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Honoring others by accompaniment

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Honoring Others by Accompaniment

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Submitted in partial fulfillment of
the requirement for the degree of
Doctor of Nursing Practice

AUGSBURG COLLEGE
MINNEAPOLIS, MINNESOTA

April, 2016

Augsburg College
Department of Nursing
Doctor of Nursing Practice Program
Scholarly Project Approval Form

This is to certify that **Merrilee Jean Brown** has successfully defended her Graduate Project entitled "**Honoring Others by Accompaniment**" and fulfilled the requirements for the Doctor of Nursing Practice degree.

Date of Oral defense April 29, 2016.

Committee member signatures:

Advisor: Joyce Miller, DNP, RN Date 4/29/2016

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Reader 2: Alison DNP, APRN Date 5/2/2016

Presentations

Scott County Health Care System Collaborative
Presentation to all Scott County Healthcare Providers
Safety Net Service Collaboration
on May 28th, 2014
at Shakopee, Minnesota

Scott County Public Health Staff Meeting
Presentation to Public Health Nurses
Honoring others by Accompaniment
on February 1st, 2016
at Shakopee, Minnesota

HONORING OTHERS BY ACCOMPANIMENT

Dedication

This project is being dedicated to the staff at Scott County Public Health. For eighteen years, we showed up every day to embrace each other and worked tirelessly to make lives better for the undocumented, invisible, forgotten, and despised and oh yes, we quietly looked after the health of the whole county.

This DNP evolution is dedicated to my adult children, Carly and Jesse. I am humbled everyday by your courage, strength, perseverance, and wisdom. Your support and love to finish this lifelong goal has been incredibly meaningful to me. However, may you always remember in this life I have been most proud to be your mom.

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To Bev Nilsson and Pam Weiss who believed in me while working on my BSN and who continued to mentor me for the next 20 years.

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To Katherine Baumgartner who taught me you don't have to fix everyone, most people just want someone to really listen to them and accompany them on their journey.

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To Deb Schumacher who taught me the value of critiquing research in a useful, practical, and meaningful way. She also has shared her valuable teaching wisdom as we prepare those that will follow us.

To Kris McHale who taught me to honor the elements, be open to the vastness of herbal healing, appreciate ways of knowing, and don't disavow the *magic* around us.

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Abstract

Nurses recognize that access to healthcare for marginalized individuals prevents some from utilizing western medicine basic health services. People living in the margins can experience difficult encounters to healthcare as a system and a culture. Providers in Scott County that offer access to the marginalized are referred to as *safety net services*, lack individual choice, resource coordination, or a health partnership with individuals struggling in their daily lives. Public Health Nurses recognize the need for intentional collaboration among providers. This project began with a Hispanic individual who had accessed all safety net providers in Scott County and still was not receiving adequate healthcare in our system. Hispanic Americans are the single fastest growing minority population in the United States. Many of these individuals will not have access to adequate health care access. Safety net providers in Scott County came together to identify strengths, assess gaps, and coordinate services to improve individuals healthcare based on their cultural needs. The concepts of *caring* and *culture care* based on Leininger's theory, *accompaniment*, and *honoring others* beliefs, values, and lifeways have guided this project to meet the needs of individuals living in the margins. The lived experiences of synthesizing and constructing these concepts into praxis have demonstrated advancing nursing practice. The outcome was an improved process for assisting individuals to receive effective care in a culturally, respectful manner. The development of the client referral form resulted in 54 clients from the mobile health unit making care decisions. Over one hundred individuals avoided unnecessary emergency room treatment through the collaboration of the Safety Net Providers.

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Honoring Others by Accompaniment

Chapter One: Introduction

Not everyone has access to basic health care in the United States (U.S.). The Affordable Care Act of 2010 excludes undocumented immigrants (and legal immigrants living in the U.S. for less than five years) from its benefits (Berlinger & Raghavan, 2013, p.14). The healthcare systems want individuals coming to the United States to understand how the healthcare system works. The complexity of the healthcare systems as well as the accountability of decision makers to deliver care is an arduous and ongoing struggle. Within the last five years, healthcare systems have been mandated to provide care in the community prioritizing health needs and risks. This delegation assumes a much broader responsibility than their sole hospital and clinic patient populations. Few in senior leadership positions understand the depth of cultural needs, beliefs, and traditional health practices especially with marginalized individuals. The marginalized are individuals who are socially denied access to rights and resources that other individuals are privileged to receive (Berlinger & Raghavan, 2013, p.15). Advance practice nurses can bridge this gap and increase awareness of decision makers, other healthcare professionals, and accompany individuals living in the margins by understanding culture care differences, intentional listening, and co partnering with individuals during their health, wellness, and healing journey. This project was a systems approach to provide healthcare access for the uninsured through collaboration with multiple healthcare providers in Scott County.

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Background of the Project

~~As the Public Health Director, I recognized, and was disturbed and troubled that not~~
everyone was receiving health care at the same level within our public health department. Some individuals were not getting health care at all. As a public health department, we provide basic level services, including maternal and child care, disease surveillance and management, and emergency preparedness planning. Scott County is a mixed suburban /rural county located in the southwestern corner of the Twin Cities and is the 16th largest metropolitan area in the U.S. The current Census estimated the county's population at 129,928 (2010 U.S. Census). According to the Metropolitan Council (2013), Scott County's racial and ethnic populations from 2000 to 2013 grew by 229% - the largest percentage growth in the Twin Cities. Scott County was the fastest growing county in the state over the last decade, with a 45% increase in total population (Metropolitan Council, 2013). One of the greatest health priorities in Scott County is being able to provide comprehensive health care for those with chronic health conditions. In Scott County, a total of 7.1% of the population are without health insurance (Scott County Community Health Improvement Plan, 2015 – 2019). Individuals who are uninsured or underinsured receive less medical care, wellness education opportunities and resource support. When they do receive health and or wellness care, it has often been significantly delayed and their condition and final outcome is worse.

Scott County was fortunate to have a mobile health unit that collaborated with the Mdewakanton Sioux Tribe for delivering basic health care to the uninsured. However, those services were infrequent and individuals were struggling to be able to see a health care provider in a timely manner, get necessary medicine, preventive care, immunizations, and find resources for themselves, their parents, and their children. Individuals were trying to access a healthcare

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system they did not understand and in which they were not always welcomed. I discovered an individual with Tuberculosis (TB). This person had presented on numerous occasions to the emergency room and clinic settings with severe foot pain, a rash-like skin infection, and pain medication compliance concerns. TB is easily treated unless you are one of the unfortunate individuals without access to our medical health care system. Health care is a human right.

In my role as Public Health Director, I reached out to the four healthcare providers in Scott County who provide care to the marginalized. Each healthcare provider was practicing independently and unaware of what other services were provided. The four providers met to discuss services provided and identified their own gaps in services. The healthcare providers became passionate about the potential efficiency and opportunity to collaborate. The collective goal was to reduce redundancy and gaps, and improve the individual experience benefiting those in need ensuring health care access for the uninsured and a health care home or sometimes referred to as a medical home. Having a health care home is a fairly new concept intended to provide primary care services. A health care home ensures providers, families, and individuals work together to improve the individual's health outcomes. Although establishing a health care home for all individuals was the original intent of this project, an insightful shift in thinking regarding a care model occurred.

With greater knowledge came the insight that many individuals have lifeways of their own to guide, support and rely on in times of wellness and illness. The role of the advance practice nurse must focus on the interrelationships of others beliefs, values, and care and caring they desire. I spent intentional time listening to stories of individual's struggles. It became imperative to listen, to hear what people wanted and needed to stay healthy or regain health from the perspective of their cultural beliefs and values. It became important to tell other health

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professionals and policy makers what people needed and to co-partner with those struggling in the margins to understand their story. This project demonstrated the interconnectedness of nursing concepts of culture care, caring, and accompaniment, while honoring others living in the margins. Those who benefitted from this project were health care providers, healthcare decision makers and most importantly the individuals served.

Significance of the Project

Healthcare as a right was my initial belief and was significant for this project three years ago. Health inequities are evident in everyday practice in Public Health. Public health nurses (PHN's) advocate for the marginalized on a routine basis. Scott County Public Health being one of four safety net providers was actively working to reduce disparities through their immunization clinics and a mobile health unit for the uninsured. However, there were still unmet needs for these marginalized individuals. This project was a collaboration with three other safety net providers to address gaps, redundancy, and needs in our collective individual organizations to improve appropriate, efficient, and individual centered care for our most vulnerable. The project was successful in accessing appropriate health care services and decreasing inappropriate emergency room visits. The project was led by myself undergoing my own transformation of advance nursing practice which helped me to educate the safety net providers through concepts of cultural preferences, values, and beliefs. The safety net providers continue to work in collaboration for the benefit of the entire county.

Nursing Theoretical Foundation

Caring for individuals in health care is evident and providing culturally appropriate care is essential. Leininger's (1997) culture care theory discerns and enlightens nursing regarding the interdependence of care and culture care differences and similarities among people. Leininger's

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(1997) definitions of care and culture care guided this project. As stated by Dr. Leininger (1997)

~~“I predicted that by 2010 all nurses would need to be knowledgeable and culturally competent to~~
work with people of diverse cultures” (p. 32). This prediction is more crucial today than it has ever been in nursing’s history due to increasing diversity of our society. According to Leininger (1997) “care (caring) is essential to curing or healing, for there can be no curing without caring” (p. 39). She defined culture as “the lifeways of an individual or group with references to values, beliefs, norms, patterns, and practices that are learned, shared, and transmitted intergenerationally” (p. 38) and culture care as “the culturally derived, assistive, supportive, or facilitative acts toward or for another individual or group with evident or anticipated needs which guides nursing decisions and actions, and held to be beneficial to the health or the well-being of people, or to face disabilities, death or other human conditions” (p. 38). Leininger’s definitions were used to guide this project.

Leininger (1997) conceptualized four key tenets to her theory of culture care diversity and universality. The first position is that culture care practices are different yet there are many shared commonalities. The second position is generic and professional care are both important influences that predict health, healing, and ways that people approach disability and death. The third position is generic “emic (folk)” and “etic (professional)” health aspects in different environmental circumstances influence health and illness outcomes. The final tenet has three major actions and decision guides: “culture care preservation and/or maintenance; culture care accommodation and/or negotiation; and culture care repatterning and/or restructuring” (p. 38). These actions and decision guides were beneficial for my project due to the understanding I gained by including individuals in guiding their own care. I came to recognize the importance of

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being a copartner and not the decision maker for another's health choices. This was an enormous shift in nursing in thinking and ways of knowing and understanding.

The major tenets of Leininger's work led to a number of theoretical assumptions that she used with multiple cultures. As stated by Leininger (1997) "cultural conflicts, imposition practices, cultural stresses, and pain reflect the lack of professional care knowledge to provide culturally, congruent, responsible, and sensitive care" (p. 40). Understanding these tenets inspired me to shift my ethnocentric thinking to listening to others lifeways and learning from their experiences and struggles. This led me to intentionally spend regularly scheduled time in the company of the marginalized.

Leininger (1997) developed several *enablers* as ways to explain the difficult phenomena of human care. She chose the word enabler because her theory represented participatory efforts that "included the people and/or groups involved" (p. 38). Her theory demonstrated a purposeful partnership with the people to include their perspective was essential. The two enablers most significant for this project were the "Sunrise Enabler and the Stranger-to-Trusted-Friend (also known as Stranger-Friend) Enabler" (p. 46). The Sunrise Enabler is a visual picture that uses a holistic approach to evaluate factors that impact care of various cultures. It includes identifying reasons that could influence care, such as kinship and social factors, cultural values, beliefs, and lifeways. The Stranger-Friend Enabler's purpose is to serve as a guide for the nurse to gain insight of their own actions, feelings, and facts as they relate to others of different cultures. In order to obtain meaningful information, nurses need to transition from being an outsider or stranger to be trusted. Being aware of self-behavior is of paramount importance while actively engaged with individuals, families, and groups.

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The work of Dr. Leininger (1997) was instrumental and provided great depth to understanding differences of others but more importantly the similarities that are shared among humans. Her contributions were illuminating, and applicable to incorporate into my nursing project. In Chapter Two, the concepts of culture care, caring, accompaniment, and honoring others will be explored through literature, and nursing practice application. Leininger's *enablers* guides nurses to become more aware of how their own actions affected others.

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Chapter Two: Literature Support

~~There is much deliberation regarding lack of healthcare for the uninsured. Exploring the~~ literature for the marginalized was enlightening and disconcerting. It also provided insight into four interrelated and significant concepts pertinent and essential for all nurses. The concepts of culture care, caring, accompaniment, and honoring others will be explained regarding culture care and cultural barriers.

Culture Care

The term culture care was important to the project. Defined by Leininger (1997) “the culturally derived, assistive, supportive, or facilitative acts toward or for another individual or group with evident or anticipated needs which guides nursing decisions and actions, and held to be beneficial to the health or the well being of people, or to face disabilities, death or other human conditions” (p. 38). I defined this as an intention to become familiar with culturally appropriate and a valuable exchange of information for different or similar cultures based on research, respect, and communication. We may not understand the same language but there are many non-verbal ways to express understanding

Cultural unawareness limits nurses’ ability to meet diverse client needs. This is where miscommunication begins. When the nurse lacks cultural understanding of diverse individuals, congruent and competent care is unachievable. A study by Lee, Anderson, and Hill (2006) identified how cultural barriers limited the nurse’s ability to meet client needs which negatively affected both the nurses and clients experience related to culture care. Following the educational session, nurses’ knowledge increased significantly in caring for culturally diverse populations.

Being able to provide health care to all is a core responsibility for public health professionals. Public health nurses know that health care is available for everyone and their role

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is to find needed resources. Access to health care for the marginalized challenges health care professionals' values and attitudes on a regular basis. It is additionally significant to assess one's own personal and professional factors related to health care access, to know oneself. According to Ruis-Casares et al. (2013), "clinicians were more likely than support staff to endorse full access to health care services" (p. 292). "Administrators and support staff would benefit from training on migrant health and human rights- particularly the principle of the best interest of the child in order to enhance sensitivity and individual and institutional accountability" (p. 297).

Nurses need to discern institutional policies for ethical practice. Ruis-Casares et al. (2013) recommend a review compliance of provincial and territorial government and health institutions' policies and procedures with the *Canadian Charter of Rights and Freedoms* (1982) and the *Canada Health Act* (1984) - particularly its' two main principles of universality and accessibility (p. 296). Values of health as a human right does not necessarily shape positive attitudes of access for health professionals. Understanding the incongruence is important for working with other practitioners and facilitating open discussions. The results of this literature support the project purpose of nurses needing to raise awareness with senior healthcare leadership of culture care facilitative acts to benefit the health and lifeways of all people.

Care-Caring

Care is a term that has many meanings, feelings, and attitudes for nurses. Caring of others involve emotions that require a professional and compassionate presence. According to McFarland and Wehbe-Alamah (2015), "care is largely an embedded, invisible, and often taken for granted phenomenon that is difficult for nurses to quickly identify or grasp with in-depth meaning" (p. 10). Caring may begin by way of advocacy. Berlinger and Raghavan (2013) state that "the advocacy role is a deeply meaningful and satisfying one to professionals who work in

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safety-net hospitals, but it can be ethically problematic if unreflective advocacy leads to unfair or poorly planned, ad hoc resource allocation. Understanding this can strengthen clinical practice”

(p. 15). This project’s focus began with coordination of safety net services in one county’s scarce resources for the marginalized. The safety net providers were providing basic health care access for the marginalized, but were unaware of other safety net services in the same county. We were also unaware of the duplication of services. There were opportunities to work together to improve individual care and resource management for our individuals living in the margins.

Caring comes in the form of intentional listening. According to McGuire and Georges (2003) “nurse clinicians who interface with undocumented women can invite their stories, concerns, and perspectives to locate broad health concerns. From this base of knowledge, nurses could be brilliant at developing interventions in partnership with groups of undocumented women that help to alleviate some of the suffering of separations, for example, that foster consciousness toward political solutions” (p. 192). Intentional listening requires practice. The practice of mindfulness can be of great assistance. Williams and Penman (2012) state that with practice “gradually, you may become aware that it is impossible to nourish others without nourishing yourself” (p. 200). This project recognized the relationship of culture care and caring by way of being a true listening co-partner with the marginalized wishing to be heard by expressing their values and lifeways. Co-partnering also involves walking alongside another where the concept of accompaniment intersects.

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Accompaniment

Advanced nursing practice requires nurses to respect the health care choices of the individual as their first priority. “As a society, we are happy to help and serve the poor, as long as we don’t have to walk *with* them where they walk, that is, as long as we minister to them from our safe enclosures” (Farmer & Gutierrez, 2013 p. 128). But if we have chosen to co-partner with others, we have accepted the responsibility to journey beside them. This means the individual decides as they are able or assist in decision making for their health options and choices based on their beliefs and values.

Leininger’s (1997) Sunrise Enabler was beneficial to this project particularly in the concept of accompaniment. Within the Sunrise Enabler are three decision actions that provide culturally sensitive and person inclusive nursing care. The first is “Culture Care Preservation/Maintenance” (p. 38). This action supports what the person is currently doing to maintain health, healing and well-being. This action fit well with the project because nursing was supporting what practices were meaningful for one’s health. Nursing sustains the lifeway of another. That alone was revolutionary. The second action was “Culture Care Accommodation/Negotiation” (p. 38). This action allows the client and nurse a co-partnership for the health practices of the other and respectful conversation guiding nursing practice recommendations. The third action was “Culture Care Repatterning/Restructuring” (p. 38). This action is guided by the nurses understanding of cultural beliefs, values, and lifeways and the multitude of factors that affect meaning to one’s health. These three decision actions fostered a new understanding of being inclusive to the others’ beliefs and values. It is empowering the person in their decision making. Accompaniment is a gift we give with authenticity to become a light for others. But accompaniment can be difficult.

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Crockett (2001) stated “accompaniment goes beyond solidarity in that everyone who enters into it risks suffering the pain of those we would accompany. It calls for us to walk with those we accompany, forming relationships and sharing risks, joys and lives. We enter into the world of the one who suffers with no assurance that we can change or fix anything” (p. 79). According to Farmer & Gutierrez (2013) “understanding how the suffering of the poorest is perpetuated is not the same as fighting it: the real protagonists of the war on poverty will of course include those struggling to free themselves from it. But if we believe that knowledge can inform practice- if we believe in praxis as pragmatic solidarity- then it is best to have intellectual and pragmatic accompaniment as we move the social justice agenda forward” (p. 134).

Honoring Others

Those on the periphery of life, often dehumanized as the poor, voiceless, needy, despised, and marginalized deserve a positive descriptor as well as a respected place in society. I have chosen the expression: honoring others. Advanced practice nurses can provide the leadership to transform the social stigma that so many live in everyday of their stress filled lives. Honoring others is not just an experience, it is a process.

According to Vasas (2005) “nurses interface with the concept of marginalization in three important ways: we must be able to understand the *experiences* of marginalized people. This will allow us to work in a more meaningful and responsible way to understand the relationship between health disparities and marginalization. Nurses also need to understand the physical and psychological *consequences* as they affect health and well-being. Finally, nurses must also understand the *process* of social marginalization and increase our awareness ways to resist or contribute to the marginalization of our patients within our practice and research” (p. 199). Vasas (2005) supports the process of giving voice to those who have been silenced to the attention of

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those with power to make change. McGuire & Georges (2003) referred to this as hearing the stories. Farmer & Gutierrez (2013) identified that “in some way help ensures that those without a voice find one. Being an agent of one’s own history is for all people an expression of freedom and dignity, the starting point and a source of authentic human development” (p. 156). This is imperative to allow the stories or voice to be heard accurately to honor others.

In this chapter, the literature has established the importance of understanding differences and more importantly the similarities of human beings. It is additionally important to know one’s self by carefully looking inward. By knowing oneself, it becomes equally important to be able to discern ethical institutional practices. Caring comes by way of advocacy, walking beside another, listening, and hearing the voice of those suffering. The next chapter will speak to the project and how by honoring others gave them voice.

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Chapter Three: Honoring Others by Accompaniment

This project began as a collaborative between Scott County Public Health and the other safety net providers in the county. The healthcare organizations were providing basic health services to the uninsured. Additionally, the goal of these services was to find a permanent Health Care Home for this population. When an undocumented Hispanic man, presented with a communicable disease, we recognized the system was problematic, not the individual. The four safety net providers had all seen Francisco, but what was illegible was the difficulty and consequences for this man. He had accessed all safety net providers and was still lacking adequate healthcare for his treatable, communicable disease. This project was developed to increase access for healthcare for the uninsured by providing timely provider appointments and avoiding unnecessary emergency room visits.

Description of the Project

This project began as I discovered the lack of healthcare access for this Hispanic man. His limited English, his inability to understand the medical system and his untreated communicable disease were the push points to try and change our current community health practice. This individual needed adequate healthcare. He and the community were at risk.

Scott County Public Health has been part of a collaborative with the Mdewakanton Sioux Community in Scott County since 2009. This collaboration began with discussions between myself and the tribal leadership to expand the partnership for those with unmet health needs within Scott County. The intent was to continue to provide basic health services to those without access to healthcare, provide resources to support maintenance and wellness options, and secure a health care home for those without a primary care provider. A health care home is a permanent location that encourages providers and care teams to meet individual needs from

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simple to the complex conditions. A mobile health unit, a large van on wheels, with a paramedic driver, was donated by the tribe. The mobile health unit staff were the public health nurses and the medical director from Scott County. The mobile health unit traveled twice a month to three different locations within Scott County. The locations were the parking lot of a Russian Baptist church in Shakopee, a library in Savage, and a local grocery store in Jordan, within Scott County. The sites were chosen because they either had the greatest diverse populations or lacked a health care provider in that community. The city of Jordan had neither a clinic nor a pharmacy.

The majority of those accessing services were undocumented or without insurance for a number of unfortunate circumstances. As I began to spend more time listening to individuals' stories, I began to hear their frustrations to get help with their acute and chronic conditions. I heard about their inability to find anyone that would listen or help them. Often they were given another resource to pursue on their own and sent away with a phone number on a scrap of paper. I began to understand their stories of struggle, of brokenness, and of hopelessness. I began doing follow up client visits, and I discovered that Francisco had untreated Tuberculosis. He arrived at the mobile health unit one afternoon as instructed by the emergency department at St. Francis Regional Medical Center. Upon further conversation, due to limited English, Francisco did not understand his disease. He also did not understand the healthcare system. He had been seen at St. Mary's Clinics, River Valley Nursing Center, the mobile health unit, and St. Francis's emergency department. With Francisco's approval, I reviewed his records over the past twelve months from all four safety net providers. With the detailed information, I discovered that Francisco had made thirty visits to four Scott County providers. I chose to use one individual's lived experience to explain the complexity to the safety net providers that the individual was not the problem, but the system itself was problematic. This was an opportunity to discuss a

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collaborative provider problem solving and uncover ongoing gaps in care for just one undocumented, uninsured individual struggling for health care in the margins.

The four safety net providers have been in existence for some time. They are responsible for health care services for the uninsured in Scott County to provide limited services of health care access. St. Francis Regional Medical Center has been in existence for several decades. St. Mary's Clinics have been well established in multiple communities for many years. The River Valley Nursing Center was established in 2003 as a result of serious state budget deficits and was modeled after the Nursing Center of Augsburg College, now called the Health Commons. The Augsburg Central Health Commons was founded in 1992 (previously called the Nursing Center). The mobile health unit began in 2009 as a collective partnership between Scott County Public Health and the Mdewakanton Sioux Community.

As a nurse representing Scott County, I invited the other three healthcare providers to meet and discuss current services, redundancies, unmet needs, and explore opportunities to coordinate and potentially enhance the client experience. Much of public health's role is to collaborate with others. This was a perfect example of collaboration at the system's level using the Minnesota Department of Health (2001), Public Health Intervention Model.

The meeting was cordial, but many had never met before. The partners established the first meeting as an opportunity to become introduced and acquainted with each other. As stated by Estavo and Prakash (2001) "in the modern world, there is an interface between individuals selves who are the possessors of the calling cards; classifying them in terms of the statistical "we" (p. 76). In villages and other spaces of the social majorities, introductions take a completely different course" (p. 77). I realized that people needed time to learn to trust one another before they could share strengths and their vulnerabilities collectively. As stated by Scott (1998)

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“legibility is a condition of manipulation. The greater the manipulation envisioned, the greater the legibility required to effect it” (p. 183). What is illegible is that many providing care think they are doing a great social justice, but what the experts (or planners) were missing was the complexity and consequences of what was actually occurring to the individual or individuals who received services. People at the top don’t see what’s happening until they are told the end user story.

The providers continued to meet regularly following the story of Francisco. Being able to define our systems gaps brought group consensus that *the system had failed him*. A form of structural violence. Structural violence refers to inequalities of human dignity and rights that could protect the vulnerable (Farmer & Gutierrez 2013). Power and organizational policies neglect the ethical inequalities of the sick and the poor. All of the healthcare providers thought they were providing best practice. Further inquiry revealed that the complexities of someone’s real life were not being recognized. According to Farmer (2005) “some of the problems born of structural violence are so large that they have paralyzed many who want to do the right thing” (p. 245). However, Francisco’s story moved the healthcare providers from self-interest to mutual interest. The healthcare providers developed a grid of their individual services, redundancy was identified, and gaps discovered. The healthcare providers agreed to develop and share a common referral form that became simpler to use, inter-agency friendly, and allowed clients a better understanding of how they could coordinate their care needs. Healthcare providers became familiar with each other’s services and identified strengths of each other. Collectively the healthcare providers identified known gaps within the system. The major gap identified through the healthcare providers was that the uninsured were still without a primary care provider.

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The healthcare providers met with the healthcare system senior leadership to educate the decision makers of this innovative collaboration and coordination of scarce resources. Those in need were identified by personal stories of the use of the safety net services and the disconnect of their beliefs and values. Senior leadership demonstrated verbal support and requested further inquiry of information about this population. The four healthcare providers have continued their collaboration and efforts to coordinate services for the marginalized.

The healthcare providers presented a report on the gaps in safety net services to leadership at the Health Care System Collaborative (HCSC) of Scott County. This collaborative comprises management representatives from Park Nicollet and Allina Health Systems, Fairview, St Francis and Waconia Medical Centers, all eleven health clinics, and Medica, Health Partners, UCare, and Blue Cross Blue Shield public program representatives. Following the presentation to the HCSC, the healthcare providers were requested to discuss action steps of securing a primary care provider with senior leadership of Allina and Park Nicollet Health systems. The information provided asked for Charity Care slots to be opened in both systems to accommodate the uninsured. Senior leadership requested further clarification of the requests for charity care slots in their clinics. According to Campbell and Gregor (2004) “before attempting to gather data, the researcher needs to look at any situation *as an institutional ethnographer does*. They are interested in the particular conditions under which experiences arise and are lived *by someone*” (p. 59). The healthcare providers retrieved the data as an ethnographer. I met with the Chief Financial Officers of Allina and Park Nicollet Health systems. Opening Charity Care slots became a tremendous challenge, but I was making inroads with the gatekeepers of the Charity Care programs. The healthcare system leaders and the safety net providers discussed holding one clinic slot opening when the safety net providers were open. If someone required a same day

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visit, the individual could be accommodated in one of the two major health systems. However, based on previous listening sessions with the marginalized, and after this conversation with senior leadership, the realization occurred to me that maybe there were individuals who did not want a western medical model of care or a Health Care Home. I began discerning with the marginalized trying to understand their beliefs, values, and lifeways to what they want and/or need for health, healing, and holistic wellness. My conversations with individuals began with me listening to what they wanted for their health and wellness instead of me telling them how the system would care (work) for them. I began learning that many individuals had their own preference for what they needed and wanted for care. I was encouraged by their stories of struggle and perseverance. I was also stirred and becoming grounded in my chosen nursing theorist, Dr. Madeleine Leininger.

Theoretical Framework and Conceptual Model

Leininger (1997) inspired nurses to engage in cultural assessment with people to explore meanings and expressions, through intentional presence of hearing people's stories. The Ethnonursing method as defined by Leininger (1997) "focuses on naturalistic, open discoveries, and largely inductive modes to document, describe, explain, and interpret informants' worldview, meanings, symbols, and life experiences as they bear upon actual or potential nursing phenomena" (p. 42). The enablers developed by Leininger are guides to acquire general, yet detailed, in-depth knowledge. The goal of this framework covers multiple factors related to care patterns and expressions. According to Leininger (1997) "the Sunrise Model was developed as a conceptual holistic research guide and enabler to help researchers discover multiple dimensions related to the theoretical tenets of the Theory of Culture Care" (p. 40). Cultural assessments and

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enablers contributed to structure, focus, and encouragement to listen purposefully to individual's struggles.

The Sunrise Enabler Model was beneficial to this project. The factors of cultural values, beliefs and lifeways were lifted up, and stories were encouraged while engaged in intentional conversation. New understanding of how these factors affect health were becoming apparent. This allowed my conversation with the undocumented and uninsured to be more relaxed, informal, personal, and engaging. There was so much more to the interaction of the emic (insider) and etic (outsider) view. There was a mutuality to our relationship. These individuals became my brothers and sisters. Within the Sunrise Enabler are three decision actions that provide culturally sensitive and person inclusive nursing care. The first is "Culture Care Preservation/Maintenance" (Leininger, 1997 p. 38). This action supports what the person is currently doing to maintain health, healing and well-being. This fit well with the project because nursing was supporting what practices were meaningful for one's health. Nursing did not need to change anything. That alone was revolutionary. The second action was "Culture Care Accommodation/Negotiation" (p. 38). This action allows the client and nurse a co-partnership for the health practices of the other and respectful conversation guiding nursing practice recommendations. The third action was "Culture Care Repatterning/Restructuring" (p. 38). This action is guided by the nurses understanding of cultural beliefs, values, and lifeways and the multitude of factors that affect meaning to one's health.

The Stranger-to-Trusted-Friend Enabler was relevant to this project. This enabler encouraged the nurse to reflect on one's own behavior and feelings. This was extremely insightful and helpful as people shared stories of cultural health practices and of pain and suffering of living in the margins of our society. Listening, being mindful, and being fully

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present has taken time to learn. Being with the marginalized on a regular basis has encouraged a more thoughtful, listening, understanding presence within myself. This is important learning for all caregivers as they work with persons from cultures previously unfamiliar and illegible.

Nurses interface with marginalized people in very different ways. According to Vasas (2005) “nursing uses the concept of marginalization to refer to an abstract process; one that results in certain people having limited access to social power, being barred from physical or nonphysical resources, and being subject to differential treatment” (p. 195). Farmer (2013) has remarked that the poor are a consequence of our making and we are answerable for them. One can’t understand the marginalized without considering “who are the poor?” The poor is my neighbor, my sister and brother who have experienced inequality for reasons I may or cannot understand. Struggle has often been associated with marginalized peoples. Tuhiwai Smith (2012) has stated that “struggle is associated with psychological torture. Struggle is simply what life feels like when people are trying to survive in the margins” (p. 199). These thoughts have personalized, yet expanded my worldview of who are the struggling and that must include that their struggle becomes my struggle. I began to see others more similarly to myself than I had before. With this new knowledge, a deeper understanding as well as deeper compassion emerged. According to Farmer and Gutierrez (2013) “understanding poverty requires listening to those most affected by poverty, which is to say the poor and otherwise marginalized. Listening is also a significant part of accompaniment” (p. 20). Accompaniment as defined by Merriam-Webster (2015) is intended to give completeness. As stated by Farmer and Gutierrez (2013) “as long as poverty and inequality persist, as long as people are wounded and imprisoned and despised, we humans will need accompaniment-practical, spiritual, intellectual” (p. 24). I have begun to see individuals as just that. *They are no longer sick patients needing me to fix them.*

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They are more like me than different from me. Their suffering is my suffering. We are connected and need to journey this time in life together to find our mutuality.

A conceptual nursing model that expresses this project is in the form of a Mandala (see Appendix A). The word Mandala means circle. According to Webster (2016) a Hindu or Buddhist graphic symbol of the universe; specifically: a circle enclosing a square with a deity on each side that is used chiefly as an aid in meditation. Circles appear in nature (flowers, sun, and earth) and are also powerful symbols in different cultures throughout the world. Mandalas are used to aid in meditation and are used in sacred rites as a transformative tool to promote healing. Circles are believed to help people focus inward. The circle is a symbol of wholeness, connection, unity, and harmony, and the cycle of life. This conceptual model lifts up the concepts of honoring others who are marginalized, through accompaniment, caring, and culture care.

The outer ring represents the Sunrise Enabler and the worldview that is essential for advanced practice nurses. It is yellow to represent the sun, but the color yellow also represents mental clarity, learning and wisdom. The circle (or petals) in green represent the Public Health Interventions of the individual, the community and systems. The color green was chosen to represent healing, nature and the environment. The orange circle represents the four primary concepts that were chosen for this project. The color orange was chosen for transformation, reflection and self-awareness. The red center circle has been changed to a heart. The color red represents the heart and soul of nursing strength, purpose and passion. Together, each of these concepts plays a significant role in the interconnected circle of the Mandala. Transcultural nurse leaders must lift up each of the components to address concerns surrounding marginalization through the knowledge of culture care, our caring, accompaniment, and live by honoring others.

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Implications for Advancing Nursing Practice

Health care is a right for everyone. This project began as an opportunity to advocate for the uninsured, those struggling in the margins, and those misunderstood. It was seen as an ethical, health disparity, and social justice issue. The change that occurred over the time of this project was more exciting than I could have imagined. Discovering Francisco's plight was extremely enlightening. Once the data was gathered, it was an obvious next step to bring the other healthcare providers together. We were basically unknown to each other. However, a collective partnership grew quickly. Once we discovered what each of us did independently, there was commitment to work collaboratively. The safety net providers developed a grid which was a great visual that showed our individual strengths and gaps, and brought working together a natural next step. We committed to each other for the benefit of the community and individuals needing our collective wisdom. We did what was best and organized ourselves so to not overlap service delivery. We promoted each other service based on days when the organization was open. We developed an internal form to be able to expedite services for individuals. We improved the complex navigation process in our community. This project benefitted practice outcomes through commitment and partnership collaboration. The change that occurred for the partners was the development of a universal referral form. This was a praxis approach and intentionally designed to improve the client experience. We walked alongside these individuals to ensure they got to the appropriate healthcare provider. Most recently, the conceptual model was shared with the Scott County Public Health Department. Their comments were affirming: "the model clearly describes the complexity of what we do as PHN's". The staff have requested the model be incorporated into their daily practice.

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The work of Dr. Leininger (1997) guided new, worldview thinking. The concepts of culture care, caring, accompaniment, and honoring others have stimulated critical analysis of social, cultural, and current circumstances to innovative meaning and understanding at a broader, deeper level.

According to Chinn and Kramer (2008) “best practices in nursing are those that arise from praxis-critical reflection and action to change what has been in the past and to create a future that you want to create” (p. 2). Chinn and Kramer (2008) state that “Emancipatory knowing requires an understanding of the nature in which knowledge itself, or what is taken to be knowledge, contributes to larger social problems” (p. 5). Critical reflection and wanting to change current practice lead to this project. Being grounded in both clinical and public health practice has allowed me to be able to see through other ways of knowing. Advanced nursing practice education has helped bring understanding of a much broader worldview and paradigm of nursing. The conceptual model is inclusive of the four concepts of culture care, caring, accompaniment, and honoring others expresses absolute interconnectedness for my nursing practice. Inclusion of emancipatory knowledge is advanced nursing practice and involves ongoing reflection, action, and desire to seek out worldview change opportunities of health for all. Emancipatory knowledge has never been more important than now.

This project began with a social justice issue that was intended to be advanced through advocacy beginning at the community level. Through exploring the literature and listening to stories of others lived experiences, I increased knowledge of how illegibility, problematic, and structural violence belong to some and can produce unintentionality. The understanding has brought new awareness and appreciation of the advanced nursing’s practice worldview of health

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and healthcare from a transcultural perspective. The next chapter will describe the evaluation process, insights gained, and how my vision changed after the project.

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Chapter Four: Evaluation and Personal Reflection of the Practice Project

~~Extending healthcare access to all people, including the undocumented and underserved~~ populations is beneficial for society. I identified the health disparity of unequal access for healthcare in Scott County. I reached out to the safety net providers in the county to discuss a person that had been seen by all safety net providers and yet did not have an adequate plan of care for his infectious disease. Together we began a journey of exploring how to improve care for our community, increase awareness of individual services, explore the opportunity of collaboration for improving the client experience, and determine best practice standards with our limited resources for our community. This chapter will discuss the outcomes of the changes made as a public health department and the safety net healthcare providers for Scott County.

As the safety net providers discussed their strengths, the Scott County Public Health immunization clinic was lifted up as being the most efficient and appropriate resource for immunization access among the partners. This clinic is staffed by the same public health nurses that support the mobile health unit. According to Nandi, Loue, and Galea (2009) “limited access to basic preventative measures among the undocumented immigrants, such as immunizations, may increase the proportion of individuals to particular susceptible disease in the population. Additionally, restricted access to testing may increase the proportion of infected individuals in the population by increasing the probability that persons unaware that they are infected come in contact with susceptible individuals” (p. 435). With new knowledge within the safety net providers, people like Francisco will receive needed services in a timely and appropriate place.

Healthcare reform continues to morph, change, and expand. Those seeking to enter this complex system often find themselves overwhelmed and unable to gain access. Fuentes-Afflick and Hessol (2009) state that “immigration status has been associated with health insurance status

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and access to healthcare. Reported barriers to care include written and spoken language, such legal issues as being undocumented, lack of familiarity in applying for and enrolling in public insurance, fear of payment for services, and long waiting times at healthcare settings” (p. 1275). St. Mary’s Clinics now provides a navigator to assist those with this challenging process. This has streamlined the practice for acquiring insurance in a timelier manner. The referral form utilized by all safety net providers allows for one-on-one assistance to complete the multipage insurance form in multiple different languages with multilingual navigators.

Since the inception of the client referral form that was developed to improve client experience and communication between safety net providers, fifty four clients from the mobile health unit have had inclusive decision making by the client themselves. The mobile health unit and the River Valley Nursing Center have utilized each other for ongoing care needs of clients. PHN’s provide nursing assessment, education, monitor health conditions, offer ongoing support, assist with resource needs, and always include time for conversation. The services are scheduled on different days and different locations to provide flexibility and accommodate the community. The mobile health unit has access to basic labs which the River Valley Nursing Center does not. Blood sugars, hemoglobin and cholesterol are examples of blood draws available for individuals. The mobile health unit is sharing this equipment with the River Valley Nursing Center and in exchange the River Valley Nursing Center is purchasing the lab strips for the tests from the mobile health unit. This is another example of new and innovative collaboration of shared scarce resources.

The emergency room states that they too have seen a change since the collaboration began. They are seeing less use for generalized medical care. One of the implementation efforts has been to have a financial worker as part of the emergency room team members. By doing this,

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financial workers have been able to determine financial eligibility sometimes within one day.

However, over the last year the emergency room practitioners have seen an increase in domestic violence, chemical dependency issues as well as severe and persistent mental illness (B Gabor, personal communication, April 6th, 2016). They are currently gathering data to support these changes in emergency room usage.

The safety net providers have gained respect for each other's strengths and challenges, and have collectively committed to work together in a whole new way that will enhance and personalize the client experience and create opportunities to continue to work together. There will always be unfinished business in healthcare. I think the cohesiveness and collective commitment is commendable and an example of the caring spirit these healthcare professionals have for honoring those in the margins of Scott County. Although the safety net providers have not met for the last year, there is new interest to reestablish momentum from where they left off. They have just scheduled monthly meetings over the next year.

What is left undone at this point is the collective voice of the safety net providers to discuss with healthcare policy makers the accomplishments of the safety net providers to date. But that is not enough. Berlinger and Raghavan (2013) state "even as we turn serious attention to immigration reform, this puts the burden of caring for the undocumented entirely on the shoulders of clinicians and the organizations in which they work. Forcing healthcare professionals into ethical dilemmas and moral distress should not be an option for our society. Policy makers should resist the temptation to shift our national responsibility to individuals and organizations and instead seek guidance from those experienced in meeting the health care needs of their undocumented patients" (p. 16). The safety net providers have many client stories and creative and innovative collaboration to share.

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There are still those in the margins, invisible, suffering and in need of the total healthcare system to acknowledge, respect, plan for inclusiveness in ones' own care, and lead the way for other healthcare systems to join them in providing healthcare for all. According to Ruis-Casares et al. (2013) "whatever their roles, medical/health care professionals have the responsibility to "work together, in their professional organizations, to convince decision-makers in government and elsewhere of the existence of unmet needs and advocate forcefully for the expansion of resources and changes in policies to meet patients' needs, both within their own countries and globally" (p. 296). This is the hard, ethical work yet to be resolved. The advanced practice nurse can be the courageous convener to expand thinking to be inclusive of all from a worldview vision.

I had the opportunity to present my scholarly work that began in 2013 to the Scott County public health PHN nursing staff. All PHN's were present as well as the Public Health Director. Following the presentation, there was applause and many comments. Nurses felt validated for the work that they do with their complex families. They appreciated the Sunrise Enabler but even more they seemed to resonate with the Stranger to Trusted Friend Enabler. They were able to articulate that trust takes time and that was reaffirming for them as well. They resonated with the conceptual model and asked to incorporate this model into their practice. They saw how the conceptual nursing model enhanced their current practice model of the PHN Intervention Wheel and commented that this conceptual model would be extremely beneficial for their practice, self-reflection and future care planning with clients.

What I learned immediately following the presentation was that the concepts that were presented were seen as outcomes of the nurses care practices. The nurses saw principles of mutuality, hospitality, and being a trusted friend in a safe place for client interactions. This

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appeared to be reaffirming and extremely positive. This information was presented in a new way for public health nurses. I feel that after more self-reflection, there will be additional opportunities to practice all four concepts in a more intentional, inclusive manner. The affirmations that I discovered were that the PHN's were inspired to improve their client's experience. The entire nursing staff appeared open to change and practice in innovative ways.

There were many measurable outcomes from this project. One hundred fifty individuals received necessary blood work screenings. The River Valley Nursing Center did not own this equipment and the mobile health unit began to share these services with them. Thirty five individuals received health resources through Project Community Connect, an annual resource center serving homeless individuals, because the safety net providers worked as a collaborative at this event. Thirty nine uninsured individuals received healthcare through public programs as the mobile health unit worked closely with St. Mary's clinics to secure permanent health access for the uninsured. The safety net providers coordinated seven library outreach events providing fifty individuals health insurance. Twenty four individuals were referred to the River Valley Nursing Center for ongoing chronic disease management as their center is open two times per week. One hundred plus individuals potentially avoided care from the highest cost health access- the emergency room.

My vision to advocate for healthcare access changed to incorporating concepts of culture care has enriched my personal transformation. I saw an issue of health inequity for those without insurance and planned to ensure a health care home for marginalized individuals. What I uncovered throughout this DNP program, was a new understanding to the worldview of others. I learned what culture care and caring really means to others. Learning to include others' values, beliefs, and lifeways is paramount to what others want for health and healing. Others are capable

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to manage their health and need nurses to understand and respect, and only when asked to ~~advocate on their behalf. We must listen intentionally for understanding as we co-journey with~~ others. This is the role of an advanced practice nurse.

A practice change occurred within the safety net partners as individual organizations but more importantly as a collective approach to caring for the most vulnerable. This collaborative work has brought awareness, insight, and practice change together serving the underserved. The safety net providers took brave and bold steps to see their strengths, share their individual challenges and together enhanced healthcare access for the benefit of those needing their care in an unequal healthcare system. The next chapter will provide the project conclusions, the meaning for advancing nursing practice, and a vision for the future.

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Chapter Five: Conclusions, Implications and Plans for Future

Practicing independently in an organization is one way to practice healthcare and often this is the accepted standard of practice. The four safety net providers in Scott County took a bold approach to work collectively to improve the client experience for the underserved and challenge the practice norm. They came from a variety of organizational and management structures. The safety net providers challenged the healthcare system as a whole to improve care and improve ethical care practices. Today the safety net providers practice differently, cooperatively, collaboratively, and collectively. This chapter explains what the safety net providers need to accomplish to continue to improve collaboration among themselves and advance the healthcare experience for individuals.

This collaborative effort continues to explore additional creative outreach ways to meet the underserved where they are at in seeking health and wellness. But, there remains more to do. The policymakers need an awareness of the collective process that the safety net providers have accomplished. According to Berlinger and Raghavan (2013) “ethics committees or grand rounds should offer opportunities to talk about this issue. These discussions should be facilitated to encourage expression of different perspectives. A future discussion with the decision makers is warranted to update the collaborative efforts of the safety net providers and the current outcomes. A well facilitated discussion process offers clinicians and administrators insight into the challenges, including which departments may bear greater responsibility for patient advocacy or feel forced to improvise to provide medically appropriate care. This process can also help hospital leaders become more informed, since they are responsible for protecting safety-net funding or investing in care for vulnerable populations” (p. 16).

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Things to consider for advancing this project include acknowledging the courage of the safety net providers to change practice by focusing on the strengths of others. The safety net providers allowed themselves to be vulnerable to their own challenges in the company of unfamiliar providers for the benefit of the underserved populations' experience. The providers and senior leadership as a partner should be encouraged to develop a work plan with measurable outcomes to contribute to best practice enhancement. The safety net providers must communicate collectively to the healthcare system leaders to describe the successes of their collaboration to date, the current challenges they continue to face, and the expectation of leadership to invest in the most vulnerable to finally create health equity for all. The referral form that has been created as an internal document should be expanded to additional partner agencies; school nurses, social workers, mental health workers, jail nurses, and the nurse navigators who work closely with individuals to solely help navigate the insurance process. The navigators speak many languages. The safety net providers have seen this work so well many times at the library outreach events. Lastly, a common documentation system (or electronic health record) that would complement health care systems would make connecting client information meaningful, efficient, person oriented, and improve communication for non-English speaking individuals.

Future projects need to begin with the question: What needs to change? How will you know you made a difference? What should be studied is: What does it mean to be marginalized? Whose voice should be heard? Whose needs do we want to meet? What is meant by accompaniment? How do we demonstrate honoring others? These questions and facilitation must be led by advance nurses practicing in transcultural nurse leadership because nurses at this level of practice discern the various *ways of knowing* (Chinn & Kramer, 2008), articulate the cultural

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stories, the lifeways of others, the struggles of the marginalized, and the qualitative and quantitative data validity. The discussion must include all the healthcare providers and senior administrators who are responsible for policy decisions if true awareness and opportunities for change are to occur. This is where *nursing's ways of knowing* becomes imperative. Chinn and Kramer (2008), states "what is conveyed in a nurse's actions is a simultaneous wholeness or whole of knowing that textbooks can never portray" (p. 4). Nurses practicing with a transcultural leadership focus have unique knowledge and a worldview of nursing. This knowledge will increase cultural awareness at the individual, community and systems level. This is imperative for today's practice. Our society has never been more diverse than it is today. Nurses knowledgeable of transcultural concepts can use their ways of knowing in an intentional and beneficial way with healthcare professionals and non-professionals to improve culture care, caring, accompaniment, and to honor others in the margins.

This DNP project contributed to my knowledge of new nursing approaches. My nursing approach to *ways of knowing* (Chinn & Kramer, 2008), validated previous nursing praxis, life experiences, nursing ethics, a passion for the profession of nursing, an awareness of a multitude of advanced nursing concepts, and a deep respect and practice application for the worldview contribution of Leininger's (1997) nursing theory. The emancipatory knowing of this nurse brought other caring professionals together to change a situation with the intent to improve the health, encourage the voice of the underserved and invisible, and accompany and honor all people.

This project began as advocacy for individuals from the role of the PHN and the PHN Intervention Wheel. Utilizing my leadership position, allowed me to reach beyond my organization and stretch to the community level and then to the systems level for advocacy.

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Recognizing not everyone had the same access to healthcare became my mission. Originally I ~~had hoped to find a permanent medical home for the undocumented.~~ I garnered support within Scott County Public Health and the four safety net providers within our county. This enlarged our focus to community. With perseverance, I was able to gather healthcare system leadership and this brought the project to the systems level. I thought I knew what people needed, and I was going to get access to healthcare for all. But, a shift came in my thinking during this project and through this DNP journey, I came to realize maybe not everyone wanted or needed our western medical way of health practice. I made a turn inward. I started listening to individuals and began discovering what they wanted. It was my turn to learn. Through the application of Leininger's (1997) theory, I learned individuals need to be respected for their own values, beliefs, and lifeways. Other literature taught me to accompany or walk with others on their health journey. The marginalized are not the *other*. They are my brothers and sisters. Advocacy today means something entirely different for me. The safety net providers continue to advocate for the marginalized and this is their good work for the community. I admire their strength to keep making a difference in the health of others.

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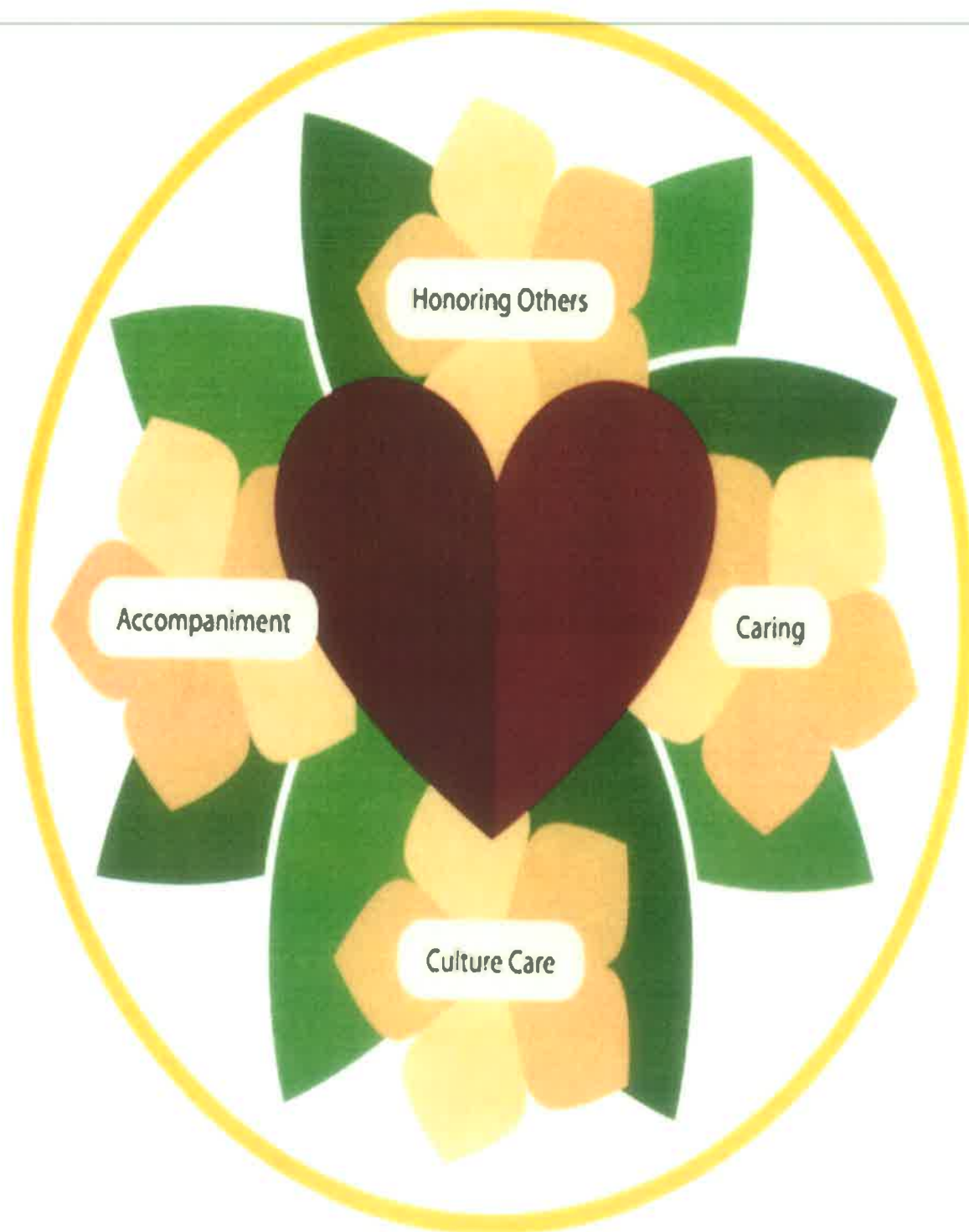
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Appendix A: Honoring Others



Honoring Others by Accompaniment

Merrilee Brown MA, RN
Augsburg College

Submitted in partial fulfillment of the requirement for the degree of
Doctor of Nursing Practice

Presentation Objectives

- Discuss DNP Project from Advocacy to Accompaniment for the uninsured in Scott County.
- Describe Scott County Public Health Services and Safety Net Providers.
- Examine collaboration among Safety Net Providers in Scott County.
- Apply Leininger's theory used to guide my project.
- Illustrate my conceptual nursing model.
- Summarize project outcomes.
- Explain application of project to advance nursing practice.
- Share an artistic expression of my transformation.

Project's Purpose

- Advocate for health care as a human right for the uninsured in Scott County.
- Identify services provided by four healthcare providers.
- Explore and uncover gaps in healthcare services.
- Develop a coordinated approach to healthcare services.
- Improve the individual experience for the uninsured.

Scott County as a Public Health Agency

Scott County Community Health Improvement Plan, 2015 - 2019

- Population
- Diversity
- Uninsured
- Health Issues



Francisco's Story

- Age 35
- Mexican resident
- Medicalization
- Misdiagnosed



My Journey Begins

- A collaboration with other safety net providers to uncover current practices.
- My goals were;
 - Explore strengths and gaps in services
 - Decrease duplication of services
 - Maximize limited resources
 - Improve the client experience



Safety Net Providers

- St. Mary's Clinics
- River Valley Nursing Center
- Mobile Health Unit
- St. Francis Regional Medical Center

St. Mary's Clinic



Providing health care services at no cost to low income, uninsured individuals and families in our communities

River Valley Nursing Center



Health Care Services and Community Resources

River Valley Nursing Center serves uninsured and under-insured people in Scott and Carver counties connecting them to local resources and free or low-cost health care services.

Mobile Health Unit



St. Francis Regional Medical Center



Health Care is a Right

- Advocate for Francisco.
- Collaborate with others.
- Look for opportunities.



My Journey Shifts

- Listen to the voices of the uninsured.
- Hear their story of struggle and their beliefs.
- Wanting someone to listen and accompany them.
- Caused me to pause

Listening

Strategy to Educate Decision Makers and Outcomes

- Educate Policy makers of need for Charity Care slots
- Shared Francisco's story
- Discussion occurred
- Outcomes



Nurse Theorist Dr. Madeleine Leininger

Culture Care Diversity and
Universality
(also known as Culture Care
theory).



Concepts

Culture Care-

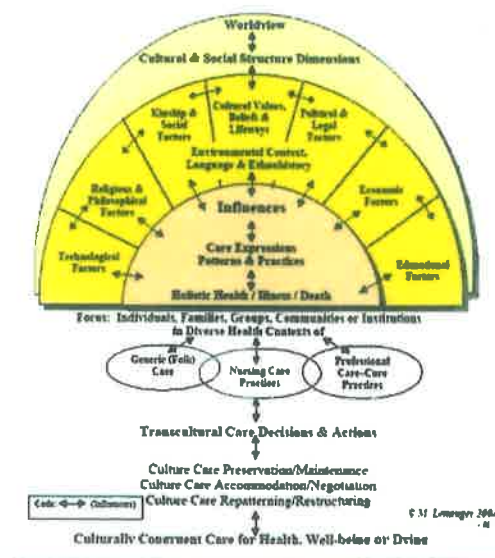
- **culturally appropriate and valuable for different or similar cultures based on research, respect, and communication. We may not understand the same language but there are many non verbal ways to express understanding (my definition).**

Caring-

- **a professional presence that speaks not necessarily with a spoken language but through presence, intentional listening, touch (if appropriate), and/or silence (my definition).**

Enablers Pertinent to this Project

- Culture care preservation/maintenance
- Culture care accommodation/negotiation
- Culture care repatterning/restructuring



Enablers Pertinent to this Project

- The Stranger-Friend Enabler guides the nurse to **gain insight of their own actions, feelings, and facts.**
- Nurses transition from being a **stranger to be trusted.**
- **Genuine presence.**
- Individuals become **willing to speak** to what they feel as important.

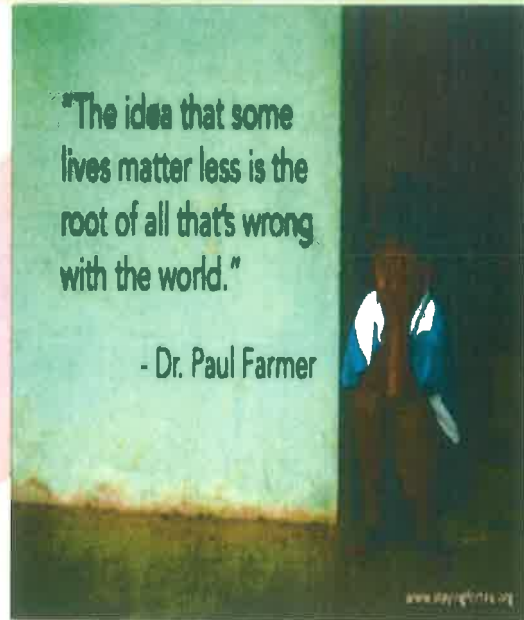


Concepts

- Accompaniment-
 - as long as poverty and inequality persist, as long as people are wounded and imprisoned and despised, we humans will need accompaniment- practical, spiritual, intellectual (Farmer 2013).
- Marginalization-
 - to Honoring others- the poor are a consequence of our making and we are answerable for them. One can't understand the marginalized without considering "who are the poor?" (Farmer 2013).

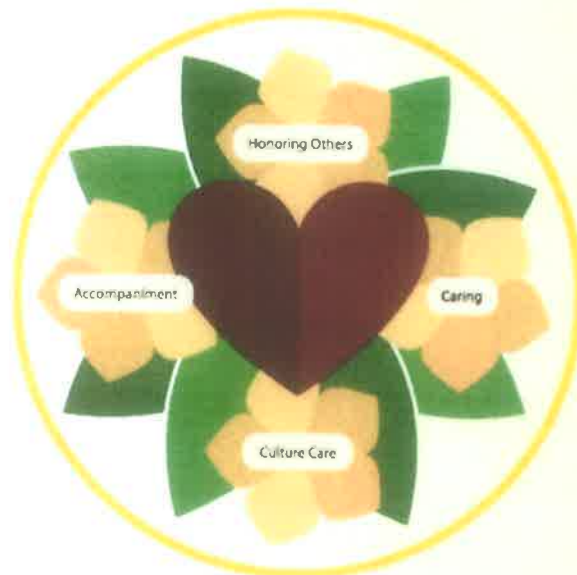
"The idea that some lives matter less is the root of all that's wrong with the world."

- Dr. Paul Farmer



Conceptual Nursing Model

- Mandala
- Sunrise Enabler
- PHN Intervention wheel
- Concepts related to project



Outcomes of Accompaniment

(Safety Net Provider data over 18 months)

- 150 individuals received necessary labs due to sharing resources.
- 35 individuals received health resources through Project Community Connect.
- 39 uninsured individuals received healthcare through public programs.
- 7 library outreach events provided 50 individuals insurance.
- 24 individuals were referred to RVNC for ongoing chronic disease management and wellness resources.
- 100 plus individuals potentially avoided care from the emergency room.

Current Status of Safety Net Collaboration

- Safety Net Providers had a one year hiatus from meeting.
- Moving forward they have reestablished regular meetings.
- Recently presented to Families and Individuals Sharing Hope (FISH).
- Outreach to Community Action Partnership (CAP), Scott County mental health center and food shelves in Scott County.



Advancing Nursing Practice

- Presentation given to Scott County Public Health Nurses
- Being fully present **and listening respects others** lifeways.
- Nursing model integrated into practice.
- Collaboration improves practice and the client experience
- Service efficiently and effectively reduces redundancy.
- Emancipatory Knowing

My personal transformation



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