

Vulnerable Populations Paper

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N314: Introduction to Professional Practice

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February 23, 2024

Cultural competency is defined by Guzman (2016) as our ability to productively work and interact with people from various cultural backgrounds while also forming beneficial relationships with them. Cultural competency is vital to working in the field of nursing because it encourages us to look past the names and statistics on our charts and consider all the outside factors that impact our patients' lives. Culture can be influenced by economic status, mental health, religious beliefs, and learned social behaviors, and therefore should be considered when approaching a patient. Perhaps a disgruntled patient is simply concerned about how they will pay the sizable bill for their hospital stay, or a combative patient is fighting a mental illness we are yet unaware of. It is impossible to know all the stressors resting on a patient's shoulders upon your first entry to their room and it is important to stay open-minded and humble.

As healthcare workers we share the common luxuries of being educated and employed so it can be effortless for us to see the impoverished population as inferior to ourselves, but this is an apathetic point of view to bear. The impoverished population includes (but is not limited to) military veterans, refugees of political unrest, the mentally ill, and the chronically ill; every category mentioned experiences hardships caused by circumstances beyond their control and together compose a population to be considered with compassion and understanding, not malice or conceit. According to Sullivan (2021), on any night in January 2020 580,466 people experienced homelessness in the United States showing a 2.2% rise since 2019, and Covid-19 has only increased these numbers. On top of this, Watts (2021) reports that the homeless population faces an increased risk of chronic conditions such as diabetes, heart attack, and hypertension, while also being three times more likely to experience substance abuse problems and six times more likely to struggle with depression or contract Hepatitis C. In addition to increased risk of disease and homelessness the impoverished population also experiences food

insecurity, inability to provide appropriate childcare when working, a lack of access to basic hygiene, and an array of mental health disorders, all of which they struggle to remedy because of a lack of accessible resources such as insurance and state aide. As I read these facts, I am ashamed to admit that I have also passed judgement on the unfortunate for being unkempt, unruly, or sometimes even just existing. It is easy to look down from high up, but I hope that going forward in my future practice that I will remember the stress these people experience every day trying to meet their most basic needs. We never know what another person has been through previously or what they are currently struggling with, but we do know what help we can provide them with.

When it comes to providing healthcare to the homeless and impoverished, I believe that they are not only a population in need of help but a population that we sign up to help when we enter the nursing field. Nursing is not compatible with favoritism. It is our duty to provide equal care with integrity to every patient that comes into our care. One way that we can help the impoverished and homeless populations is to be supportive of Medicaid expansion. Medicaid can cover permanent supportive housing and make safe and sanitary housing available for many who otherwise would not have the option, which results in some of the financial burden for the healthcare system being lifted. Charania's (2021) study uncovered the following facts on the subject:

A study in Oregon reported a 55% reduction in Medicaid costs 1 year after individuals experiencing homelessness received permanent supportive housing. Another study in Chicago found that providing transitional and long-term housing to individuals experiencing homelessness led to a 29% reduction in hospital days and a 24% reduction in emergency department visits. Similarly, a program in New York State that provided

2300 supportive housing units and housing support services for individuals experiencing chronic homelessness reduced the average number of inpatient days and emergency department visits over a 12-month period. The program also reduced average Medicaid costs by \$9526 per person over a 2-year period. (para 6)

As we can see, Medicaid expansion would significantly reduce the overall cost of treating the impoverished in many ways. With access to stable housing patients would be less exposed to the elements and therefore require less hospital visits from exposure-related injuries. A safe place to call home would also help to relieve a large percentage of the anxieties felt by the impoverished reducing the cost of mental health treatments as well. With a steady address patients would be easier to reach and less likely to miss existing appointments, and it would reduce the risk of substance abuse by reducing exposure to addictive narcotics. These are not benefits that any human should feel that they do not deserve, and I believe that by supporting Medicaid expansion we would simultaneously be showing our impoverished and homeless populations that they are worthy and will not be forgotten.

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