SESSION E3

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<th>Meeting the Patient Where They Are</th>
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<td>Vulnerable &amp; Marginalized Patients: Now you See Them, Now you Don't. How to Truly See and Hear Your Patients So that They will Come to See You</td>
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<td>Tera Roberts, D.N.P., F.N.P.-C.</td>
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SESSION E3 OBJECTIVES

- Identify the under-represented and/or vulnerable populations and the way traditional health care structures limit their voices.
- Recognize the social determinants of health that limit the voice of the under-represented and/or vulnerable populations.
- Learn non-traditional communication strategies to improve health care advocacy and access.

SESSION E3 SPEAKER

Tera Roberts, D.N.P., F.N.P.-C.

Dr. Roberts attended Oregon Health & Science University for her undergraduate and graduate degrees in Nursing and was a trailblazer in the first Post Baccalaureate Doctor of Nursing Program offered at OHSU. Tera completed her doctoral clinical hours and research focusing on the barriers to care in rural communities and centered her work in Vernonia, Oregon and other rural communities in Columbia and Washington Counties.

Dr. Roberts has practiced in private practice, specialty care and have a long history of engagement with public health work in Columbia and Washington counties. Currently, she is partnered with Virginia Garcia Memorial Health Center as the on-site clinical provider at the Century School Based Health Center in Hillsboro Oregon and serves as the Associate Medical Director for SBHC’S at Virgina Garcia. Her practice focuses on public health, reproductive/adolescent health and improving care in rural and underserved populations.

Tera currently resides in Vernonia, Oregon and has served on numerous wellness committees and health boards in that community over the past 23 years while raising a family of 9 children in the beautiful forest of the Pacific Northwest. The lived experience in this rural climate has allowed Tera to grow and question many of our current care practices and health care models.
Vulnerable & Marginalized Patients:

Now you see them...now you don't. How to truly see and hear your patients so that they will come to see you.

Dr. Tera Roberts, DNP, FNP-C

Disclosures

No conflicts of interest for the material contained in this presentation & No disclosures
Class Outline

Introduction to topics:

- Class Expectations
- Course Objectives
- Identifying Vulnerable Populations
- Setting the stage
- Communication- “How’s your Driving?”
- Striving for Cultural Competence
- Case Studies – small group/role play.
- Provider’s as part of the problem?
- “Burn out” vs “Moral Injury”
- Summary
- Citations
Class Expectations

• This is a safe and shared learning environment where the goal is to be reciprocal with our learning.

• For this class to be successful participants are encouraged to come prepared to share their personal experiences from their various professional and personal backgrounds—comments encouraged.

• This class will not take class time to cover books, articles or research on the topics discussed as those are referenced on the last slides of the power point.

• You may leave this class with more questions vs answers on the topics discussed—leave the class hungry to learn, search, seek more answers.

• This class will be interactive and participants may be asked to role play, participate in small group activities or read aloud in the class.

Course Objectives

- Identify the under represented/vulnerable populations and the way traditional health care structures limit their voices.

- Recognize the social determinants of health that limit the voice of the under represented/vulnerable populations.

- Learn non-traditional communication strategies to improve health care advocacy and access.
Who are the vulnerable and marginalized patients...

- Low income
- Persons of color
- Low literacy
- Low health literacy
- Mental Health Issues
- Developmentally Delayed
- Physically challenged
- Female
- Gender fluid/trans
- Rural
- Migrant Workers
- Children
- Teens
- English as second language/ not native language
Setting The Primary Care Stage
(who’s stage are you setting)

**Western Medicine**
- Scheduling an appointment
- Fees for showing up late or late cancelling a patient
- Insurance and billing for care
- Waiting room and exam rooms sterile, neutral tones, impersonal settings.
- Use of technology- EHR and MyChart.
- Telephonic interpretation
- Seeing someone in the “Care Home Model” at the clinic
- Appointment length 10-20 minutes

**Cultural Considerations**
- Walking in for care and waiting
- No fees for coming late and will be seen when they show up
- Barter and trade
- Use of colors, furniture, posters or marketing in line with cultures being served.
- Having tangible examples of medications, treatments, and including pictures on after visit summaries with instructions in their language at their literacy level.
- Seeing the same provider that they know and trust.
- Appointment length- longer due to cultural considerations-language, health literacy, mental illness, youth, etc.

**Communication**
- Consider that 80% of our communication is not what we say.
- Trust is a key component in making a connection in these populations and not easily regained once lost. How do we build trust in these populations?
- What does your body language and body positioning in the exam room say to the patient?
- What do your clothes say?
- What does the tone of your voice say?
- What does typing in the EHR during the office visit say to the patient?
- How does touch play a role in communication and does this improve trust?
How do you gain cultural competence if you are not from the background of those you are serving? Can you gain competence?

Consider some topics that you may not have thought of as “cultures”.

- Guns-rural climates
- Depression, SI and Suicide
- Poverty
- Lack of formal education
- Sex Trafficking
- LGBTQ
- Religious or faith based/support groups
- Addictions
- Clubs and professions (agricultural, logging, fishing, etc.)
One of the ethical and practical challenges in this environment is gaining a sufficient understanding to work within the culture of the patient and the community, with its strengths and weaknesses, in a way that does not communicate judgment of the values and the culture itself.” Nelson, W.(2009).

The way in which we use our communication skills will impart the following

Unconsciously incompetent to consciously incompetent 

VS

Consciously competent to unconsciously competent
Case Studies

- Parent with 7 year old boy with ear pain.
- Twenty year old female with possible vaginal issues who is significantly developmentally delayed
- Parent with nine year old female with eye issue- family from Guatemala
- Forty-Five year old male heavy equipment operator on a logging crew in rural community in for high blood pressure.
- Sixteen year old teen in process of gender transition.
- Sixty year old Hispanic female with mobility issues in for follow-up on arthritis.
- Twenty-four year old male from rural community in for follow up on dysthymia and anxiety who has a gun and concealed carry permit.
How Do We As Providers and Gate Keepers of Health Become a Barrier to Access?

- What is meant by the term “burn out”
- What is “moral injury”
- How do our current health care models support continued "moral injury” to health care providers?
- Video- “It’s not Burnout, It’s Moral Injury” It's time to stop the victim shaming...and call it like it is. [https://www.youtube.com/watch?v=L_1PNZdHq6Q](https://www.youtube.com/watch?v=L_1PNZdHq6Q) - by ZDoggMD- 6:20 minute video

Are we becoming part of the problem due to our current health care models??

**Moral injury** refers to an injury to an individual’s moral conscience resulting from an act of perceived moral transgression which produces profound emotional shame. The concept of moral injury emphasizes the psychological, cultural, and spiritual aspects of trauma. Distinct from pathology, moral injury is a normal human response to an abnormal event.

**What is burnout in health care?**
Burnout is common among health care workers. Characteristics of the health care environment, including time pressure, lack of control over work processes, role conflict, and poor relationships between groups and with leadership, combine with personal predisposing factors and the emotional intensity of clinical work to put clinicians at high risk.

**Burnout, Professional.** An excessive stress reaction to one's occupational or professional environment. It is manifested by feelings of emotional and physical exhaustion coupled with a sense of frustration and failure.
Techniques & Strategies to Improve Identifying vulnerable populations and to improve their voices in health care.

- Study the Purnell Model
- Simulation Lab participation
- Get involved in the culture where you practice, take time to get familiar with that culture's concerns, barriers, daily activities, heritage, etc.
- Identify the barriers in your agency/medical practice that create barriers-create moral injury to health care providers.
- Advocate at the local, state and federal levels for health care reform and development of health care models that are culturally competent.
Thank-you for your comments and sharing this time to consider how we as a group can make positive changes for our vulnerable patient populations.

Please contact me with any lingering questions or suggestions at troberts@vgmhc.org

Enjoy the Week-end!!

Citations & Research


5- The meaning of community involvement in health: the perspective of primary health care community. Mchunu GG, Gwele NS. Curationis. 28(2):30-7, 2005 May.


16- It’s Not Burnout, It’s Moral Injury | AMA 15 - YouTube https://www.youtube.com/watch?v=L_1PNZdHq6Q. March, 2018