Care of the Impoverished

The rate of poverty is increasing in the US. Currently over 15% of persons in this country live below the poverty line, up from 9.8% in 2006. This trend along with the thousands of newly insured patients accessing healthcare, makes achieving competence regarding the culture of poverty an important outcome for nurse practitioner students. Since many of these persons have not previously accessed the healthcare system, healthcare professionals and students have had little experience with this population or its unique world view. Knowledge of the effect of poverty on healthcare will be required to provide effective care to this new wave of impoverished patients. It is imperative that nurse educators prepare students adequately for this vulnerable population.

A Midwestern health sciences college established a free clinic in partnership with the local Salvation Army to provide free preventive care to the underserved and a service-learning opportunity for nurse practitioner students. Students are required to provide 20 hours of service at the nurse-run clinic while supervised by licensed faculty. Free physicals, lipid panels, education and referrals were offered. With the clinic located at the Salvation Army which serves 250-350 people daily, no community wide promotion was planned, anticipating a large response from current clients. However, it was quickly evident that predictions were wrong. It appeared current clients of The Salvation Army had little interest in preventive care. After a review of the literature on the culture of poverty it became evident that preventive care would be a hard sell. The idea of seeking medical care when not sick is completely foreign to those who previously had to carefully evaluate the cost versus the benefits of paying privately for services. As a result of this experience, the following lessons were learned about the special considerations needed when caring for persons in poverty.

Cultural value orientation and world view

Persons in poverty are present oriented…

- Therefore preventive care is not understood or is not a priority

Persons in poverty have less robust language and less ability to think abstractly…

- Therefore rely (and absorb) less on written word and more on hands on and visual cues

Persons in poverty perceive little control over their circumstances…

- Therefore believe personal choices make little impact

Persons in poverty value relationships over health and possessions…

- Therefore brief visits that focus only on the health issue have little impact on behavior

Health Belief Module: Barriers of poverty

Parameter	Barriers for persons in poverty
Perceived susceptibility	Unaware of risk factors due to lack of education and experience with healthcare (they do not know what they do not know).
Perceived risks and benefits of treatment	Cost of meds and follow up make risk of treatment greater than benefits (especially when meds for

	chronic disease do not make patients "feel better")
Perceived threat of illness	Other concerns like food and rent are more pressing threats than a 10 year risk of a cardiac event
Cue to action	Lack support to take action since peers come from same cultural view

Strecher, V.J. & Rosenstock, I.M. (1997).The health belief model. In Andrew Baum (Ed.) *Cambridge Handbook of Psychology, Health and Medicine (*pp. 113-116). Cambridge, MA: University Press. Retrieved from http://books.google.com/books?hl=en&lr=&id=zVh30FrAuDsC&oi=fnd&pg=PA113&dq=health+belief+model&ots=Ij8TpwtKrn&sig=miesYUMaeDJCLwQrlsgsTkdAXMs#v=onepage&q=health%20belief%20model&f=false

Lessons from service-learning in a free clinic

Make healthcare relational

- Take time to hear the patient's story then use patient education to build relationships (one-on-one)
- Use provider/patient bond to increase self-efficacy and encourage positive choices

Make healthcare a priority

- Use acute illness to make healthcare a priority in the present
- Provide immediate feedback with point of care testing to avoid lack of follow up

Make patient education effective

- Use simple (non-medical) language, pictures, models
- Patient satisfaction survey results show patients are interested and will respond

Results of anonymous patient surveys

I understand about my health much better after seeing the health professional at ACE-SAP Free Clinic.	92%
Do you plan making any health changes after this visit?	42%

Health Belief Model: Solutions to poverty

Parameter	Culturally specific solution
Perceived susceptibility	Use relational orientation to educate on risk factors one-on-one
Perceived risks and benefits of treatment	Reduce or eliminate costs (especially for medications for chronic illness and prevention)
Perceived threat of illness	Use acute illness as a motivator and address prevention while the patient feels susceptible
Cue to action	Provide immediate feedback using point of care

	testing (lipids/ glucose/ A1C) to motivate action and reduce attrition due to lack of follow up. Encouragement from a trusted provider increases confidence and provides support

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Are your NP students prepared?

Prior to implementation of the service-learning requirement less than 4% of patients seen during clinical experiences were coded as underserved. This means that unless students sought clinical sites specific to this population (like the local federally funded health clinic), they may lack sufficient exposure. After the implementation, 8% of patients seen are coded as uninsured. The impact of this experience is evidenced in this student reflection.

> I've seen poverty and low SES [social economic status] in my practice as a nurse and I've often had the attitude of others who have never walked in their shoes. I thought it was laziness or they just didn't care about themselves. But I somehow hadn't thought that their value orientation is different from the rest of the middle and upper class in America. Being taught that in class and then having the opportunity to be the healthcare provider and hear their whole histories, not just snippets that you get as a nurse, gave me new perspective on the situation. They aren't looking at their lives with the same eyes that we are. While we're focused on our future and becoming what we want to be as individuals, those in poverty are focused on the present and what they are doing now to solve the problems they feel they have little control over. Learning how best to treat a patient who is in this mindset is the next learning experience I would like to master as I continue to volunteer service hours at ACE-SAP Clinic (Bensink, 2012 p.5).

Students were also asked to voluntarily complete anonymous pre and post service surveys, the results show students' cultural competence and knowledge increased significantly after their service-learning experience.

Statements regarding cultural competence	Mean pre score	Mean post score	p-value
1. I feel well prepared to practice my profession in a community similar to the community in which my placement was located.	3.32	2.36	<0.0001*
2. I feel comfortable providing services to people from different ethnic and racial groups from my own.	2.47	2.03	0.0048*
4.Upon graduation, I would like to work in setting where health care professionals are underrepresented.	3.18	2.74	0.0064*
5. Upon graduation I would like to work in a setting with patients/clients of various cultural backgrounds.	2.55	2.13	0.0006*

Note: Asterisk indicates a statistically significant finding. Adapted from Centers for Healthy Communities (1999). Student pretest/ posttest*. Wright University.*

Statement scale ranges from none (1) to extensive (5). My knowledge/ understand of …	Average score before	Average score after	p-value
1. The types of community resources available for the population with whom I worked.	3.32	3.50	<0.0001
2. The health care needs of the community in which I served	2.51	3.57	<0.0001
3. The responsibilities of other health care professionals in a multidisciplinary team.	3.0	3.78	<0.0001
4. The barriers to receiving health care in the community that I served.	2.55	3.89	<0.0001
5. The impact of socioeconomic status on health and illness.	2.86	3.93	<0.0001
6. How my placement site is perceived in the community.	2.26	3.54	<0.0001
7. How to work with clients/ patients who have various levels of health care knowledge.	2.80	3.78	<0.0001
8. What the terms community resources and community service mean.	3.10	3.93	<0.0001

Note: Asterisk indicates a statistically significant finding. Adapted from Centers for Healthy Communities (1999a). Student posttest. *Wright University.*

Summary

Nurse practitioners are the key to provision of quality, low cost care in the future. Service-learning provides an evidence-based method to assure nurse practitioner students have the knowledge and experience to be leaders in advocating for patients living in poverty.

References

Bensink, S. (2012). Post-service reflection paper. Allen College, Waterloo, IA.

Centers for Healthy Communities (1999a). Student posttest*. Wright University.* Retrieved from http://www.med.wright.edu/chc/tech/docs/studentposttest.pdf

Centers for Healthy Communities (1999b). Student pretest. *Wright University.* Retrieved from http://www.med.wright.edu/CHC/tech/docs/studentattitudepretest.pdf

Payne, R. K. (2005). *A Framework for Understanding Poverty.* (4th ed.)Highlands, TX: aha! Process, Inc.

Strecher, V.J. & Rosenstock, I.M. (1997).The health belief model. In Andrew Baum (Ed.) *Cambridge Handbook of Psychology, Health and Medicine (*pp. 113-116). Cambridge, MA: University Press. Retrieved from http://books.google.com/books?hl=en&lr=&id=zVh30FrAuDsC&oi=fnd&pg=PA113&dq=health+belief+model&ots=Ij8TpwtKrn&sig=miesYUMaeDJCLwQrlsgsTkdAXMs#v=onepage&q=health%20belief%20model&f=false

United States Census Bureau (2012). Income poverty and Health insurance. Retrieved from https://www.census.gov/hhes/www/poverty/data/incpovhlth/index.html

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