



## Gaining Skills for Patient and Family-Centered Care with Diverse Populations through a Social Work Course



**A**ccess to oral health care is a challenge that faces millions in the United States.<sup>1</sup> This has a significant impact on underserved and vulnerable populations including those with financial problems, disabilities, young and old ages, and lack of insurance.<sup>2</sup> Dental hygiene educational programs play an important role in preparing future professionals to address this challenge. In addition to providing care within their own clinics, many partner with community based-clinics and Federally Qualified Health Centers (FQHCs) to provide dental hygiene services. Not only does this help address access, but it also provides clinical and population-based experiences to help prepare students to meet the evolving health care needs of the public.

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# HEALTH LITERACY NOT ONLY AFFECTS THE ABILITY TO UNDERSTAND DENTAL TERMINOLOGY BUT ALSO HOW A PATIENT MAY MAKE DECISIONS ABOUT THE CARE THEY NEED

Underserved and vulnerable populations offer unique challenges in providing patient-centered care. In offices where patients may have a low income or only Medicaid coverage, it can be difficult to provide the best quality of care due to financial constraints. Cost can keep patients from seeking or receiving care as can their level of health literacy. Health literacy not only affects the ability to understand medical or dental terminology but also how a patient may make decisions about the care they need.<sup>3</sup> In populations where income and/or health literacy is low, there are often significant unmet oral health needs.

For decades, the University of Michigan (U-M) Dental Hygiene Program has been committed to providing care in the community. Students currently go on outreach rotations to three non-profit community clinics as well as provide care within a Public Act 161 Public Dental Prevention Program. In addition, each student spends one week during each of the last two semesters of their program at an FQHC in an underserved area of the state. These patient care, service-learning experiences have been described as “life-changing” by students as they observe oral health disparities firsthand and have an opportunity to make a positive impact on their patients’ oral health. Although students may be prepared clinically, they have not always been equipped to address the social, ethnic and cultural contexts in which they would be treating these populations.

## University of Michigan Social Work Course for Dental Hygiene Students

In order to better support students working with vulnerable and underserved groups, in 2015, the U-M Dental Hygiene program partnered with faculty of the U-M School of Social Work to develop a course entitled Skills for Patient and Family-Centered Care with Diverse Populations. One goal of this course was to prepare students for their outreach rotations by expanding their knowledge not only in the topics of cultural humility and health disparities, but also health literacy, social exchange, social justice and American poverty. Another goal was to provide students the opportunity to reflect and debrief about their outreach experiences, many of which involved treating patients with complex socioeconomic, psychological and medical challenges.

This two-credit course used a flipped classroom approach where students completed assignments using videos prerecorded by nationally renowned dental hygienists, dentists, social workers and public policy experts. Video topics included oral health literacy, public health, health disparities/role of poverty and how discrimination can be associated with overall health. In addition, each outreach site developed a video introducing students to the clinic’s mission and provided an overview of the population they serve. Guest lecturers also

joined classroom sessions and covered content in cultural humility;<sup>4</sup> health care experiences from members of the Lesbian, Gay, Bisexual, Transsexual or Transgender, Queer or Questioning (LGBTQ) community; and social identities. These topics were openly discussed in the classroom, allowing students to prepare or reflect upon their outreach and identify how the topics directly affected their behaviors or treatment process.

Through lectures, assignments and experience, this course engaged students and stimulated conversation about any fears/concerns before going on outreach as well as serving an opportunity to share thoughts and/or feelings upon returning. In the beginning of the semester, the class had more conversation about the videos and assignment topics. However, as the semester progressed, students began to share their experiences — not just from outreach, but also from their other patient interactions.

Students were required to write a reflection prior to going to their week-long outreach that was designed to have them consider their own identities in comparison to the target population, and help them to become aware of the differences they might encounter. One guest presenter spoke about social identities and how these might present themselves in different clinical settings. For example, visible identity aspects are those that can be perceived or assumed by looking at a person, such as skin tone, hair color or type of clothing. Invisible factors are things that define an individual

that cannot be seen. These types of identities could be religion, nationality, social class or level of education. These visible and nonvisible factors can affect how a patient is perceived by a provider and vice versa. Students then wrote about their own identities and shared them in small groups, comparing which aspects were more “noticeable” than others.

One particularly powerful assignment was called a “photo voice.” This required students to capture one photo of an experience or observation made while on outreach that had a particular impact on them. In addition to the photo, students would compose one or two lines of text explaining their photo and how it related to their community or population they were serving. For example, one student was struck by the number of appointment cancellations and/or no-shows during her outreach week. Her photo voice assignment captured the emptiness of the treatment room with thoughts on the possible complex psychosocial factors associated with missed appointments (Figure 1).

While on outreach, students were to think about the experiences they were encountering and select one incident that stood out the most to them. This incident needed to spark an emotional reaction, relate to social determinants of health and health equity, and provide an opportunity to reflect on the outreach experience as a whole, as well as compare it to their pre-reflection. This assignment was not to be about what the student had gained in terms of clinical experience,

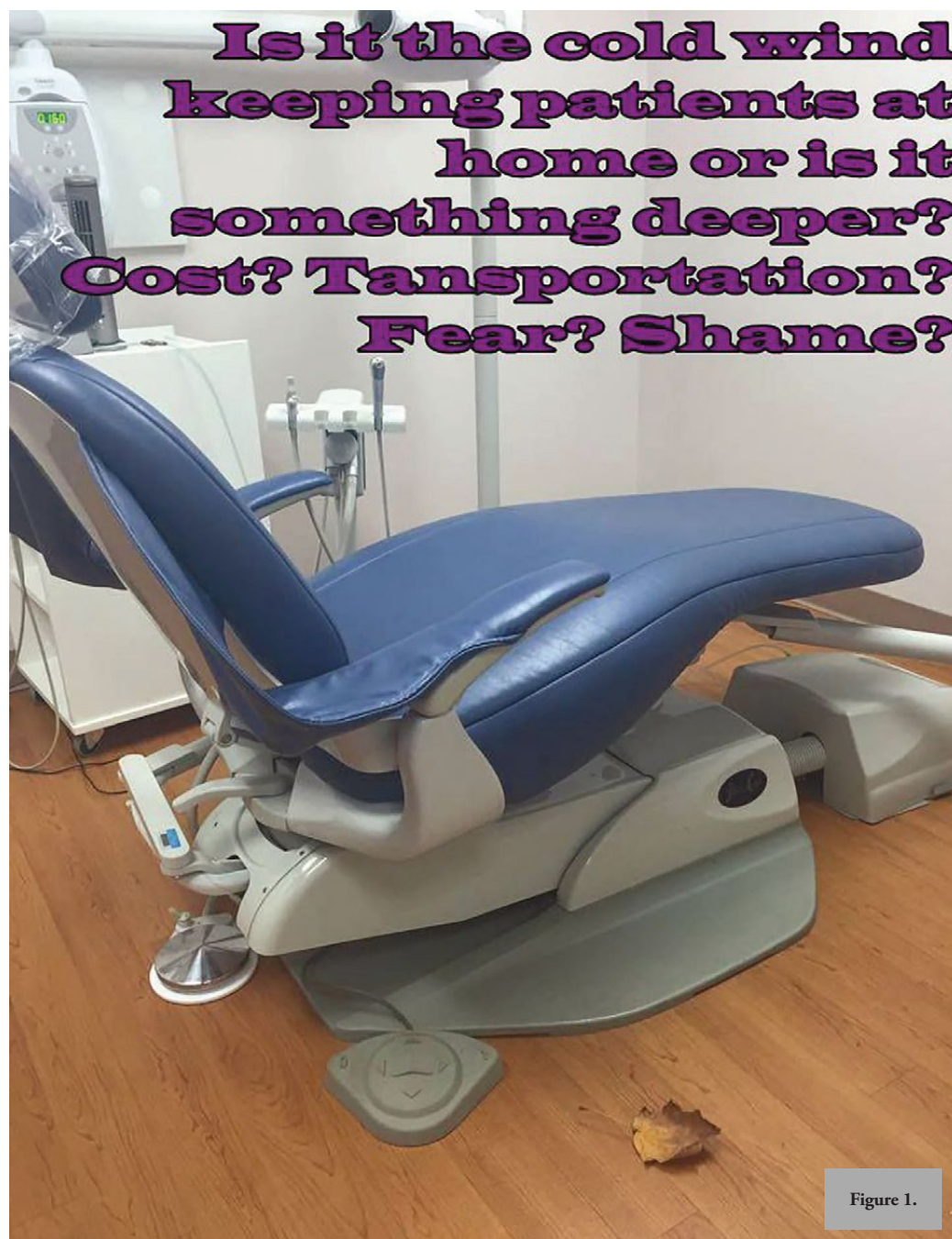


Figure 1.

but something that affected them on a deeper level of learning and impacted their philosophical and ethical views as a professional or as an individual.

## Course Impact on Students

Through involvement in this course, students came to a much fuller understanding of how providing patient-centered care requires attention to all aspects of a patient’s life. Social history is a crucial, yet frequently overlooked aspect in the provision of oral health care. Some social behaviors, such as tobacco use and/or alcohol consumption, are routinely included in the health history.<sup>5</sup> Work schedule or eating habits can also provide a

lot of insight into a patient’s health as well. Having conversations with patients about their lives and lifestyles tests providers’ critical-thinking skills; these conversations can help to fine-tune the dental hygiene diagnosis to be more individualized.

Students came to the conclusion that this was an important course to have in the dental hygiene curriculum and suggested that it might be offered sooner in the program. Even students who did not usually participate in class found their voices and wanted to share the experiences they had while on outreach. This course taught students that it is understandable to not know everything about a patient’s life, and that it is also safe to admit that to patients. Opening up this dialog can

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lead to a clearer understanding between patient and clinician, allowing for both better communication and better quality of care.

On a personal level, I had a conversation with a patient who had a high caries risk and many areas of decay despite the fact that she brushed twice daily. I engaged her in a discussion and learned that she worked a night shift job so that family could help watch her daughter. To help stay awake, she would eat snacks throughout the night and sip on soda. She confided in me that her daughter was very young, and that she tries to leave for work quickly to avoid upsetting her; thus, she found it easier to pick up snacks at a convenience store. Eating on the go had become a habit, and one that seemed to fit her lifestyle needs. I explained the process of carbohydrate breakdown and why sipping soda and eating all night long were contributing to her level of decay. Together, we determined that she could integrate taking a water bottle to work and would aim to set aside time once a week to prep meals as an activity with her daughter so these could be ready to go when she needed to leave. We also concluded that, in addition to improving her oral health, there could be an economic benefit to this approach.

Without engaging in a conversation and finding out more than just information about the foods she was eating and drinking, I would not have been able to understand the social context surrounding her long nights of snacking and soda sipping. Using motivational interviewing techniques like asking open-ended questions and

reflective listening, I now try to gain an understanding about my patient as an individual before I make recommendations.

Rather than making assumptions about a given individual because I was too afraid to ask, I have now learned it is far better to have a conversation with the patient than assume they do not want me to discuss these issues. After having these types of conversations in class with peers and presenters, I found that I was thinking about my own patients on a much different level. When providing care, rather than recommending the same products or suggestions to every patient, I tailored my recommendations to be truly patient-centered. I found myself really wanting to understand more than the oral health needs of my patients by trying to learn who the patient is as an individual and how I can better suit their oral health regimen to their lifestyle. ■

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