

Changing the Stigma of the Homeless in Nursing Students

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Abstract

Stigmatization of individuals and groups of people can directly affect their health. Ideally, health professionals are blind to stigmatizing patients in their care and would provide them with the same attention, resources, and care. However, many studies have observed that stigma exists among healthcare providers and that stigmatization affects the care provided. Stigmatizing patients by healthcare workers leads to poorer health outcomes and social isolation. A review of the literature discovered a recurrent theme of how nurses' negative perception of the homeless client acted as a barrier to them accessing healthcare.

Given that Hawai'i has the highest homeless rate per capita in the U.S. and that homeless individuals have multiple health needs, healthcare professionals will encounter homeless people in their practice. It is therefore imperative to train future healthcare providers to deliver ethical, compassionate care without prejudice and stigma to persons who are homeless. Interventions to decrease stigmatization from healthcare providers of vulnerable population would theoretically increase compassionate care and improve health outcomes.

The purpose of this project was to develop and pilot a multi-modal education seminar in an undergraduate nursing program to alter perceptions of homeless persons and decrease stigmatization. An analysis of the participants' perceptions of the homeless before and after the education seminar demonstrated a statistically significant decrease in stigma of the homeless particularly in the 20-30 year-old age range. The pilot project provided evidence that a multi-modal educational seminar can impact stigma perceptions. Further expansion to a larger sample group of students is recommended.

Chapter 1: Statement of the Problem

On any given night in the United States, over half a million people experience homelessness. In 2016, the majority were staying in emergency shelters or transitional housing (68%) while the other 32% were unsheltered. Thirty-five percent of the homeless were families with children (Henry, Watt, Rosenthal, & Shivji, 2016). Homelessness has a profound effect on the physical, behavioral, and mental health of individuals. Homelessness renders this distinct population with vulnerabilities including complex health needs. Children are particularly vulnerable to the effects of a stressful and unstable living situation and have been found to have a higher level of developmental delays, learning disabilities, behavioral and mental health problems (Bassuk, Richard, & Tsertsvadrze, 2015; Buckner, 2008; Marcal, 2017; Nabors et al., 2003).

The homeless are often stigmatized by society and healthcare providers. Homeless individuals are considered the poorest of the poor in society. Violence and conflict are predominant in their lives along with a higher risk of substance abuse. Many studies describe the numerous health disparities suffered by this vulnerable population including higher morbidity and mortality (Rog & Buckner, 2007).

Nurses and physicians have been tasked to care for the physical and mental health of people. With that responsibility healthcare workers are expected to conduct themselves in an ethical and caring manner. Medical professionals are guided by ethical principles of conduct which includes the principle of justice. The principle of justice or fairness dictates that anyone should have equal access and care without prejudice. However, many studies have supported that healthcare workers stigmatize and discriminate among their patients (Rao, et al. 2009). Provider stigmatization leads to disparities in access to health services, resources, and poorer

health outcomes for the stigmatized. Parkinson's (2009) review of the literature suggests "that education and experience of working with homeless people was an important factor in changing nurses' attitudes" (p. 12). Interventions to decrease healthcare providers' stigmatization of the homeless population would theoretically increase compassionate care to this vulnerable population.

De-stigmatizing strategies include advocacy, education, and personal contact. To address healthcare provider stigmatization of vulnerable groups, an educational seminar is proposed to expose nursing students to the healthcare vulnerabilities of the homeless population. The proposed intervention would be a multi-modal educational offering on homelessness conducted in an undergraduate nursing program.

Introduction to the Problem

The state of Hawai'i has the highest per capita rate of homelessness in the nation accounting for 487 homeless individuals per 100,000 (Hawai'i Department of Human Services Homeless Programs Office, 2018). In Hawai'i, 7220 individuals were counted as homeless during the statewide Homeless Point-in-Time Count in January of 2017 with 2685 individuals living in 666 family households (most headed by a single mother). Eighty-one percent of the families were staying in shelters. A factor that contributes to homelessness in Hawai'i is the high cost of housing. According to Rent Jungle, an online site for people looking for rentals, the current average rent for a two-bedroom apartment in Honolulu in 2018 is \$2333/month. The current minimum wage in Hawai'i is \$10.10/hour. Based on these figures, a person working at the minimum wage would need to work at least 63 hours per week just to pay for rent. This does not include any other expenses needed for basic needs such as food, utilities, clothing, etc.

Homelessness and the events that lead to homelessness are complex and multi-factorial. Multiple studies have found that homelessness impacts the physical, emotional, and mental health of unhoused individuals. However, there are differences among the homeless subgroups. The 2007 Homelessness Symposium report (Rog & Buckner, 2007) summarizes the impact of homelessness (particularly the chronically homeless) on the health and wellbeing of this group (p.4-3 – 4-5). These include:

- Disability from psychiatric and substance use disorders
- Lifetime mental health problems
- Higher co-morbidities and mortality rates
- High rates of chronic diseases
- Persistent unemployment

With the associated physical, behavioral and mental health problems suffered by the homeless population, healthcare professionals will encounter this group in many sectors of the healthcare community. The complex nature and needs of homeless individuals and families calls upon healthcare workers to understand and provide compassionate care to a vulnerable population. However, lack of preparation or experience in caring for this population can create dispassionate care based on preconceived ideas and stigmatization.

Parkinson (2009) reviewed literature on nursing attitudes towards homeless clients. Although there were only ten articles to review, several themes emerged. Negative attitudes by nurses towards homeless people was identified in six studies. A very small study identified a possibility that the negative attitude to homelessness could lead to less investment in the health of the homeless person. A consequence of the homeless person's perception of healthcare personnel's negative attitude was that they were reluctant to continue with follow-up care. Other

studies have identified stigmatization towards homeless people and the mentally ill by healthcare workers (Ertugrul & Ulug, 2004; Rao, et al., 2009; Ross & Goldner, 2009). Homeless individuals and families often suffer from mental illness, and so they have the potential to be doubly stigmatized (Vandentorren, et al., 2015). Given that Hawai'i has the highest homeless rate per capita in the U.S. and that homeless individuals have multiple health needs, healthcare professionals will encounter homeless people in their practice. It is therefore imperative to train future healthcare providers to deliver ethical and compassionate care without prejudice or stigma to persons who are homeless.

Homelessness has been identified as a risk factor for high utilization of emergency and hospital care and longer length-of-stays in the hospital (Bell, Turbow, George, & Ali, 2017; Bharel, 2016; Kushel, Perry, Bangsberg, Clark, & Moss, 2002; Lin, Bharel, Zhang, O'Connell, & Clark, 2015). Ku, et al. (2014) found that urban homeless had a disproportionately high percentage of emergency department (ED) visits and costs. Although this group accumulated charges of \$4.8 million, the ED was reimbursed \$482,928. This high-risk group often underutilizes ambulatory health care offerings even though they may have government health insurance for these services.

A study of patients admitted to Queens Medical Center (QMC) in Honolulu, Hawai'i with identified preventable congestive heart failure or diabetic related complications found that for 23% of them, lack of stable housing precipitated their admission (Quensell, Taira, Seto, Braun, and Sentell, 2017). Lack of stable housing limited their access to healthy foods (low fat, low salt, no food), clean water (to care for wounds), and safety of self and belongings. Managing complex conditions like congested heart failure (CHF) and diabetes mellitus (DM) was difficult without housing as there was no electricity for equipment or a place to refrigerate

medications like insulin. Another theme that was identified in these interviews was how the stigma of homelessness interfered with the relationship between homeless patients and their health care providers. The physicians treated them with less medical attention and care, particularly if they had mental health illness or substance use. Furthermore, the perceived negative attitudes prevented these patients from accessing and using health care that was available to them. Therefore, this study adds evidence that lack of stable housing contributes to over-utilization of in-patient services in Honolulu.

Not only does homelessness put clients at risk for utilization of higher acuity hospital admissions, but it poses a hefty financial out cost for institutions that is not recovered. The cost of homelessness in the state of Hawai'i is increasing, largely due to the severity and chronicity of the physical and mental illness of this population. The average emergency room visit in Hawai'i is \$830 per visit, the ambulance transport is \$1000, and the average cost of a hospital stay in 2015 was \$2563/day in 2015 (Consillio, 2016; Ellison, 2013). A report to the state legislature by the Hawai'i Interagency Council on Homelessness (HICH) cited a study conducted by the local newspaper that found eight out of the ten most frequent users of EMS services were homeless (HICH, 2013). Homeless clients' length of stay is usually two to four days longer than housed clients (Hwang, Weaver, Aubry, & Hoch, 2011; Wadhera, Choi, Shen, Yeah, & Joynt Maddox, 2019). In 2015, the QMC in Honolulu, Hawai'i accounted for 62 percent (10,126 visits) of the health encounters for the homeless. QMC estimates that the cost of providing care for the homeless population was \$37.2 million of which \$27 million was reimbursed by Hawai'i Medicare/Medicaid. This places the medical center at a \$10 million deficit in homeless care expenses (Consillio, 2016; Hawaii Healthcare Information Corporation [HHIC], n.d.) and places the burden of covering healthcare expenses for the homeless onto taxpayers.

Problem Statement

Stigmatization of individuals and groups of people can directly impact their health. Hatzenbuehler, Phelan, & Link, (2013) proposed that stigma is a fundamental cause of health disparity and requires attention when considering social determinants to health. Ideally, health professionals should not stigmatize patients in their care but should provide all patients with the same attention, resources, and care. However, many studies have observed that stigma exists among healthcare providers (Rao, et al. 2009; Ross, Goldner, 2009; Law, Rostill-Brookes, Goodman, 2009) and that stigmatization affects the care provided. Stigmatizing patients by healthcare workers leads to poorer health outcomes and social isolation. Parkinson's (2009) review of the literature discovered a recurrent theme of "how nurses' prejudice acted as a barrier to homeless people accessing healthcare" (p. 9). Woith, Kerber, Astroth, & Jenkins (2016) found that homeless people seeking healthcare perceived that nurses did not treat them fairly or with respect and that their health concerns were not taken seriously. Evidence strongly suggests there is a need to develop de-stigmatizing curriculum that cultivates compassion and open-mindedness in future healthcare providers so that care of vulnerable populations like the homeless is comprehensive and without prejudice.

The purpose of this scholarly project is to determine if a destigmatizing education program can change negative perceptions of the homeless in the undergraduate nursing student.

Project Aims and Objectives

Specific Aim 1: Design an educational program grounded in the available evidence towards reducing stigmatization of the homeless population by future healthcare professionals.

Objective 1: Perform a database search for articles from the academic literature on the topic of destigmatization strategies.

Objective 2: Perform a needs assessment within the current nursing curriculum and based upon this assessment, develop student-learning outcomes related to decreasing stigmatizing attitudes and increasing compassionate nursing care.

Objective 3: Identify a validated tool for assessing the presence of stigmatizing attitudes in nursing students towards homeless individuals.

Objective 4: Create an educational program on homelessness and stigma and its effect on health outcomes.

Specific Aim 2: Pilot the program.

Objective 1: Obtain approval for delivering stigma reducing educational module in undergraduate nursing program.

Objective 2: Implement the educational program with a cohort of nursing students.

Objective 3: Evaluate the effectiveness of the program for changing stigmatized perceptions of homeless individuals.

Chapter 2: Background and Project Description

Introduction

In this chapter, an analysis of the concept of stigma is delineated to understand the underlying purpose of the proposal. The Framework Integrating Normative Influence on Stigma (FINIS) which creates the foundation for the project is described. The FINIS aids in the understanding of the complex systems that form stigma and supports the intervention proposed to decrease stigmatization development and perception of the homeless population. A review of the literature will look at describing the impact of stigmatization on vulnerable populations, particularly in health outcomes, and strategies to prevent or decrease the development of stigmatization in healthcare providers.

Theoretical Framework

Stigmatization is a concept that has been actively studied by many disciplines within the social psychology and healthcare realm. It has been defined in varied ways with the emphasis dependent upon the discipline's frame of reference. However, Link and Phelan (2001) believe that "because of the complexity of the stigma phenomenon, it seems wise to continue to allow variation" (p. 365) with the caveat that there should be consistency in the definition of stigma. Stigmatization cannot be understood without understanding of the word *stigma*.

Taken literally, a stigma can be a physical characteristic that is seen and identifiable such as dark or light skin, almond-shaped eyes, or an amputated limb. However, stigma can also be something abstract, an attribute not physically seen but a characteristic, label, or perception that is given to someone. Although a stigma can be a concrete characteristic, the concept of stigmatization is an abstract concept that is consciously or subconsciously actionable. It is done

within an individual or a group that is then reflected through behavior. It cannot be physically touched, seen, heard, smelled, or tasted but it is emotionally sensed and perceived.

Social psychology has been in the forefront of defining and studying stigma in society. Link and Phelan (2001) took on the task of analyzing the concept of stigma through the perspective of social psychologists. They indicate that the influx of stigma research was stimulated by Erving Goffman's publication of *Stigma: Notes on the Management of Spoiled Identity* in 1963. In this book, Goffman defined stigma as an "attribute that is deeply discrediting" (p. 3) and that stigmatization was the process of devaluing that person. He also posed that stigma could not be seen as just a stand-alone attribute but in the context of relationships. What one person or group or area may see as a stigma, an illegal immigrant for example, another individual or group may not see it as a negative attribute to stigmatize. Perhaps they see that same person as an economic refugee who should be given all manner of support. The idea of a stigma is seen in relation to an individual's or societal perspective. In order for something to be a stigma or considered abnormal, someone (the normal) must deem it to be so. Goffman also described one's "virtual social identity," as the identity or attributes that is ascribed upon a person versus the "actual social identity" (p. 2) which are the real attributes they embody. Stigmatization does not take into account the actual social identity of the person. Goffman's seminal work on stigma and stigmatization has led to further additions to his original descriptions. Jones et al. (1984) expounded that it was not having the attribute that stigmatizes the person alone but the process of then assigning further aspects of the stigma to the person or an overgeneralization (stereotyping) of the stigma.

Link and Phelan (2001) subsequently added that stigmatization includes an aspect of power which discriminates against the stigmatized person/group causing a loss of status. The

loss of status of the stigmatized group leads to inequality. The authors further describe four components that come together for stigma to occur. They state that first, labeling persons who are different occurs. Secondly, they are linked to undesirable attributes (stereotypes) by the values of the dominant culture. Third, they are then negatively categorized as “them” and finally, lose status and become discriminated against. This fourth component was important to their definition of stigma as they were studying stigma in the context of society. However, what Link and Phelan have proposed in their fourth component is the *outcome* of stigmatization; what happens when someone is stigmatized.

Before stigma formation can occur, an individual, culture, or society has identified attributes that are valued. The individual appraises another person for these valued attributes from their own perspective. The appraisal is influenced by the individual’s family, cultural group, society and their personal experiences. If the individual recognizes or perceives that the other person does not have the valued normative attribute, then a conclusion is made of “not normal” and a stigma (label) is placed upon the person (stigmatization). So, identification of normative values, cultural and societal influences, and perception precede stigmatization.

The Framework Integrating Normative Influence on Stigma (FINIS) is a framework addressing the formation and impact of the stigma of mental illness from micro to macro levels. Stigma is a complex social phenomenon that is embedded within individuals and the social structure in which they live and interact. The FINIS developed by Pescosolido, Martin, Lang, and Olafsdotir (2008) provides a framework that incorporates the realms of the individual (the stigmatized and the stigmatizers) and society (including community, media and government), and the intersection of the medical (treatment) system (see Figure 1). The micro level includes individual characteristics (the mark) such as social and illness characteristics which are then

stigmatized. The macro level of the community integrates the larger world in which one lives and influences society’s cultural values, economic and resource distribution, healthcare system, and government policy. Both levels come together in the meso level where social networks and media characterizations reinforce the stigmatizing characteristics and the labelling that occurs to stigmatize the individual or group. Stigmatization of individuals then produces responses within the individual and society which can be seen as negative (social withdrawing) or positive (advocacy). The responses of the stigmatized individual or group and society can lead to health disparities over their life course. The treatment system is influenced by all levels of the framework. The response of the treatment system (healthcare systems and providers) can also be positive or negative. The FINIS conceptualizes the complex interactions of individuals, the community, and the national view that forms stigma. Although this framework was formed to explain mental illness stigmatization, it can be used for other stigmatized groups.

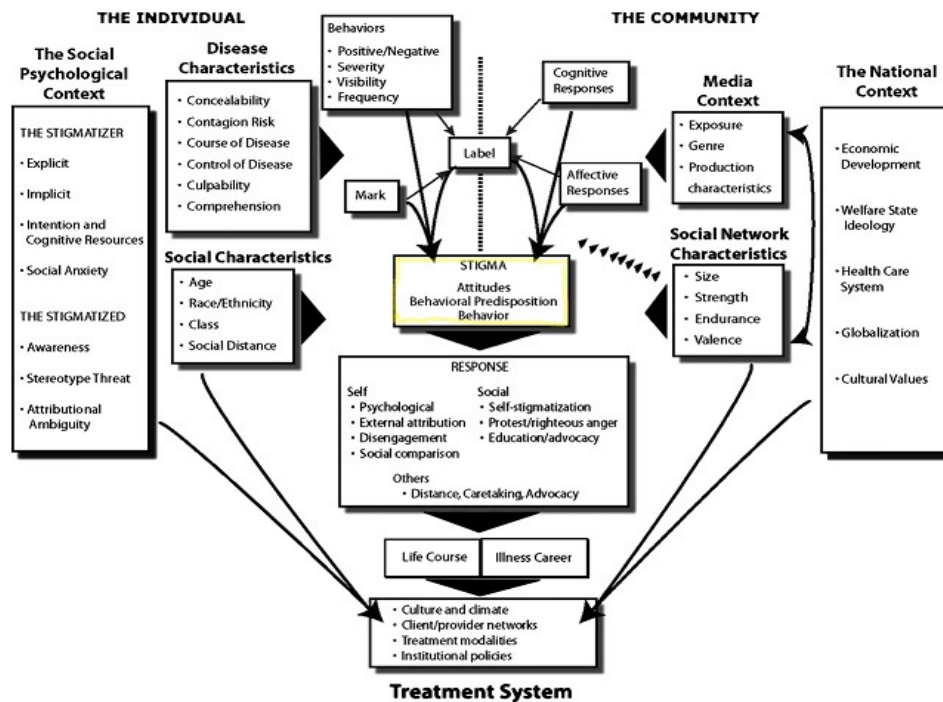


Figure 1. Framework integrating normative influences on stigma (FINIS).

The framework that the FINIS proposes is a comprehensive view of stigma and how the medical community is affected. Using the framework provides a theoretical basis for addressing individual characteristics of the homeless, the cultural/societal influence on developing stigmatization, and the response of the healthcare provider. It explains the why and how of stigmatization. By identifying the “why” and “how”, interventions can be developed and tested to assess any changes in stigmatizing attitudes. The FINIS provides the larger picture of the multiple factors that contribute to stigmatization and helps to categorize stigma research previously undertaken within its framework.

Stigmatization is difficult to change as it is a complex process integrating societal values, cultural and familial influences, and individual experiences to determine acceptable norms in which to perceive those not meeting the expected standards. It is often intricately woven into the fabric of a person’s psyche and society as a whole and consequently one is often not aware of their own stigmatizing attitudes or behaviors. However, the one who is stigmatized senses and outwardly experiences the effects of being cast as not normal. This in turn can cause the stigmatizer and the victim to develop defensive coping mechanisms such as social isolation (the victim staying away from social interactions or the stigmatizer physically moving away from the stigmatized). Social isolation from either side perpetuates stigmatization. Individuals or groups of people who are classically stigmatized are those who suffer mental illness, poverty, homelessness, or in other ways differ from the society’s or culture’s norm. Interventions that have been proposed to decrease stigma are aimed at reframing individual’s perceptions and helping to decrease negative identification and defensive coping mechanisms. This development of stigma and its impact on individuals or groups is illustrated in Figure 2. Interventions to affect or change the formation of stigmatization are depicted by the red arrows. To intervene in the

formation or to change perceptions of stigma, interventions are aimed at the normative group or individual depicted by the left arrow. Interventions can also be created for the stigmatizer or the stigmatized to alter negative defensive coping behaviors such as isolation depicted by the right arrow.

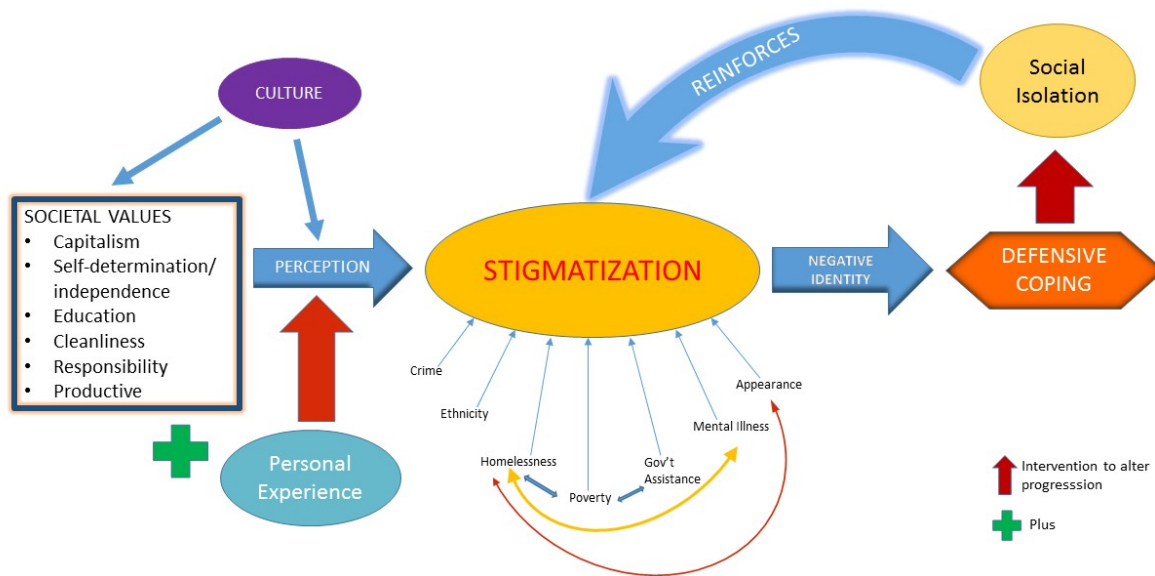


Figure 2. Concept Map: The Process and Effect of Stigmatization Formation.

Review of the Scholarly Literature

A review of the literature will examine the evidence how stigma affects marginalized populations specifically the mentally ill, poor, and homeless and how stigma relates to healthcare providers and care given. It will then follow with an overview of destigmatizing strategies and effectiveness of experiential learning.

Stigma of marginalized populations.

Stigmatization negatively affects social determinants to health such as income, education, housing, and living environment and is believed to be a fundamental cause of health inequalities

(Hatzenbuehler, Phelan, & Link, 2013). Stigmatized individuals or groups perceive the differences in attitude and behavior towards them and both the stigmatized and the stigmatizers decrease interactions (Clement, et al., 2015; Ertugrul & Ulug, 2004). Both groups can socially distance themselves from each other or the dominant social group can segregate the stigmatized. Individuals who feel stigmatized or internalize society's view of them (self-stigma) could socially isolate themselves from the stigmatizers and remove themselves from society, such as the homeless population, or increase negative coping mechanisms (Kidd, 2007; Kidd, 2009).

Research findings support the hypothesis that the homeless would experience more stigmatization than poor-but-housed and that homelessness would elicit more social distancing (Phelan, Link, Moore, and Stueve, 1997). Other studies have provided evidence of stigmatization towards homeless people (Corrigan & Watson, 2002; Corrigan, et al. 2012). Several studies also depict stigmatization of these populations by healthcare workers (Rao, et al., 2009; Ross & Goldner, 2009). Therefore, the concept of stigmatization is central to health disparities found in the homeless.

When perceived to be stigmatized, homeless clients were found to decrease their interactions with healthcare providers. This avoidance affected follow-up care, impeded health-seeking behaviors, created a negative effect on caring for their health, increased behaviors that pose higher risk to health, and led to distrust of healthcare workers (Parkinson, 2009; Clement, et al., 2015; Quensell, et al. 2017). The decreased provider contact was cited as a reason for preventable hospitalizations of homeless clients with complications of chronic obstructive pulmonary disease (COPD) and diabetes mellitus (DM), and contribute to the rising expenditures of healthcare costs (Quensell, et al., 2017). O'Toole, Johnson, Redihan, Borgia, & Rose (2015) identified that stigma from primary healthcare providers was a reason homeless veterans delayed

care in the ambulatory setting leading to increased healthcare expenses for emergency and inpatient care and prolonged lengths of stay.

Stigma within healthcare.

As disappointing as it is, healthcare professionals have been found to discriminate against patients with certain diseases such as HIV/AIDS, mental illness, and obesity and people with low socioeconomic status (SES) such as the homeless (Kammer, 1993; Puhl & Heuer, 2010; Rao, et al., 2009; Ross & Goldner, 2009; Whetten, Reif, Whetten, & Murphy-McMillan, 2008). The impact of discrimination by healthcare professionals can lead to poorer health outcomes in several ways. For example, clients with a history of a mental health (MH) disorder who enter the emergency services with behavioral or psychotic symptoms are assumed to have an exacerbation of their MH diagnosis. They are transferred to an inpatient psychiatric unit for the care of the presumed MH issue without considering that the behavior changes are due to medication adverse reactions or another physical problem such as intracranial diseases, metabolic, or electrolyte disorders.

Two previous reviews of literature on stigma and nursing found few studies specific to nursing. However, stigma was found to take several forms in nursing. Nurses were found to be either stigmatizers, stigmatized, or destigmatizers. Nurses who stigmatized were felt by the patient or family to not treat them with dignity and caring. Nurses' dehumanizing attitudes led to fragmentation of the patient's care when the nurse felt the symptom was related to a MH condition. Nurses who had MH disorders felt stigmatized by their colleagues and some became victims of horizontal violence (Ross & Goldner, 2009; Parkinson, 2009).

Destigmatizing strategies.

In medical and nursing science, there are hundreds of studies examining the effect of stigmatized groups and health outcomes. Stigmatization of vulnerable populations leads to social, economic, and political discrimination and results in health disparities. In order to begin to address the health disparities of stigmatized groups, healthcare researchers must rely on our social scientist colleagues to understand how stigmatization occurs and develop interventions to intervene in stigma formation.

In response to the 1999 White House Conference on Mental Health, many anti-stigma campaigns were developed in the U.S. to destigmatize mental health disorders and persons suffering from them. These campaigns focused on personal contact, education, and advocacy as strategies to decrease stigmatization. These approaches have been found to affect different types of stigma (personal stigma, perceived stigma, and self-stigma) with varying effectiveness. In a historical perspective of destigmatization, Clair, Daniel, & Lamont (2016) identified advocacy as being particularly effective in decreasing cultural stigmatization when presented by respected public figures who provided evidence debunking previously held societal constructs. This type of persistent advocacy restructured the perception of the stigmatized group that their behaviors were to be blamed for their condition and replaced it with the construct that “it could happen to me.”

Interventions to decrease healthcare providers’ stigmatization of the homeless population would theoretically increase compassionate care to this vulnerable population and ultimately improve health outcomes. Corrigan et al. (2012) performed a meta-analysis of anti-stigma approaches for people with mental illness. They identified three broad tactics to decrease stigmatization and found that personal contact had the best outcome in destigmatization. This

tactic of experiential learning strategies was found to improve healthcare providers' and healthcare students' perceptions of marginalized populations in several studies (Dela Cruz, Brehm, & Harris, 2004; Jarrell et al., 2014; Loewenson & Hunt, 2011; and Zrinyi & Balogh, 2004). Educational destigmatizing strategies were found to decrease stigmatizing but less strongly than personal contact (Corrigan, et al., 2012; Griffiths, Carron-Arthur, & Reid, 2014).

Experiential learning experiences that place student health professionals in direct contact with vulnerable populations (poor, homeless, or MH disorders) made a positive impact on their perceptions of these client populations. When measured before and after the experience, student attitudes and perceptions improved with new awareness of their client's circumstance. This learning strategy provided healthcare students an opportunity to develop social responsibility to care for vulnerable clients (Dela Cruz, Brehm, & Harris, 2004; Chung-Park, Hatton, Robinson, & Kleffel, 2004; Jarrell, et al., 2013; Kooker, Baylor, & Schwend, 2014; Loewenson & Hunt, 2011; Zrinyi & Balogh, 2004). Corrigan, et al. (2012) also found that direct contact was better than videotaped contact in diminishing stigma, but that videotaped contact also made a significant difference. Videotaped strategies are effective in reaching a broader and larger audience. However, Chan, Mak & Lawrence (2009) found that adding a video-based contact significantly improved an anti-stigma program of mental illness if presented after education, not before.

Experiential simulation, also called Point-of-View simulation, is a strategy that is most effective in increasing empathy in the participant (Bearman, Palermo, Allen, & Williams, 2015; Bosse et al., 2012; Bunn & Terpstra, 2009; Daepfen et al., 2012). Students play the role of the client/family seeking services. It provides the student a safe learning environment while engaging the learner in the experience of what it is like to have the condition or situation. It

places the student in the role of the client, which develops empathy. Debriefing after the role-playing is important to conduct as it increases the learning (Aebersold, 2018; Jeffries, 2005; Jeffries & Rizzolo, 2006).

Summary

Although a significant amount of literature has been generated on the development of stigmatization in both the social and health sciences, communities and societies continue to struggle with the effects of stigma in marginalizing groups of people. Stigma can lead to prejudice and discrimination and places the stigmatized at a significant disadvantage in many aspects of their life. It impacts their physical and mental health, education, job opportunities, and financial stability.

Despite the amount of literature on stigma and destigmatizing strategies, nursing research on stigma is limited. Healthcare professionals are not immune to the effects of stigmatization and specific action must occur to confront, change, or decrease stigmatizing perceptions early in their training. Zrinyi & Balogh (2004) recommend that nursing curriculum emphasize ethics education and modeling of positive faculty behaviors. Preparing the nursing student for their professional role begins in the undergraduate curriculum. It is where destigmatizing strategies can and should be embedded.

Social scientists have explored stigma and society at length. However, there are several gaps in the literature in regards to stigma and nursing. Nursing research on stigma is limited with very few studies found. The effect of stigmatization on patient care and healthcare relationships is important to understand. Characteristics of healthcare professionals that stigmatize versus those that destigmatize in healthcare would also be an area to explore. Effective strategies to reduce perceived stigma or self-stigmatization have not been generated in

the literature. There is also a lack of prospective studies on whether destigmatizing approaches persist in the long term. Stigmatization in healthcare is an area that is necessary to explore.

Chapter 3: Project Design and Evaluation Plan

The goal of this Practice Inquiry Project is to improve the nursing curriculum in addressing the homeless population, the influence of stigma and healthcare outcomes, and to directly impact destigmatization of homeless clients by future healthcare providers. Specific aims are developed to guide the process to accomplish the PIP goal. In this chapter, methods for meeting the project's specific aims are described for each objective. Protection of human subjects will be addressed and the evaluation plan to assess results of the intervention is presented in detail.

Human Subjects Protection and Ethical Assurance

The proposal for the project was approved by the University of Hawai'i Hilo's Scientific Review Committee (SRC). Ethical treatment of subject certification (CITI) was completed and Institutional Review Board approval for exemption status from the University of Hawai'i (UH) was given in order to proceed. A Memorandum of Understanding (MOU) was obtained between Kapi'olani Community College (KapCC) where the project was implemented and UHH. The sample of subjects was unknown to the investigator. The investigator had no previous contact with subjects nor had influence on the student evaluations or progress. The investigator had no financial or commercial interests in implementation of this project. The nursing faculty at the UHH Doctor of Nursing Program advised and supervised the project.

Recruitment of Study Participants and Confidentiality Protection

A convenience sample of nursing students currently enrolled in their first semester of the nursing curriculum at KapCC Associate Degree in Nursing program (ADN) was identified as subjects for the pilot project by the KapCC nursing faculty. The concept of Health Disparities is introduced at this level and it was determined that the topic of healthcare stigma and

homelessness was a good fit for this concept. Three hours were allotted for the education intervention. The cohort consisted of 23 first semester nursing students ranging in age from 21 to 43 years of age with 17 women and 6 men. In this pilot project, study participants were not assigned or randomized into study groups and the study was conducted in their naturalistic setting as a student. The investigator had no previous contact with the students and was not involved with evaluation (grading) of the students in this course.

Confidential standards were strictly enforced. The students were informed that the purpose of the intervention was to pilot and evaluate a new education module on health disparities among certain populations and that participation in the data collection was on a voluntary basis. The informed consent was reviewed in detail (see Appendix A) and all students in the cohort opted to participate in the project evaluation. There was no attrition from the sample cohort. 30 numbers within the range of 1 to 100 had been randomly selected by a random number generator prior to the class. The student then randomly selected a number from this set as their personal identity number. No names, addresses, student ID numbers, or other identification was collected so that the investigator is unable to match the identity number with a student. The purpose for the identity number was to match pre- and post-test results. Gender, age, and personal experience with homelessness was collected for data analysis purposes. Informed consents and test results are kept in a locked document holder that is accessible to the investigator only and will be destroyed one year from pilot implementation. The voluntary participation of the student will not affect their standing as this seminar is not associated with a grade. Confidentiality was maintained in all phases of the pilot study. Data analysis will be aggregated to further keep subject responses anonymous.

Data Collection and Instruments

To evaluate the effectiveness of the educational offering in affecting stigma of the homeless, stigma perceptions will be measured before and after the project using items adapted for the homeless population from a social distance scale, the Mental Health Provider Self-Assessment of Stigma Scale (MHPSASS), and the Opening Minds Scale for Health Care Providers (OMS-HC).

There are no stigma assessment tools specific for healthcare perceptions towards the homeless population. Therefore, items from several stigma assessment surveys were used in the pilot survey to determine healthcare stigmatization towards the homeless as clients and in the general community. Using items from these three stigma tools, the pilot survey attempts to assess the future healthcare provider's stigmatization of the homeless population by measuring social distancing, attitudes in general towards the homeless, and attitudes towards their clients that are homeless. (see Appendix B for Survey).

The Social Distance scale has been a standard tool in the social sciences since 1926 (Mather, Jones, & Moats, 2017) to measure stigma. Statements in regards to how a person would respond to another with a stigmatized situation or condition (poverty, obesity, illness, mental illness, etc.) depict the amount the responder would distance themselves from that person, thereby representing the amount of stigma projected. The more a person would distance themselves from another would represent more stigmatization and vice versa. Snow (2013) created a variety of vignettes of homelessness and mental illness to measure social isolation. A brief description of a homeless person with or without a mental health condition was given and the subject answered several statements on a Likert scale from 1 to 5 regarding this person with 5 indicating "Strongly agree" and 1 indicating "Strongly Disagree." A vignette, that was adapted

from Snow (2013), was used in the pilot survey to measure the construct of Social Isolation towards the homeless population (see Appendix B for survey items 1-5).

The OMS-HC is a self-report questionnaire that was developed to assess the attitudes and behaviors of health care professionals towards people with mental illness (Kassam, Papish, Modgill, & Patten, 2012). The tool was developed with the purpose of having a valid and reliable tool to evaluate best practices to reduce stigma towards mental illness. It has been tested for validity and reliability by the Mental Health Commission of Canada (MHCC) through its Opening Minds (OM) initiative and was found to be “an acceptable measure for capturing health care provider stigma” of the mentally ill (Modgill, Patten, Knaak, Kassam, & Szeto, 2014, p. 7). The OMS-HC questionnaire evaluated by Modgill, et al (2014) had 20 items which incorporated three subscales measuring Attitude, Disclosure and Help-seeking, and Social Distance using a Likert scale. The items were scored from 1 to 5 with higher scores indicating a more stigmatizing attitude. The authors suggested that 5 items could be eliminated as the 15-item version analysis was stronger than with 20 items. Cronbach’s alpha coefficient for the 15 items was 0.79 with the three subscales ranging from 0.67 to 0.68 which was deemed acceptable. Five items from the Attitudes and Disclosure subscales were adapted for homelessness for the pilot (see Appendix B for survey items 10-14). As this survey was geared towards mental illness, not all items could be applied to the homeless population such as, “I would not mind if a person with a mental illness (homeless) lived next door to me” (see Appendix C for OMS-HC 15-item survey).

While the OMS-HC measures the provider’s attitude in general about mental illness, the MHPSASS was developed to measure provider-based stigma *towards* the clients they serve and provides a reliable measure of this type of stigma (Charles & Bentley, 2018). Twenty items are

identified with four subscales: Irritation and Impatience, Choice and Capacity, Adherence and Dependence, and Devalue and Depersonalize. Overall, the MHPSASS “possesses acceptable internal consistency, face, and content validity, as well as potential construct validity” (Charles & Bentley, 2018, pp. 45). Four items from the MHPSASS adapted for the homeless client were selected to reflect provider-based attitudes towards their clients and (see Appendix B Survey items 6-9).

The OMS-HC Attitude and Disclosure and Help-seeking subscales, the MHPSASS, and a social distance vignette were adapted for the homeless population and used in the survey for pre- and post-testing using a 5-point Likert scale ranging from “strongly disagree” to “strongly agree.” The survey had a total of 14 items with each item scored from 1 to 5 with some items reverse scored. The survey range of scores is 14-70 with higher scores reflecting higher stigma perceptions (see Appendix C for Survey Key). A decrease in the post test scores would indicate a decrease in stigma and vice versa, an increase in test scores would indicate an increase in stigma. A change score of zero from pretest to posttest would indicate no change. A positive change score would indicate increased stigma and a negative change score would indicate a decrease in stigma.

Methodology

After obtaining informed consent and prior to beginning the educational intervention, the pre-test was administered with the student’s randomly selected identity number placed on the form. The pre-tests were collected then placed and sealed in an envelope identified as Pre-tests. The seminar was then conducted over a three-hour period. It consisted of multi-modal teaching strategies that were designed to actively engage the students and introduce them to the concept of health disparities, its influence on health and health outcomes of marginalized populations, social

determinants of health, and the role the healthcare provider can play. Teaching strategies included a polling or audience participation mobile app, a PowerPoint presentation embedded with hyperlinks to videos, data, and other audiovisual links, three simulation scenarios, and interactive discussion. The polling app (sift.ly©) allowed the audience to input their responses on any electronic device (mobile phone, tablet, or computer) and watch the responses populate in real time on the presentation screen. The responses would then become a wordle (a puzzle made from the written responses) with most frequent responses displayed as larger words. Point-of-View simulation cases played a large part of the seminar as having homeless individuals or families come to the seminar was not logistically possible. Therefore, the experience of homelessness was portrayed through simulation. The students were randomly assigned in groups of four and given a simulation scenario to role-play homeless clients, family members, and health professionals. The homeless client character(s) included a family recently immigrated into Hawai'i, a runaway teenager, and an adult male (see Appendix D). The scenarios included a stigmatizing healthcare professional or situation that could worsen due to stigmatization of the homeless client. One student in the scenario was assigned as a recorder to observe the interaction and the unfolding of the scenario. Once the scenarios had been played out, a debriefing of the cases occurred with all students participating in an active discussion of the situations with a focus of how healthcare provider perception and attitude towards the homeless impacted their health outcomes. The seminar concluded with recommended activities to recognize personal stigma, ways to increase diversity in their personal lives, and work towards ending health disparities by addressing social determinants of health.

At the end of the seminar, the survey was re-administered to subjects as the post-test with the student's identity number placed on the form. These tests were then placed in an envelope labelled as Post-tests and sealed.

Data Analysis Plan

The survey results were analyzed using the IBM Statistical Package for the Social Science (SPSS) Version 25. Data checks of linearity, homoscedasticity, normality, and multicollinearity were analyzed prior to quantitative analysis of the pre- and post-test results. Data analysis was conducted in three phases. First, subject variables are described using univariate (descriptive) analysis. Second, survey items were analyzed for data integrity and internal validity and consistency using the Cronbach's alpha. Third, the relationship between the stigma constructs from pretest to posttest was examined using bivariate analysis. Fourth, predictor variables, such as age, gender, and experience of homelessness, associated with the dependent variable (pre- to posttest change score) was entered into a multiple regression model for multivariate analysis at a statistically significant level ($p < .05$). Of the 23 study participants, there were no missing data.

Chapter 4: Results

Project Implementation and Results

The purpose of this project was to develop, pilot, and evaluate an education seminar in an undergraduate nursing program to address stigmatization of homeless persons and poverty. The methods to meet the objectives to obtain the aims of the project are summarized below with data analyzed where appropriate.

Specific Aim 1: Design an educational program grounded in the available evidence toward reducing stigmatization of the homeless population by future healthcare professionals.

Objective 1: Perform a database search for articles from the academic literature on the topic of destigmatization strategies.

A systematic search of several databases was undertaken to identify strategies that provide evidence of decreasing stigmatization in subjects. Searches include databases from CINAHL, MEDLINE, Academic Search Complete, accessed through EBSCOhost, and Google Scholar. Key words include homeless, homelessness, stigma (including variations of stigmatize, stigmatization, destigmatize), perception, learning, education, strategies, nurse/nursing ± student(s), experiential learning, and healthcare in a variety of combinations. Much of the literature collected through these searches were primarily from sociologic journals or in healthcare journals for specific conditions (HIV/AIDS, obesity, mental illness). There were few references about stigma found specific to nursing/nursing students and the homeless population. However, the search does elicit several articles with evidence of strategies that were effective in destigmatizing certain conditions such as mental illness that could be used in other conditions prone to stigma. These articles provided the evidence to develop a teaching approach based on

the most effective strategies to destigmatize. Best strategies included direct contact and education. An experiential simulation (Point-of-View) was implemented as a method of direct contact with a homeless person through case scenarios role-played by students.

Objective 2: Perform a needs assessment within the current nursing curriculum and based upon this assessment, develop student learning outcomes related to decreasing stigmatizing attitudes and increasing compassionate nursing care.

A meeting with nursing faculty was conducted to gather information to ascertain whether the topic of homelessness or stigma is presented, discussed, or explored in the course. Based on the information gathered, the development of the education offering on homelessness will be aimed at introducing healthcare stigma of the homeless under the concept of Health Disparities. Nursing students in their first semester of the nursing curriculum at Kapi'olani Community College were identified as subjects for the pilot project by the nursing faculty. The concept of Health Disparities is introduced at this level and it was determined that the topic of healthcare stigma and homelessness was a good fit for this concept. Three hours was allotted for the education intervention. A concept module for Health Disparities was developed which included student learning objectives (see Appendix E for Health Disparities concept module).

Objective 3: Identify a validated tool for assessing the presence of stigmatizing attitudes in nursing students towards homeless individuals.

A literature search was performed for identification of a validated assessment tool of stigmatizing perceptions or actions towards the homeless population. Survey tools were reviewed for validity and consistency. Items from The Social Distance, MHPSASS, and OHM-HC surveys that evaluated stigma perceptions were adapted for the homeless and utilized to develop the pilot survey tool (see Data and Collection Instruments in Chapter 3 for details of

survey items). Internal consistency of the adapted survey and its constructs are analyzed for validity of the survey (see Specific Aim 2, Objective 3).

Objective 4: Create an education module on homelessness and healthcare provider stigma and its effect on health outcomes.

Based on the findings from Objectives 1-3, this project intervention was focused using an educational approach with multiple teaching strategies geared towards nursing students. A three-hour educational seminar was designed using a multi-modal interactive teaching approach including a classroom polling app (sift.ly), a PowerPoint presentation with embedded videos and links to data charts and activities, active discussion, and role-playing through simulation scenarios with debriefing.

The content of the course covered health disparities and social determinants of health and focused on the concept of stigma and the effect it plays on social determinants of health and its impact on health and economic outcomes. Personal or direct contact with a homeless person was simulated with students playing the roles of homeless clients, healthcare providers, and family members in various scenarios. This activity provided an account of homeless persons' experience of homelessness and healthcare stigmatization. A debriefing of the simulation scenarios was conducted immediately after the activity to provide students an avenue for dialogue regarding feelings, observations, perceptions, and reflection of the scenario. The seminar concluded with methods for addressing personal stigma and the ethical expectations of healthcare providers for all clients.

Specific Aim 2: Pilot the education program.

Objective 1: Obtain approval for delivering stigma reducing educational module in undergraduate nursing program.

Approval for this intervention was granted by the Chancellor, Dean of the Health Division, and nursing faculty. The proposal for the project was approved by the University of Hawai'i Hilo Scientific Review Committee (SRC). A Memorandum of Understanding (MOU) was obtained from the school where the project was conducted. Ethical treatment of subject certification (CITI) was completed and IRB approval was given to proceed.

Objective 2: Implement the stigma education module with a cohort of nursing students.

A convenience sample of 23 first semester nursing students was identified by the nursing faculty to participate in the intervention. Enrollment was voluntary. There were no exclusion criteria. Informed consent was obtained. No subjects withdrew from the activity. No data was excluded.

Characteristics of the sample are presented in Table 1. The 23 subjects ranged in age from 22 to 43 years of age (see Figure 3). There were 17 women and 6 men. Eight subjects personally knew someone who experienced homelessness and one subject reported experiencing homelessness and knew someone who experienced homelessness. They were grouped together as an independent variable of homelessness exposure. Prior to starting the seminar, the survey was administered and following completion of the seminar, the survey was readministered and collected.

Table 1

Characteristics of nursing students who participated in pilot seminar

Characteristics	N participants	%
Gender		
Female	17	74
Male	6	26
Exposure to Homelessness		
Yes	9	39
No	14	61
Age range (years)		
21-25	10	44
26-30	4	17
31-35	5	22
36-40	1	4
41-45	3	13

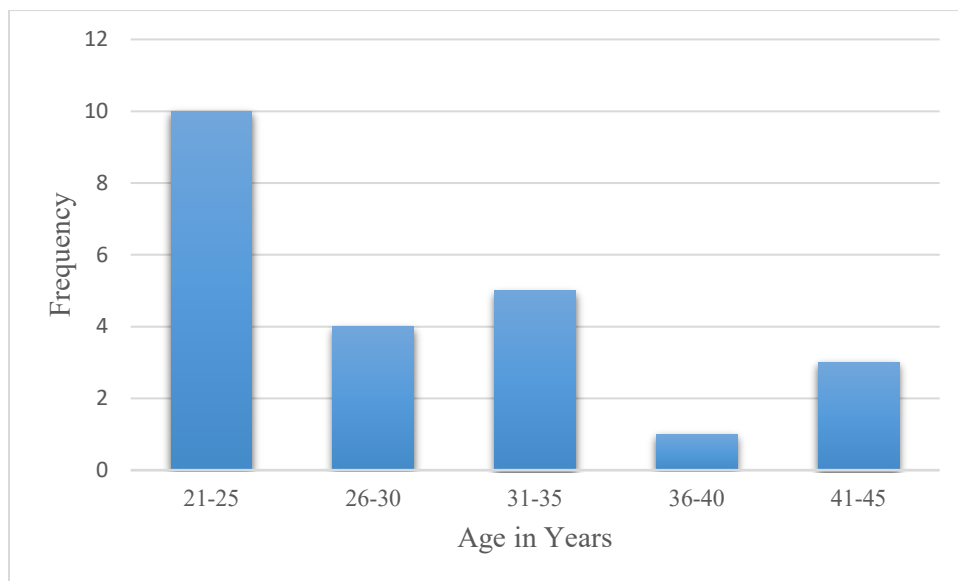


Figure 3. Age range distribution of nursing student participants

Objective 3: Evaluate the effectiveness of the program for changing stigmatized perceptions of homeless individuals.

Subjects completed the pre- and post- test surveys. Tests to check for data integrity were performed prior to bivariate and multivariate statistical analysis. These tests include normal distribution, checks for outliers, linearity, homoscedasticity, and multicollinearity. All checks for data integrity were deemed sound for the data collected and valid for bivariate and multivariate analysis.

Analysis of survey item reliability was performed on the pretest and posttest since survey items were adapted for the homeless population from several stigma surveys. Items were analyzed for internal consistency reliability using Cronbach's alpha with a value of 0.70 as acceptable reliability. The pretest items calculated a Cronbach's alpha of 0.47 while the same items in the posttest gave an alpha of 0.802. Individual constructs within the pretest and posttest survey were also analyzed (see Table 2). Internal validity of items adapted from the three surveys were also analyzed for internal consistency (see Table 3).

Table 2

Reliability testing results for survey constructs

Construct	Survey Items	Pretest Cronbach's alpha	Posttest Cronbach's alpha
Social Isolation	1, 2, 3, 4, 5	.552	.840
HC Irritation	6, 7	.611	.559
HC Attitudes	8, 9, 10, 13, 14	.703	.580
Disclosure	11, 12	.651	.713

Table 3

Reliability testing results for items modified from developed stigma surveys

Survey	Survey Items	Pretest Cronbach's alpha	Posttest Cronbach's alpha
Snow vignette	1, 2, 3, 4, 5	.552	.840
MHPSASS	6, 7, 8, 9	.128	.236
OMS-HC	10, 11, 12, 13, 14	.695	.651

Changes in the pre- and post-test scores of the survey items (change score) were analyzed using SPSS to determine the effectiveness of the educational seminar to change stigma perceptions of participants. A comparative boxplot visually shows a drop in the median of the survey scores from pretest to posttest (see Figure 4) as well as a decrease in posttest scores in the inter-quartile range. The range of pretest scores was from 32 to 49 with a mean of 37.7. The range of scores for the posttest was 23 to 48 with a mean of 33.5. A paired samples t-test compared the means of the pretest and post scores between subjects. The difference of the mean scores from pretest to post test was 4.217. Paired sample t- test results demonstrate a significant difference between pre and post test scores ($t_{22} = 3.66, p < 0.001$) (see Table 4).

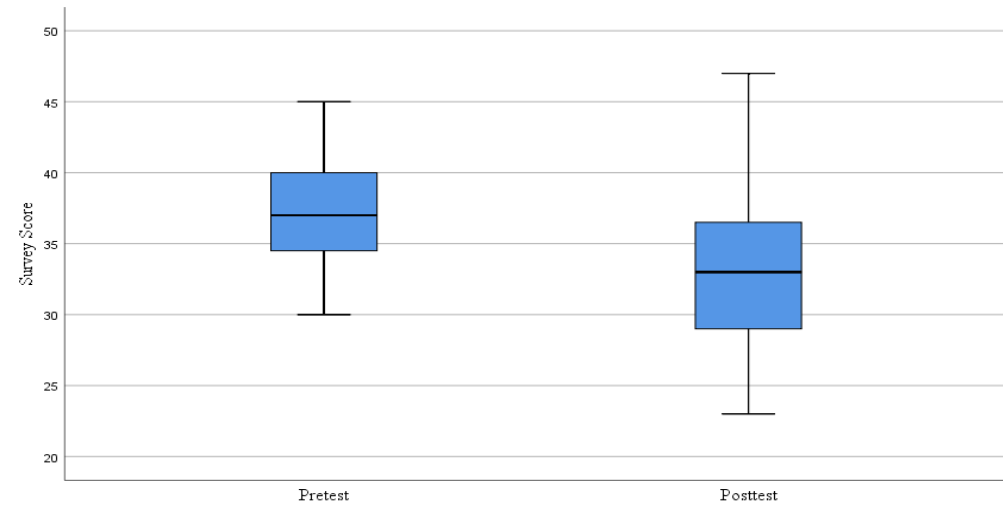


Figure 4. Boxplot comparing distribution and median of pretest and posttest scores

Table 4

Results of paired samples t test for pretest and posttest scores.

Paired Samples Test								
	Paired Differences					t	df	Sig. (2-tailed) p value
	Mean	Std. Deviation	Std. Error of the Difference Mean	95% Confidence Interval				
				Lower	Upper			
Pretest score - Posttest scores	4.217	5.526	1.152	1.828	6.607	3.660	22	.001

Bivariate analysis was conducted to determine if age, gender, or personal exposure to homelessness was related to the change score. Independent samples t-test was used to compare gender and experience with homelessness to the change score (see Table 5). Neither variable reached significance to the change score which indicates no statistical relationship. Correlation test was used to compare age to the change score (see Table 6). Pearson correlation of 0.548 was significant at p of 0.01 level, which indicates that age and the change score are closely

associated. Figure 5 visually demonstrates that the greater decrease in survey scores occurred in the subjects in the 21 to 30-year age range while Figure 6 depicts the spread between pretest and posttest scores and age.

Table 5

Results of bivariate analysis comparing homeless exposure and gender to change score.

Variable	Levene's Test for Equality of Variances		t-test for Equality of Means			
	F	Sig.	t	df	Sig. (2-tailed)	
Homeless Exposure						
Change score	Equal variances assumed	2.764	.111	.382	21	.706
	Equal variances not assumed			.358	13.698	.726
Gender						
Change score	Equal variances assumed	1.672	.210	.058	21	.954
	Equal variances not assumed			.048	6.580	.963

Table 6

Correlations of change score and age.

		Change score	Age
Change score	Pearson Correlation	1	.548**
	Sig. (2-tailed)		.007
	N	23	23
Age	Pearson Correlation	.548**	1
	Sig. (2-tailed)	.007	
	N	23	23

** . Correlation is significant at the 0.01 level (2-tailed).

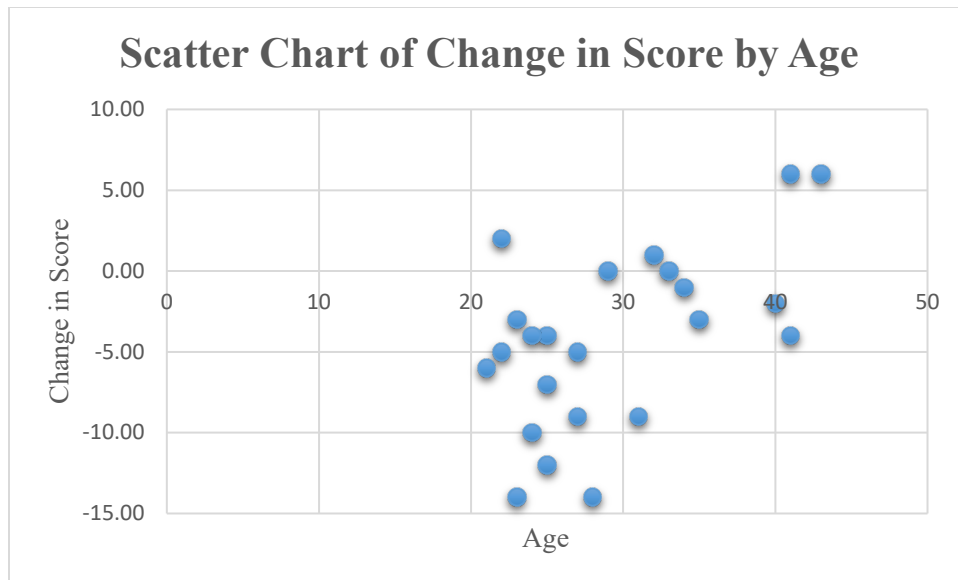


Figure 5. Scatterplot comparing change in survey scores and age. A zero change in score indicates that the subject had the same pretest and posttest score with no change in their stigma. Values below zero indicate a decrease in the posttest score (less stigma) and values above zero indicate an increase in posttest score (more stigma).

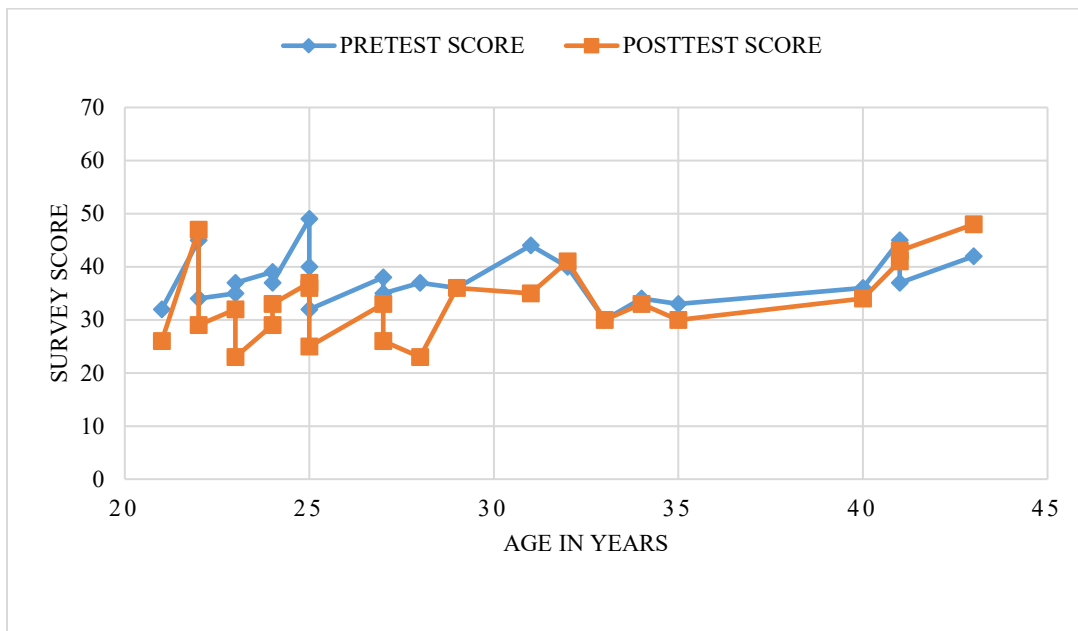


Figure 6. Comparison of pretest and posttest scores of subjects and age in years.

Chapter 5: Discussion, Implications for Practice, and Conclusion

Discussion

This project's purpose was to affect a change in stigma perceptions of homeless clients of future healthcare providers through an educational seminar. A decrease from pretest to posttest mean scores of the stigma survey was found to be statistically significant ($p < 0.001$). This finding supports that the educational seminar was effective in decreasing stigma perceptions of the homeless in first semester nursing students. Age was found to be related to the change in score from pretest to posttest with a larger change in score observed in younger subjects (21-30 years) than older subjects (31-43 years). Figure 6 plots the difference between subjects' scores with older subjects demonstrating slight or no change. This difference in older students hypothetically could be related to having more years of life experience thereby developing a more consistent view of homelessness and life that is not influenced by a single educational experience.

Overall range of scores in pretest and posttest finds nursing students' stigma towards homeless persons in a medium range (stigma survey has score range of 14 – 70). People who gravitate towards nursing often have an intrinsic desire to be of service to people (Baskale & Sercekus, 2015; Halperin & Mashiach-Eizenberg, 2014; Price, 2011; Wilkes, Cowin, & Johnson, 2015) so nursing students may have a fundamentally less stigmatizing view of the homeless.

Adaptation of stigma survey items from the Snow social isolation vignette, MHPSASS, and OMS-HC for the homeless population was found to have consistency in the social isolation construct in the posttest with a Cronbach's alpha of 0.884, poor internal validity in both pretest and posttest for the MHPSASS constructs (Cronbach's alpha 0.128 and 0.236 respectively), and acceptable validity for the OMS-HC items (Cronbach's alpha 0.695 and 0.651). The social

isolation construct results support the historical validity and usefulness in gauging stigma in identified populations. The OMS-HC items bring in a different aspect of stigma by assessing the provider's view of a person with the stigmatizing condition, in this case homelessness.

However, the MHPSASS items are geared towards a provider who is directly caring for this client. The first semester nursing students have not had an opportunity to experience caring for a client at the time they participated in the seminar. Consequently, these items may have been confusing or difficult to answer based on their lack of direct care experience as a healthcare provider. Cronbach's alpha is concerned with the interrelatedness of test items measuring the same constructs such as social isolation. However, it "cannot simply be interpreted as an index for the internal consistency of a test" (Tavakol & Dennick, 2011, p. 54). Having a small number of test items for a construct can underestimate reliability so increasing items within a construct would improve reliability.

Implication for Practice

This pilot project aimed to assess if a multimodal education method could decrease stigmatization of the homeless in undergraduate nursing students. Results from this pilot produced evidence that this modality did produce the desired effect. It can be concluded that the educational intervention decreased stigma of the homeless population by the student nurses. Using simulation as a method for experiencing the impact of stigma of the homeless, providing data and information, and using interactive technologies were effective in educating nursing students of the homeless population. This method to impact a change in perspective supports previous studies of direct contact (albeit by simulation) and education as effective strategies for destigmatization and can be used for all students in healthcare professions. This pilot project

provides evidence that this method has the potential to destigmatize marginalized clients and should be confirmed on a larger scale.

Improvement of the survey is recommended by removing the MHPSASS items as they did not support validity of these constructs for this level of student. More items from OMS-HC survey adapted for the homeless could be added by removing the MHPSASS items. Further testing with a larger number of subjects of the amended survey should continue for validation of the internal consistency of survey items and constructs. A Factor Analysis can be performed to better identify the constructs of the survey and refinement can proceed as needed. A longitudinal study design would be important to undertake to determine whether the effect of destigmatization of the homeless persists over time in healthcare students who have graduated. This information would add to the literature whether destigmatization strategies have a lasting impact.

Conclusion

Healthcare provider stigma plays a part in the outcomes of the homeless client. Preparing the healthcare student for their professional role begins in the undergraduate curriculum. Addressing stigma in the healthcare student's curriculum can change the student's perception. This is where destigmatizing strategies can be embedded with the purpose of developing compassionate care for all populations.

Sartorius (2007) charges health professionals to observe their personal behaviors and determine if they are part of stigmatization of individuals. As healthcare providers, we must be aware of our own stigmas and how our actions may impact the health of our patients. If we are vigilant in noticing and intervening when stigmatization occurs in our practice, we may be able to slowly extinguish the labeling and inequities that occur when stigmatization occurs. We

should also actively confront behaviors, attitudes, and policies that stigmatize individuals, groups, or populations. When this occurs, we will improve health outcomes for all.

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Appendix A

Informed Consent

CONSENT TO PARTICIPATE IN AN EVIDENCED BASED EDUCATION PROJECT

Below is a description of the procedures and an explanation of your rights as a study participant. You should read this information carefully. If you agree to participate, you will sign in the space provided to indicate that you have read and understand the information on this consent form. You are entitled to and will receive a copy of this form.

You have been asked to participate in an educational seminar entitled "Nursing's Impact on Changing Health Disparities" conducted by Laura Ohara, a professor in the Department of the School of Nursing in the Health Division at Kapiolani Community College.

WHAT THE STUDY IS ABOUT:

The purpose of this project inquiry is to pilot and evaluate a new education module on health disparities among certain populations.

WE WILL ASK YOU TO DO:

Students will attend an educational seminar. During this seminar, students will be asked to anonymously complete a survey before and after the education presentation. A debriefing will be held after completing the post-course survey to discuss the effect of participating in the seminar. Students will also be asked to complete an anonymous evaluation of the training.

DURATION AND LOCATION OF THE STUDY:

Your participation in this exercise/study will involve two to three hours of your time.

POTENTIAL RISKS AND DISCOMFORTS:

The research procedures described above may involve the following risks and/or discomforts: reflections on homelessness, poverty, or mental health issues may cause emotional and psychological discomfort. The facilitator of the training, the principle investigator of the study, will be available for one-on-one discussion at the request of any student. Students will be informed of college resources as necessary. If you wish, you may choose to withdraw your consent and discontinue your participation at any time during the study without any consequences.

BENEFITS:

The possible benefits to you of participating in this study are 1) Gaining insight into the healthcare needs and outcomes of the marginalized populations and applying the knowledge to your nursing practice; 2) Contributing to the learning of future nursing students 3) Gaining experience in the process of evidence-based practice.

PRIVACY/CONFIDENTIALITY:

(NOTE: Anonymity means that no identifying information such as name or student ID number is collected, so the privacy of participants is assured. Confidentiality means that the researcher will have a record of who participated but the data will be kept private.

Any data you provide in this study will be kept confidential unless disclosure is required by law. In the event that this study is submitted for publication, no information will be traceable to any individual. Specifically, all data will be aggregated and no personal identification will be written on the submissions.

At the end of one year from the date of the exercise, the master list as well as all consents to participate in the exercise/study will be destroyed.

COMPENSATION/PAYMENT FOR PARTICIPATION:

There is no payment or other form of compensation for your participation in this study. The student will receive a certification of completion for this learning module.

VOLUNTARY NATURE OF THE STUDY:

Your participation is voluntary and you may refuse to participate without consequence or effect on your standing in the nursing program.

OFFER TO ANSWER QUESTIONS:

Please ask any questions you have now. If you have questions later, you should contact the principal investigator: Laura Ohara, ohara3@hawaii.edu or by phone 808-734-9293. If you have questions or concerns about your rights as a participant in this study, you may contact the University of Hawaii Human Studies Program at:

Human Studies Program
2425 Campus Road, Sinclair 1
Honolulu, HI 96822
Email: uhirb@hawaii.edu

I HAVE READ THE ABOVE INFORMATION. ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED. I AGREE TO PARTICIPATE IN THIS RESEARCH PROJECT AND I WILL RECEIVE A COPY OF THIS CONSENT FORM.

PARTICIPANT'S SIGNATURE

DATE

Appendix B

Pre- and Posttest Survey

ID # _____

Place a check in the box that most closely indicates your thoughts. Your answers are anonymous. When complete, please place this in the survey box. THANK YOU!					
Taylor is a 26-year-old who has been homeless for the past 2 years. Taylor is currently working at a minimum wage job. Answer the following questions based on Taylor.					
Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. I would feel comfortable renting a room in my home to Taylor.					
2. I would <i>not</i> feel comfortable working on the same job with Taylor.					
3. I would be comfortable having Taylor take care of my children for a couple of hours.					
4. I would <i>not</i> be comfortable recommending Taylor for a job working for a friend of mine.					
5. If I was an employer, I would be comfortable hiring Taylor.					
Respond to the following statements as it pertains to your role as a healthcare provider.					
Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
6. It is hard not to sometimes be irritated with clients who are homeless.					
7. When a homeless client isn't trying hard enough to be healthy, I may not go out of my way to help them.					
8. When a homeless client is not taking prescribed medication, they are probably resistant to treatment.					
9. Clients who are homeless have a hard time making good choices for themselves, so providers need to help them.					

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
10. More than half of people who are homeless do not try hard enough to get better.					
11. If I was homeless, I would not disclose this to any of my colleagues.					
12. I would be reluctant to seek help if I was homeless.					
13. There is little I can do to help people who are homeless.					
14. I struggle to feel compassion for a person who is homeless.					

Demographics				
Your age in years				
Gender (circle)	Female	Male	Other	Prefer not to answer
You are or have been homeless.			YES	NO
You personally know someone who is or has been homeless.			YES	NO
Please add any additional comments:				

Appendix C

Survey Scoring Key

ID # _____

Place a check in the box that most closely indicates your thoughts. Your answers are anonymous. When complete, please place this in the survey box. THANK YOU!					
Taylor is a 26-year-old who has been homeless for the past 2 years. Taylor is currently working at a minimum wage job. Answer the following questions based on Taylor.					
Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. I would feel comfortable renting a room in my home to Taylor.	1	2	3	4	5
2. I would <i>not</i> feel comfortable working on the same job with Taylor.	5	4	3	2	1
3. I would be comfortable having Taylor take care of my children for a couple of hours.	1	2	3	4	5
4. I would <i>not</i> be comfortable recommending Taylor for a job working for a friend of mine.	5	4	3	2	1
5. If I was an employer, I would be comfortable hiring Taylor.	1	2	3	4	5
Respond to the following statements as it pertains to your role as a healthcare provider.					
Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
6. It is hard not to sometimes be irritated with clients who are homeless.	5	4	3	2	1
7. When a homeless client isn't trying hard enough to be healthy, I may not go out of my way to help them.	5	4	3	2	1
8. When a homeless client is not taking prescribed medication, they are probably resistant to treatment.	5	4	3	2	1
9. Clients who are homeless have a hard time making good choices for themselves, so providers need to help them.	5	4	3	2	1

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
10. More than half of people who are homeless do not try hard enough to get better.	5	4	3	2	1
11. If I was homeless, I would not disclose this to any of my colleagues.	5	4	3	2	1
12. I would be reluctant to seek help if I was homeless.	5	4	3	2	1
13. There is little I can do to help people who are homeless.	5	4	3	2	1
14. I struggle to feel compassion for a person who is homeless.	5	4	3	2	1

Demographics				
Your age in years				
Gender (circle)	Female	Male	Other	Prefer not to answer
You are or have been homeless.		YES		NO
You personally know someone who is or has been homeless.		YES		NO
Please add any additional comments:				

Appendix D

Point-of-View Scenarios Synopsis

- 46-year-old Male unemployed due to injury and lost his job, death of father, divorce, and became homeless.
- 15-year-old female run-away escaping violence at home living on streets for 6 months
- Micronesian family who lost their home when landlord sold it. Unable to afford housing as parents do not have steady job. Living in park with relatives.

Appendix E

Health Disparities Concept Module

**Kapi'olani Community College
Associate in Science Degree Nursing Program
NURS 210 Health & Illness I**

**UNIT: Professional Nursing and Health Care
THEME: Health Care Delivery
CONCEPT 54: Health Disparities**

Definition: *Differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the U.S.*

Health and Illness Concept Objectives:

1. Describe the socio-ecological theory as it relates to health disparities.
2. Discuss factors that contribute to health disparities in various populations.
3. Identify personal, cultural, and community perceptions that could contribute to health care disparities.
4. Discuss how healthcare perceptions contribute to health outcomes of clients.
5. Develop a plan of care for a client from a marginalized group with healthcare needs including community resources.
6. Describe social determinants of health and its impact on health outcomes.

Inter-related Concepts: Genetics, Culture, Communication, Health Promotion, Health Policy, Health Care Quality, Health Care Law.

Interdisciplinary: Physicians, policy makers, social leaders,

Resources: Giddens p. 504-510; Potter p. 101-102.

Classroom Competency Integration	Terminology	Exemplars	Learning Experiences	Evaluation Methods
<p>1. Ethical Practice Identifies ethical principles in the care of people from diverse populations.</p> <p>2. Reflection Identify how self-perceptions of people can contribute to health care disparities.</p> <p>3. Evidence-based practice Seek evidenced-based clinical guidelines in planning care for people with health disparities.</p> <p>4. Leadership Discuss the role that leaders play in contributing to improvement or worsening of outcomes of marginalized populations.</p> <p>5. Collaboration Identify members of healthcare team and community who care for people with healthcare disparities.</p> <p>6. Health Care System Issues Describe factors in health care delivery system that impact health outcomes for</p>	<p>Attribute</p> <p>Stereotype</p> <p>Perception</p> <p>Prejudice</p> <p>Discrimination</p> <p>Culture</p> <p>Stigma</p> <p>Socio-ecological theory</p> <ul style="list-style-type: none"> • Microsystem • Mesosystem • Macrosystem • Exosystem <p>Life course</p> <p>Epigenetics</p>	<p>Homelessness</p> <p>Poverty</p> <p>Disease conditions:</p> <ul style="list-style-type: none"> • HIV/AIDS • Obesity • Psych/Mental Health • Substance Abuse/Addiction 	<p>Simulation scenarios</p> <p>Case studies</p> <p>Lecture</p> <p>Discussion</p> <p>Interactive polling app</p>	<p>Classroom:</p> <p>Course exams</p> <p>Pre-, Post-tests</p> <p>Group Discussion</p> <p>Group work/presentation</p> <p>On-Line discussion</p> <p>Clinical practicum:</p> <p>Observe communication with clients with health care disparities or from marginalized populations.</p> <p>Plan the care of clients from a socio-ecological approach.</p>

Classroom Competency Integration	Terminology	Exemplars	Learning Experiences	Evaluation Methods
<p>clients with health care disparities.</p> <p>7. Client-centered care Discuss how the nurse promotes health of marginalized populations.</p> <p>8. Communication Practice communication with clients with potential or actual alterations in health due to health care disparities.</p> <p>9. Clinical Judgment Develops a plan of care for client to alter health disparities.</p>				