First, Seek to Understand: Deconstructing the Concept of Poverty for Nursing Education

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January 31, 2024
DOI: 10.3912/OJIN.Vol29No01Man04

Article

Abstract

Poverty, an important social determinant of health, is a multifaceted issue that impacts the health of individuals, families, and communities. People who live in impoverished communities have limited access to many necessary resources. This deficit often results in increased risk for mental illness, chronic disease, higher mortality, and lower life expectancy and greater need for healthcare services. There is a call for nurse educators to provide multiple opportunities throughout curricula for students at all levels to develop competencies to assess and intervene in outcomes impacted by social determinants of health. Doing so requires a perspective of empathy, grounded in cultural humility, to advance health equity and advocate for persons facing challenges, such as those who experience poverty. This article provides an overview of poverty in the context of the social determinants and discusses strategically designed experiential learning experiences, such as simulations and community-academic partnerships. An exemplar of an interprofessional community-academic partnership is provided to illustrate an ongoing successful effort that has fostered a deeper understanding of the lived experience of poverty for students of nursing and other professions.

Key Words: Poverty, social determinants of health, nursing education, population health, equity, health disparities, cultural humility, person-centered care, nursing essentials, stigma, experiential learning, simulation, community-academic partnerships

Poverty is a public health crisis. One in ten people live in poverty within the United States (US), with many more struggling to afford necessities of everyday life including food, housing, and healthcare (Schrider & Creamer, 2023). It is estimated that four of five Americans will struggle with economic insecurity at some point in their lives. The United States has one of the highest rates of poverty in the developed world, disproportionately impacting Black and Hispanic families compared to their White counterparts (Kaiser Family Foundation [KFF], 2023b).

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Poverty negatively affects the health of individuals across the lifespan. However, health professionals often have limited personal experience and receive little formal education to prepare them to understand what life in poverty conditions is like and how it influences the worldview of their patients (Bloch et al., 2011). This may contribute to suboptimal patient care and outcomes (Marrast et al., 2022). Understanding the lived experiences of individuals, especially those in impoverished situations, is crucial for health professionals. Socioeconomic status can significantly impact health outcomes, access to healthcare, and ability to follow medical advice.

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According to the *Future of Nursing 2020-2030* (National Academies of Sciences, Engineering, and Medicine ([NASEM], 2021), much of the focus on the education for nurses, and the public perception of their role, is on the treatment and management of disease. However, our societal paradigm must shift to also include a focus on preparing nurses to address the social determinants of health (SDOH) and social needs that contribute to health outcomes. To optimize the effectiveness of

traditional and alternative health strategies, health professionals should consider cultural competence training and empathy and active listening. This ensures that nurses at all levels of practice can work to promote health and advocate for patients and communities who live in poverty.

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To advocate, nurses must be skilled in assessing the economic determinants of health in acute care and community settings; possess an awareness of their own attitudes towards and experiences with poverty; and demonstrate the ability to cultivate empathy in order to provide the best level of care. By integrating these considerations into their practice, health professionals can enhance their ability to connect with individuals in impoverished situations and develop more effective and culturally sensitive health strategies. This, in turn, can contribute to improved health outcomes and overall well-being for those facing socioeconomic challenges (Ehmke & Sammer-Stiehr, 2021)

Social Determinants of Health

The SDOH are non-medical factors that influence health outcomes, such as the social and economic conditions into which people are born, grow, live, play, work and age, as well as the wider set of forces and systems that shape conditions of daily life (Centers for Disease Control and Prevention [CDC], 2022a). These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems (World Health Organization [WHO], 2023). Research has demonstrated that the influence on health by SDOH can be more important than healthcare or lifestyle choices. For example, healthcare in the United States shapes only 20% of health; genetics influences another 20%, with 60% resulting from social, environmental, and behavioral factors (Tilden et al., 2018). In addition, an estimated 60% of preventable deaths can be traced to SDOH; nevertheless, the over 95% of healthcare expenditures go toward direct medical services, rather than to address these upstream contributors to disease and illness (Braveman & Gottlieb, 2014; Phelan et al., 2015).

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The SDOH also contribute to wide health disparities and inequities in areas such as economic stability; education and healthcare quality and access; neighborhood and built environment; and social and community context. These determinants are closely interrelated with the concepts of diversity, equity, and inclusion; health policy; and communication (CDC, 2022b). Therefore, addressing differences in SDOH influences progress toward achieving health equity, a state in which every person has the opportunity to attain the highest personal level of health. As a result of this significance, the SDOH are one of three priority areas, along with health equity and health literacy, set forth by Healthy People 2030 (Healthy People 2030, n.d.).

The levels of health inequity that currently exist within the United States will not be relieved by members of one healthcare profession alone, yet nurses hold the greatest capacity to address this major challenge of the 21st century (Thornton & Persaud, 2018). In 2008, Sir Michael Marmot, an early researcher who identified the significance of SDOH, asserted that if we are to achieve health equity, we must act on the SDOH. Marmot noted that this will require capacity building among healthcare providers, including the incorporation of content about SDOH into the curricula of all heathcare professionals (Marmot et al., 2008). With approximately 5.2 million U.S. nurses holding active Registered Nurse (RN) licenses as of December 2021 (Smiley et al., 2023), the social mandate is clear that nurses must take an active role to address health equity through education and an acute focus on evidence-based interventions that target SDOH.

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Poverty and Inequity

Poverty is a significant SDOH that can have profound and far-reaching effects on various aspects of an individual's life. It is a multidimensional influencer of health that entails more than simply a lack of financial resources and essentials to ensure a stable standard of living. Manifestations of poverty include disparities in hunger and malnutrition, homelessness, unemployment, limited access to education, essential healthcare, and other basic services, social discrimination and exclusion, as well as the lack of participation in decision-making (Beech et al., 2021; Braveman et al., 2010; Keith-Jennings et al., 2019; United Nations [UN], n.d.).

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In 2022, the official poverty rate in the United States was 11.5%, representing 37.9 million people (Shrider & Creamer, 2023). Among wealthy nations, the US currently has among the highest rates of poverty, the most extreme wealth inequality, and ranks near the bottom in terms of economic mobility (Horowitz et al., 2020). The economic and population health

consequences of the COVID-19 pandemic in the US have increased the prevalence of unemployment, food insecurity, and housing instability (World Bank, 2023). For many marginalized and historically disadvantaged communities, the COVID-19 pandemic exacerbated existing vulnerabilities and socio-economic and structural disadvantages.

Poverty disproportionately impacts certain categories of individuals, such as those under age 18, members of female-headed family households, and individuals with disabilities (Brucker et al., 2014; Fernandez et al., 2021; KFF, 2023a; KFF, 2023b; Minkler, et al., 2006). Racial inequalities are often starkly evident in poverty statistics, with the largest rate being noted in American Indian and Alaska Native populations, followed by 17.1 % of Black, 16.9% of Hispanic, and 8.6% of White populations (Shrider & Creamer, 2023). By age 65 more than half of all Americans will have spent a year of their life below the poverty line, and by age 85, two thirds of them. Rather than an isolated event, the reality is that the majority of Americans will encounter poverty firsthand during adulthood (Rank & Hirschl, 2015). Most often, poverty is a situation people want to escape (World Bank, 2023); however, for many, poverty is an intergenerational legacy that is difficult to avoid.

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Impact on Health

Poverty is one of the most powerful determinants of health, an important statistic considering that 11.8% of the U.S. population live in poverty conditions (Schrider & Creamer, 2023). Poverty negatively impacts health outcomes and shortens life expectancy (Canudas-Romo, 2018). Across adult populations, poverty is associated with higher rates of chronic and acute infectious diseases, cancer, higher rates of acute illness, kidney disease, and less access to quality healthcare (Chetty et al., 2016; Hall, 2018; Kollman & Sobotka, 2018; Mersky et al., 2021; Mode et al., 2016; Norris & Beech, 2021; Singh & Siahpush, 2006). Poverty also impacts mental health. In addition to the more traditional mental health conditions that may limit a person's daily functioning, individuals living in poverty often experience chronic stress due to the daily challenges associated with meeting basic needs. The constant struggle to secure necessities like food, shelter, and healthcare can contribute to a range of physical and mental health issues. This can impair cognitive processing and memory, impacting the ability of the individual to follow up on medical appointments and provider recommendations (Khullar & Chokshi, 2018).

Poverty also impacts mental health.

Poverty has been strongly linked with poor maternal and child health outcomes. Women living in poverty experience higher rates of chronic hypertension, diabetes, obesity, chronic stress and anxiety, and increased morbidity and mortality, all of which are exacerbated during pregnancy and after giving birth (Marti-Castaner et al., 2022). These factors also increase the risk for birth complications and job loss (Fernandez Turienzo et al., 2021). Children experience numerous health-related consequences of poverty, including higher rates of childhood obesity, elevated blood lead levels, lower neurocognitive function, poorer cancer outcomes, and higher rates of psychological distress (Chokshi, 2018; Eamon, 2001; Gitterman et al., 2016; Gross et al., 2021; Justice et al., 2019; Wolfson, 2021). Experiencing poverty in childhood has long term effects on both physical and mental health in middle and later life, independent of educational attainment and socioeconomic status in adulthood (Evans & Kim, 2012; Murray et al., 2022; Ridley et al., 2020; Wagmiller & Adelman, 2009).

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People who experience poverty are also disproportionately impacted by natural hazards and disasters (Hallegatte et al., 2020). This can be attributed to the fact that they often are forced to live in under resourced areas because of limited financial means, and the necessity to reach resources typically centralized in these regions. However, by living in these areas, they are at increased risk of exposure to natural hazards and of being directly impacted by disasters. At the same time, they experience a shortage of the resources and safeguards that allow them to be resilient in the face of lost assets due to the disasters (Hallegatte et al., 2020).

Stigma

Stigma is defined as a set of negative and unfair beliefs that a society or group of people has about something, or as a mark of shame or discredit (Merriam-Webster, n.d.). Therefore, the stigma associated with poverty manifests as societal judgments directed at individuals who live in poverty, representing a form of public stigma. The United States is still a country where persons are often blamed and stigmatized for living in poverty, and that has created social policies that are considered punitive (Gross et al., 2021). Due to societal values and negative images in the media, many individuals tend to attribute poverty to personal flaws such as lack of motivation and hard work. This perception can lead to discrimination such as that experienced in healthcare settings by individuals who are economically disadvantaged (Inglis et al., 2019).

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Patients who live in poverty face barriers to obtaining the same quality of care. They receive less diagnostic and treatment information from providers and are less likely to be involved in decisions regarding their treatment (Chokshi, 2018). In addition, due to limited screening for SDOH, providers are often unaware of the economic challenges their patients face, which may lead to inappropriate care plans that are challenging to implement due to time and resource constraints (Bloch, et al., 2011; Douglas et al., 2020). Even providers who are aware may feel unprepared to provide patients who are experiencing financial difficulties with appropriate care or be ill-prepared to link them to community resources (Loignon et al., 2014).

Poverty is associated with higher rates of mental illness and lower levels of well-being. One contributing factor is the stigma associated with, and felt by, individuals living in poverty. Navigating the challenges of daily survival in the face of public stigma and biases can have detrimental emotional consequences, with individuals often internalizing the shame they feel as a result of this judgement, resulting in self-stigma. This sense of shame can result in avoidance to obtain healthcare if they feel providers lack respect and compassion (Allen et al., 2014). When they do seek care, they may respond to real or perceived stigma by attempting to hide their financial status (Reutter et al., 2009). Parents or guardians who are experiencing financial difficulties may conceal their financial situation in pediatric settings due to feelings of shame and fear of being perceived by medical providers as incompetent parents (Knowles et al., 2018).

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Stigma and biases are often the result of a lack of knowledge and exposure needed to understand a situation, resulting in a lack of empathy. Experts have suggested that anti-stigma interventions with an aim to increase understanding of poverty and reduce biases toward low-income groups may be effective to lessen this contribution to socioeconomic-based health inequities (Juntunen et al., 2022).

Preparing Students to Care for Individuals, Families, and Communities in Poverty

Nursing education is constantly evolving and growing to better prepare nursing students to work in an ever-changing environment, and to serve an increasingly diverse patient population. Providing students with tools for success in their academic and professional journey is the objective of all nurse educators. Recent calls to better prepare nurses for practice outside the acute care environment emphasize the need to integrate the SDOH in nursing curricula. Efforts have been made to address SDOH content in nursing education; however, the emphasis is usually within community health nursing courses. There is a fundamental need for nurses who practice in the acute care environment to also understand and assess for SDOH; therefore, experts have recommended integration of content about SDOH throughout each didactic course and clinical experience (NACNEP, 2019; 2023).

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It is imperative that educators facilitate experiences to help future healthcare professionals understand the SDOH. Recognizing the relationship between poverty and health (NASEM, 2016) is important to deepen nurses' understanding of the lives and constraints of patients who are economically disadvantaged. Teaching students how to assess and interact with patients who live in poverty can increase their empathy and assist them to recognize upstream factors in communities and create solutions for this patient population. Several professional organizations and government agencies have set forth recommendations to guide nurse educators in integrating the SDOH into nursing education and practice; these are discussed below.

American Association of Colleges of Nursing Essentials

The American Association of Colleges of Nursing ([AACN], 2021) has defined quality in nursing by the essentials that outline core competencies for professional nursing education for both entry-level and advanced-level nurses. Based on recommendations contained in the new AACN *Essentials* (AACN, 2021), nursing students must not only be introduced to the knowledge and values of the discipline, but also educated to practice person-centered care by seeing patients through the lens of wholeness and interconnectedness with family and community. Person-centered care is individualized, respectful, empathetic, and compassionate, requiring the intentional presence of the nurse seeking to know the totality of an individual's lived experiences and recognize the impact of health disparities and the SDOH on that person's health outcomes (AACN, 2021).

Students must also develop competencies such as effective communication through collaborative practice experiences with individuals, families, communities, and populations across the lifespan. They must effectively communicate with other health professionals, in both acute care settings and in the community (AACN, 2021). Expanding upon existing population health competencies in nursing curricula, students need to develop the necessary competencies to co-create partnerships with

communities. These include social justice and systems thinking, teamwork, care continuity, advocacy, ability to forge alliances and build trust, willingness to suspend long-held beliefs, cultural humility, cultural competence, cultural sensitivity, and empathy (AACN, 2021; Tilden et al., 2018).

National Advisory Council on Nurse Education and Practice (NACNEP)

Improving nursing practice will require more education to address the SDOH. In two reports National Advisory Council on Nurse Education and Practice (NACNEP 2019; 2023) experts discussed the need for programs to support education in the SDOH within both undergraduate and graduate nursing curricula. They indicated that nurses are trained to work within the confines of the healthcare system. However, without formal education about the SDOH they may miss more substantial opportunities to improve the health of patients, families, and communities by considering interventions that address the larger social, political, economic, and physical environment. The goals are to ensure that graduating nurses are well-equipped to care for underserved populations through community engagement that incorporates the concepts of SDOH, and that nursing faculty are prepared to teach these opportunities.

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The profession of nursing has strong, proud roots in the community. Nurses have always assessed various community level factors that influence health, even if we did not formally recognize them as the SDOH. Therefore, the challenge now facing nurse educators is to build linkages for students between existing community level experiences and the settings where they complete other acute care clinical requirements.

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Students need to be able to shift their focus from the bedside to the community outside of the hospital window, because patients come from and return to those communities. Nurse educators must guide students in “walking upstream” where they can identify factors that contribute to the downstream health outcomes they are learning to treat. An expanded definition of nursing interventions would recognize that any intervention directed at one social determinant has the potential to improve health. This same expansion of focus also applies to education for nursing students in the area of health policy. For example, a housing policy that supports provision of safe, affordable housing is also a health policy. Any policy that targets one of the SDOH and contributes to improved health outcomes becomes a health policy. This approach expands the ability to enact change; we now have multiple points of intervention beyond those viewed through the more focused lens of the traditional medical model of health.

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National Academies of Sciences, Engineering and Medicine

Two reports from the NASEM, *A Framework for Educating Health Professionals to Address the Social Determinants of Health* (2016) and *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* (2021), contain recommendations for preparing future nurses to care for vulnerable populations, such as those experiencing poverty, through a focus on the SDOH. These recommendations are based on the recognition that students from various socioeconomic and cultural backgrounds may find it challenging to comprehend the structural, political, and societal factors that influence health outcomes (NASEM, 2016).

Experts have noted that nursing education coursework and experiential learning that prepares students to promote health equity, reduce health inequities, and improve the health and well-being of the population will build the capacity of the nursing workforce to meet future needs. Substantive education in community settings, including schools, workplaces, home healthcare, public health clinics, homeless shelters, and prisons, allows nursing students to learn about the broad range of care environments. With this knowledge, they can work collaboratively with other health and non-health professionals, including those for whom they are providing care, while at the same time preparing them for future roles leaders and advocates (NASEM, 2016; 2021). Finally, these experiential learning opportunities provide an opportunity for students to engage in the process of cultural humility by recognizing implicit biases, stigmas, and stereotypes that may unjustly influence their care delivery.

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National League for Nursing

The National League for Nursing (NLN) also recognizes the importance of the contribution of SDOH to inequity, both in the United States and globally. In the context of their core values, the NLN states that the profession of nursing must focus attention on SDOH as part of the social mission of the nursing profession and our unwavering commitment to social justice, health equity, and reduction of health disparities (NLN, 2019). Nurse educators are charged with the urgent need to design

curricula that provide a better understanding of the root causes that contribute to individual health, the reasons health disparities exist, and how health equity can be achieved by all people, regardless of socioeconomic status. Three key NLN recommendations for curricula revision include: (1) raise students' consciousness about SDOH; how to develop an inclusive understanding of SDOH; and how recognition of the impact on health and wellness leads to new perspectives related to differences and mitigates bias and racism; (2) create partnerships with community agencies to provide experiences that intentionally expose students to address the impact of SDOH on patients, families, and communities; and (3) thread SDOH education throughout the program of learning in varied educational settings while intentionally providing opportunities for students to assess and implement nursing actions to address SDOH in a variety of settings (NLN, 2019).

Educational Strategies

Provider stigma and discrimination remain as barriers to quality healthcare for low-income patients. Education focusing on the lived experience of poverty is vital to promote empathy and compassion in nursing students.

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Poverty Simulations

Poverty simulations, a form of experiential learning, are an educational tool that can be a valuable method to promote empathy, cultural competence, and awareness of the multifaceted nature of poverty. There are several existing poverty simulations; all are designed as immersive experiences with the goal to improve attitudes toward poverty and enhance cultural competency (Reid & Evanson, 2016). A recent longitudinal study explored baccalaureate nursing students' knowledge and perceptions of client care as they relate to the SDOH (Lee et al., 2018). The majority of students related social conditions to lifestyle choices, rather than circumstances, during their initial exploration early in the program. Overcoming these biases is necessary to properly address SDOH.

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Simulation can provide students with first-hand experiences that increase awareness and support the need to reconsider individual biases. Poverty simulations are effective in reducing stigma and increasing awareness about external causes of poverty. Long-term evaluation does indicate a need for ongoing cultural competency training to reduce disparities in health outcomes for patients who live in poverty conditions (Murray et al., 2022; Noone et al., 2012).

In addition to enhancing student understanding of poverty, simulations can be effective to develop empathy (Bas-Sarmiento et al., 2017; Northrup et al., 2020). Empathy is considered an essential nursing skill and competency that can be learned through education and practice experiences. Empathy is a fundamental quality in any therapeutic relationship and leads to greater patient satisfaction and therapeutic adherence (Bas-Sarmiento et al., 2017). The ability of a nurse to demonstrate empathy is valued by patients and family members; likewise, a lack of empathy is also noted and is one factor that influences patient dissatisfaction with care (Derksen et al., 2017).

Simulation can also be used to enhance student understanding of literacy, culture, transportation, availability of food, and access to healthcare. A key component to addressing SDOH is screening; the skills needed to properly screen can be practiced and evaluated within simulation to better prepare students to integrate screening for SDOH into their assessments (Thornton & Persaud, 2018).

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Poverty simulations, when implemented with intent and critical consideration of experience, reflection, and assessment, may provide an opportunity for students to engage in a lasting learning about poverty. However, nurse educators must thoughtfully and cautiously plan and facilitate these activities. It is important to ensure that participants who have experienced poverty themselves are not re-traumatized and that the process does not trivialize the realities of poverty or reinforce stereotypes (Browne & Roll, 2016).

Hidden Identities. Nurse educators cannot ignore the possibility of persons with hidden identities participating in simulations of poverty in their classrooms. Hidden identities are individual personal attributes that are not easily apparent, especially from outward appearance (Vandrick, 1997). Many aspects of student identity can be overtly distinguished, such as race, ethnicity, or some gender identities. There are other hidden identities that individuals carry with them every day, including sexuality, familial relationships, certain diseases or disabilities, mental health issues, religions, coming from various class backgrounds, living with or surviving rape or domestic violence, and socioeconomic status, including poverty. An important feature of these identities is that that they can be hidden – a type of privilege by virtue of having a choice. Ironically, the fact that there is a choice can lead to psychological problems of guilt or ambivalence. Suppression and concealment of hidden identities may exacerbate feelings of exclusion and undermine psychosocial gains often associated

with active learning environments that faculty try to create. For example, when students working in groups drift into conversation not directly related to course content, such as how they spent their weekend, students with hidden identities must consider whether to reveal personal information about themselves that might lead to discrimination from peers as a result of conscious or unconscious bias (Henning et al., 2019). This inner conflict takes up a tremendous amount of emotional energy and affects student learning (Henning et al., 2019; Vandrick, 1997).

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Awareness that a student with a certain identity or situation may be sitting in the classroom should increase vigilance about ignorant or derogatory remarks in class materials and discussions. Faculty should actively attempt to create classrooms where students feel safe to be open about various aspects of their lives and identities, even if they do not choose to do so.

Trivializing Poverty and Reinforcing Stereotypes. Without the right facilitator or critical thinking applied to the event, a simulation could potentially reinforce false assumptions about poverty and the people who experience it. This is in direct contrast to the actual goal of poverty simulations, which is to break down those stereotypes and spur civic action to end poverty.

Personal reflection and self-disclosure afford an opportunity to illustrate the critical importance of proper facilitation of poverty simulations in academic settings. Both authors share the lived experience of growing up in poverty, one in an Appalachian community in Virginia, the other in an Appalachian Ohio community. As adults, both individuals are nursing professionals have completed many years of formal education. While they do not outwardly reflect the many hardships associated with their upbringing, those childhoods steeped in poverty and impacted by its multifaceted nature are an integral part of their identities, as much as their accumulated nursing degrees.

It is this intersectionality of identities that the authors bring to their roles as nurse educators. This intersectionality was present when the first author, as a new faculty member, was assigned to attend a poverty simulation in her college in order to support facilitators of the event. Despite the best of educational intentions, the simulation developers had failed to consider the potential impact for those who had experienced first-hand socioeconomic hardships. Their focus was shifted from lectures and content slides to using active learning to convey content. Unfortunately, in reflecting on that experience now, some thirteen years later, images remain fresh of undergraduate nursing students laughing and joking as they moved through various stations representing hardships faced by individuals and families living in poverty. Students casually moved to tables where they applied for food stamps, sought care for sick children, attempted to avoid eviction or obtain housing, realized they could not afford to repair their broken-down car, and other experiences faced far too often by those living in poverty, or “others.”

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For this one faculty member, the experience was anything but light play-acting. This was her lived reality, and an example of trivialization even if unintended. Childhood memories flooded back, resulting in an urge to hide, to avert her gaze from their faces lest they know her shame. Her visceral reaction and the tears she fought to hold back were far too real because this simulation triggered memories of what this nurse educator now knows were adverse childhood events. There was no post simulation debriefing opportunity for faculty who participated as the focus was on the learners. However, this experience did inform the evolution of this author’s teaching philosophy and afforded her the opportunity to identify ways in which we can create safe spaces for simulated learning.

Strategies to Promote Respectful and Safe Simulations. Funkunga Luna Victoria & Kuehn (2020) provided guidelines to conduct poverty simulations that avoid some of the previously identified dangers, as follows:

- Identify a poverty simulation that fits with your team’s objectives and satisfies ethical concerns. Some simulations draw upon low-income volunteers or community resource agency staff to lend an element of reality to the experience.
- Collect information on participants’ exposure to poverty. This can enable team members to better prepare for emotional responses.
- Recognize that some “real-life” scenarios in poverty simulations may be emotionally triggering for some participants. Develop a plan for handling emotional responses, including resources available such as counseling services or student advising teams.
- Create educational tools that provide participants with up-to-date information on local poverty statistics in order to enhance student relevance.
- Evaluate the debriefing plan provided in the chosen simulation curriculum to determine whether it aligns with their ethical concerns and objectives.
- Consider ethical implications of a simulation that assigns family roles to participants based on “real-life” situations. It is important that everyone involved recognizes that a poverty simulation is not a game, but rather the lived experience of

many individuals.

Community-Academic Partnerships

Despite all the advances in nursing technology and simulation, there is still a disconnect between students and their communities, especially related to patients who present poverty as a hidden identity. Simulations are not a substitute for direct, immersive experiences outside traditional classroom walls where students can engage with the voices and experiences of individuals, families, and communities who are experiencing poverty.

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One core element of the newly updated *Essentials* (AACN, 2021) is the concept of partnerships between the academic setting and real-world settings, including low-income communities. By embedding students within the community, they are able to witness SDOH and how they impact the lives of residents, including those experiencing poverty. Structured learning initiatives and student experiences guided by these essential elements will facilitate partnerships and collaborations between students and communities. Working in and with communities, nurses have a long tradition of attention to SDOH. In a wide range of settings, from public health and home health programs to schools, prisons, homeless shelters, and immigrant health centers, nurses have worked to bridge health and social services to meet the needs that matter most to patients and families through community clinical placements and service learning opportunities (Douglas et al., 2020; Ezeonwu et al., 2021; Forg & Paun, 2021; Johnson et al., 2023; Tyndall et al., 2020; Voss et al., 2015).

By embedding students within the community, they are able to witness SDOH and how they impact the lives of residents, including those experiencing poverty.

Federal Funding and Support. Nurse educators must create innovative opportunities for students at all levels to develop a deep understanding of the SDOH and issues that face vulnerable populations. It is important for them to gain competencies to create partnerships with communities. These experiences will allow students to identify community strengths upon which they can build in their efforts to improve the care of diverse populations. In a report to the Secretary of Health and Human Services and Congress on the integration of the SDOH in nursing education, practice, and research, NACNEP leaders made several recommendations for funding of initiatives to support this work, as follows (NACNEP, 2019):

- The Secretary and Congress should fund/support academic-community organization partnerships to establish clinical placements and service learning opportunities for nursing students that provide a range of practice experiences with an emphasis on addressing the SDOH with nurse-led interprofessional teams. These experiences should include care coordination, telehealth, and health promotion/health opportunities for individuals, families, and the community.
- The Secretary and Congress should provide funding for research/demonstration projects that implement innovative strategies for integration of the SDOH curricula for nursing students that include faculty development, effective care delivery models, and identification of best practices.

Building Bridges: An Exemplar. The author would like to provide one example of a successful community-academic partnership from her role as a nurse educator and founding member to illustrate the tremendous learning opportunities afforded through these collaborations. In 2010, a group of interprofessional faculty and student leaders from across the University of Cincinnati Academic Health Center (UCAHC) launched an Institute for Healthcare Improvement (IHI) Open School chapter (OSC) at the University of Cincinnati (UC). Chapter activities include monthly meetings to plan events and discuss online courses in healthcare improvement through IHI, quarterly Open School Seminar Series to share healthcare improvement concepts and stories with other faculty and students from the UCAHC, and weekly Saturday morning sessions at the UCOSC, a free clinic located at the St. Vincent de Paul (SVDP) agency in the West End community of Cincinnati. SVDP is a trusted community agency with a 150-year history of meeting the needs of Cincinnati residents, including providing social services, a food pantry, and a charitable pharmacy.

This array of services was selected based on a needs assessment of the client population...

Each Saturday morning the free clinic is staffed by a team of 3 to 5 students and two faculty members who provide health screenings, immunizations, health education, nutrition counseling, self-management support, and referrals to local healthcare organizations for more comprehensive care. This array of services was selected based on a needs assessment of the client population in fall 2010 when the clinic began, and on guidance from the SVDP pharmacists and staff who cited uncontrolled hypertension, diabetes, and obesity as the primary health concerns in the population.

Of note, since its inception, the UCOSC has been open every Saturday morning without exception until March 2020 when operations were suspended due to the COVID-19 pandemic. At that time, UCOSC students continued identifying ways to promote the health of West End residents and SVDP clients by creating health information handouts that were distributed in food and pharmacy pick-ups. Translated into approximate numbers, prior to COVID-19 lockdown, UCOSC held

approximately 500 Saturday morning clinics, with 6 to 10 students from across the disciplines of nursing, medicine, social work, nutrition, physical therapy, and dental hygiene at each clinic serving an average of eight patients per week. During this time period, there were many patients who returned to the clinic one or two times each month for health screening and behavior change counseling. In Spring 2022, UCOSC in-person services resumed.

Engagement through this community partnership has mutual benefits for all involved. From the academic partner perspective, both faculty and students who engage in the UCOSC are able to translate into practice the skills learned during their respective educational programs as members of an interprofessional team. They can expand classroom learning to the real-world environment of the West End of Cincinnati. Students witness first-hand the impact of SDOH. They witness the barriers faced by underserved populations that impact health outcomes, such as lack of transportation, literacy challenges, lack of adequate health insurance, poor or no housing, and poor nutrition.

Engagement through this community partnership has mutual benefits for all involved.

In recent years, students have also provided care to immigrants and refugees in our area, thus putting a face on social issues facing our country as a whole. Through interactions with patients, faculty, and students from other health professions, these students also develop and practice critical skills needed by all healthcare providers, such as interpersonal and interprofessional communication, collaboration, and teamwork. Expert faculty are able to guide students in client encounters and help them develop cultural humility and empathy. This experience, and the lessons learned, follows students into their future practice and is an important step to address health disparities and inequity.

Community members also benefit from engaging with the faculty and students who participate in the UCOSC. Stated simply, the students and faculty are able to emphasize the “caring” component of healthcare through compassionate interaction with patients who seek services in the clinic. Students are not limited in the amount of time they spend with patients. They use evidence-based practice to educate patients and provide guidance on health promotion and management of chronic-diseases. SVDP staff members regularly meet with the clinic faculty mentors to identify ways to promote the health of community residents through this collaborative partnership.

Conclusion

Approaches presented in this article address poverty, just one component of the broader strategy needed to address challenges related to SDOH. A holistic and ongoing educational approach that combines experiential learning with cultural competency skill development will be vital in reducing health disparities and fostering an equitable society. Now more than ever, the social mandate for professional nurses is to improve every patient’s physical, mental, and social health and to promote health equity for all. Nurses are uniquely positioned and ethically obligated to lead the charge to reduce health inequities by addressing issues that impact health, such as poverty. To do this, they must focus on the SDOH and possess both the skills and knowledge needed to identify needs and connect patients with necessary resources.

In this way, community residents and organizations can partner with nursing faculty and contribute to the “real-world” education of students.

Nursing students – the nursing professionals of tomorrow – must engage with content throughout the curricula that strategically integrates consideration of SDOH. However, it is not enough to transfer knowledge to our students. We must also encourage them to understand, reflect, analyze, and apply this content to future experiences and encounters. This can best be accomplished through experiential learning and collaborative activities, such as partnerships with communities, public health, industry, academic, healthcare, and local government agencies. Through carefully designed simulations that consider hidden identities, promote psychological safety, and are skillfully facilitated, nursing students have the opportunity to engage with content that may be outside their lived experiences, or to successfully navigate experiences that may trigger emotional reactions due to their familiarity.

Outside the walls of our traditional educational spaces, nurse educators can build bridges that reach from the academic campus into surrounding communities. In this way, community residents and organizations can partner with nursing faculty and contribute to the “real-world” education of students. Likewise, nursing students and faculty can provide vital health promotion and disease prevention services to those communities, thus enhancing communication and trust. Engaging in these, and other holistic educational activities, nursing students will gain confidence to contribute to the development of interventions, policies, and a healthcare system that promote social justice and health equity for all.

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Misty Bauer has been a nurse for 15 years, with practice experience in community health clinic settings, primary practice, pediatric home care and acute medical surgical care. Misty has worked as a bedside nurse, clinical coordinator/educator, and nursing professional development coordinator in classroom, online, and simulation education. She has developed, implemented, and evaluated yearly nursing and patient care technician competencies system wide and participated in the buildout and execution of a New Nurse Residency program. Misty was hired as the Nurse Educator Track Liaison in the UC College of Nursing through a grant from the Ohio Board of Nursing. In this role, she contributed to the development and implementation of a nurse educator track focus within the RN to BSN program. She has developed and maintained relationships with grant partner clinic sites while teaching as an adjunct course instructor. Misty is currently enrolled in the Doctor of Nursing Practice program at UC.

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Citation: Lee, R.C., Bauer, M., (January 31, 2024) "First, Seek to Understand: Deconstructing the Concept of Poverty for Nursing Education" OJIN: The Online Journal of Issues in Nursing Vol. 29, No. 1, Manuscript 4.

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