adding services to better address the healthcare needs of unaccompanied youth?

Assessing the needs of homeless unaccompanied youth from their own perspective and the best method for addressing these needs may help improve the health outcomes while also speaking towards ways to eliminate adverse health outcomes for homeless unaccompanied young adults altogether.

Focus Group (Unaccompanied Youth) TNM

The focus group audio recordings and notes were transcribed by Dedoose, an online transcription service and an initial line by line open coding was performed by the PI after instruction from Faculty to identify key terms which developed. A secondary analysis was performed also by the PI with assistance from an experienced researcher and reviewed by an additional experienced researcher to combine codes into a list then we combined codes into categories and later established themes using notes taken during the focus group.
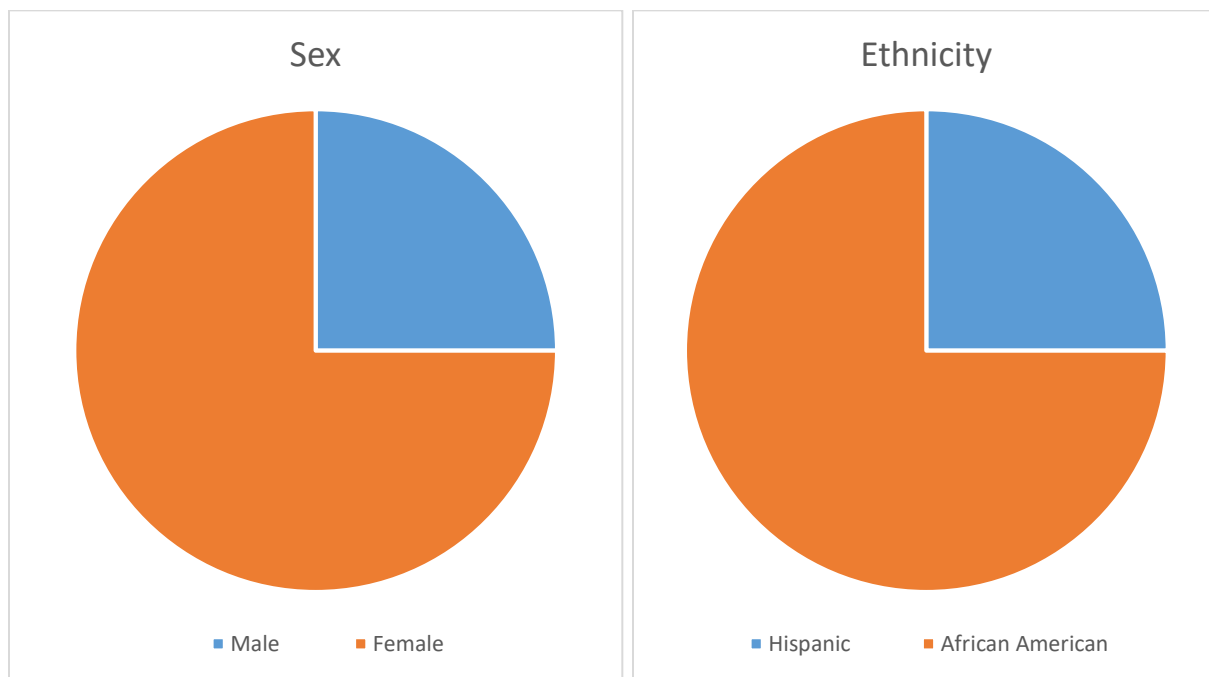
Results (TNM Focus Group Unaccompanied Youth)

Focus Group (Unaccompanied Youth) TNM

Overall 4 youth participated in the focus group (N=4). Among those interviewed, 75% were female (see Figure 1) and African American or Black; 25% were Hispanic. All participants

were age 18 and older.

Figure 1 *Gender and Ethnicity of Unaccompanied Youth (N=4)*

The focus group findings are presented based on the prevailing themes that are associated

with the participants' responses. The presented themes primarily relate to the perceptions of the

participants (unaccompanied homeless youth at TNM) regarding the nature of the most

appropriate approach to addressing the health needs of the homeless youth. Three main themes

emerged as 1. Need for Staff Training, 2. Youth Participation in program and policy

development, and 3. Youth Empowerment. Themes were further categorized using the

Donabedian Framework

Figure 2 *Focus group data themes (N=4)*

Theme	Purpose	Donabedian Framework
1. Need for Staff Training	Ensures consistent treatment of youth by staff. Ensures privacy protection.	Structural Aspects
2. Youth Participation in program and policy development	Ensures that services are in alignment with the specific needs of the individuals being addressed.	Process of Care
3. Youth Empowerment	Ensures that youth feel loved and supported. Ensures youth accomplish their goals.	Outcome of Services

1. Need for Staff Training

The youth felt overall that staff should receive training on how to be more professional

and engaging with youth to ensure overall consistent treatment, supportive treatment, behavior

more consistent with the organizational mission and values, including respectfulness. The staff

also needs to possess sufficient information regarding the privacy issues of the clients and hence

knowing the kind of information to disclose or the ones that should not be publicized. Lastly, the

participants outline that the need for staff to be consistent in discipline of the homeless young

adult, suggesting that all policies are followed with little to no variation across staff and

healthcare providers. Overall, the youth feel the staff should have an interest in working with

homeless young adults, and should also have the appropriate qualifications to perform their job

functions.

Youth	*Do they sit down and talk about, "Hey, what's going to be the best support for these kids that we see every single day?" Do they do that because I don't feel like they do? I feel like everybody has a different way of doing this.*
Youth	*I ain't seen it like this for instance. Like some of 'em is right in the head, like some of them right, like when I mean by right in the head, they show motivation, they show, you know, a lot of positive energy. Some of them don't. They just want to just make fun of people and just think it's funny, but it's not.*
Youth	*Maybe regular meetings might help to refocus the work staff's focus on what the real main goal.*
Youth	*Maybe the staff should have regular meetings that might help them to refocus the work staff on what the real main goal is.*
Youth	*They just want to just make fun of people and just think it's funny, but it's not.*
Youth	*I feel like the mission doesn't match up with the intentions of the staff. I mean, I'm not taking no sass or nothing, but at the same time, certain people come here, certain staff members come here because it's a job.*

2. Youth Participation in program and policy development

The second theme observed is the need to involve the youth when developing programs and operational policies. The inclusion of the homeless youth ensures that a people-centered approach to the provision of care is accomplished and ensure that services are in alignment with the specific needs of the individuals addressed. They feel that programs cannot be developed for them without their input. Therefore establishing a process to ensure youth involvement in program and policy activities would be best supported.

Youth	*Wouldn't that be great if you had a teenager section, and then adults can even be mentors to the teenagers? That would be something.*
Youth	*It would be nice for us kids to or could decide what we want to do, like yoga or something, an art class, cooking class, and if they have volunteer things going on, we should get to decide on the program.*
Youth	*They make the dinner chart or lunch chart on the refrigerator, but I feel like we should make that. I feel like why are they deciding what we going to eat? They not eating it. So yeah. I feel like we should make the chart sometimes, at least sometimes.*
Youth	*And more staff. Wouldn't it be nice to see a couple of more people? Yeah, it would be nice. Yeah, more staff, because it seems like this place is bare.*

3. Youth Empowerment

The third is the need for the staff to be more encouraging as well as being supportive of the youth. Similarly, the participants emphasized the fact that the staff should not be judgmental of the experiences and choices of the youth under their care. The supportive and non-judgmental approach to the care for the homeless youth ensures that such individuals not only develop a feeling of being loved but also empower them towards accomplishing their life potential. Overall, the youth stated if they felt they were being supported by staff, that would help motivate them to take greater interest in their own personal interests.

Youth	*I was talking to her straight up, like I was talking to her and I was serious about they need to show like a little bit more encouragement instead of being mad all day.*

Youth	*And it's hard to know which side, you know, the staff is on. Like are they on our side trying to help us through this situation, or is it mockery?*
Youth	*Like for example, they could ask things like, "How did your day go" or "What are you going through?"*

The attributes that are expected of the staff by the homeless youth include empathetic, encouraging, sincerity, supportive, consistent, trustworthy, and fair. According to the participants, if staff were to possess these attributes listed above, this would motivate them to make consistent changes in their lives.

Overall, homeless young unaccompanied young adults did not believe the services provided were adequate to meet their needs and believe the major barriers to this include improper training, not allowing young adults to offer input when developing youth programs, and policies and inconsistencies of staff in implementing program rules and guidelines.

To further establish recommendations for improving the overall quality of healthcare services, themes were categorized utilizing the Donabedian Framework. The conceptual links between process, structure, and outcome made by the youth were strongest for proper training of staff, and needing increased support and encouragement of youth by staff. Homeless unaccompanied youth suggested youth participation also when considering the structure, process, and outcomes related to quality of care. Specifically they felt by "asking their opinions about programs and rules first" as the best way to engage youth in activities related to improving their health overall. Most importantly, the youth felt having a mentoring relationship with staff based

Qualtrics Survey (Ignite Promise)

There were a total of 8 participants (N=8) who completed the online survey at Ignite Promise. Demographic data from Ignite Promise revealed 87.5% were female (n=7), 75% were

African American (AA) (n=6), 100% were staff members of Ignite Promise, none were

healthcare providers, the ages ranged between 25 years and 65 and 50% (n=4) fall between the

age range 35-44 years, 62.5% (n=5) reported having at least a Master's degree, however there

was a more broad range in terms of years of experience working with homeless youth, 12.5%

(n=1) reported either 1-2 years or 5-10 years of experience, 25% (n=2) reported less than 1 year

of experience, and 37.5% (n=3) reported 3-5 years of experience. The figures below outline the

gender, ethnicity, role, educational level, age, and years of experience of the survey participants

of Ignite Promise (see Figures 1-5).

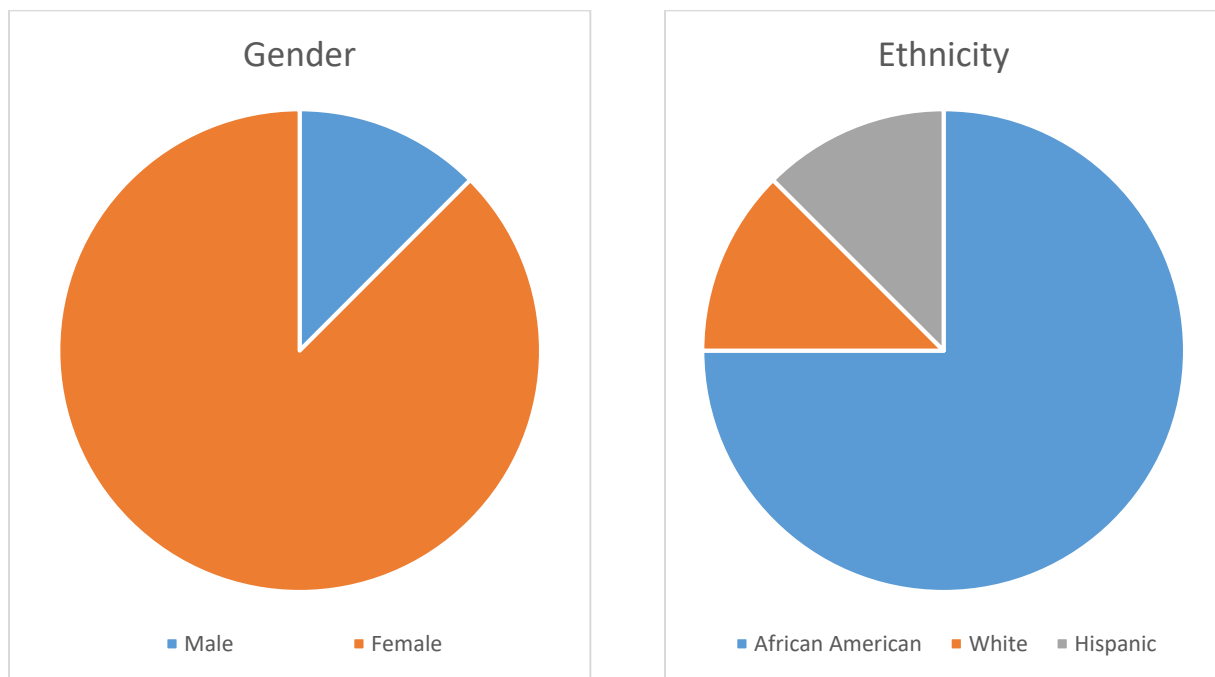**Figure 3** *Gender and Ethnicity of Unaccompanied Youth (N=8)*

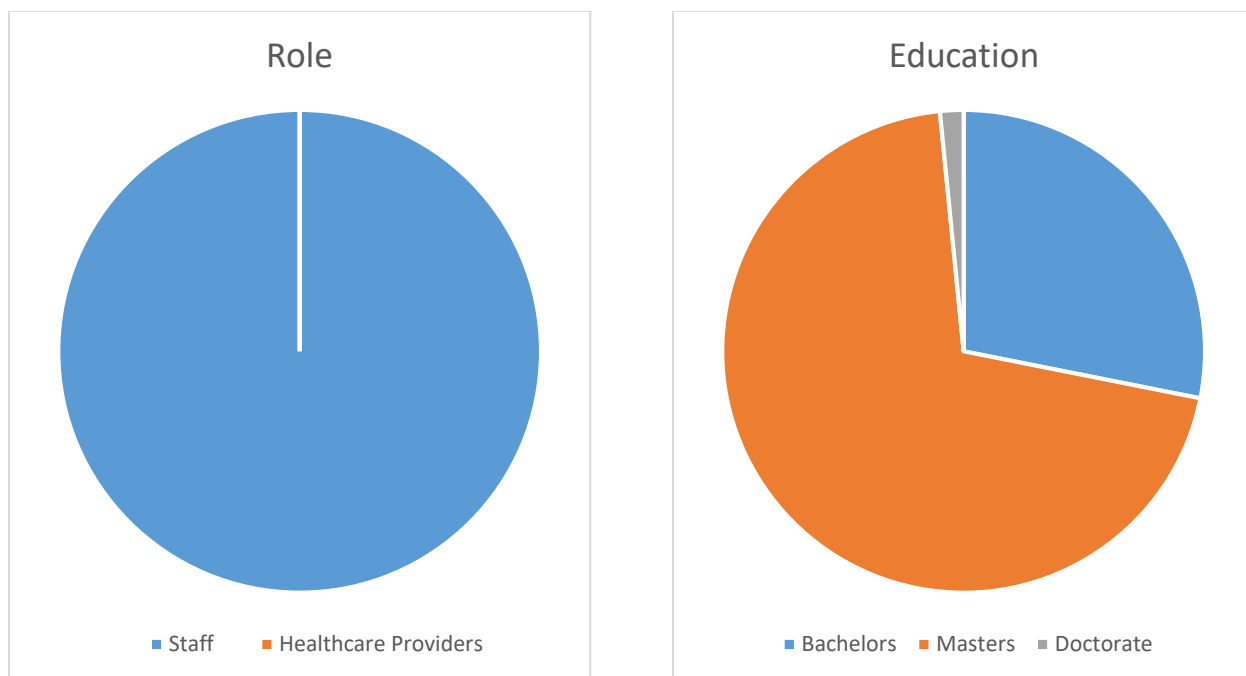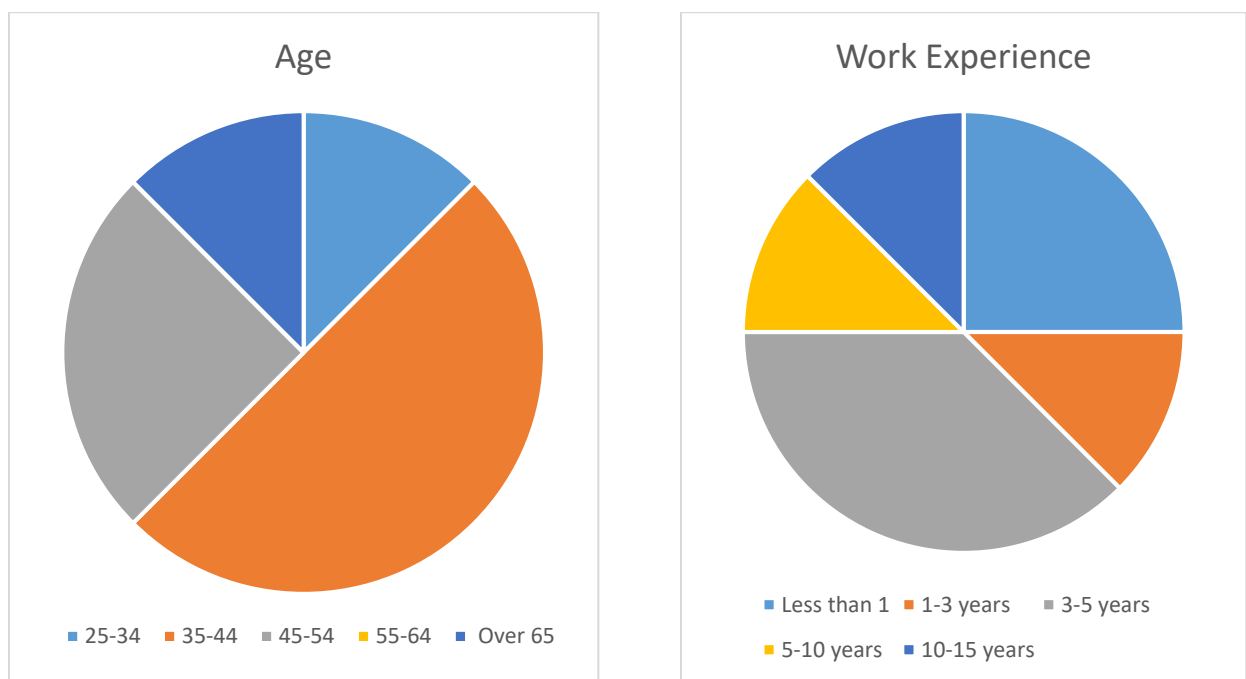**Figure 4** *Role and Education of Ignite Promise Survey Participants*

Figure 5 *Age and Work experience of Ignite Promise Survey Participants*

Common Healthcare Needs of Unaccompanied Homeless Youth

Ignite Promise survey participants identified various common health needs of the unaccompanied homeless youth, such as family planning, STI screening and treatment, employment and school, sick visit, and mental health services. Mental health services are identified as the most prevalent healthcare needs of homeless unaccompanied young adults at Ignite, with 33.33% of the responses being associated with the aspect followed by the need for employment/education and STI screening and treatment at 22.22% and 16.67% respectively. Family planning and sick visit needs are reported as each constituting 11.11%. The other needs are 5.56%. Table 1 below lists the most common needs of homeless youth according to the survey participants of Ignite Promise.

Table1 *Summary of the Common Healthcare Needs of the Unaccompanied Homeless Youth*
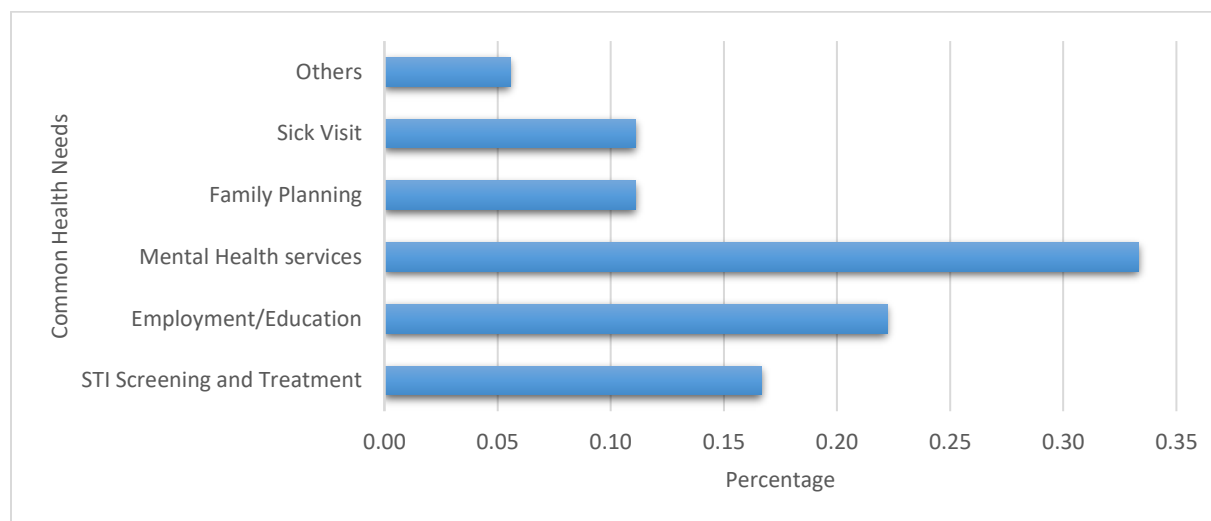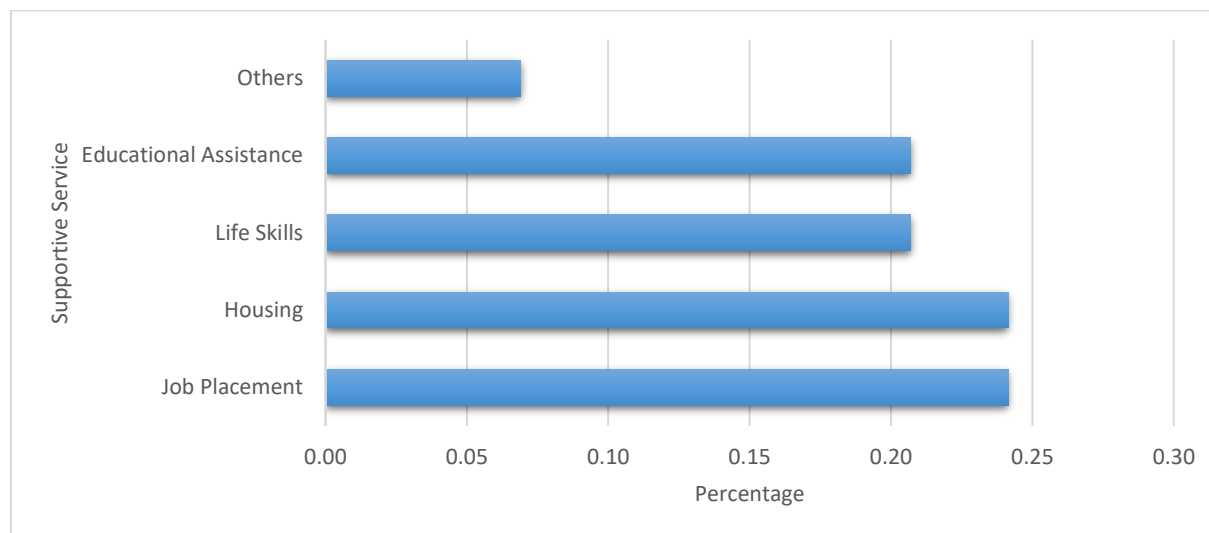

Supportive Services Needed for Unaccompanied Homeless Youth

According to the survey participants of Ignite Promise, the supportive services needed to address the needs for unaccompanied homeless young adults were varied. The services include

housing (24.14%), job placement (24.14%), life skills (20.69%), educational assistance

(20.69%), and other (6.90%). Table 2 lists the supportive services needed for homeless youth

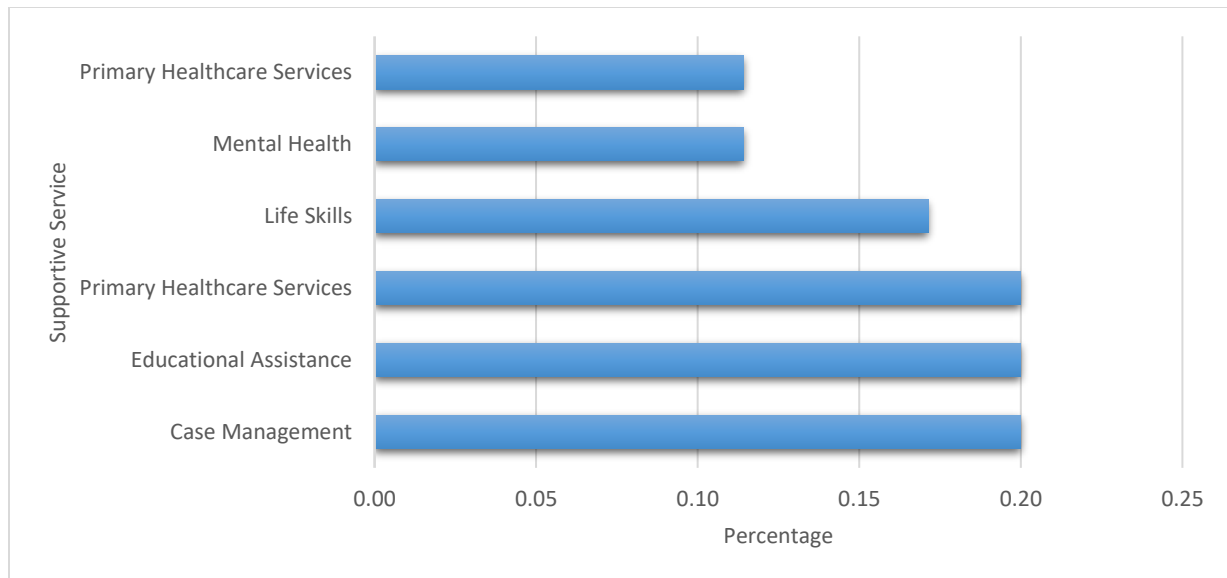according to the survey participants of Ignite Promise.

Table2 *Summary of the Supportive Services Needed for Unaccompanied Homeless Youth*

Supportive Services Provided for Unaccompanied Homeless Youth

According to respondents, the services currently provided to unaccompanied homeless

young adults include case management, mental health services, housing placement, life skills

training, educational assistance, and primary healthcare services. Case management, educational

assistance, and housing placement were the most common services provided by the organization

at 20.00% of all the responses. Life skills training was 17.14%, followed by mental health

services and primary healthcare services, each at 11.43%. Ignite Promise currently does not

provide acute illness care or any other services. Table 3 lists the supportive services provided for

homeless youth according to the survey participants of Ignite Promise.

Table 3 *Summary of the Supportive Serviced Provided for Unaccompanied Homeless Youth*

Adequacy of the current services provided

The majority of the respondents (57.14%) indicated that the services provided at Ignite were adequate, while 2 participants (28.57%) stated that services were not adequate. One respondent (14.29%) was not sure about the adequacy of the provided services. Table 4 lists the adequacy of the current services provided for Homeless youth according to the survey participants of Ignite Promise.

Table 3 *Adequacy of the current services provided for Unaccompanied Homeless Youth.*
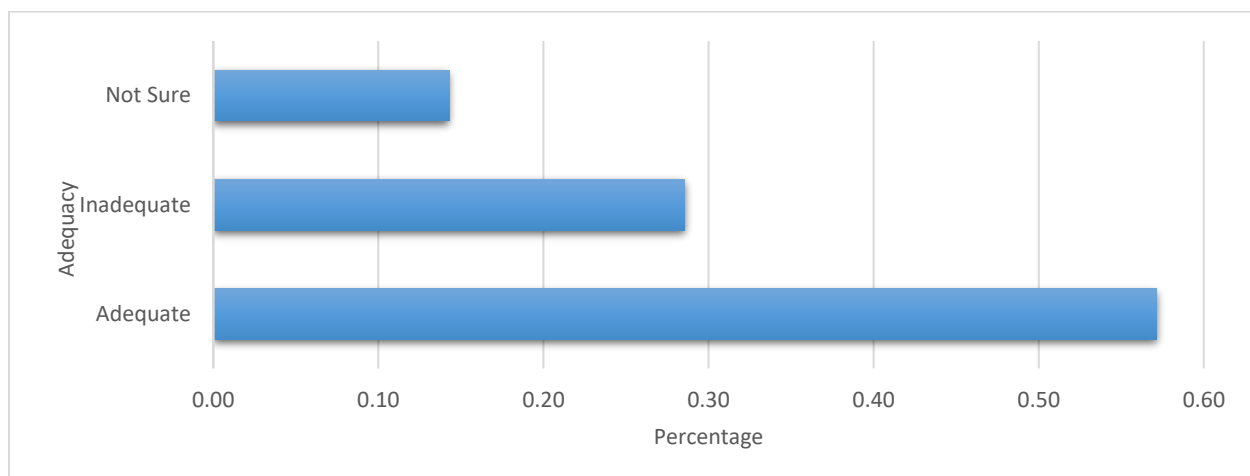
Other Services Needed

      Participants also identified other services that are required further to address the needs of the homeless as: an onsite healthcare clinic (38.58%), permanent housing placement (21.05%), job training (21.05%), and life skills training (26.32%). Table 5 lists the Other Services Needed for Homeless youth according to the survey participants of Ignite Promise.

Table 4 *Other Services Needed for Unaccompanied Homeless Youth.*
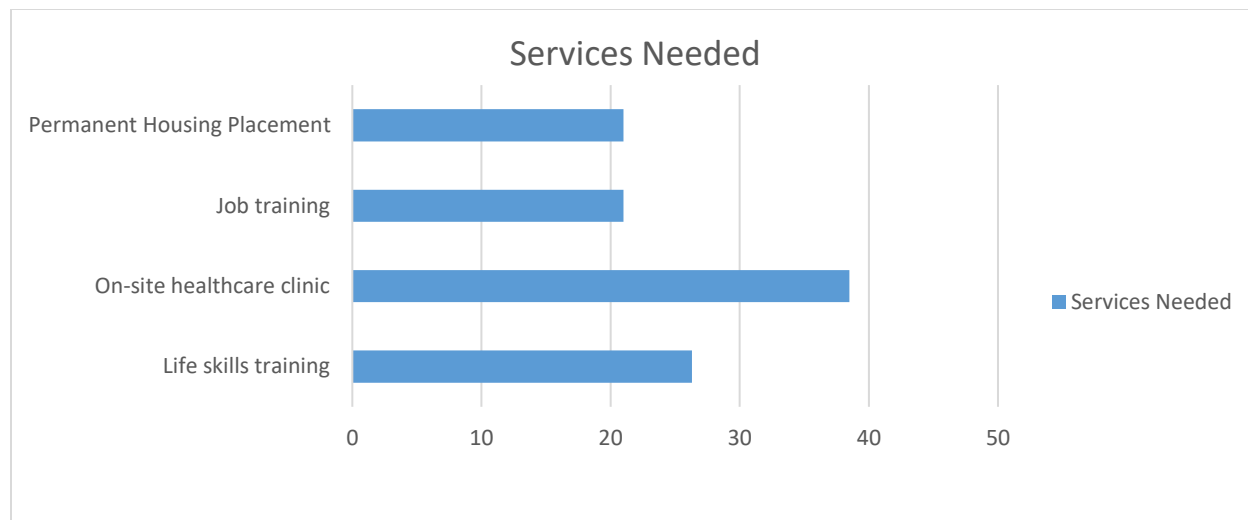
Barriers to Care of the Unaccompanied Homeless Youth

      The barriers to care for the unaccompanied homeless young adults include income (30.43%), transportation (26.09%), knowledge (26.09%), uninsured (8.70%), and age (8.70%). Table 5 is a summary of the identified barriers to care according to the survey participants of Ignite Promise.

Table 5 Summary of the Identified Barriers to Care
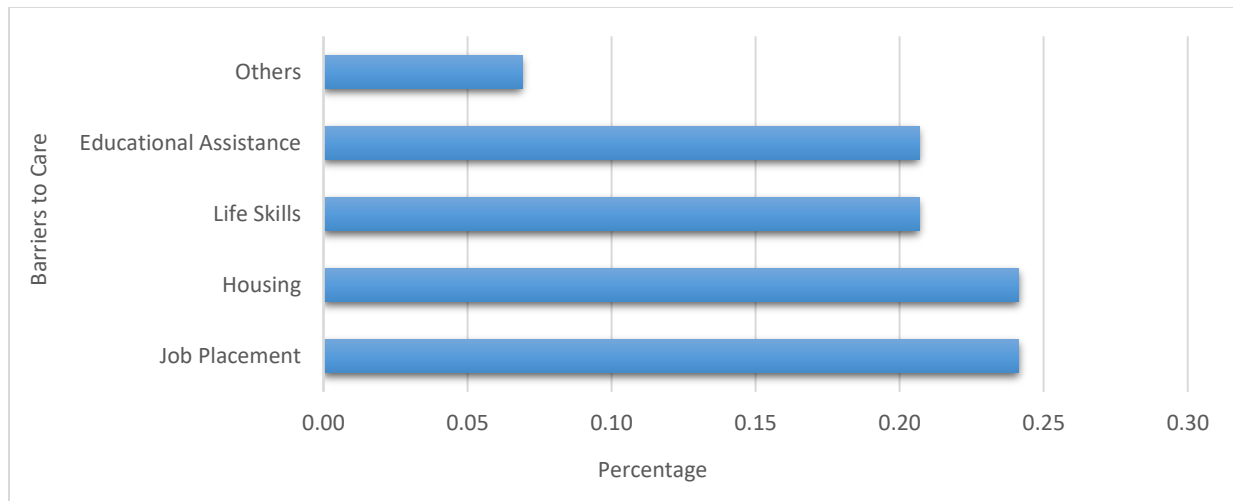
Qualtrics Survey (TNM)

Although 3 participants completed the online survey (N=3) , no data including demographic data was available for TNM.

Results (Ignite Promise and TNM Qualtrics Survey)

The following details the healthcare services and supportive services received by homeless unaccompanied young adults, the healthcare services and supportive services needed by homeless unaccompanied young adults, the services including supportive services needed for homeless unaccompanied young adults, and lastly the barriers to receiving adequate healthcare services and supportive services for homeless unaccompanied young adults, and any suggestions to overcome these barriers.

Mental health services and screening health services were identified by the homeless unaccompanied young adults at TNM and by staff of Ignite Promise as the services they receive most often. However, the staff at Ignite Promise also identified STI screening, school physicals, family planning services, and sick visits as additional healthcare services received by homeless unaccompanied young adults. Mental healthcare services, school and employment physicals, STI

screenings, family planning, and sick visits were also identified as the healthcare needs for homeless unaccompanied young adults, by both the staff of Ignite Promise and homeless unaccompanied young adults at TNM.

Supportive services identified by both the staff of Ignite Promise and homeless unaccompanied young adults at TNM include case management, housing placement, job placement, job skills training, resume assistance, food assistance, clothing and use of a computer room. The supportive needs listed by the staff of Ignite Promise and homeless unaccompanied young adults at TNM included permanent housing services, and life skills training. Homeless unaccompanied youth focused more on mentoring programs, career advice and life advice from the case managers and staff, and lastly homeless unaccompanied young adults felt it is important overall to receive daily encouragement from staff to help motivate youth and help them to overcome challenges in life.

The services which should be added according to the homeless unaccompanied youth and the staff of Ignite Promise include an on-site healthcare clinic which would increase access to healthcare services overall. Lastly both groups identified the need for an onsite job training program to help with employment.

According to the homeless unaccompanied young adults at TNM, the services which should be added to improve the care provided overall include a staff training program to ensure consistency amongst staff, they also felt TNM should develop all of their youth programs and policies with the input or participation from youth, and a change in the mission and values statement to ensure young adults have access to more programs, and have more input in operational policy development.

Various barriers were identified by the staff of Ignite Promise as issues preventing them from having a more quality life. Income, lack of transportation, lack of knowledge of the healthcare system, and lack of healthcare insurance. Homeless unaccompanied young adults identified barriers as more of an issue with the organization itself. This included lack of training of staff, lack of input from youth for program development and policy development, and lack of programs which meet the mission of the organization. Lack of appropriate providers, cultural barriers, and distrust of healthcare providers have consistently been identified as major barriers for homeless young adults (Christiani, Hudson, Nyamathi, Mutere, & Sweat, 2008).

Discussion

The aim of the DNP project was to engage homeless youth in providing their perspectives about the healthcare issues they experience and also to assess the existing healthcare services from the perspectives of the homeless unaccompanied young adults, the staff and healthcare providers and to determine their thoughts on how to improve these services provided at two institutions, TNM and Ignite Promise. Although the major themes emerging from the focus group data were not well supported by the survey data of staff at Ignite Promise, the traditional healthcare service needs reported by homeless youth were consistently supported by the staff of Ignite Promise. This finding, however further supports an unstated hypothesis, that staff and healthcare providers do not have a holistic understanding of the needs of homeless youth. Instead staff focus on more traditional programs and service needs which is inconsistent with what was reported by the homeless youth.

There is also very little known about the evaluation of healthcare services for homeless youth populations especially from the perspective of homeless unaccompanied young adults.

According to Ferguson, Kim & McCoy (2010), "Being recognized and validated as individuals through voicing their opinions promotes self-sufficiency and resilience" (p, 15).

Kurtz et al. (2000) suggests that establishing trusting relationships with supportive, and caring staff, helps youth create a sense of safety for homeless youth and helps them to trust others. However, homeless unaccompanied youth reported consistent experiences of feeling distrust or a disconnect from shelter staff which impacted their ability to trust the healthcare system, and overall ability to make lasting connections which could help to improve their livelihood overall. Lack of appropriate healthcare staff, cultural barriers, and distrust of healthcare providers were identified as barriers to access of healthcare services by homeless youth (Christiani, Hudson, Nyamathi, Mutere, & Sweat, 2008).

Overall, homeless young unaccompanied young adults did not believe the services provided were adequate to meet their needs and believe the major barriers to this include improper training, not allowing young adults to offer input when developing youth programs, and policies and inconsistencies of staff in implementing program rules and guidelines.

Limitations

While the findings of this study suggest the importance of assessing the healthcare needs of homeless unaccompanied young adults from their perspective, there are many limitations that should be considered when interpreting the results. Youth in this study were recruited from a single shelter in Chicago, Illinois and were only recruited over a period of one week prior to the study. In addition, the sample size reflects youth who are already connected to healthcare services, however youth unconnected might have a varied perspective of needs. Due to the small sample size, extrapolation of data is difficult, therefore making an evaluation of homeless unaccompanied young adult programs difficult utilizing the results from this study.

Also, the first site, TNM, experienced some administrative miscommunications which resulted in not being able to access a larger pool of staff and healthcare providers as originally agreed, which also eliminated the ability to include any data or results from this site as previously arranged. The barriers impacting the completion of the study included prevention of the survey link to be completed by the shelter staff, and the shelter healthcare providers at TNM. This further limited the ability to verify the data from staff and healthcare providers of TNM on this issue. Without the data from the staff and healthcare providers of TNM, there is no way to gather their perspective on the services provided at the shelter at TNM. Therefore, we could only make assumptions from the data provided by the staff at Ignite Promise.

Lastly, the site Ignite Promise though agreed to participate in this study, the timeline may have further limited the number of participants able to participate and provide timely feedback. Further limiting the data from staff and healthcare providers to a single shelter site in Chicago, Illinois for a limited timeframe. This may not generalize to other shelter sites with large numbers of staff and healthcare providers who provide services to homeless unaccompanied young adults. Thereby more research is needed to verify the results of this study.

Human Subjects Protection

"Researchers must collect, analyze, and report data without compromising the identities of the participants" (Kaiser, 2009, p.1632). To protect the confidentiality of the participants of this DNP project, participants were identified utilizing a pseudonym to reduce the chances of the participant being readily identified (Lee & Hume-Pratach, 2013).

Risks to this study include threats to internal and external validity either with inadequate sample size which may limit generalizability of relevant findings or use of an unreliable instrument, or high attrition rates due to the mobile nature of homeless youth populations. Lastly

breach of participant confidentiality via "deductive disclosure" (Kaiser, 2009, p.1632) which occurs when participants are easily identified in research reports should be avoided. "Vulnerable populations such as youth and subordinates in the workplace might face negative consequences if their identities are revealed" (Kaiser, p.1632).

Cash was be provided as compensation for participants of study.

Prior to the start of this study, the PI completed the CITI (Collaborative Institutional Training Initiative training, Institutional Review Board (IRB) approval was obtained from DePaul University.

Conclusion

The obvious benefit of this DNP project is examining the perspective of homeless youth and their providers on their health could potentially lead to the development evidence-based protocols, toolkits, and effective models of care for addressing the healthcare needs of homeless youth populations. According to (Hudson, Myamathi, Greengold, Slagle, Koniak-Griffin, Khalilifard, & Getzoff, 2010, "one way to achieve high-quality programs designed to improve the health of homeless youth is to solicit their input" (p, 3).

Other possible benefits of this DNP project include identification of innovative, comprehensive, youth-based approaches for addressing homelessness amongst youth. "When consumers are involved in decision making, and planning, interventions to improve their quality of life are more successful" (Hauff & Secor-Turner, 2015, p. 104).

Nurse practitioners and other healthcare providers who provide healthcare services to homeless unaccompanied homeless young adults are important in identifying the needs of this vulnerable population. Though challenges in providing care may arise, homeless youth continue to interact with staff and healthcare providers in shelter like environments regardless of use of

services. However, based on youth shelter staff and healthcare providers may need additional

training to assist with most current needs of homeless youth which include providing a trusting

environment, and feeling acceptance. Additionally, though many youth report having access to

healthcare insurance, there tends to be more contact with healthcare providers who provide

healthcare services in the shelter like environment.

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Appendix A. Evidence-Based Table on Nurse Led Clinics and Homeless Youth

Author & Year	Study Objectives	Methods	Study Variables	Instruments	Statistics	Study Findings	Conclusion
Clendon and White (2001)	To determine the feasibility of establishing a nurse practitioner led, family focused, primary health care clinic within a primary school environment to address the health needs of children and families. To determine if the public health nurse is the most appropriate role to	Community Needs analysis- data collected from 3 sources, -known demographic data quantitative. -17 key informants interviews, two focus groups. -setting included primary school. Qualitative data: the health needs of the community, Perceptions concerning the role of the public	N/A	N/A	-analysis were exploratory and descriptive, triangulating the qualitative and quantitative data. -answers from focus groups, and key informants.	- identified a wide range of health issues. asthma, poor parenting, problems with refugee, and migrant populations. – indicated the need for understanding the role of the public health nurse. – also found that further skills would be needed to address	-overall indicated that establishing a np led clinic which is family focused, and provides primary care services within a primary school environment. would be feasible. -while a public health nurse role would fulfil the role of the np, advancement to the np role would be required.

run the clinic.	health nurse, the practicalities of establishing a clinic, as well as the services they would expect the clinic to provide. -coding matrixes and a context chart were used to map data from interviews and demographic sources.					the needs of the clinic.	
Hegarty, Parker, Newton, Forrest, Seymour, and Sanci (2013)	Investigated the feasibility, acceptability, and cost of establishing a nurse-led clinic for youth in Australia.	Purposive sampling of practice nurses(PN), general practitioners (GP). -Informed consent was obtained. -participant	N/A	N/A	-content analyses of interviews using inductive thematic approach, coding of transcripts at two levels,	-three practices were implemented in rural and regional areas. -clinics were poorly attended by youth	-The implementation of a youth clinic is not feasible in a short time frame, also to maximize the use of the clinics,

| | | s took a 5hour workshop, teleconferences were conducted after clinics opened.

-interviews were conducted after 16 weeks, focus was on experiences, perceptions of barriers, nursing role, youth friendliness, nurse scope of practice.

-interviews were digitally recorded, cost study utilized comparison to costs of services, cost per practice, | | | | -nurses identified several barriers to clinic attendance including the short time frame, hours of the clinic, clinics lack of support by outside clinics resulting in low referral.

-The cost were from &5912 to $8557 to establish. –benefits included increased staff knowledge of youth health issues and improved | all members need to find the clinics acceptable. |
|---|---|---|---|---|---|---|---|

		cost of researcher time and administrative costs. Fixed and variable costs were combined.				relationships between general practice teams.	
Heale, James, and Garceau	-purpose of the multi case study was to evaluate for quality of care for patients with diabetes, and multimorbidity in 5 nurse practitioner led clinics (NPLC). -diabetes was chosen due to its complexity. -multiple chronic conditions allowed for better understanding of extent of practice for NPs.	-evaluation of a nplc was conducted using a multiple case study design derived from Stake (2006). -3 types of data were collected including: chart audits in each nplc, np interviews and a document analysis of policy and organizational features impacting nplc. Setting	N/A	Use of the Donabedian quality framework	-multiple case analysis -cross case analysis of 5 nplcs.	-analysis revealed outliers in organizational structure, including skill mix, and time of practice, and nature of physician collaboration. -no differences across 5 nplcs in the cross analysis -4 themes emerged: np as primary	-study outlined many issues related to structure and process of nplcs that influence quality of care. Research derived from these findings could be used as areas for further exploration especially those directed at np recruitment and retention, np education,

		included nplc with different levels of organizational maturity, differing community resources, and varying levels of np skill. -5 nplc three within urban areas, two within rural areas, all focusing on the chronic disease approach.				care provider, np recruitment and retention, healthcare resources, patient vulnerability.	and expansion of nursing education to include curriculum to included np as the primary care provider. -ongoing evaluation by healthcare organizations should assist with addressing issues with facilitate or impede quality of care.
Shiu, Lee, and Chau (2011)	-a study to discuss the development of expansion of the advanced nursing practice in nurse-led clinics in Hong Kong.	-a multiple-case study design was used with six nurse led clinics with three specialties, and broken into six	-4 embedded units of analysis -non participant observation of nursing	N/A	-data collected in 2009 with cross case analyses conducted.	-cross case analysis resulted in six elements of good advanced nursing practice in nurse	-the six criteria evaluated may be used as criteria for evaluation of nurse led clinics, and proposed

		case studies. -two clinics focused on incontinence, two on diabetes, two on wound care.	activities, nurse interviews, doctor interviews, and client interviews.			led clinics, and showed potential to expand the practice by reshaping 4 categories of boundaries: community, hospital, public-private, and professional practice. These suggest a model to advance the nursing practice in nurse led clinics.	model provides direction for expansion of nurse led practice.
Britto, Klostermann, Bonny,	-to determine if a multidimensional school-	-2832 students grades 7th through	-variables gender, age,	-use of a modified version of the in	-Bivarate analysis examined the	-in both years over 45% of	-results confirm that many adolescent

Altum, and Hornung (2013)	based intervention including physical, and mental health services increased adolescent use of needed medical care and preventative care, while decreasing ED usage.	12th across six public urban intervention schools and 2036 students in six demographically matched comparison schools completed a previously validated survey regarding health status and healthcare utilization, spring 1999 and 1998. -the group included interventions such as anger management, substance prevention, tutoring, home visits, and enhanced	race/ethnicity, maternal education, grade in school, school district, health status, chronic health problems.	school questionnaire designed for the National Longitudinal Study of Adolescent Health (Add Health). -the final questionnaire contained 106 questions, only in English. -the Add Health questionnaire was not tested for reading level. -the additional 11 questions had 6th	association between intervention status and year 1 and year 2 outcomes. -stepwise multivariate logistic models tested differences between the intervention and comparison groups across years, controlling for potential confounding variables. -the interaction term for group x year	students in both groups reported not seeking care they believed they needed. -emergency room use decreased slightly in the intervention schools and increased slightly in the comparison schools between year 1 and 2. -there were no major changes in healthcare delivery, demonstr	s have unmet healthcare needs. -those with poor health status were most likely to report underutilization, and unmet needs. -the study also demonstrated the benefit of use of comparison groups when suggesting the need for better understanding of community level changes and perceived healthcare access and use.

				grade reading level.	was used to test the effect of the intervention. - multivariable modeling was used to determine if student factors independently associated with healthcare utilization.	ating the need for improved access for adolescents. -of student factors: health status, having a chronic condition, and being in a higher grade were independently associated with student's report of not seeking health services.	
health services.							
Xue and Instrator (2016	Provides policy recommendations to expand the role of NPs working with rural and underserved populations.	N/A	N/A	N/A	N/A	N/A	Suggested the following: -The need for regulatory, workforce, and educational policies. -The need for establishmen

	The policies should focus on three key policy levers: NP scope-of-practice regulation, distribution of the NP workforce, and NP education.						t of legislative authority, or full practice authority for NPs. - Improvement in pay and incentives for NPs working in rural and underserved areas.

Appendix B. Logic Model

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES
Human Resources Nurse Practitioner, Collaborating MD, Nursing Students, University of Nursing Affiliation Agreement, Staff, Volunteers	Introduce NMHC to community partners. Apply for community partnership agreements. Conduct needs assessment to determine types of services needed in the community.	Number of patients who were seen at clinic. Number of nursing students able to complete clinic hours. Number of teaching faculty able to maintain practice hours.	Linkages to patient centered medical homes for homeless teen population. Reduced number of patients without health insurance. Coordination of healthcare services with interprofessional team.
IT EMR Updated website marketing clinic Financial Resource Grant application, Donations Physical Resources Preexisting facility, Exam room Waiting area Medical supplies	Establish timeline. Determine the services needed for the population. Apply for grant funds. Establish agreement with Medicaid providers. Order supplies and equipment. Select EMR.	Number of adolescents who abstained from risky behaviors. I.e. Unsafe sexual practices, use of drug and alcohol consumption. Improved access to immediate healthcare services. Increased community partnerships.	Decreased number of ED visits for acute care health issues. Improvement in chronic disease management including asthma, HIV/AIDS, Diabetes. Improvement in behavior health management i.e. Depression, anxiety.

Medical equipment			
Time Process for determining feasibility of establishing clinic. Process for establishing clinic. Barriers Endorsement from community partners. Issues with funding. Issues with certification, accreditation, etc.	Build out of clinic. Select billing process. Train staff, volunteers, and employees of new services, practices, methods of marketing, and establishing community partnerships. Provide healthcare services to underserved populations. Provide health education for vulnerable populations.	Evidence supporting benefit of NMHC for homeless teens at drop-in center. Increased number of clients with patient centered medical home.	Reduction in cost of healthcare services to the US. Established partnerships with community, clients, and MCOs.

<div align="center">

Appendix D
Participants are needed in a Research Study:

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Improving Care for Homeless Young Adults: A Shelter Client and Health Service Provider
Perspective

Criteria
You may participate in this study if:

You are an unaccompanied young adult confronting homelessness and are a current resident of
the shelters at The Night Ministry
You are 18 years of age and older.
English speaking
Non-pregnant
Agree to be audio recorded during the focus group.

Purpose of Project
To determine the quality of healthcare services at the shelters at The Night Ministry.

What are you asked to do?
You are asked to take part in an audio-recorded focus group which will include asking you open
ended questions regarding the quality of healthcare services provided at TNM and your
healthcare coverage.

Time Commitment
One-hour audio recorded focus group

Location
The Night Ministry West Town Shelter
Chicago, IL

<div align="center">

**Shelter residents who complete the focus group will receive $20 cash after
completing the research study.
Light refreshments will be served during the focus groups.**

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If Interested?
Contact:
Kenya Hemingway MSN, FNP-BC, APHN, DNPc at 312-282-4787 or khemin1@yahoo.com

Appendix E
Recruitment Email for Staff and Healthcare Providers

Dear Night Ministry Shelter Staff member and/or Healthcare provider

My name is Kenya Hemingway, I am a graduate nursing student at DePaul University. I am conducting a research study about improving the healthcare needs of the homeless unaccompanied young adults residing at The Night Ministry or Ignite Promise shelters. I am emailing to ask if you would like to take about 15 minutes to complete a survey for this research project.

Participation in this study is completely voluntary and your answers will be anonymous.

Staff and healthcare providers may participate if they are:
1. Age 18 years and older
2. English speaking
3. Provide services to the homeless unaccompanied young adults at the shelters of The Night Ministry or Ignite Promise.

If you decide to participate in this research study, you will be asked to answer some basic demographic questions about your age, gender, ethnicity, highest level of education, role at TNM or Ignite Promise, and years of experience working with homeless youth. You will also be asked a series of open-ended questions about the healthcare services at The Night Ministry or Ignite Promise shelters.

You will not receive any incentives for your participation in this research study.

If you are interested, please click on the link for additional information and to access the survey:

http://depaul.qualtrics.com/jfe/form/SV_9X2tFvyuak4m3Sl

If you have questions about the research study, please email or contact me at khemin1@yahoo.com or cellphone 312-282-4787.

Sincerely,

Kenya K. Hemingway
Doctoral Student
DePaul University
College of Nursing

Appendix H

Introduction:
Welcome and thank you for participating in this focus group.
My name is Kenya Hemingway, I am a graduate student at DePaul University.

Before we get started, I want to go over what the research involves. I will be passing out a consent form that I will read aloud. If you have any questions, please let me know. (PASS OUT CONSENT FORMS)

If there are no (no other) questions, please take a few minutes to get refreshments, use the bathroom, or talk amongst each other. We will start in a few minutes.

This conversation is being recorded for research purposes. Please let me know now if you do not agree to being recorded. You may request that the recording stop at any time.

A focus group is like a group interview. We are interested in everyone's responses to the questions. There are no right or wrong answers.

To help ensure the privacy and confidentiality of everyone here today, we ask if you would not discuss the names of the individuals here today or any of the details discussed in the study with anyone else. Please don't' repeat what is said in the focus group to others who are not part of the focus group.

I will not participate in the discussion; however, I will act as a moderator. I will ask questions during the focus group, and also, I will clarify any questions or concerns you may have.
 Do you have any questions for us before we begin?

If you have any questions, please feel free to ask them at any time.
Also, if you need to use the restrooms or get up for any reason, please feel free to do so. However please be mindful of the audio recorder.
Please remember to speak up when you respond to questions as the recorder is unable to pick up for example, nodding yes for responses.
Please remember you can withdraw your consent at any time.

Focus Group Questions

1. What healthcare services do you receive at TNM?

2. What supportive services do you receive at TNM?

3. What are your healthcare needs?

4. What supportive services do you need?

5. What services should be added at TNM to better address your healthcare needs?

Appendix I
Verbal Recruitment Script

My name is Kenya Hemingway, I am a graduate student at DePaul University. I will be conducting a focus group for a research study today between the hours of TBD.

If you are interested in participating, please meet in Room TBD, at time TBD.

The details of the study are listed on this recruitment flyer, however more detailed information will be provided once the study begins.

The purpose of this focus group is to assess the healthcare needs of homeless unaccompanied young adults who reside at the shelters.

The focus group will last about 1 hour, participants will be asked open-ended questions regarding the quality of healthcare services at The Night Ministry. In addition, participants will be asked about their healthcare coverage. Your responses will be audio recorded and for your privacy, your responses will be coded with a code letter or number.

You will be provided a small incentive for your participation in the focus group. You will be provided $20 cash.

Your participation is voluntary.
Light refreshments will be provided.

However, to participate in this study, you must be at least 18 years of age to participate in this study and agree to be audio-recorded during the focus group.
The complete criteria to be considered for the research is listed on this recruitment flyer.

Are there any questions?

If you would be interested in participating in a focus group today, please meet me in Room TBD, at time TBD.

Thank you