

NHMA 26th Annual Conference

Workshop B3: Medical Education/Cultural Competence – CME

Friday, April 28th 2:15pm - 3:15pm CT

Toronto (Ballroom Level) | Hyatt Regency Chicago | Supported by J & J



Judith Flores, MD, FAAP, CHCQM
Moderator
Clinician/Consultant



Enrique Cazares-Navarro, MS
MS3, Michigan State University College of
Medicine
*Development & Evaluation of a Case Based Medical Medical
Spanish Curriculum for First and Second Year Medical Students*



Lucille Torres-Deas, MD, FACP
Associate Professor, Department of Medicine Director,
A.C.N. Internal Medicine Primary Care Sites, West, Co-
Chair, Diversity, Equity, Inclusion - Division of Internal
Medicine, Allen, Columbia University Irving Medical
Center/New York-Presbyterian
*Integrating Health Justice into the Biopsychosocial-Spiritual
Model to Promote Well-being & Belonging*



Aldana Julia Garcia, MS
MS3, Michigan State University College of
Medicine
*Development & Evaluation of a Case Based Medical Medical
Spanish Curriculum for First and Second Year Medical Students*

Joint Accreditation Statement



In support of improving patient care, this activity has been planned and implemented by Amedco LLC and National Hispanic Medical Association. Amedco LLC is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Physicians (ACCME) Credit Designation

Amedco LLC designates this live activity for a maximum of 16.00 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.



Learner Notification

**National Hispanic Medical Association
2023 LIVE NHMA 26th National Conference
April 27, 2023 - April 30, 2023
Chicago, IL**

Acknowledgement of Financial Commercial Support

No financial commercial support was received for this educational activity.

Acknowledgement of In-Kind Commercial Support

No in-kind commercial support was received for this educational activity.

Satisfactory Completion

Learners must complete an evaluation form to receive a certificate of completion. You must attend the entire webinar as partial credit is not available. If you are seeking continuing education credit for a specialty not listed below, it is your responsibility to contact your licensing/certification board to determine course eligibility for your licensing/certification requirement.

Accreditation Statement



JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

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Amedco Joint Accreditation Provider Number: 4008163

Physicians (ACCME) Credit Designation

Amedco LLC designates this live activity for a maximum of 16.00 AMA PRA Category 1 Credits™ for physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Objectives - After Attending This Program You Should Be Able To

1. Describe how healthcare innovations and policies influence outcomes of medical care delivery to be more effective in increasing access to care, quality, and value-based physical and mental healthcare.
2. Review clinical research focusing on knowledge related to Hispanics that show promise of eliminating health disparities.
3. Explain new vaccines, other prevention and treatment modalities, and strategies to educate Hispanic patients and families about COVID-19, heart disease, diabetes, cancer, obesity, asthma, depression, Alzheimer's disease, and HIV/AIDS in order to decrease morbidity and mortality among Hispanics.
4. Identify cultural competence, literacy, and messages targeted to Hispanics to increase access and compliance with healthcare.
5. Describe how to develop a partnership between NHMA and medical education through leadership and diversity, equity, and inclusion efforts at all levels

Disclosure of Conflict of Interest

The following table of disclosure information is provided to learners and contains the relevant financial relationships that each individual in a position to control the content disclosed to Amedco. All of these relationships were treated as a conflict of interest, and have been resolved. (C7 SCS 6.1-6.2, 6.5) All individuals in a position to control the content of CE are listed in the program book. If their name is not listed below, they disclosed that they had no financial relationships with a commercial interest.

Development and Evaluation of a Case-Based Medical Spanish Curriculum for First- and Second-Year Medical Students

Enrique Cazares-Navarro, BS, MS; Aldana Garcia, BS
NHMA 26th Annual Conference
Medical Education/Cultural Competence Series
Chicago, IL
April 28th, 2023



Objectives



Background



Methodology



Results



Conclusions



Acknowledgements

We have no financial disclosure or conflicts of interest with the presented material in this presentation.

Background

PERSPECTIVE

Open Access

Strategies for Teaching Linguistic Preparedness for Physicians: Medical Spanish and Global Linguistic Competence in Undergraduate Medical Education

Pilar Ortega,^{1,2,*} Norma Pérez,³ Brenda Robles,⁴ Yumirle Turmelle,⁵ and David Acosta⁶

Abstract

In accordance with Liaison Committee on Medical Education (LCME) curriculum content standards, medical schools are expected to teach physician communication skills and cultural competence. Given the sustained U.S. Spanish-speaking population growth, importance of language in diagnosis, and benefits of patient–physician language concordance, addressing LCME standards equitably should involve linguistic preparedness education. The authors present strategies for implementation of linguistic preparedness education in medical schools by discussing (1) examples of institutional approaches to dedicated medical Spanish courses that meet best practice guidelines and (2) a partnership model with medical interpreters to implement integrated global linguistic competencies in undergraduate medical curricula.

Keywords: language concordance; medical Spanish; patient-physician communication; Hispanic/Latino health; linguistic proficiency; medical interpreters; clinical communication skills

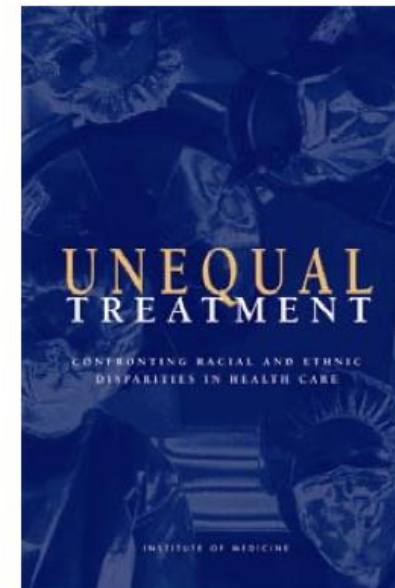
**Ortega P, Pérez N, Robles B, et al. Strategies for teaching linguistic preparedness for physicians: medical Spanish and global linguistic competence in undergraduate medical education. Health Equity. 2019;3: 312–318.*

March 2002

INSTITUTE OF MEDICINE

Shaping the Future for Health

UNEQUAL TREATMENT: WHAT HEALTHCARE PROVIDERS NEED TO KNOW ABOUT RACIAL AND ETHNIC DISPARITIES IN HEALTH- CARE



News accounts of the state of healthcare delivery seem to be full of bad news, including concerns about rising healthcare costs, patient safety and medical errors, and the growing numbers of uninsured Americans. To add to these

**Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: The National Academies Press, 2003. https://www.nap.edu/resource/10260/disparities_providers.pdf*

Table 2.

Population by Race and Hispanic Origin: 2014 and 2060

(Population in thousands)

Race and Hispanic origin ¹	2014		2060		Change, 2014 to 2060	
	Number	Percent	Number	Percent	Number	Percent
Total population	318,748	100.0	416,795	100.0	98,047	30.8
One Race	310,753	97.5	390,772	93.8	80,020	25.8
White	246,940	77.5	285,314	68.5	38,374	15.5
Non-Hispanic White	198,103	62.2	181,930	43.6	-16,174	-8.2
Black or African American	42,039	13.2	59,693	14.3	17,654	42.0
American Indian and Alaska Native	3,957	1.2	5,607	1.3	1,650	41.7
Asian	17,083	5.4	38,965	9.3	21,882	128.1
Native Hawaiian and Other Pacific Islander	734	0.2	1,194	0.3	460	62.6
Two or More Races	7,995	2.5	26,022	6.2	18,027	225.5
Race Alone or in Combination²						
White	254,009	79.7	309,567	74.3	55,558	21.9
Black or African American	45,562	14.3	74,530	17.9	28,968	63.6
American Indian and Alaska Native	6,528	2.0	10,169	2.4	3,640	55.8
Asian	19,983	6.3	48,575	11.7	28,592	143.1
Native Hawaiian and Other Pacific Islander	1,458	0.5	2,929	0.7	1,470	100.8
Hispanic or Latino Origin						
Hispanic	55,410	17.4	119,044	28.6	63,635	114.8
Not Hispanic	263,338	82.6	297,750	71.4	34,412	13.1

¹ Hispanic origin is considered an ethnicity, not a race. Hispanics may be of any race. Responses of "Some Other Race" from the 2010 Census are modified. For more information, see <www.census.gov/popest/data/historical/files/MRSF-01-US1.pdf>.

²"In combination" means in combination with one or more other races. The sum of the five race groups adds to more than the total population, and 100 percent, because individuals may report more than one race.

Source: U.S. Census Bureau, 2014 National Projections.

Medical Spanish Elective Curriculum

Session #	Topic
1	<u>Foundation</u> : Introductions, conversational topics, HPI, review of systems, past medical history, surgical history, social history, family history, allergies, medications, and organ systems led by Dr. Aramburu. Health maintenance case with spanish-speaking standardized patients
2	<u>Clinical Scenarios</u> : Hypertension and diabetes led by Dr. Aramburu. New onset diabetes case with spanish-speaking standardized patients
3	<u>Clinical Scenarios</u> : Abdominal pain and respiratory complaints led by Dr. Peterson. Gastritis case with spanish-speaking standardized patients
4	<u>Clinical Scenarios</u> : Women's health led by Dr. Romero. Polycystic Ovarian Syndrome case with spanish-speaking standardized patients
5	<u>Clinical Scenarios</u> : Mental health and musculoskeletal led by Dr. Bierema. Depression case with spanish-speaking standardized patients
6	<u>Final Oral Assessment</u> : New onset diabetes case was used as assessment tool with spanish-speaking standardized patients

Patient Information

Patient Name: Micaela/Michael Rodriguez

Setting: PCP Office

Case: M. Rodriguez is here for a chief complaint of epigastric abdominal pain for the past four months.

Vitals:

RR	14 per minute
HR	60 bpm
BP	121/78 mmHg (left arm, sitting)
Temp	98.5 F
BMI	20

Student Tasks:

1. You have 15 minutes during this encounter
2. Introduce yourself to the patient
3. Perform a focused history including HPI, PMH, FHx, SHx, allergies, and medications
4. Review of systems (cardio, endocrine, respiratory, neuro, gastrointestinal, etc.)
5. Explain the treatment/management plan.

Standardized Patients Recruitment & Training

FINAL ORAL ASSESSMENT CHECKLIST

Medical Student Name:	YES	NO
Student introduces self and identifies role		
Used open-ended questions to initiate history		
Addressed psychosocial component of visit		
Engaged scenario with cultural sensitivity		
Summarized and checked for accuracy		
Elicited Past Medical History (Major illnesses, surgical history)		
Elicited medications (name, dosage, and frequency)		
Elicited allergies		
Elicited family history		
Elicited social history (relationships, living situation, occupation, drugs, alcohol use, smoking history, sexual history, last menstrual period, pregnancies, abortions, occupational/environmental exposures)		
Elicited review of systems		
Summarized and shared next steps		
Asked questions at a comfortable pace		
Showed effort and patience throughout the encounter		
Overall Score (Need to score 6/14 to receive full credit for assessment)		
Evaluator Name:		
Evaluator Comments:		

Results

Demographics (n = 28)

Gender

Taken a high school level Spanish language course

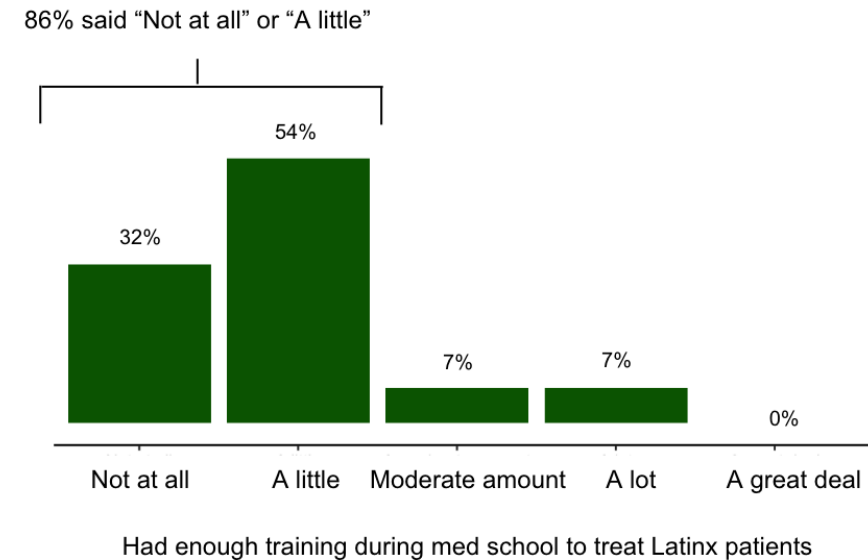
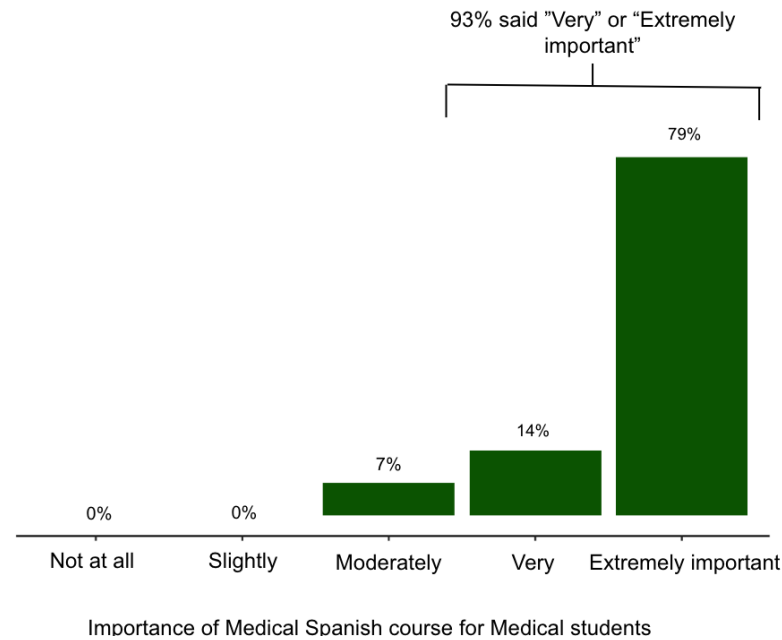
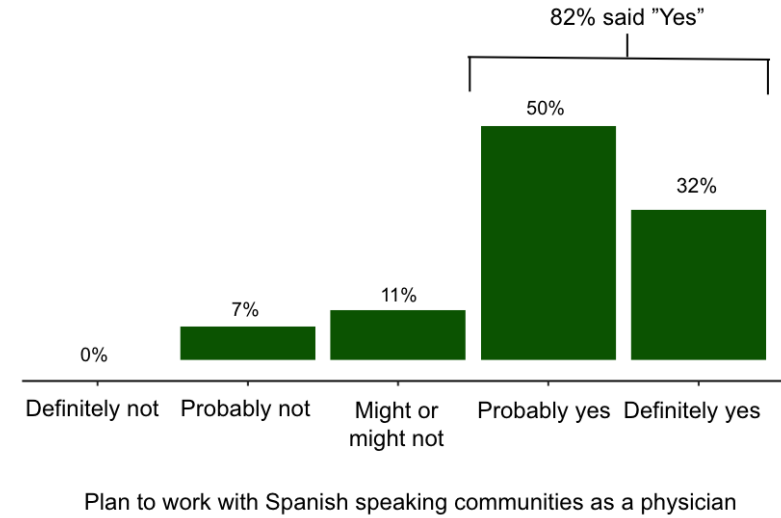
Race

Taken a college level Spanish language course

Ethnicity

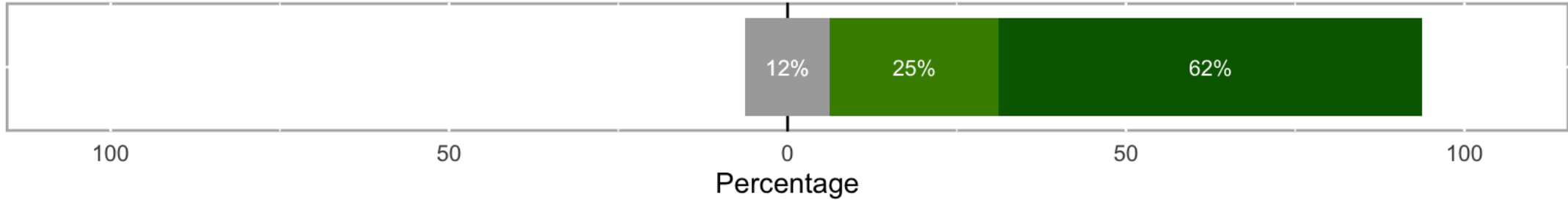
Taken any Spanish language course outside of high school or college

Student's Perceived Curricular Needs (n = 28)



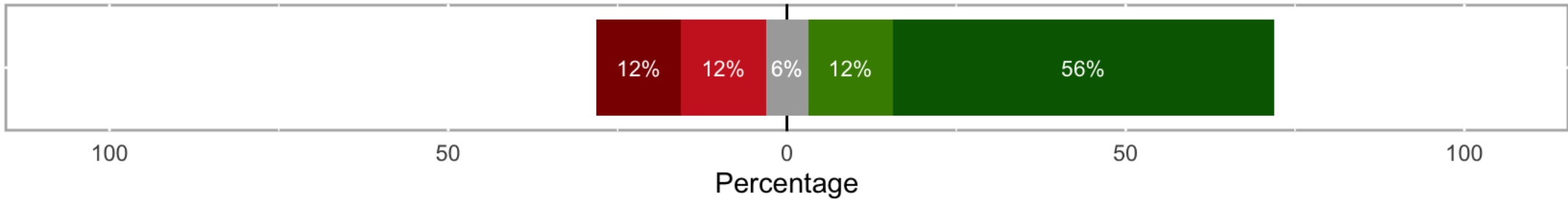
Student's Perceived Course Effectiveness (n = 16)

Satisfaction with the chief complaints discussed during the course



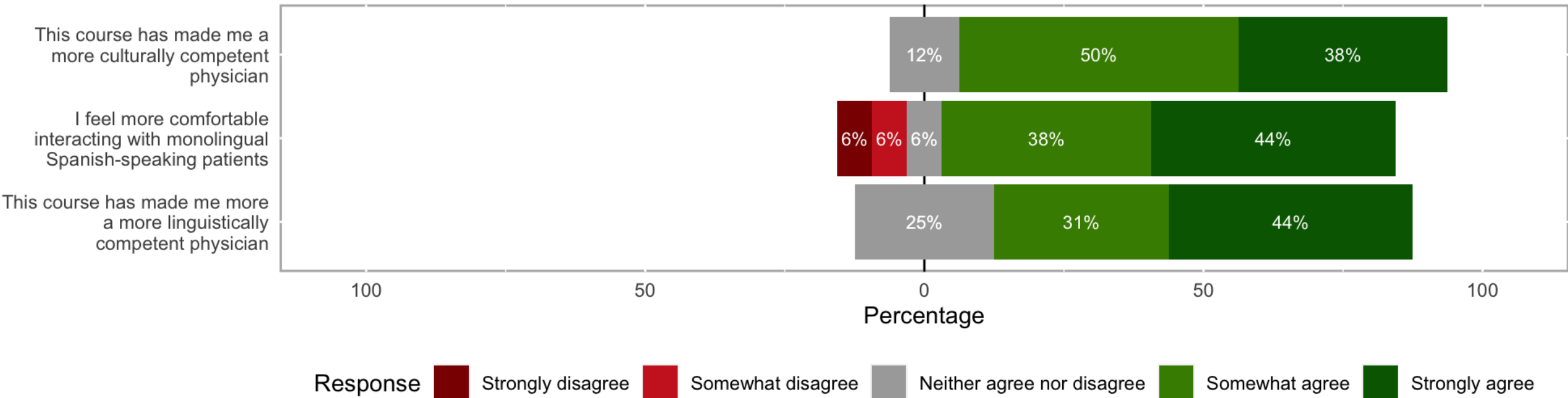
Extremely dissatisfied Somewhat dissatisfied Neither satisfied nor dissatisfied Somewhat satisfied Extremely satisfied

Likelihood of recommending elective to colleagues



Extremely unlikely Somewhat unlikely Neither likely nor unlikely Somewhat likely Extremely likely

Student's Perceived Course Effectiveness (n = 16)



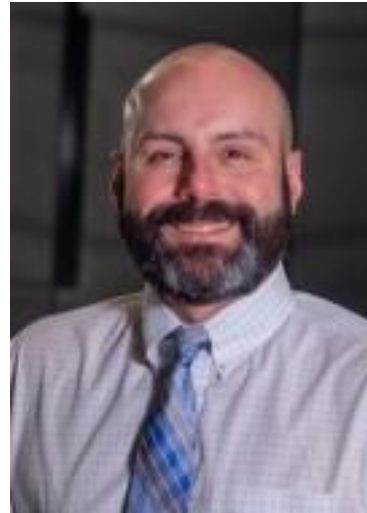
Conclusions

STRENGTHS

**TAKEAWAYS
FOR FUTURE
COURSES**

NEXT STEPS

Acknowledgements



College of Human Medicine
MICHIGAN STATE UNIVERSITY

References

1. Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: The National Academies Press, 2003. https://www.nap.edu/resource/10260/disparities_providers.pdf
2. Morales, R., Rodriguez, L., Singh, A. et al. National Survey of Medical Spanish Curriculum in U.S. Medical Schools. J GEN INTERN MED 30, 1434–1439 (2015). <https://doi.org/10.1007/s11606-015-3309-3>
3. Ortega P, Park YS, Girotti JA. Evaluation of a Medical Spanish Elective for Senior Medical Students: Improving Outcomes through OSCE Assessments. Med Sci Educ. 2017 Jun;27(2):329-337. doi: 10.1007/s40670-017-0405-5. Epub 2017 Mar 27. PMID: 29910972; PMCID: PMC5998671.
4. Ortega P, Pérez N, Robles B, et al. Strategies for teaching linguistic preparedness for physicians: medical Spanish and global linguistic competence in undergraduate medical education. Health Equity. 2019;3: 312–318.
5. Sadanand A, Ryan MH, Cohen S, Ryan MS. Development of a Medical Spanish Curriculum for Fourth-Year Medical Students. PRIMER. 2018;2:17. <https://doi.org/10.22454/PRIMER.2018.738688>
6. U.S. Census Bureau. (2020). Retrieved from: <https://www.census.gov/library/stories/2021/08/improved-race-ethnicity-measures-reveal-united-states-population-much-more-multiracial.html>
7. Colby S, Ortman JM. Projections of the Size and Composition of the U.S. Population: 2014 to 2060. Population Estimates and Projections. Current Population Reports. P25-1143. 2015
8. Ortega P, Perez N, Robles B, Turmelle Y, Acosta D. Teaching Medical Spanish to Improve Population Health: Evidence for Incorporating Language Education and Assessment in U.S. Medical Schools. Review. Health Equity. 2019;3(1):557-566. doi:https://dx.doi.org/10.1089/heq.2019.0028
9. Timmins CL. The impact of language barriers on the health care of Latinos in the United States: a review of the literature and guidelines for practice. J Midwifery Womens Health. 2002;47(2):80-96. doi:10.1016/s1526-9523(02)00218-0



Enrique Cazares-Navarro

Aldana Garcia

cazarese@msu.edu

garci560@msu.edu

Thank you!

Integrating Health Justice into the Biopsychosocial-Spiritual Model to Promote Well-being

Lucille M. Torres-Deas, MD, FACP

Associate Professor, Department of Medicine - CUIMC
Director, A.C.N. Internal Medicine Primary Care Sites
Director, A.C.N. IM Community & Population Health
NYP - West/Allen

 National Hispanic Medical Association Conference 2023

April 28, 2023

**AMAZING
THINGS
ARE
HAPPENING
HERE**

Disclosure

No Financial Disclosure



Full disclosure, perspective of:

Latina

From Humble Beginnings

Objectives

- Define the concepts of Biopsychosocial-Spiritual Model and Spirituality
- List three methods to integrate the model into everyday clinical practice in order to promote Wellbeing for patients
- List three methods to integrate the model into medicine in order to promote Wellbeing & Belonging for Latinx students, residents, and faculty



Is It Time to More Fully Address Teaching Religion and Spirituality in Medicine?

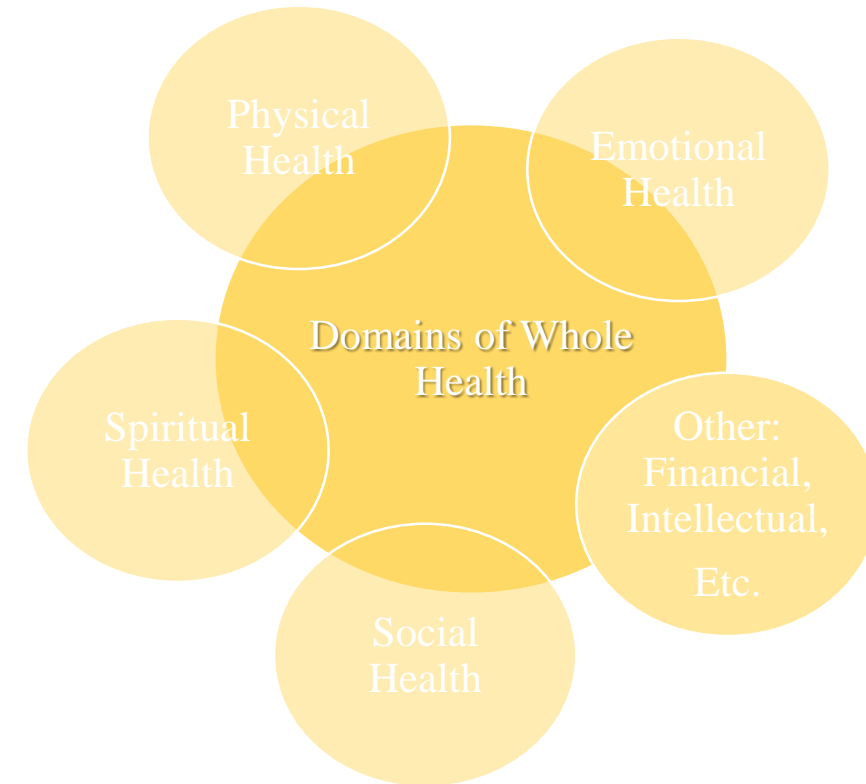
Kristin M. Collier, MD; Cornelius A. James, MD; Sanjay Saint, MD, MPH; and Joel D. Howell, MD, PhD

These professional organizations stated that it is the responsibility of all clinicians to attend to the physical, psychosocial and spiritual suffering as well as physical pain:

- Association of American Medical Colleges, 1999
- American Medical Association, 2001
- American College of Physicians, 2004
- International Council of Nursing, and the American Association of Colleges of Nurse, 2005
- JCAHO, 2010
- Liaison Committee on Medical Education
 - » Created a curriculum on spirituality

Whole Person Care Models

- Tournier: The Whole Person in a Broken World, 1964
- Saunders: Bio-Psycho-Social Spiritual, 1972 (“Total Pain”)
- *Engel: The Biopsychosocial Model of Care, 1977
- Puchalski and Ferrell: Whole Person Care Clinical Guideline, 2009
 - Using Biopsychosocial-Spiritual Model for palliative care
 - Spiritual care as respectful care, honoring diversity
- Puchalski: International Guidelines for Whole Person Care, 2014
 - Using Biopsychosocial-Spiritual Model for all patients



Model of Spirituality & Compassion

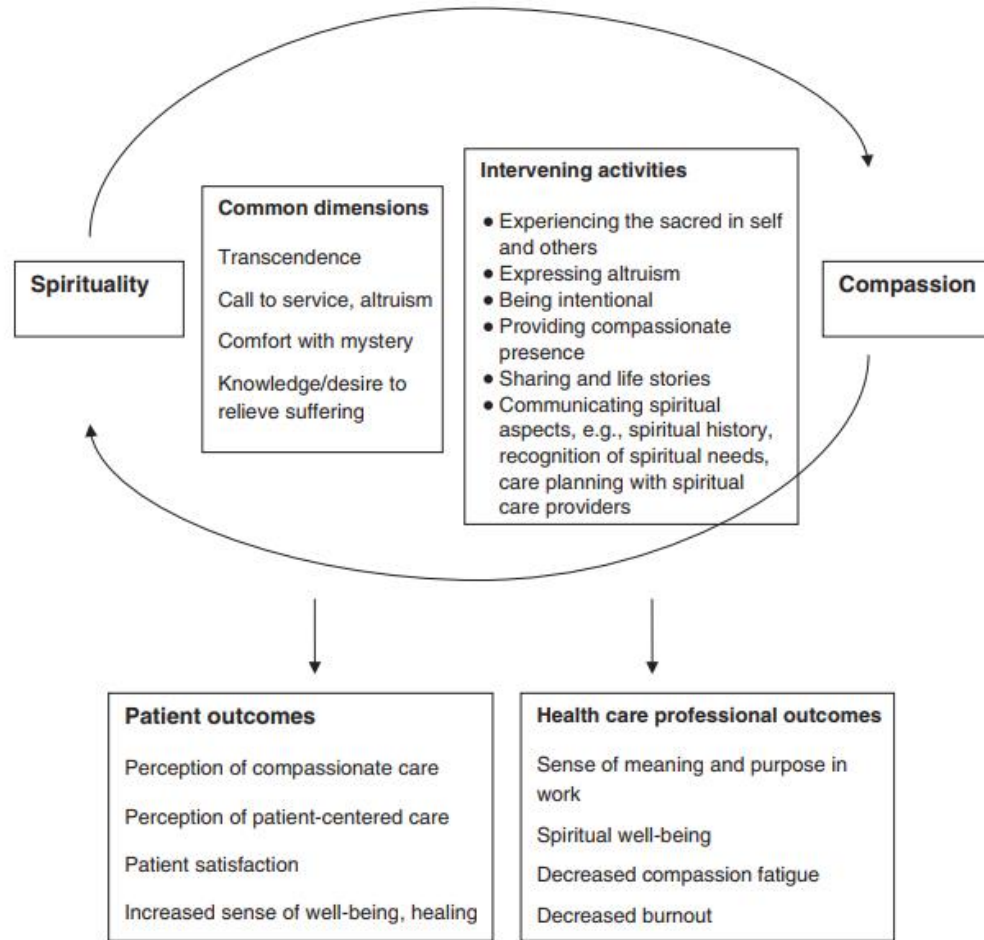
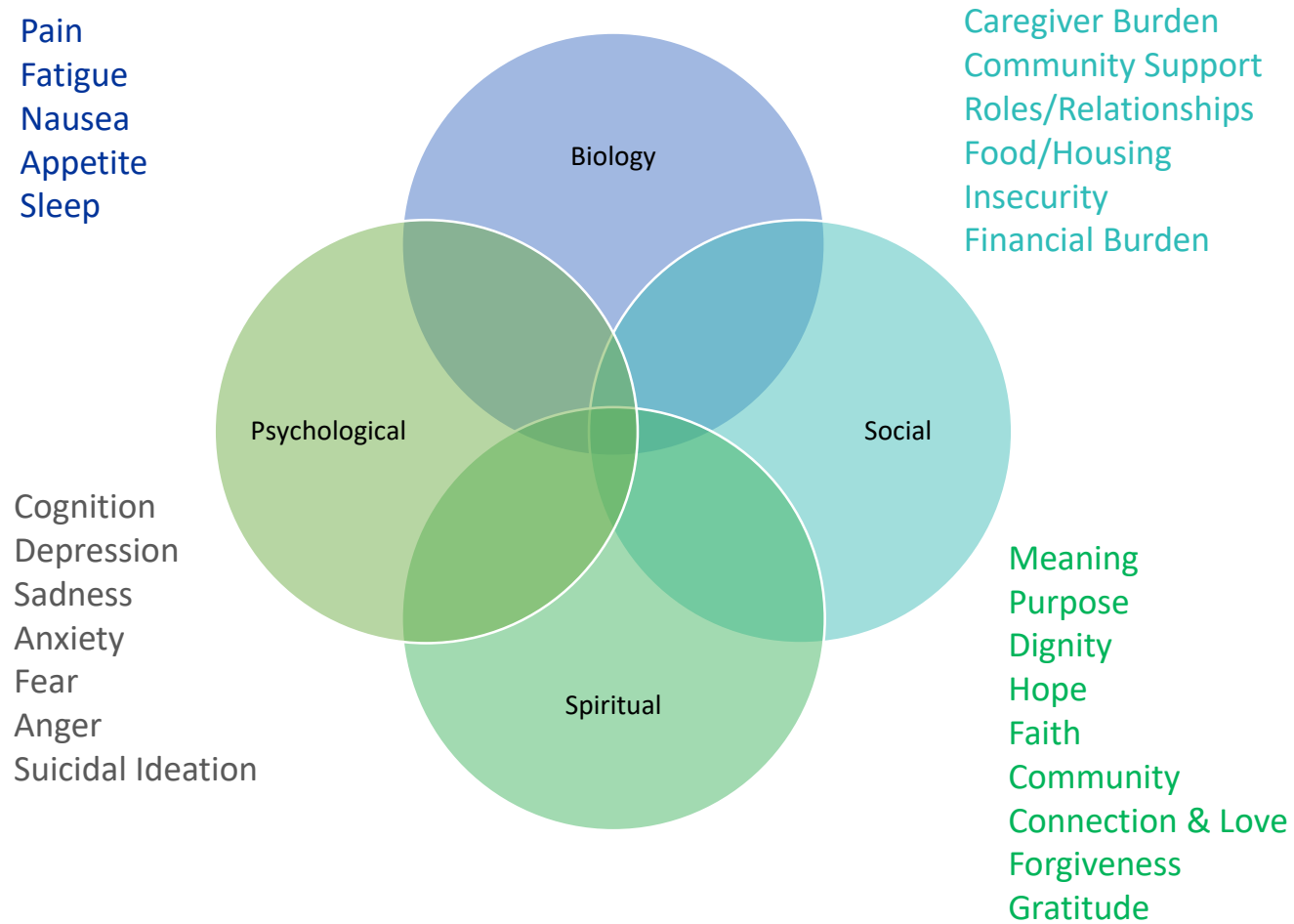


FIG. 1. Model of spirituality and compassion.³³

The Biopsychosocial-Spiritual Model



The biopsychosocial-spiritual model assumes the totality of patient's experience in the context of disease, management to address all dimensions of care

which includes interdisciplinary

Spirituality Defined in Medicine

- Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred.
- Spirituality is expressed through beliefs, values, traditions, and practices.
- Spirituality **may include** religion but is not defined only by religion which is why the definition of spirituality is framed on how persons seek ultimate meaning, purpose, and connectedness and how people experience relationship in many different ways.



Spirituality (cont)

Spirituality is that which gives you your fullest experience of being human. Today.

Integrating Health Justice into the Biopsychosocial-Spiritual Model to Promote Wellbeing

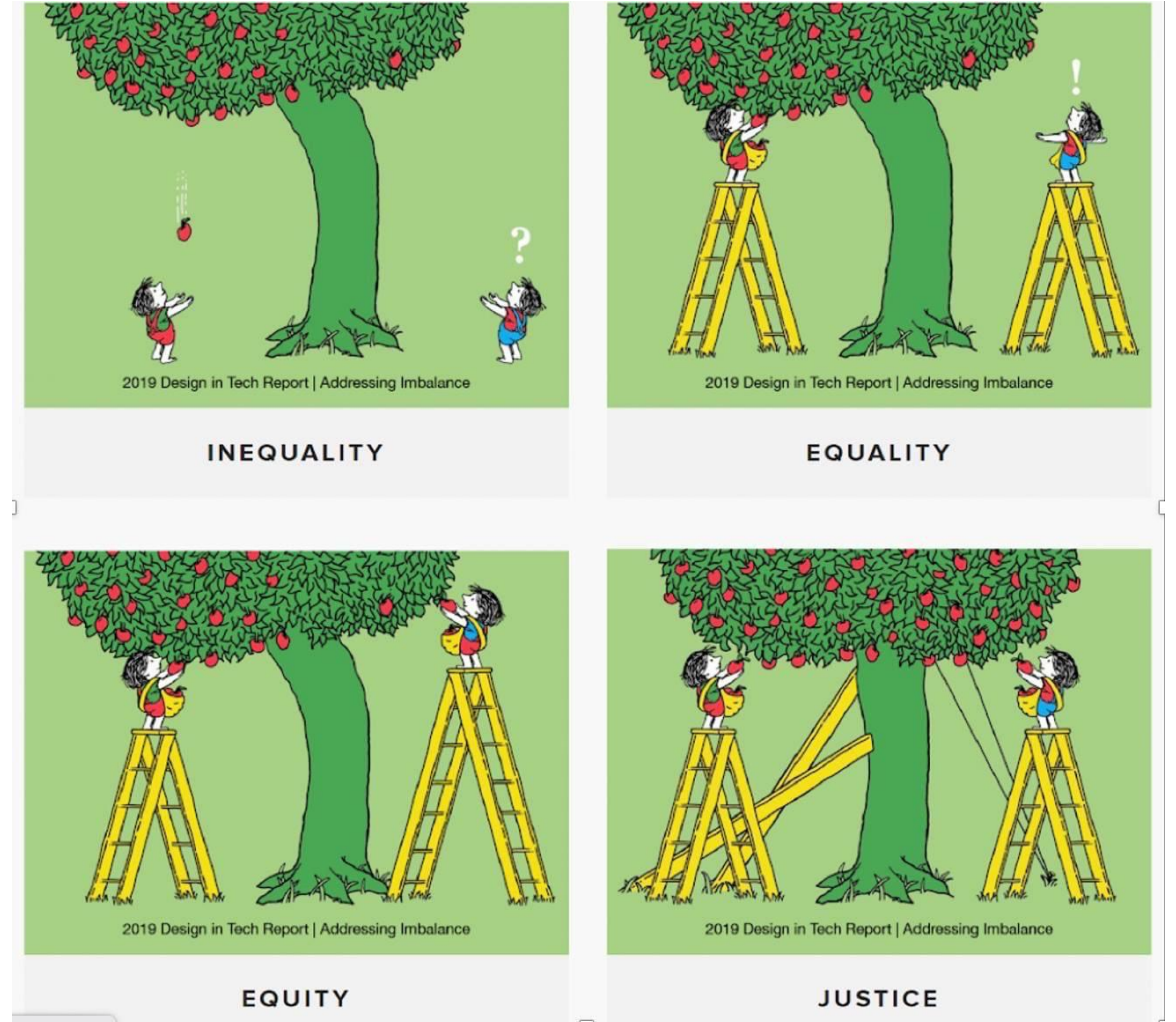
Defining Wellbeing & Health Justice

- **Wellbeing:**

- Wellbeing is a state of positive feelings and meeting full potential in the world.¹

- **Health Justice:**

- Requires that all persons have the same chance to be free from hazards that jeopardize health, fully participate in society, and access opportunity.
- Means dismantling the effects of racism and working towards sustainable policies and innovations that will last through generations
- Meeting the needs to bring equity and fairness to the forefront, where people can live to their fullest potential.”²



1. Simons G, Baldwin DS. A critical review of the definition of 'wellbeing' for doctors and their patients in a post Covid-19 era. International Journal of Social Psychiatry. 2021 Dec;67(8):984-91. doi: 10.1177/00207640211032259

2. Benfer EA. Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Justice. Am. J. Public Health. 2015;105(2):275

Biology

Pain

Fatigue

Nausea

Appetite

Sleep

Access to Medication

Access to Quality Primary &

Preventative Healthcare

Access to Timely Specialty Care

Psychological

Cognition

Depression

Sadness

Anxiety

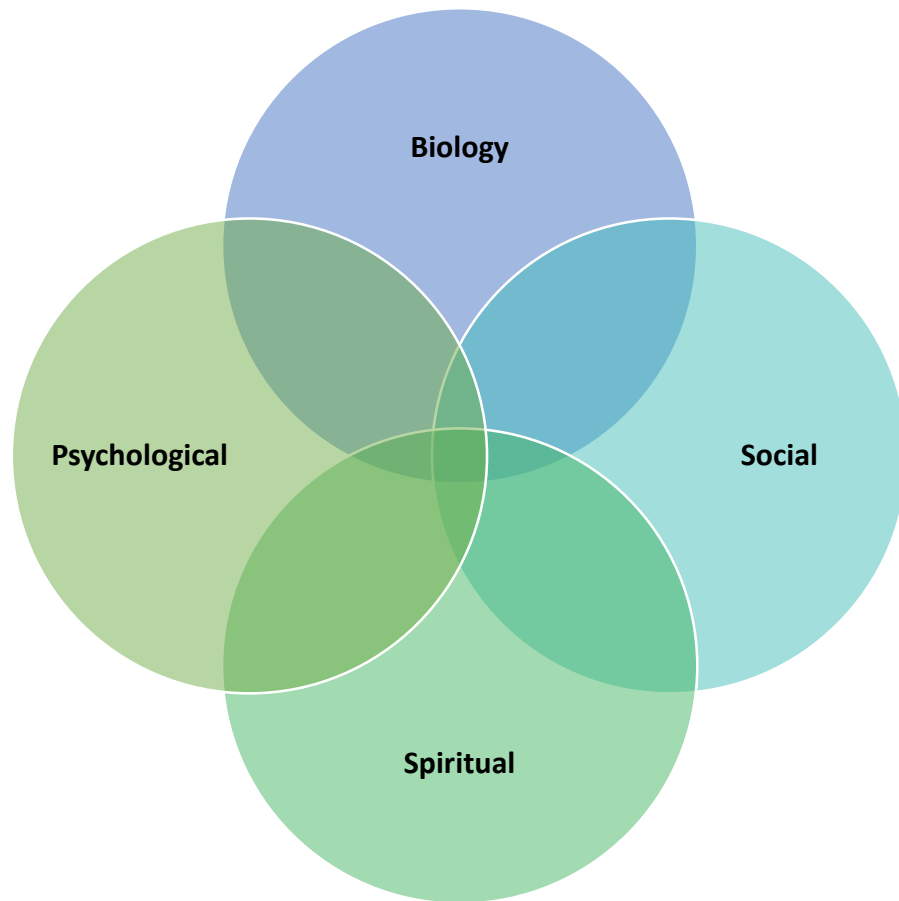
Fear

Anger

Suicidal Ideation

Mistrust

Access to Quality Behavioral Health



Social

Adverse Childhood Events

Caregiver Burden

Community Support

Roles/Relationships

Food/Housing Insecurity

Financial Burden

Access to Internet/Smart Devices

Structural Racism

Trauma

Climate Change

Spiritual

Meaning

Purpose

Dignity

Hope

Faith

Community

Connection & Love

Forgiveness

Gratitude

Peace

Time & Access for Spiritual Practices

Urgent need: Diagnosing and Treating Spiritual Distress

- Existential, lack of meaning, purpose,
- Abandonment by God or others,
- Anger at God or others,
- Concerns about relationship with deity,
- Conflicted or challenged belief systems,
- Despair/ Hopelessness,
- Grief/loss,
- Guilt/shame,
- Reconciliation, Isolation,
- Religious specific, Religious/Spiritual Struggle



Whole Person Diagnosis, Assessment, and Treatment Plan

Make a diagnosis

(use FICA©, discern biopsychosocial and spiritual distress)

Distinguish simple from complex

Recommend interventions

Referral to other professionals

(chaplain, social worker, psychiatry, etc.)

Write up plan

Follow up

Develop a plan

- The treatment plan should be patient-centered and include but not limited to:
 - Create a daily routine
 - Take breaks and set boundaries with work/home-life
 - Limit media use/watching the news
 - Advise alternative exercise routines that they can do at home/low cost
 - Go outside if possible!
- Try to find joy/laugh daily
- Spiritual Health – patient specific and develop with patient
 - 5 to 10 minutes per day, but stress to do daily – prayer, yoga, breath work, dance, garden, etc.
 - What work for he/she/them may change over time
 - **Give a Rx:** Do daily, BID, prn more frequently. Do alone, with loved ones, and/or children.
 - Write in your note so you remember what works for him/her/them!
- If the patient has spiritual distress, differentiate that from physical, emotional or psychosocial distress, make appropriate referrals, including chaplain/pastoral services, practice compassionate presence
 - Quick fixes do not work



Home Activities to Incorporate the Biopsychosocial-Spiritual Model - FOR FREE/low

- 10 minutes 30-day Yoga Challenge with Cassandra or Adrienne (beginner's version)
- Chair yoga, Tai chi for older adults and/or physically impaired
- Apps: Headspace, Insight Timer, Calm, Smiling Mind (for children too),

Abide or Encourager

- Mindfulness-approach with activities that they enjoy
 - Listening to music, gardening, painting/coloring, being with family, etc.
- Prayer, Church services
- Breath work
- Exercise – dancing
 - Heather Roberston – HIIT
- Going outside (ensure it's safe)
- For children:
 - Cosmic Yoga and/or Yoyo Yoga
 - Blissful Kids @ blissfulkids.com – complete with children



give

fulness activities to



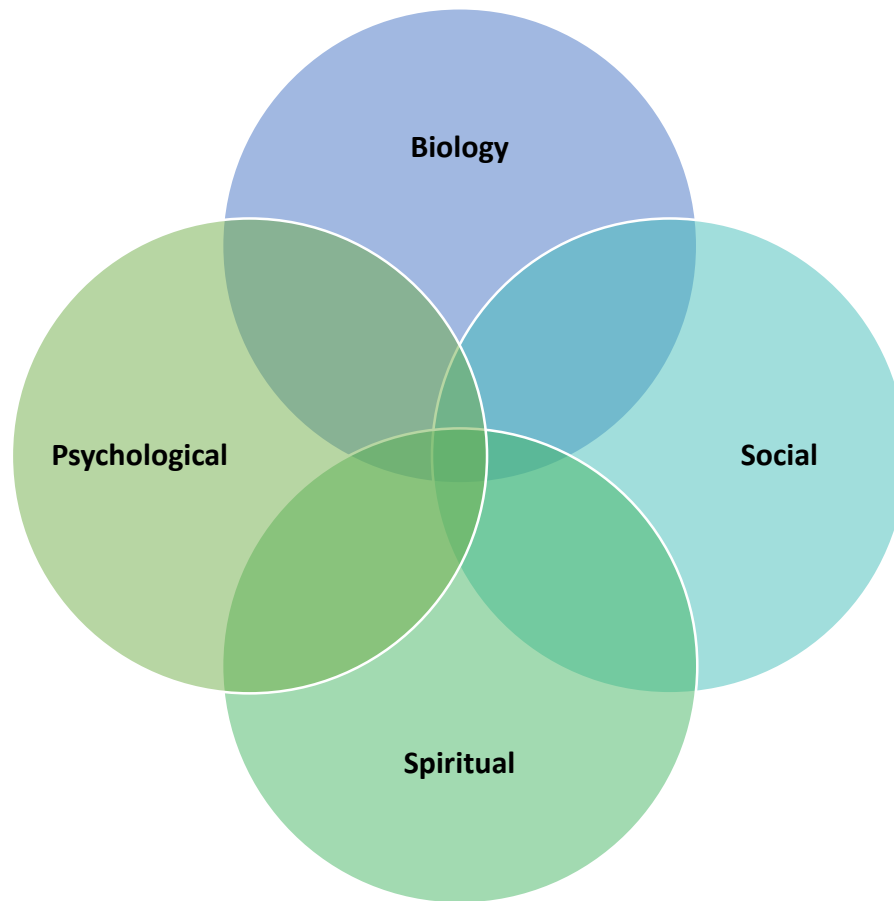
Integrating Health Justice into the Biopsychosocial-Spiritual Model to Promote Wellbeing & Belonging for Latinx HCWs

Biology

- Pain
- Fatigue
- Nausea
- Appetite
- Sleep
- Access to Medication
- Access to Quality Primary & Preventative Healthcare
- Access to Timely Specialty Care

Psychological

- Cognition
- Depression
- Sadness
- Anxiety
- Fear
- Anger
- Suicidal Ideation
- Mistrust
- Access to Quality Behavioral Health



Social

- Adverse Childhood Events
- Caregiver Burden
- Community Support
- Roles/Relationships
- Food/Housing Insecurity
- Financial Burden
- Access to Internet/Smart Devices
- Structural Racism
- Trauma
- Climate Change

Spiritual

- Meaning
- Purpose
- Dignity
- Hope
- Faith
- Community
- Connection & Love
- Forgiveness
- Gratitude
- Peace
- Time & Access for Spiritual Practices

What does it all look like for Latinx HCWs?

Some examples:

Biology	Psychological	Social	Spiritual
Time to go to Medical Appointments	Access & time to go to Mental/Behavioral Health Appointments	Reduce/eliminate cost or fees for exams and/or applications	Time & Access to Spiritual Practices
Time to exercise	Building trust	Food/housing/smart devices access and security	Defining Meaning & Purpose in Medicine
Maximizing roles/responsibilities	Improving the system	Building work connections and outside connections	Paid time to volunteer

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Your homework

- Try any of the interventions discussed. See what works for you.
- Build breaks into your schedule.
- Remind yourself it's ok to take care of you.
- Start a daily practice. Make it a priority.
- Take time to care for yourself – Mind, Body, Soul/Spirit
 - Be kind to yourself. Have fun.
- Make time to care for/connect with others. Spread positivity/happiness.
 - Check-in on your colleague or others at work/home.
- Promote importance of well-being & health justice for all.
- Seek help when needed. Don't wait!
- Remember your meaning and purpose in medicine.





Breath Work

- Various types of breath work
- Can be used anywhere at anytime. Even if you do 1 or 2 breaths, you can find some benefits
- Simple one to use:
 - Sit in a comfortable position with hands on legs or on belly.
 - **Inhale:**
 - Take slow, deep, breath through the nose.
 - Breathe in until all the lungs are full.
 - **Pause** for 2 – 4 seconds
 - **Exhale:**
 - Exhale through nose or mouth, slowly and completely until all air is out and gently push a little more.
 - Then, repeat.
- Can use visualization while completing breath work.



“The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head.”

- Osler

An acronym which can be used to remember what to ask in a spiritual history is:

F – Faith and Belief and Meaning

- "Do you consider yourself spiritual?" or
- "Is spirituality something important to you" or
- “Do you have spiritual beliefs that help you cope with stress/ difficult times?”
 - Contextualize to reason for visit if it is not the routine history.
- If the patient responds "No,"
 - The health care clinician might ask, "What gives your life meaning?"
 - Patients might respond with answer such as family, career, or nature.
- If the patient responds “Yes,”
 - The question of meaning should also be asked even if people answer yes to spirituality.

I – Importance and Influence

- "What importance does your spirituality have in your life?"
- Has your spirituality influenced how you take care of yourself, your health?
- Does your spirituality influence you in your healthcare decision making?"
 - e.g., advance directives, treatment etc.

C – Community

- “Are you part of a spiritual community?”
- Communities such as churches, temples, and mosques, or a group of like-minded friends, family, or yoga, can serve as strong support systems for some patients.
- Can explore further:
 - Is this of support to you and how?
 - Is there a group of people you really love or who are important to you?"

A – Address in Care/Action in Care

- “How would you like me, your healthcare provider, to address these issues in your healthcare?”
- With the newer models including diagnosis of spiritual distress, “A” also refers to the “**Assessment and Plan**” of patient spiritual distress or issues within a treatment or care plan)

Diagnosis

The first step is to make a diagnosis (discern biopsychosocial and spiritual distress)

- **Psychosocial distress** - discomfort related to cognition, behavior, emotions, and social interactions; includes unhealthy thought patterns, emotional dysregulation, diagnosable psychiatric conditions, interpersonal conflict, and social upheaval
- **Spiritual distress** – difficulty in finding purpose, meaning, or connection with others, God, or another transcendent belief; children- withdrawal, anger, betrayal, apathy, self-doubt, bitterness towards God or a higher power, despair, disappointment, lying, greed, chaos, fatigue, or making noise

National & International Guidelines: Standards for Spiritual Care

- Spiritual care is integral to compassionate, person-centered health care and is a standard for all health settings.
- Spiritual care is a part of routine care and integrated into policies for intake and ongoing assessment of spiritual distress and spiritual well-being.
- All health care providers are knowledgeable about the options for addressing patients' spiritual distress and needs, including spiritual resources and information.
- Development of spiritual care is supported by evidence-based research.
- Spirituality in health care is developed in partnership with faith traditions and belief groups.
- Throughout their training, health care providers are educated on the spiritual aspects of health and how this relates to themselves, to others, and to the delivery of compassionate care.

National & International Guidelines: Standards for Spiritual Care

- Health care professionals are trained in conducting spiritual screening or spiritual history as part of routine patient assessment.
- All health care providers are trained in compassionate presence, active listening, and cultural sensitivity, and practice these competencies as part of an interprofessional team.
- All health care providers are trained in spiritual care commensurate with their scope of practice, with reference to a spiritual care model, and tailored to different contexts and settings.
- Health care systems and settings provide opportunities to develop and sustain a sense of connectedness with the community they serve; healthcare providers work to create healing environments in their workplace and community.
- Health care systems and settings support and encourage health care providers' attention to self-care, reflective practice, retreat, and attention to stress management.
- Health care systems and settings focus on health and wellness and not just on disease.

My Patient's Story

- Ms. LC is 35yo F with no significant PMH, who presented to Allen hospital for worsening back pain and neck swelling x 4 months in mid-August 2020. She had been seen by outside PCP and found to have enlarged lymph nodes. They had recommended biopsy of the nodule. She went to one specialist who said he didn't do the biopsies. He referred her to another specialist at Sinai given high suspicion for cancer. The biopsy was scheduled for 2 months from that date. At the Allen, surgery had recommended biopsy as an outpatient. Due to being uninsured and limited access due to pandemic, it was further delay in her care and treatment. With the advocacy from ICU physician, surgery team biopsied in-house. She was diagnosed with Classic Hodgkin Lymphoma. She was discharged with plan to receive treatment at MSKCC.
- During admission, reported domestic violence, mother of teen adolescents, uninsured and undocumented, spoke Spanish only, believed in God/had faith.
- Last Friday (Sept 2020), she called me on my cell stating she couldn't receive treatment without authorization and needed help. After speaking to Oncologist team at MSKCC and CUMC, they told me she couldn't be seen because she was out-of-network. Oncologist told me she could have a cure rate of 85-95% given her current stage. She needed treatment as soon as possible.
- Appointment scheduled at Montefiore. Slides must be sent from Columbia to Monte so the oncologist can review slides and she needs to write a letter to get her fee waived for the processing fee for the slides.

My Patient's story (cont)

- In summary, this 35yo woman no significant PMH, presenting with worsening back pain and swelling x 4-5months, after start of pandemic, who is uninsured, undocumented, speaks Spanish only, with three children – teen twins, with Classic Hodgkin Lymphoma, which 85-95% cure rate given age if treated only, who is living in a homeless shelter with her children to escape domestic violence, is facing multiple barriers to receive timely care to cure cancer and prevent death.
- What are the health justice factors that are impacting this patient?
- How would you apply the Biopsychosocial-Spiritual Model to her care?

Large Group Debrief

Small Group Breakout 2

- What does spirituality mean to you as healthcare worker?
 - If comfortable sharing, what practices do you incorporate?

- What is your meaning and purpose in medicine?

Large Group Debrief

Thank you!

NHMA 26th Annual Conference

**We want your
feedback!**

Please complete the
evaluation for this session.

