Perceptions of Heart Healthy Behaviors by Homeless Women: A Qualitative Inquiry

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Myles Friedman Honors Program Capstone Project

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April 25, 2022

Abstract

The research regarding cardiovascular health, including predisposition and risk behaviors, among homeless women is deficient. A typical study emphasizes the effect of cardiovascular disease among women in general or the effect that the condition of being homeless has on the overall health of an individual. However, very few focus on the bridge between these concerns. This study was conducted to examine the perceptions and prioritization of heart healthy behaviors among homeless women in a southern state. This qualitative study selected participants, women ages 18 and older, on a voluntary basis through the use of flyers. These women represented a diversity of ages and ethnicities. After the completion of eligibility screening, a demographic table, and a consent form, participants were interviewed by the research team. In total, 10 homeless women were interviewed. The responses were later reviewed and patterns were identified. Key findings included a general lack of consistent healthy food and drink options as well as limited support for establishing healthy habits (exercise, eliminating risk factors, healthcare, etc.). However, despite being homeless, many of the participants exhibited awareness regarding their health and a desire to improve it. The results of this study validated the need for nursing-led interventions among homeless women to improve their quality of life.

Keywords: perceptions; heart healthy; homeless; women

Perceptions of Heart Healthy Behaviors by Homeless Women

According to the Centers for Disease Control, cardiovascular related disorders are the leading cause of death among women (CDC, 2020). These disorders are not biased and affect women of all ages, ethnicities, and backgrounds; however, homeless women are at an exacerbated risk. These women are at a greater risk because they are statistically inclined to hazardous behaviors and they lack the resources for a heart healthy lifestyle (Brown et. al., 2018). Homeless women are in need of heart healthy interventions that are long term, realistic and that will promote a better quality of life (Weber, 2019). This study investigates the perceptions of cardiovascular health conditions among homeless women in a southern state and the likelihood of these women implementing new resources if they were made available to them. Examples of these interventions include but are not limited to thorough and updated education on heart healthy behaviors, participant specific education, level appropriate workout courses, nursing led-telehealth services, and periodical blood pressure screening. It is important that we recognize the limitations of this population and that we work to promote attainable health outcomes among the community of homeless women (Nanja et. al, 2020).

Review of Literature

Historically, the research and support surrounding women as a whole is very limited. This is even more true for the women that belong to vulnerable populations such as the homeless community. Compared to homeless men, homeless women are less likely to receive an adequate education, income, and resources that are needed to lead a healthy lifestyle (Winetrobe, et al., 2017). When paired with their current living situation, these health disparities create the perfect storm for cardiovascular concerns to insidiously impose themselves on these women. According to a study done in the United Kingdom, based on audits of the electronic health records (EHR) of

nearly 9,000 individuals, cardiovascular disorders were more prevalent among those who were homeless compared to those with adequate housing (Nanja et al., 2020). While these numbers alone are alarming, it is suspected that the data collected in these studies underestimate the true amount of cardiovascular concerns among this population due to their transient lifestyle and infrequency of healthcare visits.

When applying Maslow's Hierarchy of Needs to the situation, an emphasis on healthy behaviors seems unrealistic. Maslow states that in order for an individual to progress through stages to self actualization, they must first meet their basic needs. These include food, water, and shelter. The homeless population is often unable to fulfill these needs on their own, so they rely on community resources. Community resources often operate on grants and local donations that may not place an emphasis on health because it does not seem significant when compared to the big picture problem. Hence the use of the unsympathetic phrase "beggars can't be choosers." However, supplying the homeless population of women with heart healthy options is an investment in their individual success and the success of the community. A person with a cardiovascular disorder is at a high risk for recurrent hospitalizations (Schaik et. al, 2017). Each hospital visit that is unable to be paid for affects personal, facility, and community finances. This is just another reason to implement practical, long term interventions to treat the problem at its root. The objective of studying perceptions of heart healthy behaviors by homeless women is to learn how to directly invest in their lives to promote their personal health and the health of the community.

Philosophical Framework

The philosophical framework of this project is based on Husserl's idea of phenomenology. "Phenomenology is the study of the human lived experience" (Melnyk, B. &

Fineout-Overholt, E., 2019, p 195). This framework was utilized in order to accurately assess the perceptions each participant has of her own health. Because perceptions are subjective, Husserl's philosophy was an exemplary foundation to build upon. This particular study utilized a descriptive form of phenomenology, meaning the participants were allowed to directly share their own experiences with maintaining a heart healthy life (Melnyk, B. & Fineout-Overholt, E., 2019, p 647). In order to effectively utilize this philosophical framework, the researcher must first evaluate their own perceptions of the people and processes that are being studied. This is especially important when culturally stigmatized individuals such as the homeless population, are the subject of the research. Also, by personally including the participants in the research, we are able to build rapport with these clients that will aid in effectively implementing the interventions when that time comes.

Methodology

Sample

The sample of participants was defined as a group of 10 homeless women, ages 18 and older whose environment makes it difficult to maintain a heart healthy lifestyle. These women may or may not display signs and symptoms of an unclassified cardiovascular concern or have a cardiovascular disorder as a primary or secondary diagnosis. Volunteer sampling was used to find participants that met the inclusion criteria. Snowballing sampling was also used, where participants were asked if they knew of any female that met the inclusion criteria and would be interested in participating. Exclusion criteria included men, women who are not homeless, and women under the age of 18.

Data Collection

At the time of each participant's interview, they were given an explanation of the study, and they were asked to complete a consent form to continue the research process. They also completed a demographic table to be reviewed during the data analysis. Demographic data collection included age, ethnicity, marital status, number of children, length of time homeless, healthcare facility location, current smoking and drinking habits and history, recreational drugs, and compilation of diagnosed cardiovascular disorders. Each participant was assigned an identification number for the study. Their real name and assigned number were not connected in any context to uphold confidentiality. The participants were informed that they could ask questions, refuse to answer questions, and leave at any time during the interview with no repercussions. Next, each participant was privately interviewed by the research team. Questions and answers were exchanged verbally while being recorded. Then, the recordings were individually transcribed and reviewed by each research team member following the completion of all interviews. The participants were given a gift card at the end of the interview, in exchange for their time.

Data Analysis

The data that was collected was examined using Colaizzi's method for qualitative data analysis. The seven steps of Colaizzi's phenomenology analysis were applied to each transcription of the participant's interviews. This process included a thorough audit of each transcript, highlighting major themes that related to heart healthy perceptions, organizing the observations and similarities among the interviews, and clustering meaningful data together to formulate conclusions (Polit & Beck, 2021). This process was completed by each member of the team individually to validate the research. The final step of Colaizzi's method is to share the

results of the study with the participants, but it is often difficult to follow up with this population due to their frequent relocation.

Data Storage

The printed data collection sheets were each labeled with a number that corresponded to the number given to each woman that was interviewed. At the end of the interviews, these forms were placed in a folder and stored in a locked cabinet. The recorded transcriptions of the interviews were stored on a password protected computer. Only the research team had access to this information. Once the entire study was completed, the data collection sheets and transcriptions were shredded.

Methodological Rigor

Methodological rigor was established through Lincoln and Guba's "Four Dimensions Criteria." These dimensions include credibility, dependability, confirmability, and transferability. Credibility was maintained through the "pre-work" that included education of the researchers on the homeless population and cardiovascular disease prior to the study, also known as a literature review. Data was also collected directly from the participants to provide more than one source of information. To ensure that this study is replicable, detailed documentation of weekly meetings among the research team and the interactions with the participants were kept on file. All the information was organized and shared among the researchers to ensure that the information was transferable (Nowell et al., 2017).

Findings

To organize our findings, we first analyzed the demographics of the sample population. This included age, ethnicity, marital status, length of time homeless, number of children, primary location of healthcare, participation in risk behaviors (tobacco, alcohol, and recreational drug

use), and diagnosed cardiovascular disease. Overall, we found that there is evidence to support a possible link between homelessness, lack of resources, risk behaviors, and cardiovascular diseases among these women. Through examination of each transcription by the research team, we identified five major themes.

Theme 1: Different Perceptions of What it Means to be Heart Healthy

Each of the ten participants had a different perception of what it means to be heart healthy. Heart health included physical, emotional, and spiritual health for many of the participants. However, even among their differences, there was a general understanding of what needs to be done in order to lead a healthy lifestyle. These women are not unhealthy due to a lack of understanding, but rather due to a lack of resources available to them.

Theme 2: Walking is the Main Source of Transportation

We found that walking was the main source of transportation for most participants. While this is considered a form of exercise, it is done out of requirement and does not contribute to the mindset of heart healthy living. These women should be encouraged to set time out of their week to implement intentional exercise with the goal of a healthy life in mind. Community exercise courses or groups should be adjusted according to the current physical health of these women to avoid excessive expenditure on their bodies. These women also need to be educated on the appropriate food and drink options they need to consume to fuel their bodies for exercise. Several of these women also reported mental health concerns. Exercise is a great non-pharmacological treatment for mental health that in turn can improve physical health.

Theme 3: Lack of Resources to be Healthy

Several participants admitted to having resources for food, but when asked to describe their food choices, they said “it’s a lot of junk food” and “there’s always something sweet,” mentioning donuts, pasta, soup, soda, and coffee as frequent options. Few women reported that

they ate three meals a day and that they drank very little water throughout the day. While these women claim to have a place to be fed, the meals they receive are often far from heart healthy, and provide little to no nutrients for their body. These food options are not under the control of the women, so the intervention must be targeted to the community resources through education on heart healthy alternatives to what is being served.

Theme 4: Understanding of the Importance of Following Heart Healthy Behaviors

Every participant was able to give at least one reason why heart healthy behaviors are important, but many lacked the desire or support to follow through. The main obstacle to this was that many of the participants had been involved in more severe risk behaviors in the past, so they feel that what they are currently doing is a better alternative than what they have done before. While this is true, these women should be encouraged to reach their full potential, and they should receive support from local resources to do so. This begins with education.

Theme 5: Fear of a Decline in Health Due to Heart Disease

When asked about their concerns related to heart disease, the participants explained many different fears to us. Some of the women have already been told by medical professionals that they are at an increased risk for a heart attack, and many have a family history of heart disease. We want these women to feel in control of their health and their ability to take care of themselves and their families. Though we want to mitigate their fear through education and application, these concerns may be used as a motivator to implement change.

Limitations of Study

The main limitation of this study is that the participants chosen were from one state at a single day treatment facility. While this is a good assessment of perceptions and implications for the needs of heart healthy interventions among this set of women and the small town they are in, it is not a definitive representation of the condition of all current homeless women both inside

and outside of this southern state. The study would need to be conducted on a larger scale and repeated in several locations to enhance its validity.

Implication for Nursing

In the past, health care has been based on a reactive system rather than a proactive one. This means that healthcare entities typically do not come into the equation until there is already a problem to be solved. However, as our world evolves and the rate of chronic illness rises, individuals are beginning to become more conscious of their health. This means they are attempting to participate in their care and work alongside the healthcare team. With that, the health care mindset has begun to shift its focus to prevention rather than treatment.

Community oriented nursing is a specialty of nursing that focuses on promoting the health of entire populations at the source (Stanhope & Lancaster, 2018, p 1). These nurses would be ideal for pioneering a care plan for preventing cardiovascular concerns for the local community of homeless women. However, this issue is the responsibility of the entire field of nursing regardless of position, title, or specialty. There are several nursing-led interventions that may be implemented in order to improve outcomes for this population. These include routine blood pressure clinics, telehealth services, nursing-led education sessions on heart healthy behaviors, regular focused physical exams, support in eliminating risk behaviors, and implementing overall health promotion techniques.

Another implication for nursing is educating those who are not homeless on how to properly support this population. Running groups that provided homeless women with proper workout attire, healthy snacks, and placed focus on enjoying the exercises showed positive results among the study participants. Education can be used to break the stigma and inform others on what to donate and ways to help these women obtain a higher quality of life. The

health of this population is not just the responsibility of a nurse, but as a primary patient advocate, it is important for local nurses to collaborate with the appropriate disciplinaries to improve health outcomes for these individuals and the population as a whole.

Conclusion

This study affirmed the possible lack of obtainable resources and education for local homeless women to lead a heart healthy lifestyle. The conditions that these women are in make it incredibly difficult to focus on positive health outcomes. This is why it is important for the local nursing community to advocate and collaborate with outside resources to aid these women in obtaining a higher quality of life and reduce the already growing risk of cardiovascular concerns. An investment in these women is an investment in the healthcare system and the community's overall success.

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