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Feeding the homeless through collaboration: A proposal for consideration

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This is to certify that **Valetta Johnson Massaquoi** has successfully defended her Graduate Project entitled **"Feeding the Homeless through Collaboration: A proposal for Consideration"** and fulfilled the requirements for the Master of Arts in Nursing degree.

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Committee member signatures:

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Abstract

The homeless are faced with many challenges of adverse nutritional deficiencies that predispose them to several illnesses commonly associated with the lack of adequate nutrition and the frequent utilizations of health care resources. Provision of nutritious food for the homeless can help decrease the prevalence of these identifiable markers and can be accomplished by a collaborative effort. The purpose of this project is to describe a collaboration between Regions Hospital and the Dorothy Day Center to provide supplemental nutrition for the homeless. Leininger's culture care diversity and universality theory along with culture care accommodation/negotiation are used as a theoretical framework to support this work. The steps involved in the creation of this project as well as recommendations for continual success and expansion are discussed.

Key words: nutrition, homelessness, food insecurity, food insufficiency, hunger, collaboration.

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Chapter One: Introduction

Having experienced a civil war in my native country of Liberia, West Africa, my entire family endured the struggles of food insecurity and food insufficiency while avoiding hunger. As a family we were dependent on the United Nations, other local and foreign non-governmental organizations (NGOs), and barter trade for survival. In order to eat we had to exchange clothing, jewelry, and other possessions for food. Barter trading and relying on NGOs for the provision of food were not considered socially acceptable for middle class families to obtain food in Liberia. Culturally in Liberia, individuals should utilize their finances to buy food or grow their own food to care for their family members. Low income individuals and the homeless usually rely on others or organizations for economic assistance and support. Since coming to the United States, I have observed similar struggles for low income families and homeless individuals. According to Nord, Andrews and Winicki (2002), some families in the United States experience food insufficiency and hunger for three or more months a year while other families experience food insufficiency and hunger on a monthly basis.

For 16 years, my family experienced difficult conditions during the civil war in Liberia. Food insufficiency, food insecurity, and hunger were realities on multiple occasions when I, along with other family members, had to ration out our meals. Family members were only able to eat two meals a day and had to choose which two meals they would eat. On numerous occasions, we only would eat one meal for the entire day and utilized water as a substitute meal for the rest of the day. Older family members had to

forgo a meal to take care of the needs of the younger or youngest members of the family. Our ordeal of barter trade, rationing meals, and substituting meals lasted the duration of the civil war. At the end of the civil war, my father was able to return to work and started supporting his family again. While my family could become self-sufficient and food secure again, other families and households had to continue relying on forgoing meals, rationing meals, or substituting meals, and also had to depend continuously on assistance local and foreign NGOs in Liberia. Having survived hunger and food insufficiency during the civil war in Liberia, I was fortunate to travel to the United States with hope that my experience was an issue of the past. However, I am faced with a constant reminder of my past when I see a homeless individual by the side of the road begging for handouts or when individuals I care for as a nurse confide that they have to rely daily on food shelves or soup kitchens for their food sustenance. Although homeless people are not the only segment of society experiencing hunger, this is the population identified for this project.

Living in the United States for ten years has taught me that there are many individuals in the United States who are unable to provide adequate food for themselves or their families daily. Conversely, there is a tremendous amount of food wasted in our homes, schools, and places of work. Excess, unused, or left over portions of food are tossed daily. This food wasting is a common phenomenon at my current place of employment, Regions Hospital. I have observed a great amount of unsold and leftover food in the cafeteria. Because of the amount of unused food, I decided to inquire how this food is discarded. I discovered that unsold or leftover food is tossed or sent to pig farms daily. A local homeless shelter, the Dorothy Day Center, is just 1.2 miles away

from Regions Hospital could benefit from this available excess food. A collaboration between Regions Hospital and the Dorothy Day Center would benefit both organizations, as well as provide additional nutritional food for the homeless utilizing the Dorothy Day Center.

Background of the Project

Homeless individuals are faced with difficulty in fulfilling their basic needs for food. Frequent occurrences of food insecurity, food insufficiency and hunger predispose the homeless to poor or adverse health outcomes. "Food insecurity is defined as having limited or uncertain availability of nutritionally adequate and safe foods, or a lack of ability to acquire foods in socially acceptable ways. Food insufficiency is defined as having an inadequate quantity of food and is a more severe phenomenon than food insecurity. Hunger is the discomfort, illness, weakness, or pain caused by a prolonged involuntary lack of food and can be viewed as a physical consequence of food insufficiency" (Baggette, Singer, Rao, Bharel & Rigotti, 2011, p. 627).

Lack or inadequate supply of nutritional elements and vitamins can make individuals susceptible to various diseases and complications occurring from nutritional deficiencies. Inadequate intake of vitamins and other nutrients by homeless individuals can create a lack of vitamin C, thiamine, folic acid, and calcium and may lead to acute and chronic medical conditions, including cardiovascular diseases, anemia, and diabetes complications (Strasser, Damrosch & Garner, 1991). Subsequently, as a result of the precarious situation of food insufficiency the homeless face, it can exacerbate acute or chronic medical conditions, resulting in the frequent utilization of emergency departments (ED). According to Baggett et al.,(2011), 18% of the 966 homeless

respondents reported using the ED four or more times in the past year. Homeless individuals also have a higher rate of hospitalizations than individuals who are food sufficient; 46% versus 30%.

A homeless person, as defined by the Federal Guideline of the United States Congress, is anyone who lacks a fixed, regular and nighttime residence but may have a primary nighttime residence in a supervised, publicly-or-privately operated temporary accommodation, such as emergency shelters; others might dwell in cars or under bridges (Wilder Foundation, 2009). Findings from the 2009 survey conducted by the Wilder foundation indicated a 25 percent increase in the number of homeless people in Minnesota compared to the 2006 survey; the later survey showed that a total of 13,100 Minnesotans were homeless on any given night. Additionally, there was also a 46 percent increase from 2006 of a single night count of homeless youth aged 12 to 21 in Minnesota. This increase is reflective of the tough economic climate that has led to fewer jobs and less income. Furthermore, this 2009 survey identified approximately the same number of homeless military veterans in Minnesota as the 2006 survey. Homeless Minnesotans also showed marked increases in serious mental illness, chronic health conditions, and drug or alcohol abuse. The ill health of the homeless stems from poor living conditions, untreated illnesses or diets that lacked vitamins and other nutritional contents (Wilder Foundation, 2009).

Regions Hospital is a private, non-profit organization established in 1872 that provides health care services in St. Paul, Minnesota and to the surrounding communities from Minnesota, western Wisconsin, and other Midwestern states. Regions Hospital has 454 licensed beds and provides medical care with special programs in heart, cancer,

behavioral health, burn care, emergency care and trauma care (Regions Hospital, 2012). Within the population that Regions Hospital serves, those with chronic medical conditions may have high risk for homelessness, mental health disorders and or substance abuse problems. Some of these individuals utilize the hospital Emergency Department (ED) at a high frequency for non-emergency health concerns with a total number of 68 visits to eight locations in three months (Wilder Foundation, 2011). This number represents a sample of seven individuals that participated in the Hospital to Home pilot innovation conducted by Guild Incorporated, Hearth Connection, Regions Hospital and the Minnesota Department of Human Services (Wilder Foundation, 2011).

The Dorothy Day Center is a Catholic charity center that upholds the dignity of homeless people in need. This center alleviates the immediate suffering by providing hot meals, mental health services, and medical care for those experiencing homelessness, as well as providing resources to help people and families move toward self-sufficiency (Catholic Charities of St. Paul and Minneapolis, 2012). Two hundred fifty to five hundred and fifty people are served each day at this center's cafeteria and meals are planned on the morning of each day based on food that is available at their site (Ramsey County Healthy Meals Coalition, 2011). Due to the need for food donations at the Dorothy Day Center, I wanted to explore the possibility of creating collaboration between Regions Hospital and the Dorothy Day Center to supplement nutritious food to homeless individuals coming to the Dorothy Day Center. Gardner (2005) defines collaboration as both a process and an outcome in which a shared interest that cannot be addressed by any single individual is instead, addressed by key stakeholders. Bilton (2005) indicated that collaboration between hospitals and other organizations to serve the community creates

broader community benefits that include community health improvement and service to the underserved population. In this collaborative effort, Regions Hospital could philanthropically assist with the food needs of homeless individuals and the Dorothy Day Center would benefit by receiving supplemental food. Supplemental food is defined as milk, healthy snacks, fresh fruits and vegetables. This donated food would enhance the food reservoir of the center. The Dorothy Day Center currently benefits from food donated by charity organizations, individuals and by purchasing food to feed the homeless who reside and visit this center daily. There is however a limited supply of nutritious offerings acquired from most of the donated food items (N. Rocque, personal communication, March 12, 2012).

Most importantly, homeless individuals using the Dorothy Day Center could have their diets enhanced with nutrients and supplemental foods, in hopes to reduce some of their health problems with better nutrition. In an effort to establish this collaboration, meetings were held with the director of nutrition services at Regions Hospital and the food shelf coordinator and kitchen/warehouse manager of the Dorothy Center to introduce the project and to explore ideas of collaboration.

Significance of Project

The Dorothy Day Center serves four meals in its cafeteria for an average of 300 people daily. Breakfast is served daily to those who are residents at the center; lunch and dinner are served to anyone who wishes to eat, with an extended hour program snack for those needing to take medications. In addition, breakfast is also served to everyone visiting the center on Saturdays and Sundays. Recommendations from the Ramsey County Healthy Meals Coalition, of which the Dorothy Day Center is a member, indicate

that centers should make changes to improve the nutritional quality of the meals they serve (Ramsey County Healthy Meals Coalition Baseline Report, Nov. 2011). Staff at the Dorothy Day Center state that they strive to implement this recommendation with food obtained from donations, but were quick to indicate that this is not often an easy task to do because of the center's limited budget and food options. This finding indicates a strong need to provide supplemental nutrient rich foods to the homeless at the Dorothy Day Center.

Truesdell and Sani (2001) state that shelters providing food to the homeless must increase offerings of fruits, vegetables, and foods high in calcium and vitamin D in an effort to meet nutritional needs. A meeting with the food shelf supervisor and kitchen/warehouse manager at the Dorothy Day Center highlighted that healthier food options, such as wholesome snacks and fresh produce are needed, with milk being the biggest need of all. These supervisors said that the center can no longer provide milk during mealtimes due to a recent decrease in grant money (L.Stone & N. Rocque, personal communications, March 12, 2012).

During a collaborative meeting with the Director of Nutrition at Regions Hospital, I proposed donating supplemental nutrient rich foods to the homeless at the Dorothy Day Center, through the provision of healthy ancillary meals and snacks between regular meal schedules for individuals with medical problems needing to take medications. Not only will this food provide added benefits of increased nutrition, it could also aid homeless individuals in preventing complications that arise from nutritional and vitamin deficiencies. According to Booth (2005), the homeless population experience adverse

health challenges as a result of their limited food access with suboptimal levels of a range of nutrients such as iron, calcium, folate, B12, riboflavin, vitamins E and C and niacin.

Health Inequity

According to the Center for Disease Control (CDC) 2011 report, health disparities are preventable differences in the burden of disease, injury, violence or opportunities to achieve optimal health experienced by socially disadvantaged population. Homelessness is a serious health disparity and concern primarily affecting people from economically and socially marginalized backgrounds (Hodgetts, Radley, Chamberlain, & Hodgetts, 2007).

This marginalized group often experience food insecurity, food insufficiency and hunger. These conditions have significant effect on their physical and mental wellbeing resulting in poorer health outcomes. Physical health problems faced by the homeless include anemia, obesity, bowel dysfunction, dental problems, acute or chronic infections (Wiecha, Dwyer & Dunn-Strohecker, 1991). In addition to the physical problems, mental health problems associated with food insecurity include depression, distress, and anxiety (Carter, Kruse, Blakely & Collings, 2011). It can be an exhausting task, trying to just plan your day around obtaining your next meal and wondering if you will be able to eat.

Health outcomes of homeless

Homelessness is associated with poor nutrition and poor health outcomes. Homeless individuals lack the financial ability to purchase nutritional food on a daily basis and also do not have access to cooking facilities. They often rely on food shelters, soup kitchens, fast food restaurants, food pantries and garbage bins for their nutritional needs. Foods obtained from these facilities do not meet the nutritional needs of the

homeless and can often predispose them to various illnesses and diseases associated with inadequate nutritional intake. Wiecha, Dwyer and Dunn-Strohecker (1991) conducted a study to identify nutrition and health service needs among the homeless. The authors found that several shelters, food pantries, and soup kitchens only served one meal a day and that most of the foods served were low in vitamin C, thiamin, folic acid, vitamin B6, calcium, magnesium and zinc. Lack of these dietary supplements produce poor wound healing, central nervous system disorders, cardiovascular disorders, anemia, poor growth, osteoporosis, and skin rashes among other issues (Strasser et al., 1991).

Although faced with potential illnesses and diseases, homeless individuals often postpone the need to seek medical treatment or purchase needed medications and utilize whatever meager financial resources they have to purchase food instead. According to Baggette et al. (2011) "food insufficiency may adversely impact disease self-management and treatment adherence thereby leading to poorer overall disease control" (p. 632). Homeless individuals often end up taking advantage of acute care services and emergency rooms when faced with health crises, for some it may be too late.

Provision of nutrient rich foods through this collaboration could help prevent the frequency of nutritional deficiencies homeless individuals experience and help assist them in rebuilding their lives. This collaboration could help support some homeless individuals with this process because according to Siple "an important step in rebuilding one's life is rebuilding yourself and your body which you can't do without nutritious and healthy meals" (Siple, 2011, p. 2).

Statistics on hunger

Hunger in America (2010) statistics showed that in 2010, 48.8 million Americans lived in food insecure households, meaning that they do not know when and where they will find their next meal. From these initial numbers, 32.6 million were adults and 16.2 million were children. Other data presented showed the following information for those in America:

a) In 2010, 14.5% of households (17.2 million households) were food insecure.

b) In 2010, 5.4% of households (6.4 million households) experienced very low food security.

c) In 2010, households with children reported food insecurity at a significantly higher rate than those without children, 20.2% compared to 11.7%.

d) In 2010, households that had higher rates of food insecurity than the national average included households with children (20.2%), especially households with children headed by single women (35.1%) or single men (25.4%), Black non-Hispanic households (25.1%) and Hispanic households (26.2%). (Hunger Statistics, hunger facts & poverty/Feeding America 2011)

Theoretical Framework

Leininger's theory of culture care diversity and universality will provide the theoretical framework for the collaboration between the Dorothy Day Center and Regions Hospital. Her culture care theory recognizes that care is the essence of nursing: care is nursing, care is health; care is curing, and care is well-being. Leininger's premise is that true caring allows people to feel human, it gives dignity to individuals and inspires people to get well and help others (Leininger & McFarland, 2006). A caring transaction includes social engagement and continual dialogue about care needs of individuals,

extending beyond physical care and institutional boundaries. Health care workers need to expand care beyond the walls of a hospital building and provide community outreach care to improve the lives of those less fortunate. Community outreach care allows a transcultural nurse to assess, develop and strengthen community ties that alter or accommodate care practice (Leninger & McFarland, 2006).

According to Leininger, culture is the most broadest, comprehensive, holistic, and universal feature of human beings and care is embedded in the culture. Leininger believed that nurses need to understand other people's culture in order to uncover their care needs. Care and culture are the heart and soul of nursing, they are essential in the development of transcultural nursing knowledge and practices to move nursing within a multicultural and global world. Leininger's Culture Care theory has a strong focus on care and culture because "care and culture are the missing phenomena that had been long neglected and need to be discovered to grasp the full nature of nursing or to explain nursing"(Leininger & McFarland, 2006, p.7). This type of nursing focus of care supports humanistic care. "Humanistic care allows understanding and knowledge of human beings in as natural or human way possible while being with them in an assistive, helping, guiding, or enabling way to help them achieve certain goals, improve, or ameliorate a human condition or lifeway" (Leininger, 1991, p.30). These attributes of humanistic care are embedded in the role of a transcultural nurse. A transcultural nurse according to Kalayjian, Marrone, and Vance (2010) serves as an advocate, leader, collaborator, and influences health care policy development by improving health outcomes and minimizing health disparities among vulnerable and culturally diverse patients, families and communities. This humanistic care will serve as an important

aspect of the collaboration between Regions Hospital and the Dorothy Day Center and will be utilized by the transcultural nurse in interactions with homeless individuals and staff at the center.

Leininger's Culture Care theory (1991) suggests three modalities to guide nursing judgments, decisions or action in providing culturally congruent care: cultural care preservation/maintenance, cultural care accommodation/negotiation and cultural care repatterning/restructuring. This project promotes cultural accommodation and/or negotiation to provide culturally congruent care. Leininger and McFarland (2006) define cultural care accommodation/negotiation as "those assistive, accommodating, facilitative, or enabling creative provider actions or decisions that help cultures adapt to or negotiate with others for culturally congruent, safe, and effective care for their health, wellbeing or to deal with illness or dying" (p.8). Cultural care accommodation and negotiation decisions become important in promoting and maintaining health and wellness for the homeless to promote better health care outcomes.

Two other constructs of the theory, i.e. emic and etic are vital to the project. Leninger and McFarland (2006) stated that " the term emic refers to the local, indigenous, or insider's cultural knowledge and view of specific phenomena; whereas etic refers to the outsider's or stranger's view, often health professional views and institutional knowledge or phenomena" (pp.13-14). The concept of food insecurity and food insufficiency, together with my professional knowledge and understanding of the needs of the homeless from various research to obtain adequate food (etic). Additionally my my personal experience with food insecurity and hunger, interactions and relationship with homeless individuals at Regions Hospital and the Dorothy Day Center and my

insider knowledge of the procedure for disposing of unused food at Regions Hospital (emic) will be utilized to design this proposed project.

Although the project may seem simple and basic in focus, it will allow for care that is culturally congruent as a result of the incorporation of both emic and etic knowledge. Leininger identified culturally congruent care giver as "one that has a culturally based knowledge used in sensitive and knowledgeable ways to appropriately and meaningfully fit the culture values, beliefs, and lifeways of an individual for their wellbeing or to prevent illness, disabilities or death" (Leininger & McFarland, 2006, p. 15).

Homeless individuals are faced with the constant struggles of food insecurity and food insufficiency, which make it difficult for them to cope with any issues of poor health they might experience. It is important that they have access to nutritious food to decrease the prevalence of diseases or unhealthy lifeways potentially caused by nutritional and vitamins deficiencies. My personal experience with food insecurity and food insufficiency fosters my goal of minimizing this experience in other individuals, and inspired me to work towards the creation of this meaningful collaboration between Regions Hospital and the Dorothy Day Center. This collaboration could go a long way in alleviating some of the future challenges homeless individuals face. Leininger's culture care diversity and universality theory clearly supports the essence of this collaboration.

The chapter that follows explores social complexities surrounding the daily struggles and challenges of the homeless in obtaining food. It also reviews relevant literature that identifies the role of health care workers and institutions in supporting homeless individuals to overcome these challenges.

Chapter Two: Literature Review

The acquisition of nutritious meals is important in the lives of everyone but is especially essential for homeless individuals, in improving and maintaining their health. As a socioeconomic group, homeless individuals are more prone to diseases and deficiencies that arise from inadequate nutrients. Inequities created by poverty, unstable housing conditions and unavailability of nutritious meals can create an environment of poor health outcomes for homeless individuals (Wiecha,Dwyer and Dunn-Strohecker, 1991). A collaboration that will focus primarily on the provision of nutrient rich meals is essential to address these challenges. This chapter reviews literature on the importance of collaboration and socioeconomic disparities of health, especially as they affect the homeless. Existing research related to homelessness, food insecurity, food insufficiency, hunger and nutrition in the homeless revealed multiple studies that have been done. All of the studies accentuated the need for the provision of nutritious food for the homeless, while utilizing a collaborative effort.

Homelessness

Who is a homeless individual?

A homeless person, defined by the United States (U.S.) Congress, is "anyone who lacks a fixed, regular and nighttime residence. In addition, a homeless person might have a primary nighttime residence that is supervised, publicly or privately operated temporary accommodation, such as emergency shelters, transitional housing or battered women's shelters. They could also stay in a nighttime residence in any place not meant for human habitation, such as in cars or under bridges." Persons found in these types of living conditions are considered "homeless" (Wilder Foundation, 2009 p. iv).

According to the January 2011 Point In Time Count report, data listed from the National Alliance to End Homelessness (Alliance Online News, 2011), showed that approximately 636,017 people experience homelessness in the United States on a given night. In Minnesota, it is estimated that at least 13,100 individuals experience homelessness on any given night (Wilder, 2010). This number is not complete. Although it gives the figures obtained from shelters and centers that cater to homeless individuals, it does not adequately represent those who sleep on the streets, under bridges, in their cars and in abandon buildings or couch-surf, etc. Couch-surfing occurs with both young and older adults who are homeless (Busch, 2012). The term denotes sleeping on a couch, a bed, a floor, a chair inside of someone's place, whether that be a friend's home or a strangers, sometimes needing to exchange sex, drugs, food, or other items of value.

Culture of homelessness

Culture, as defined by Leininger, "is the learned, shared and transmitted values, beliefs, norms and lifeways of a particular social group that guide thinking, decision and action" (Leninger, 2006, p.13). The homeless person shows a common set of behaviors and strategies for survival and can be described from a cultural perspective (Davis, 1996). Homeless individuals, irrespective of their location, are in search of food daily and are constantly seeking out numerous avenues to obtain this basic necessity, by visiting soup kitchens, begging for handouts and/or money to buy food for survival.

Homelessness is growing daily, it is like a revolving door. Individuals are constantly moving in and out of this culture as their circumstances improve or decline (Plumb, 1997). This movement in and out of homelessness is due to the instability

individuals face as a result of their precarious economic and employment conditions or by the prominence of compounding factors and crisis situations. This can include, but is not limited to shortages of affordable housing, decline in jobs and jobs lost due to other situations. These factors may either render an individual temporarily homeless or homeless for a lifetime. Therefore, the culture of homelessness or homelessness is not a result of "faulty people" or individuals with "faulty values" as many believe (Desjarlis & College, 1996, p. 420).

In order to understand the culture of homelessness, healthcare workers must put aside their biases and stereotypes to enter a relationship, in order to seek understanding of this culture and recognize avenues for interventions. Leininger identified the need for the understanding other cultures to uncover people's care needs (Leininger, 1991). The development of cultural sensitivity and the use of cultural perspective in program planning and health/human services can empower the homeless to achieve lifestyles that are less stressful, more productive, and provide for human dignity (Davis, 1996).

Homeless individuals are often reduced to numbers, or defined as circumstances and problems by medical and socioeconomic institutions. The homeless individual however, considers their situation as a culture and way of life, one that is many times misunderstood by those who are outsiders. A narrow or reductionist interpretation of the homeless culture and lifeways diminishes the humanity and self-worth of those who are struggling (Wen, Hudak, & Hwang, 2007). It is imperative that nurses provide non-judgmental care toward individuals facing homelessness and other adverse circumstances.

Yousey, Leake, Wdowik and Janken (2007) state that nurses and other care providers need to understand the nature of homelessness in order to provide culturally sensitive care and positive experience for homeless individuals. Hunt and Swiggum (2007) also indicate that individuals need to be aware of their own values and beliefs, to understand how these affect their responses to those from cultures different from theirs. This self-awareness enhances therapeutic interventions. My personal experience with food insufficiency and hunger has taught me to look beyond the situation of an individual and focus on the person and try to create ways to assist them cope with their present situation.

Nutritional needs of the homeless

Individuals within this culture are faced with constant difficulty in obtaining food, especially nutritional food, and need to depend on others to meet this need. Adequate and nutritious food intake is essential for individuals' wellbeing and health. The United States Department of Agriculture (USDA) dietary guidelines (2010) indicate that a poor diet is associated with 72% of men and 64% of women being overweight and with one third of adults being obese. Additionally, a poor diet according to the USDA, is also associated with the major causes of morbidity and mortality which includes cardiovascular disease, hypertension, type II diabetes, osteoporosis and some cancers (USDA, 2010). The acquisition of an adequate supply of nutritious food can be challenge in today's fast paced environment, especially for the homeless because of the other unique complications that plague their everyday life. Homeless individuals may not only lack understanding of nutrition, but generally lack storage and cooking facilities needed

to store and prepare the food they obtain (Johnson, Myung, McCool & Champaner, 2009).

Several authors have concluded in their studies that the homeless are at a nutritional risk due to the shortage of micronutrients in their diets. A few of these studies will be utilized to detail the nutritional needs of the homeless. According to Wiecha, Dwyer and Dunn-Strohecker (1991), the lack of nutrients create certain health problems common among homeless individuals. The authors identified anemia, dental problems, gastric ulcers, other gastro-intestinal complaints, cardiovascular disease, hypertension, malnutrition, acute and chronic infectious diseases (such as upper respiratory, skin, tuberculosis) among others as some of the common health problems faced by homeless adults. Their study also indicated a prevalence of mental disorders associated with poor nutrition among the homeless ranging from 21-84%.

Strasser et al. (1991) indicated that the diets of the homeless are deficient in protein, calorie, vitamins B, C, B6, and B12, zinc, calcium, folic acid and iron, resulting in conditions like poor wound healing, weakened immune systems, central nervous system disorders, cardiovascular diseases, anemia, skin rashes and beriberi. These authors indicated that these conditions are often magnified within this population as a result of their prevailing living condition.

Henseler, Johnson, Myers-Williams and Wolgemuth (1996) stated that nutrients like energy, calcium, zinc and vitamin B6 were found to be below the recommended allowances for nutrients among homeless individuals. Additionally, two other phenomena's were identified within this population: under nutrition defined as upper arm

muscle area <5th percentile and wasting malnutrition that results in the loss of body protein stores.

Smith and Richards (2008) found that homeless youth in Minnesota had diets with inadequate intake of vitamins E, C, & D, zinc, calcium, magnesium, phosphorus, potassium and fiber. These homeless youths however consume excessive amount of fats, oils and sweets, predisposing them to future health problems like osteoporosis, hypertension, cardiovascular disease and obesity, because of this unhealthy dietary pattern.

All of these studies identified the need to incorporate essential vitamins, minerals and nutrients into the daily dietary intake of homeless individuals, as a measure of preventing future and further deterioration of the health status of this population and the cost associated with dealing with their health issues. The importance of improving access to food and nutritional services to enhance and meet the dietary needs of the homeless was greatly stressed.

Feeding the homeless nutritious supplemental meals, especially at soup kitchens, shelters and food pantries, which are frequently used by homeless individuals, is one easy and cost effective way of providing some of these basic vitamins and nutrients that are lacking in their diets. The collaboration between Regions Hospital and the Dorothy Day Center to provide supplemental nutritious foods to homeless individuals is an endeavor by both organizations to potentially curtail some future health problems associated with their poor dietary intake. Yousey, Leake, Wdowik and Janken (2007) stated that "health care professionals can facilitate comprehensive and coordinated health services including primary prevention efforts in areas such as nutrition" (p. 254).

Food insecurity and food insufficiency in the homeless

Kushel, Gupta, Gee and Haas (2005) determined that although housing instability and food insecurity represent the less severe and widespread forms of homelessness and hunger, they are risk factors found to be independently associated with poor access to ambulatory care and high rates of acute health care use. They further noted that housing instability and food insecurity are associated with increasing numbers of emergency department (ED) visits and hospitalizations and that homeless individuals experiencing food insecurity may delay seeking medical care due to financial constraints.

In the United States (U.S.) 14.6% of the overall national average suffered from household food insecurity. Nine states in the United States (U.S.) however exhibited statically significant higher household food insecurity rates than the U.S. national average from 2008-2010. The following nine states are listed in order of their food insecurity rates:

1. Mississippi 19.4%
2. Texas 18.8%
3. Arkansas 18.6%
4. Alabama 17.3%
5. Georgia 16.9%
6. Ohio 16.4%
7. Florida 16.1%
8. California 15.9%
9. North Carolina 15.7% (Hunger Statistics, hunger facts & poverty facts/Feeding America, 2011).

In Minnesota, 11.5% of the state's populations are food insecure. This percentage amounts to 608,770 people who struggle daily with having enough food to eat (Feeding America, Map the Meal Gap 2012). This number is represented from all eight congressional districts of Minnesota (Appendix A).

Baggette et al., (2011) wrote about the relationship between food insufficiency and higher rates of hospitalization and usages of Emergency Departments (ED) in a national sample of homeless adults. They found that food insufficiency was associated with several markers of vulnerability: chronic homelessness, history of physical and sexual assault, and low educational attainment. Additionally, with their study they discovered that food insufficient individuals use acute health services at considerably higher rates than those who are food sufficient and had ED utilization rates five times higher than those seen in the general public. Baggette et al., (2011) indicated that these findings may suggest that food insufficient homeless individuals may either: postpone treatment at earlier stages of illness until it is acute, choose to buy food over medications, utilize acute health services to obtain food and that food insufficiency adversely impacted disease self-management and treatment adherence. Increase and frequent use of acute care services also produce avoidable health care expenses and can tie up ED rooms unnecessarily (Wilder Foundation, 2011).

Hamelin and Hamel (2009) claim that food insufficient individuals have higher odds of reporting poor physical and mental health, and have impaired access to medical or surgical care far greater than that of the general population in Quebec and all of Canada. They stressed that there is a need for the provision of adequate food services, targeted towards this population that would prevent further health deterioration.

Carter, Kruse, Blakely and Collings (2011) observe a strong association between food insecurity and psychological distress in both sexes, with females portraying a slightly stronger association than males. This psychological distress may be as a result of lack of access to nutritious, affordable, culturally appropriated food and the inability to feed themselves and their families. Depression, anxiety, and stress were identified as psychological distresses associated with food insecurity.

These studies emphasize the urgent need for prompt attention to the social determinants which predispose the homeless to food insecurity and food insufficiency, in an effort to prevent further health deterioration within this group. This can be addressed through changes in public policy and the implementation of alternative interventions. The collaboration between Regions Hospital and the Dorothy Day Center would provide an alternative intervention to address food insufficiency and food insecurity facing homeless individuals living in St. Paul. Mikkelsen and Trolle (2004) affirm the idea that collaboration creates a more effective possibility for the promotion of healthy eating.

The benefits of this proposed project provide a compelling reason to make sure that the collaboration between Regions Hospital and the Dorothy Day Center comes to fruition. As this collaboration is created, it will assist in the ever growing demand of the homeless community.

Hunger

Hunger, as defined earlier in this paper can be discomfort, illness, weakness, or pain caused by a prolonged involuntary lack of food and can be viewed as a physical consequence of food insufficiency (Baggette et al., 2011). The latest estimates by the World Vision (2011) indicate that about 925 million people experience hunger daily and

that chronic hunger is widespread with a total of one billion hungry people (World Vision- Hunger Facts, 2011).

The leading cause of hunger is poverty, but other factors like famine, surge in food prices and global food crises are associated with hunger as well. Hunger in America (2010) indicated that one in every six people in America experience hunger daily. Due to the increasing amounts of hungry households, food banks that were originally created to provide short term food supply are being utilized frequently as a strategy for minimizing household hunger. Subsequently, Feeding America has embarked on an effort to help feed the hungry in the United States (Hunger in America, 2010). Key findings report the following:

1. 37 million Americans are served annually by Feeding America, including nearly 14 million children and nearly 3 million seniors.
2. Each week approximately 5.7 million people receive emergency food assistance from an agency/served by Feeding America member.
3. Feeding America food banks provide food and groceries to 33,500 food pantries, 4, 500 soup kitchens and 3,600 emergency shelters. (Hunger in America: Key Findings, 2010)

Collaboration

Gardner (2005) defined collaboration as "a process, because it involves a synthesis of different perspectives to better understand complex problems and an outcome because it involves the development of integrative solutions that go beyond an individual vision to produce resolution that could not be accomplished by any single person or organization" (Gardner, 2005, para 8). The author specified the need to

recognize collaboration as a journey that requires time and daily effort for complete success.

This project embodies the definition of collaboration because in addition to identifying food insecurity, food insufficiency and hunger as being daily struggles faced by the homeless, it shows that because of these problems, the homeless are compounded with other bigger and serious problems like cardiovascular problems, anemia, and lack of vitamins among others. Furthermore, through the establishment of this collaboration, homeless individuals at the Dorothy Day Center will benefit from supplemental nutritious foods that will help decrease their susceptibility to diseases and co-morbidities caused by their lack of basic nutrients, minerals and vitamins.

Robinson, Barnacle, Pretorius and Paulman (2004) discussed the importance and benefits of a collaborative approach to diabetic treatment. An interdisciplinary student-run clinic in Omaha, Nebraska was created to provide treatment to low income, noninsured diabetic patients. Students from a variety of disciplines including medicine, nursing, pharmacy, dietetics, and medical technology were involved with the clinic. This clinic focused on integrated care and education to diabetic patients. This approach brought about significant improvements in the management of their diabetes and the success of this clinic created a template of integrated team patient care model that could be adopted nationwide. This interdisciplinary approach to diabetic care benefitted not only those being treated by all involved, medical doctors no longer felt overwhelmed, and the patients were given more holistic and through treatment addressing all aspects of their illness.

Bilton (2005) also indicated that collaboration creates broad community benefits like the display of community health improvement, placing focus on underserved population and unmet needs, working outside the hospital and establishing coordination and strategic management inside the hospital. For example, the collaboration between Regions Hospital and the Dorothy Day Center would assist in the maintenance of health for the homeless. Dorothy Day Center would receive supplemental food that will help provide for the needs of the homeless and Regions Hospital could potentially see a reduction in the number of frequent visits to the emergency room by homeless individuals who are hungry and food insufficient. This ultimately could free up ED beds, reduce the cost associated with the provision of emergency and acute care services, and allow for better usage of the hospital resources.

Theoretical Framework

Dr. Madeleine Leininger's theory of culture care diversity and universality will be utilized as the conceptual framework for this project. Her theory has served as a guide to authors who are also striving to improve health from a community level. Shapiro, Miller and White (2006) utilized Leniniger's theory with the sunrise model along with Hersey and Blanchard's tri-dimensional leader effectiveness model, as collaborating theories in leadership building from a global and transcultural nursing perspective. The tri-dimensional leader effectiveness model is a situational leadership theory developed by Paul Hersey and Kenneth Blanchard in the late 1960's. It examines the interplay between influencing an individual or group to strive for a goal in a given situation and the leadership process as a function of the leader, the follower and the situation. This theory assesses the follower's readiness to determine the leadership style appropriate to the

situation, and effectively applies the appropriate style. The authors felt that there is no single ideal leadership style but different leadership styles that evoke various responses in different situations (Shapiro et al., 2006, p, 115). According to Shapiro et al. "situational leadership and humanistic care share a similar goal: to discover qualities of human beings to guide or enable an individual or group in achieving certain goals and that combining the two theoretical frameworks can guide the transcultural nurse in working with the community as a leader in an enabling way to help it achieve its goal and become strong" (p. 116). This idea could be apply to the proposed collaboration; as nurses get to know and understand the culture of homelessness from the perspective of homeless individuals, the participation of homeless individuals' in their care and wellbeing could be facilitated by nurses.

Leniniger's theory suggested three modalities upon which nursing care, judgments and decisions are based. These include: culture care prevention/maintenance, culture care accommodation/negotiation, and culture care repatterning/restructuring (Leininger and McFarland, 2006). Leininger (2006) defines culture care prevention/maintenance as "those assistive, supportive, facilitative, or enabling professional acts or decisions that help cultures to retain, preserve, or maintain beneficial care beliefs and values or to face handicaps and death" (p. 8). She continues by defining culture care accommodation/negotiation as "those assistive, accommodation, facilitative or enable creative provider care actions and decisions that help cultures adapt to or negotiate with others for culturally congruent, safe and effective care for their health, wellbeing or to deal with illness or dying" (p. 8). Lastly, Leninger says that culture care repatterning/restructuring is "those assistive, supportive, facilitative or enabling

professional actions and mutual decisions that will help people to reorder, change, or modify, or restructure their lifeways and institutions for better or beneficial health care patterns, practices or outcome" (p. 8). This project utilized the cultural care accommodation/negotiation. This will be implemented through the provision of nutritious foods for homeless individuals that will assist them in the maintenance of their health. Another aspect of this accommodation/negotiation for this project is that, nurses will interact with homeless individuals, and obtain first hand information of those needed resources that will assist them with healthy eating and lifestyle changes. The emic knowledge obtained from my personal experience with food insecurity, food insufficiency and hunger, interactions with homeless individuals and insider access and understanding of the bureaucracy of both organizations will also serve as a bonus in providing those assistive, accommodative and facilitative care actions and decisions that will help homeless individuals negotiate for safe and effective care.

Leininger (1988) indicated that transcultural nurses have focus primarily on health care, maintenance, recovery from illness and promotion of wellbeing as care practices for people of different cultures. She emphasized that there is a need for nurses to be cognizant of the eating patterns of individuals and families throughout their lifecycle and the availability of food for the poor in their daily survival.

The homeless often obtain their foods from local shelters, soup kitchens, fast food restaurants, and garbage bins; some of these meals lack the basic nutrients needed to maintain and promote optimal health and some carry the risk of pathogen-bourne disease. Being aware of this fact, the collaboration developed between Regions Hospital and Dorothy Day Center will enhance the diets of homeless individuals and potentially

decrease the prevalence of illnesses, deficiencies and complications associated with inadequate nutrition.

In order to provide for the homeless, it is paramount that nurses and other health care professionals understand their culture and way of life. Leininger (2006) indicated that "culture can be viewed as the blueprint for guiding human actions and decisions" (p. 13). Understanding the culture of homelessness will allow for the understanding and consideration of survival strategies for this group and can be included in service planning that are beneficial to the homeless (Davis, 1996). Subsequently, the needs of the homeless can primarily be identified by the homeless themselves and those who care and interact with them daily. This can be accomplished by sitting, eating, and talking with the homeless at the center during meals times and with those homeless individuals we care for as nurses, listening to their personal stories and by considering the food needs of the center from staff who interact with and serve the homeless daily. This emic knowledge along with etic knowledge obtained from research and professional interactions can served as framework for providing culturally congruent care for the homeless at the Dorothy Day Center.

In summary, homelessness has become a culture and way of life for many facing challenging economic and other social issues. These individuals struggle daily to obtain nutritious foods that will help sustain a healthy lifestyle thereby predisposing them to diseases and deficiencies associated with inadequate nutrition. However, there are ways to assist in the maintenance of adequate dietary intake. One step to advance this goal is through a collaborative effort between Regions Hospital and the Dorothy Day Center, by providing supplemental nutritious foods.

Chapter Three: Development of Innovative Practice Model

Review of the literature in chapter two reinforced the need for the provision of healthy foods to the homeless and emphasized the significance of utilizing collaboration to support the fulfillment of this goal. Homeless individuals face many challenges in procuring healthy foods for their survival and health maintenance as they do not have money to buy or eat many healthy foods because of the cost associated with these meals. They are often compelled to depend on foods obtain from homeless shelters, soup kitchens, food pantries, fast food restaurants among others to satisfy this need, which do not always meet their nutritional requirements. This chapter discusses the creation of a project of collaboration and a Tree of Health model that depicts the fundamentals and advantages of this project.

Project Intervention/Innovation

The purpose of this project is to develop a collaboration between Regions Hospital and the Dorothy Day Center to provide supplemental nutrition for the homeless. A thought arose from my conversation as a nurse with homeless individuals as they discussed their personal dilemma in obtaining food daily, combined with my observation of the food wasting in the cafeteria at my place of work, and my personal struggle with food insufficiency and hunger as a teenager. All of these personal aspects represent my emic experience. This thought led to the progressive idea of creating a project of collaboration to assist homeless individuals with one of life's basic necessity. My family and I were displaced from our home and had to depend on food programs, non-governmental organizations (NGOs) and our host families for the provision of food. These foods were at times not forthcoming or not enough to meet the needs of our family,

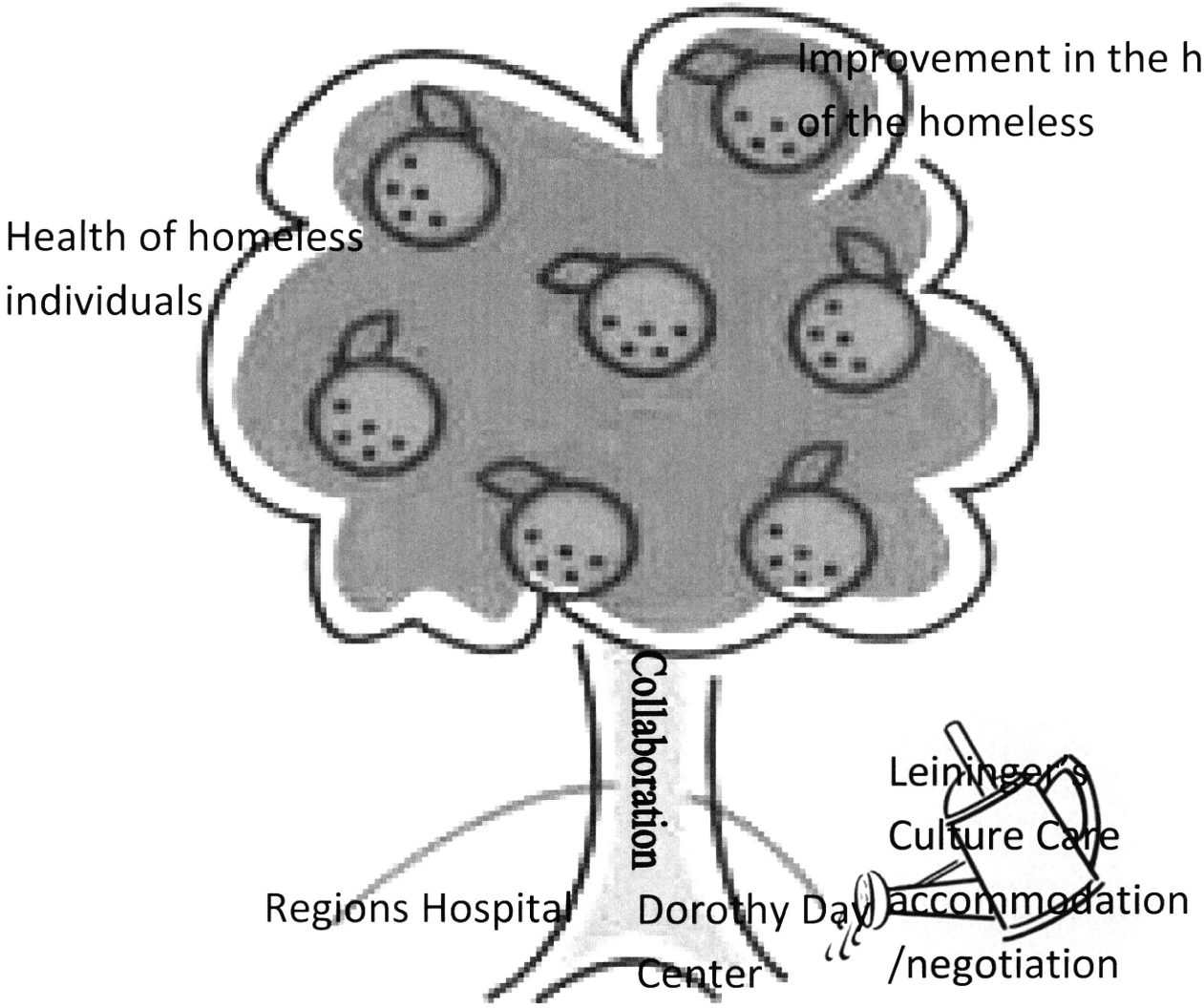
therefore we had to utilized strategies to fight food insecurity, food insufficiency and hunger. Like the homeless, our strategies did not always ensure the acquisition of healthy or nutritious meals. The project idea was discussed with several individuals who, like me, expressed interest and enthusiasm for its implementation. Based on my personal experience and the passion to assist those who are less fortunate, I decided to work on the creation of this collaboration.

A conceptual model (Figure 1, p. 32) for this project can be envisioned as a large tree being held up by strong roots, which represent Regions Hospital and the Dorothy Day Center. The trunk of the tree is the collaboration that grows into the branches. A collaboration that will create awareness of the lifeways, culture, and food needs of the homeless and also allow personal interaction between homeless individuals and those serving them; nurses, or other members of health care team sitting, talking and eating with homeless individuals at the center. The leaves and buds on the branches epitomize the health of the homeless and the fruits that emerge from the buds exhibit improvement in the health of the homeless, which appear or arise as a result of the collaborative undertaking of providing nutritious foods. A water canister representing Leininger's cultural care accommodation/negotiation provides water for the growth of the collaboration. The water represents those assistive, accommodative, facilitative or enabling care actions and decisions to help homeless individuals negotiate for safe and effective care for their well being. These assistive or accommodative care actions could be represented by the monthly food donations or by making resources available to the homeless to assist them make decisions for the improvement of their health and

wellbeing. This conceptual model demonstrates the facilitation of healthy eating for homeless individuals.

THE TREE OF HEALTH MODEL

FIGURE 1



Process

The first step in the process was to present the project to the organizations or individuals representing these organizations. In order to accomplish this several phone calls were made to set up a formal meeting with the Director of Food and Nutrition Services at Regions Hospital, to inquire about the excess foods and familiarize him with my idea of the project. The first meeting was held on March 8, 2012, to discuss my proposal. The director welcomed the idea of providing supplemental nutritious foods to the homeless at the Dorothy Day Center. In addition, he requested that I inquire about the immediate food needs of the center from their staff. Furthermore, the director also discussed some ideas or aspects that could also be included within the collaboration over time.

A meeting was also held with the Food Shelf Coordinator and the Kitchen/Warehouse manager of the Dorothy Day Center on March 12, 2012, to discuss the idea and purpose of the collaboration and to uncover the food needs at the center. The staff at the center expressed their interest in the idea of the collaboration and communicated the need for nutritious foods at the center. The Kitchen/Warehouse manager stated that they do receive food donations from organizations, as well as individuals, but indicated that, these foods often have a shortage of nutritional benefits for the homeless (N. Rocque/ personal communication/ March 12/2012). Strasser et al. (1991) stated that "assistance should be given to food providers to help optimize the nutritional contents of their offerings and meet the special needs of their homeless clients" (p. 72).

The manager articulated the need for non-perishable healthy foods and snacks, along with fresh produce; he stressed that most importantly, the center has a great need

for milk and added that "the center no longer benefits from milk grants and utilizes about 29 to 45 percent of its budget on milk" (N. Rocque/ personal communication March 12, 2012). Additionally, according to the manager "the demand for milk far exceeds the supply" (N. Rocque, personal communication, March 12, 2012). This meeting was an important step in learning about the challenges faced by the center as it will be useful in the discussion of ways to help make changes at the center while building relationships in the process. Building relationships is an important aspect of collaboration. This meeting gave an opportunity to gain information from an emic perspective from someone who works within the center.

Information obtained from this meeting was discussed with the Food/Nutrition director at Regions Hospital on April 30, 2012. The director conveyed his desire to assist with the creation of this collaboration and promised to maintain connection with me, following discussions with his bosses. He has kept his promise, by maintaining contact through emails and phone calls, as well as making available food for donations to the Dorothy Day Center on behalf of the collaboration. Two separate food donations of vegetable chips and frozen doughnuts were made to the Dorothy Day Center on May 2, 2012 and September 27, 2012 respectively since the onset of the initial meeting with discussions of providing additional donations. Another step in moving this project forward will be to set up a specific timeframe for food delivery to the center on a monthly basis with a specific list of the items that will be provided. For example, Regions hospital can decide to donate food to the Dorothy Day Center on the fifteenth of every month and provide foods like yogurt, milk, fruits, vegetable, healthy snacks among others.

Another important strategy to promote healthy eating could be the creation of an on-site healthy food display and table discussion, twice a month, to educate homeless individuals who utilize the center and kitchen staff at the center about healthy eating and its benefits. This display and table discussion could be created by nurses, dieticians and chefs from Regions Hospital, who will sit and eat with these individuals, inquire about their eating habits, food preferences, and health goals, allowing them to get to know one another. Yousey et al. (2007) believe that "health care professionals can facilitate comprehensive and coordinated health services including primary preventions efforts in areas such as nutrition" (p. 254).

During the allotted meal time, the homeless will be provided with information about healthy eating and the benefits of making these choices. Pamphlets with illustrations of healthy food choices and explanations of their benefits will be provided to them. It will also include some examples of healthy food choices to select at fast food restaurants to guide them towards healthy eating. These pamphlets will be printed in English, Spanish, and the Somali languages for appropriate information dissemination in the native tongues of homeless individuals served at the Dorothy Day Center. Provision of healthy foods and tools to guide healthy eating is one important method of staying healthy, preventing diseases, or further complications from prevailing health conditions. This mode of nursing care action is grounded in Leininger's cultural care accommodation/negotiation that supports the homeless culture lifestyle. According to Leininger (1991) nurses need to be aware that several cultural care accommodations are expected by individuals in order to regain their well-being for the provision of satisfying and beneficial care.

An application to Leininger's accommodation model is the provision of supplemental foods for the Dorothy Day Center that will assist in the health maintenance and support of the homeless who utilize the center for their food needs. This accommodation will also assist homeless individuals who might miss mealtimes, but need food in order to take medications, or those who simply need "something to eat" in the daytime.

Negotiating strategies with the staff at the center will also be employed in the provision of this accommodation for the homeless. These strategies can include, but are not limited to:

- Provision of milk or funding to purchase milk to cater to an important need of the Center.
- Provision of healthy snacks to be served between meals.
- Provision of fresh fruits and vegetables.
- Provide a display that illustrates healthy eating and the benefits associated with healthy eating.
- Table discussions while eating with homeless individuals to understand their needs, preferences, and goals, and getting to know them on an individual basis.

All of these aspects signify caring with nutrition as an important aspect of caring. Building relationships also creates trust, love, warmth, and safety which is an expression of caring as well. These aspects can help to establish healthy bodies and lifestyle changes. According to Leininger (1991) "Caring is the 'heart and soul' of nursing and what people seek most from professional nurses and in health care services" (p. 5).

In summary, the purpose of this project is the development of a collaboration between Regions Hospital and the Dorothy Day Center to provide supplemental nutrition for the

homeless. The first step in the implementation of this project was the discussion of the project idea with individuals representing these facilities. The second step was to identify the food needs of the homeless at the Dorothy Day Center. The third step is the provision of healthy foods to the center. The fourth step is to eat and discuss with the people who are served at the Dorothy Day Center, to learn about their concerns related to healthy eating and suggest ways to improve their intake of healthy foods options. The next chapter will discuss the evaluation of the project.

Chapter Four: Discussion and Evaluation

The long term goals of this proposed project will be further developed during the ongoing process. Evaluating the collaboration between Regions Hospital and the Dorothy Day Center is a key component in establishing the project's benefits. Discovering the participants who eat the supplemental food and visiting with them on the potential benefits will help evaluate whether the purpose is met. Conclusions obtained will be helpful tools to confirm the necessity of the ongoing collaboration and there might be the need for changes in practices.

Criteria for Evaluation of the Proposed Collaboration

The success of the collaboration between Regions Hospital and the Dorothy Day Center could be evaluated using a variety of criteria and statistics, to yield pertinent and useful information. Information on the number of time homeless individuals eat the supplemental food will be obtained. Continual evaluation of the process will be examined. Baggett et al. (2010) surveyed 966 homeless participants at Health Care for the Homeless (HCH) clinic sites throughout the United States to determine the association between food insufficiency and health services utilization, with specific attention to high hospitalization and ED use. The authors performed a secondary analysis of the 2003 Health Care for the Homeless (HCH) User Survey which was the first nationally representative survey of people using clinical services provided by the federally funded HCH. They analyzed the data from the survey and found that one fourth of the respondents were food insufficient, this was associated with increased odds of acute health services utilization. In conclusion, this study discovered that stronger

emphasis should be placed on the social determinants in order to address the adverse health service utilization patterns homeless individuals faced.

Regions Hospital could potentially adopt this survey or refine it for the Region's population to determine the association between food insufficiency and multiple ED or hospital visits, in order to create ways to help decrease this phenomenon. This information could help determine the ongoing success and practicality of the collaboration already started. A qualitative study could be developed that addresses the potential benefits and outcome relating to the provision of supplemental food to the homeless.

Analysis and Critical Reflection

The collaboration between Regions Hospital and the Dorothy Day Center will be a time-consuming and demanding task that will require total commitment and passion from all involved to ensure a total success. It has started on a small scale but will require continual financial and logistical support, which is dependent on the reception from the key stakeholders toward the goals and objectives of the project. It will be important to share with the shareholders that numerous studies already exist, that provide an association between food insufficiency, hunger, food insecurity and poor health outcomes in the homeless. It is fundamental to highlight the many benefits associated with the implementation of this project.

Providing nutritional food for the homeless does not necessarily suggest an over-night change in their lifestyles and eating habits. This will be a gradual and ongoing process that can eventually produce great results. This is a step in abetting some of the health inequities experienced by homeless individuals. One way to consider the success

of this collaboration is by the decrease need for additional food by homeless individuals admitted to Regions Hospital. It is imperative that these homeless individuals first understand the correlation, as well as recognize the benefits between healthy eating and their health status. As the project expands, other possible areas for attention should include identification of those other factors that contribute to the poor health outcomes of the homeless.

Appropriateness of Leininger's Theory to Support the Tree of Health Model

Leininger's (2006) culture care diversity and universality theory persists as the foundation to support the implementation of this project. Leininger emphasizes the importance of understanding the culture of an individual which is gathered from information of those individuals living within that culture as well as from observed or learned knowledge of someone outside of that culture. After observing food waste, listening to stories of patients in my care, and my own lived experience with food insufficiency, food insecurity and hunger, inquiring about the food needs of the homeless at the Dorothy Day Center was important to me. Leininger (2006) noted that accommodations and negotiations are needed to provide helpful and adequate care with the information obtained. Leininger (1988) identified the need to have a transcultural holistic perspective of food uses, beliefs, and practices and noted further that this creates a significant difference in the state of well- being and survival of health in an individual. Leininger's theory also supports the formation of collaboration to implement change and transformation. Shapiro et al., (2006) research demonstrates how Leninger's theory can be utilized with the Hersey and Blanchard's tri-dimensional leader effectiveness model to

create community transformation and advancement in health. The combination of the two theories can serve as guide to health promotion and health equity at the community level.

The gradual and small start to the creation of a collaboration between Regions Hospital and the Dorothy Center for the provision of nutritious food to the homeless will require time, finances and commitment. It is essential to recognize that changes to individuals' food habits and institutional procedures for disposing of unused food will not be implemented overnight, but will occur over time. A collaboration utilizing Leininger's culture care accommodation and negotiation can have a lasting and intense impact on the lives of homeless individuals. The collaboration will provide the homeless with less day to day struggle in acquiring supplemental nutritious foods. From this collaboration, Regions Hospital will not only be recognized as a health care facility treating diseases and other ailments, but as an organization that strives to champion the cause to fight hunger and as an organization that caters to the holistic care of patients and other members of the community.

Chapter Five: Conclusions, Personal Reflections, Plans for the Future

Healthy eating is an important goal for all. Homeless individuals and those living in poverty often experience food insecurity, food insufficiency, and hunger and are often unable to acquire nutritious meals daily. Soup kitchens, local charities and shelters provide meals to the homeless, but do not always satisfy their dietary and nutritional requirements. This shortage often affects the health of the homeless who are susceptible to various illnesses associated with inadequate nutrition. Nutrition is an important aspect of nursing and nurses play a central role in fostering the nutritional well-being of patients and their families (Weigley, 1997). The need to create a collaboration to provide nutritious meals to the homeless at the Dorothy Day Center creates an opportunity for the nurse to identify the needs of the homeless, assist in acquiring needed resources, advocate for the homeless and transform the lives of homeless individuals by providing nutritional foods. The collaboration will serve as a means for the advancement and improvement of health and well being in the lives of the homeless. The purpose of this project is to develop a collaboration between Regions Hospital and the Dorothy Day Center to provide supplemental nutrition for the homeless.

Personal Reflection

Creation of this collaboration to provide nutritious foods to the homeless at the Dorothy Day Center has been a rewarding and wonderful experience. This project, which started as an idea or thought, has led to great prospects and opportunities that will be beneficial to the homeless. I previously had some fears and apprehensions about presenting the project idea to the nutrition director at Regions Hospital. A lot of questions played through my mind: Will the staff at these facilities be receptive to this

idea? Will funds and resources be made available to the project? How do I convince the staff at both facilities about the significance of the project? And finally, where do I begin? My passion for this project has inspired me to forge ahead and work towards the realization of this project.

I have been amazed by the warm reception and enthusiasm that this project has obtained from those involved during the collaboration efforts. Little research has been done on the application of Leninger's (1991) theory to nutrition of the homeless. Although the project has started with the provision of some healthy snacks to the Dorothy Day Center, it is hoped that as time goes on more food will be provided at least monthly and that there will be a standard listing of items that will be provided for the center.

Plans for the Future

The project will be expanded to provide nutritional teachings to homeless individuals and kitchen staff at the center by nurses, dieticians and chefs from Regions Hospital working with the collaboration. Additionally expansion to the project would include healthy cooking demos at the Dorothy Day Center by chefs from Regions Hospital and the participation of homeless individuals that will also include cooking or eating on a budget with careful consideration to menu suggestions from these individuals. There will also be nurses on site to sit and talk with the homeless and seek to understand the homeless culture and identify challenges faced by those living within this culture. Brochures will also be made available in the native tongue of those represented at the center. Although the issues of food insecurity, food insufficiency and hunger are too complex for surveys, a correlation between these issues and the use of health care facilities can be identify by the utilization of surveys, as seen with the case in the study

done by Baggette et al. (2011). Future evaluation of the project can be through surveys that will provide the blue print for the continuation and significance of this project. This can be piloted in Regions Hospital ED to identify those homeless individuals that frequent the ED and determine whether this frequency is related to food insufficiency, food insecurity and hunger. A qualitative research could be conducted and participants could include those who have utilized the ED five or more times within a year. The Health Care for the Homeless (HCH) user survey can be used to obtain data that will assist in identifying the association between ED use and food insufficiency, the association between hunger and ED use, the association between lack of finances and affording food to be taken with medicines and economic challenges which can lead to delayed health and medical treatments. Additionally data that could be obtained are some of the avoidable health care expenses that accrue as a result of homeless individuals' frequent use of the ED and the inpatient resources could be analyzed. Surveys that will provide the blue print for the continuation of this project can be piloted in the ED to identify those homeless individuals that frequent the ED and determine whether this frequency is related to food insufficiency, food insecurity and hunger.

Food is a basic necessity for all, however not everyone can meet this need due to their precarious circumstances. Those who are unable to acquire nutritious foods are predisposed to various health deficiencies and illnesses associated with the lack of adequate nutrition and may utilized emergency and acute care services at a higher rate. A collaboration between two organizations can assist in fulfilling this goal for the homeless. The collaboration between Regions Hospital and the Dorothy Day Center in St. Paul, Minnesota will help improve the lives of those benefitting from this project.

Creation of a collaboration between the two organizations while utilizing Leininger's culture care culture care diversity and universality theory as the supporting framework will be a meaningful investment form both organizations and homeless individuals as well.

There is much literature supporting the effects of inadequate nutrition in relation to the health and well being of the homeless and also literature that identified the relationship between food insecurity, food insufficiency, hunger and frequent ED and acute care service use. Providing adequate nutrition for the homeless is another way of symbolizing the essence of nursing; care. This project will require many hours, finances and logistics to implement, however the benefits will outweigh the task. It is the time to invest in a culture of people that cannot provide for themselves.

If you wait until you can do everything for everybody, instead of something for somebody, you'll end up not doing nothing for nobody.

-Malcom Bane

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Appendix A

FEEDING AMERICA

Map the Meal Gap 2012

Minnesota Child Food Insecurity by Congressional District in 2010 [1]

MAP THE MEAL GAP

Congressional District	Food insecurity rate (full population)	Child food insecurity rate	Estimated number food insecure children (rounded)	Food insecure children likely income-eligible for federal nutrition assistance[2]	Food insecure children likely NOT income-eligible for federal nutrition assistance[2]
1	9.7%	15.0%	22,450	70%	30%
2	9.6%	14.6%	29,130	47%	53%
3	10.8%	15.3%	25,560	56%	44%
4	13.5%	19.5%	27,900	77%	23%
5	15.9%	21.2%	24,870	80%	20%
6	10.1%	14.7%	29,240	52%	48%
7	10.3%	17.2%	25,410	71%	29%
8	12.6%	19.3%	27,490	70%	30%

For additional data and maps by county, state, and congressional district, please visit www.feedingamerica.org/mapthegap .

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[1]Map the Meal Gap's child food insecurity rates are determined using data from the 2010 Current Population Survey on children under 18 years old in food insecure households; data from the 2010 American Community Survey on median family incomes for households with children, child poverty rates, and race and ethnic demographics among children; and 2010 data from the Bureau of Labor Statistics on unemployment rates.

[2]Numbers reflect percentage of food insecure children living in households with incomes above or below 185% of the federal poverty guideline for 2010. Eligibility for federal child nutrition programs is determined in part by income thresholds which can vary by state.