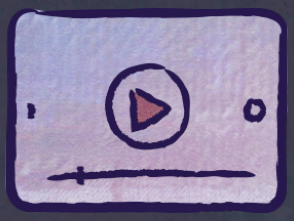
WHO CARES

A NURSE'S FIGHT FOR EQUITY

SHIFT FILMS

HOST-A-SCREENING KIT

CONTENTS



SCREENING ESSENTIALS

HOW TO HOST A SCREENING

STEP 1: TWO WEEKS OUT
Let friends know that you're hosting a screening of "Who Cares: A Nurse's Fight for Equity." Print out posters, post to social media, and share the trailer of the film. All of these elements are included in this packet. (We recommend doing this at least two weeks out.)

STEP 2: ONE WEEK OUT
Do a dry run-of-show! Send discussion questions to potential panelists, an agenda to the venue, and follow-up with potential attendees. We've included a sample in this kit. (We recommend doing this at least one week out.)

STEP 3: DAY BEFORE EVENT
Send out reminders the day before the event. Post the trailer to social media. Confirm final RSVP list and headcount.

STEP 4: DAY OF EVENT
It's showtime! In this kit, you'll find a pre-roll video, a link to the full film, as well as sample questions for a panel or breakout groups.

STEP 5: AFTER THE SHOW
Encourage your audience to share their thoughts and reactions to the film on social media. Tag us on Instagram @ shiftnursing or on Facebook. Leave a comment on the film's YouTube page. Use the hashtags #WhoCaresNursesCare #WhatNursesCareAbout.

STEP 6: THE NEXT DAY
Follow-up with your audience after the screening to share their thoughts about the film and inform upcoming SHIFT projects at this survey.

Sincerely, SHIFT Films
Contact us for support at hello@shiftnursing.com
For more resources, visit SHIFTNursing.com/WhoCares

@shiftnursing SHIFT Nursing @shiftnursing hello@shiftnursing.com

ABOUT SHIFT

SHIFT is a community for nurses to listen, read, laugh, cry, think and talk about big issues — together. We believe in the power of community because we know that you (yes, YOU) can shape the future of nursing. But none of us can do it alone.

We started this community around a podcast. In Season 2 of SHIFT Talk, we turned our focus to health equity. That's when we discovered Whitney Fear and knew we had to take our storytelling to the next level.

"Who Cares" is our first film. We hope it encourages, motivates, and inspires this generation of nurses to be advocates for health equity — and see their potential as leaders in the community.

We're constantly sharing resources to support nurses on our website. Please let us know if you'd like to become more involved in elevating nurses, together.

SHIFT — and the production of this film — is supported by the Robert Wood Johnson Foundation.

SHIFT

Robert Wood Johnson Foundation

IN THE FIGHT

FOR EQUITY,

IT'S NOT ABOUT

WHAT WILL MAKE

A DIFFERENCE,

BUT WHO.

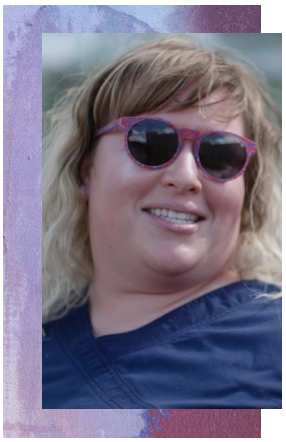
SUBJECTS OF "WHO CARES"

WHITNEY FEAR

MSN, Psychiatric Mental Health Nurse Practitioner

Whitney has spent most of her nursing career working at Family HealthCare, a federally qualified health center in Fargo, North Dakota. For her first six years, she exclusively treated patients experiencing homelessness. Her psychiatric practice takes a holistic and trauma-informed approach to treating behavioral health and substance use disorders. A member of the Ogala Lakota Nation, her firsthand knowledge of the barriers Native Americans face to good health informs the care she provides that factors in social determinants of health.

WHAT SHE CARES ABOUT: social determinants of health, health equity, Lakota culture, beadwork, her family, her new puppy — a corgi named Toast. Oh, and TikTok.



STACEY HONE

RN, Clinical Service Manager

Stacey and Whitney's long-time friendship from college brought Stacey to work at Family Healthcare six years ago. In her role as a clinical services manager, Stacey supervises nurses taking care of people experiencing homelessness, which can range from site visits to coordinating social services for patients and managing a triage line for patients. A self-described member of the "Overshare Club," Stacey places a high value on personal connection as part of her nursing philosophy.

WHAT SHE CARES ABOUT: nurse burnout, new nurse graduates, people experiencing homelessness, refugees, going on adventures with her husband and daughter, and keeping their six pets happy and healthy.

MELISSA KAISER

LBSW, Human Trafficking Navigator

Melissa is an independent consultant in the anti-human trafficking field and was the first human trafficking navigator in Eastern North Dakota for the North Dakota Human Trafficking Task Force, where she developed protocols for the state and helped develop a victim-witness program. With her specialization, Melissa trains local and national groups on person-centered, trauma-informed case management of victims. To help herself and others cope with the heaviness surrounding their work, Melissa maintains a space for supporting and encouraging other social workers on her blog and dedicates time outside of work to service projects for children in her community.

WHAT SHE CARES ABOUT: trauma-informed care, human trafficking and soaking up the sun in her new home in Florida.

For full film, visit:
ShiftNursing.com/WhoCares/Watch

FILM TEASE

Whitney Fear is someone who cares. But growing up on the Pine Ridge Reservation in South Dakota, one of the poorest areas in the United States, it could sometimes feel like no one did.

On the reservation, her family and other members of the Oglala Lakota Nation struggle to survive. Limited resources contribute to the lowest life expectancy nationwide.

But it was in her community that Whitney found the care and support she needed to discover a new path. A path to become a nurse.

Now, Whitney fights to helps others find their path, to health.

Learn more about "Who Cares: A Nurse's Fight for Equity" at
ShiftNursing.com/WhoCares

WHO CARES

A NURSE'S FIGHT FOR EQUITY

ABOUT THE FILM

As a psychiatric nurse practitioner, Whitney Fear extends the compassion, empathy and respect at the foundation of her Lakota culture to the many vulnerable populations she comes across at Family HealthCare, a federally qualified health center in Fargo, North Dakota.

Having grown up on the Pine Ridge Reservation in South Dakota, Whitney's firsthand knowledge of the many barriers Indigenous people face to good health helps her provide care that factors in the cultural, historical, and social determinants of their past — and present. This trauma-informed approach provides a step up to a more equitable and healthy future. Because that's the future of nursing. Daily acts of justice that answer the call for help from our society's most vulnerable: Does anybody care? Nurses like Whitney are the answer.

Beyond the clinic, Whitney advocates for equity for Indigenous people and other underserved populations as a founding board member of the City of Fargo Native American Commission, a steering committee member of the Culture of Health North Dakota, and a leadership team member for the North Dakota Center for Nursing.

Her story is one of adversity, compassion, and the difference it can make when one person cares. Especially when that person is a nurse.

PANEL DISCUSSION

Part of the power of documentary storytelling are the conversations they spark afterward. As part of your screening, consider hosting a panel discussion or coordinating breakout discussion groups after the film.

Consider also sharing this panel discussion hosted by the Robert Wood Johnson Foundation and SHIFT when the documentary premiered. It featured subjects from “Who Cares: A Nurse’s Fight for Equity,” as well as nurse change-makers. We have a little fun, answer some “Rapid-Fire” questions, and dive into #WhatNursesCareAbout.

Visit YouTube.com/@SHIFTnursing to watch.
“Premiere + Panel Talk | Who Cares: A Nurse’s Fight for Equity | SHIFT Films”

DISCUSSION DECK

THE FILM TOUCHES ON A LOT OF IMPORTANT TOPICS. BUT IT DOESN'T GO DEEP INTO THESE ISSUES. PLEASE USE THESE CARDS TO FACILITATE BREAKOUT GROUP DISCUSSIONS — OR OFFER THEM UP FOR A PANEL.

RESHAPING THE NARRATIVE OF NURSING

- Why does bringing your entire self to work make you a better care provider?
- Why is connecting with community resources also part of a nurse's job?
- How can nurses become leaders in their community's health?

COMPASSIONATE CARE BEYOND THE BEDSIDE

- What does it mean to be a culturally sensitive nurse?
- Why should nurses get to know their patient beyond their vital signs?
- Discuss moments when taking extra steps to engage with a patient's personal or cultural background elevated the care you provided and/or their outcomes.

INSPIRING THE NEXT GENERATION OF NURSES

- How is this generation of nurses going to change healthcare?
- What difference are you trying to make in your community's health?
- How can personal stories, inspiration and resources encourage those from disadvantaged communities to see a nursing career as accessible to them.

HEALTH EQUITY

- How can nurses be the answer for health equity?
- Why and how can nursing be an act of health justice?
- What information and resources do you use to learn more about equity issues in your community?
- Why is diverse representation in the nursing community important for the community's health?

ISSUES IN THE FILM

RESOURCE ARTICLES TO LEARN MORE

There's more nuance and context to consider around the issues discussed in the film than we could capture on screen. So, in the following pages you'll find articles about the main themes. At the end of each article are discussion questions and additional resources to take action or learn more. We've designed them to be printed or sent digitally as PDFs to your audience.

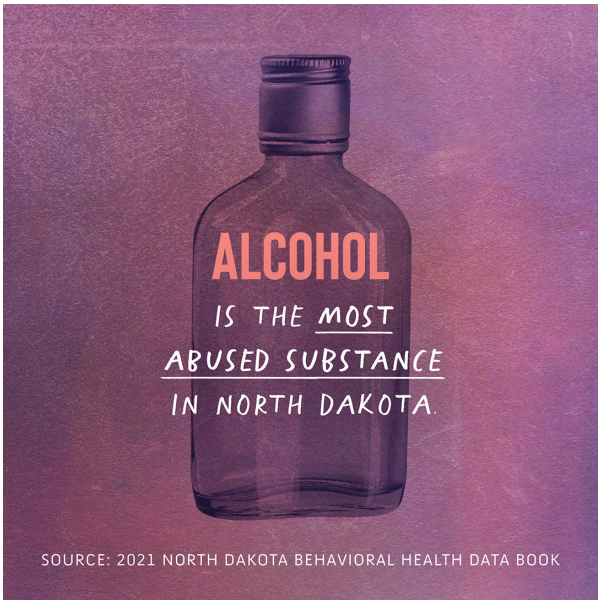
Find the individual article files at this link.

Find the articles online at SHIFTNursing.com/articles.

HOW NURSES CAN TREAT SUBSTANCE USE WITH TRAUMA-INFORMED CARE

Social determinants play an important role in a patient's experience with addiction. Here's how one North Dakota nurse makes a difference.

As a psychiatric mental health nurse practitioner at Family HealthCare, Whitney Fear fights for equity in her treatment of those with substance use disorders. In North Dakota, where alcohol is the most abused substance in the state, Whitney uses trauma-informed care with her patients, an approach that factors in adverse childhood events or other experiences that could affect their experience with addiction. In "Who Cares," we learn that Whitney used this person-centered approach to help Damon, a former patient, with his alcohol use disorder.



With substance abuse, sometimes it's not about getting people to quit using altogether if they're not ready. Instead, it's about helping your patients feel better. This is a harm reduction approach that's more productive than pushing people to quit, says Whitney, who notes that recommended guidelines are just that — guidelines. Sometimes they're not meant for every patient. Instead of an approach like abstinence, she asks her patients: "What are some things that you would like to see improve that don't involve quitting drinking altogether?"

Behind every addiction is a person with a story. Studies show that the social determinants of health — including where patients live, their race, any adverse childhood experiences, their resources, and their ability to access quality healthcare — play a significant role in their experience with a substance use disorder.

For instance, individuals living in rural communities are more likely to struggle with some form of addiction. This may be due to a variety of factors, such as fewer educational and job opportunities, limited access to medical care, and higher poverty levels. In 2020, 49.5 percent of North Dakota residents reported that they lived in rural areas — 35.4 percent higher than the average U.S. rate. And in these rural parts of North Dakota, individuals were more likely to report that alcohol use was a serious problem.

For many people in rural areas, finding help can be yet another battle on top of their addiction. As many as 13 percent of North Dakotans ages 18-25 needed treatment for alcohol use disorder in a specialty facility but could not receive treatment. And across all age groups, a higher percentage of people in North Dakota needed treatment for alcohol use disorder than the rest of the United States. Lack of Medicaid funding continues to be an issue for those seeking treatment programs throughout the state.

A North Dakota 2020 public health report showed how cultural perceptions and social norms can also influence a community's continued use of substances. Ease of accessibility to alcohol continues to be a risk factor for many North Dakotans. Compared to states like Virginia — with one bar for every 64,773 people — North Dakota has the highest number of bars per capita, with one bar for every 1,809 people. This makes it that much easier to access alcohol in areas like Fargo.

Evidence suggests that all of this contributes to a generational public health issue in North Dakota. According to a 2021 study, it's estimated that within a month, 34.1 percent of adults in North Dakota engaged in binge drinking (five or more drinks in two hours), compared to the U.S. average of 26.5 percent. In fact, 90.8 percent of adults in North Dakota believe that alcohol is consumed excessively within their community.

COVID-19 has aggravated everyday stressors, leading to an increase in alcohol consumption on a national level. Recent findings report that as many as 60 percent of individuals increased their alcohol intake during the pandemic lockdowns. Research suggests that stress-related drinking is often more dangerous, as those who use substances to cope are more likely to develop alcohol use disorder. The rise of addiction across the country has led to an even greater need for patient-centered treatment for substance use disorders.

In "Who Cares," Whitney shares her personal experience with alcohol, both individually and in her community on the Pine Ridge Reservation, a place where substance use disorders contribute to lower life expectancies. This helps inform her person-centered approach to care and gives her empathy for those she treats. For more insight, listen to her episode on SHIFT Talk and explore the resources below.

DISCUSSION QUESTIONS

1. Think about how any personal experience with substance use informs the way you approach patients. Does it lead to greater empathy or greater stigma? Why is that?
2. What did you think of the way Whitney spoke with her patient Damon about his alcohol use? How do you approach patients who have substance use disorders?
3. Think about your own community. How is Fargo, North Dakota, similar — or different? What factors might lead to an increase in substance use — or limit access to care?
4. What are the factors in a patient's personal story to consider when providing them with resources or approaching a conversation about substance use?
5. What are some ways that you can be an agent for change in how the healthcare system treats and interacts with patients in your community who have substance use disorders?

For further reading and resources to make a difference, visit this article online at shiftnursing.com/articles/substance-use.

HOW BURNOUT IMPACTS NURSING: BEFORE, DURING AND AFTER COVID-19

How more than two years of fighting the coronavirus has led to a mass exodus from nursing.

Whether it's psychiatric nurse practitioners like Whitney Fear, nurse managers like Stacey Hone or social workers like Melissa Kaiser, the work of healing, helping and saving lives every day can take a toll. And while the pandemic certainly didn't create nurse burnout, it highlighted and aggravated the problem with such intensity that it continues to threaten the healthcare workforce like never before.

The extreme demands put on nurses over the last few years has led to not only a collective feeling of grief among the profession, but has taken an unprecedented toll on nurses' wellbeing. The World Health Organization (WHO) went so far as to call burnout an "occupational phenomenon" in the updated ICD-11 codes. That was in 2019. In retrospect, we know that that feeling didn't just disappear in 2022 — it worsened.

During COVID-19, more than one-third of nurses experienced some form of anxiety, stress, depression and sleep disruption. But if you thought this might be normal during a pandemic, it's not. More nurses worldwide struggled with these symptoms during COVID-19 than they did during both the MERS and SARS epidemics. An American Nurses Foundation survey in 2021 found that 81 percent of the 22,000 nurses aged 34 years and younger expressed exhaustion; 71 percent felt overwhelmed; and 65 percent reported anxiety. In 2021, 66 percent of critical-care nurses considered leaving the profession due to the pandemic alone.

Is it any wonder that so many nurses are leaving the field? Prolonged exhaustion, heavier workloads, longer hours, understaffed hospitals, poor work/life balance, increasing nurse vacancies, climbing nurse-to-patient ratios, verbal and physical assault and even technologies like electronic health records have all contributed to an ever-widening nationwide nurse shortage. One survey found that half of nurse respondents were planning to leave their job. In another, nurses planning to leave their profession cited these top two reasons: insufficient staffing and work negatively impacting their health and emotional wellbeing. It's a vicious cycle: short staffing leads to burnout, burnout leads to turnover, and turnover leads to more short staffing, which leads to burnout . . . and the cycle continues.

This is serious for public health, as nurses are the largest segment of our nation's healthcare workforce. With more than 6 million employed in 2019, nurses represent nearly 30 percent of all hospital employees. In 2021, Dr. Ernest Grant, the president of the American Nurses Association, estimated that the country would need an additional 1.2 million nurses by 2022 to meet the increased demand for healthcare workers due to high turnover rates from COVID-19. Eventually, Dr. Grant wrote to Secretary for the U.S. Health and Human Services Xavier Becerra, pleading that Becerra officially declare the shortage a "national crisis."

But even more dire and urgent than the healthcare workforce shortage is the deadly impact of burnout on healthcare workers themselves. Since the onset of COVID-19, suicides have increased among healthcare workers due to this combination of stressors. In a March 2021 study in the Journal of Advanced Nursing, risk factors for burnout included younger age, limited social and familial support to cope with pandemic-related stressors, anxiety over contracting the virus, increased workload, longer hours working in COVID-19 wards, high-risk environments, insufficiently staffed hospitals, limited resources and minimal specialized training for the virus. As many as 34.1 percent reported emotional exhaustion, 12.6 experienced depersonalization and 15.2 percent felt a lack of personal accomplishment.

Of all healthcare workers, nurses are likely to struggle with burnout the most, with female nurses more likely to experience burnout than male nurses. Why is that? Research suggests it's because nurses are among those in closest proximity to patients infected with COVID-19, and an increased risk of infection often leads to an increase in workload. Tragically, the International Council of Nurses reported in June 2020 that, worldwide, more than 600 nurses had died due to COVID-19.

But nurses were experiencing burnout long before the pandemic. A Kronos Incorporated survey back in 2017 revealed that 90 percent of nurses needed a better work/life balance and, as a result, were considering leaving their hospital for another job. Factors that contributed to burnout before COVID-19 included heavy workloads, limited staffing, poor communication between physicians and nurses, and minimal organizational leadership — all issues that only heightened while fighting a global pandemic. Data conducted in 2018 revealed that, of those surveyed, 9.5 percent of nurses left their most recent job; and of that 9.5 percent, 31.5 percent reported that burnout contributed to their leaving their position.

Research suggests workplaces can help employees cope during an infectious disease outbreak by providing counseling services, support groups, online workshops and other training materials. But perhaps most critically, combatting burnout starts with improving the conditions of the workplace for nurses. The WHO recommends increased staffing and resources, and outlines some strategies for nurse managers — including flexible schedules, rotating nurses, effective communication, and encouraging staff to use behavioral and emotional support services.

In "Who Cares," we meet Melissa Kaiser, an anti-human trafficking social worker who works closely with Whitney to identify and help potential trafficking victims in the community. As a social worker, Melissa has expertise in psychological interventions, emotion regulation and burnout. She shares how the practice of self-care helped her cope with burnout — but not in the way you might think. Melissa says that self-care isn't just about bubble baths and red wine — it goes much deeper than that. "You have to have honest conversations with yourself," she says. "Ask [yourself], 'How am I separating myself from work?'" Melissa intentionally sets aside time, outside of work, to do things that help her recharge and bring her back to herself. In North Dakota, one of those ways was through service projects for children in her community.

As a nurse, this is certainly a moment that calls for systemic change at the institutional and national level — but that takes time, and you need relief now. Beyond reaching out to your administration and discussing solutions at work, find moments to incorporate micro-restorative techniques into your day. Then, when you finally leave work, try to set boundaries between your time on shift and your time at home. Tina Gerardi, MS, RN, CAE, executive director of the Tennessee Nurses Association (TNA), recently shared these tips: 1) take deliberate steps to find joy outside of work once again, whether that's picking up a new hobby or returning to an old favorite; 2) develop strong relationships outside of work — while friendships are great on shift, you need someone you can process with off the clock; 3) and most importantly, whether it's a walk around the block, getting enough sleep or seeing a therapist, be sure to care for your health, inside and out. Because while nurses are so busy taking care of everyone else, it's important to remember that the most important person to take care of — is yourself.

DISCUSSION QUESTIONS

1. What has been your experience with burnout? Did you experience burnout before the coronavirus pandemic? After? Discuss how those experiences compared to each other.
2. Can you recognize feelings of burnout in yourself or others? What tends to happen when this occurs?
3. In "Who Cares," Melissa Kaiser shared some of the ways that she separates herself from her work. Did you connect with her approach? What are some ways you personally combat burnout?
4. In what way does having a strong community of fellow nurses around you play a role in helping you cope with burnout?
5. Think about your own hospital (or another workplace). What resources can help with exhaustion, anxiety or stress at work?

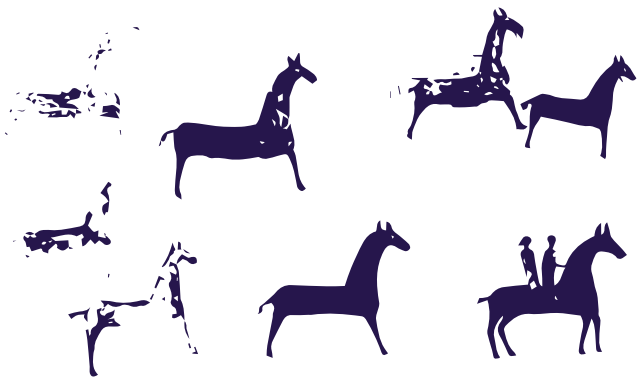
For further reading and resources to make a difference, visit this article online at shiftnursing.com/articles/nurse-burnout.

WHAT LED TO HEALTH DISPARITIES FOR NATIVE AMERICANS ON THE PINE RIDGE RESERVATION — AND WHAT CAN NURSES DO ABOUT THEM?

The Pine Ridge Reservation is evidence of how social determinants and systemic issues like racism led to our nation's health inequities

Camp No. 334: This was the name of the 2.8-million-acre stretch of land in South Dakota that held Indigenous prisoners of war in 1889. It is where Native Americans were forcibly relocated by the U.S. army. It is also home to the Oglala Lakota Nation, one of seven bands of the Lakota division of the Great Sioux Nation. Today, that same stretch of land is known as the Pine Ridge Reservation. One of 325 reservations in the United States, Pine Ridge is not just a painful reminder of America's violent encroachment on Native American lands. The reservation's hills harbor the trauma of its people, as well as one of the poorest parts of America.

Pine Ridge is also where Whitney Fear, a psychiatric mental health nurse practitioner in Fargo, North Dakota, and subject of the documentary "Who Cares," grew up. On the reservation, Whitney's family struggled to survive. As a member of the Oglala Lakota Nation, Whitney's firsthand knowledge of the barriers to care that Native Americans face informs her culturally appropriate, trauma-informed approach to her patients

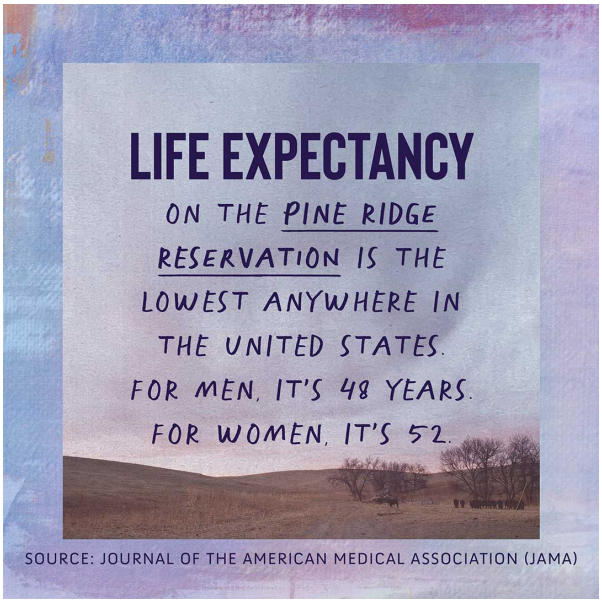


Pine Ridge has poverty levels comparable to that of developing nations, with economic disadvantages and other social determinants contributing to poor health outcomes among its residents. On the reservation, women have a life expectancy of 52 years and men have a life expectancy of 48 years. Of all racial and ethnic groups in America, members of the Lakota nation have the lowest life expectancy. According to the Indian Health Service (IHS) they're more likely than other Americans to die from cervical cancer (500 percent higher), suicide (74 percent higher), alcoholism (552 percent higher), homicide (83 percent higher), diabetes (800 percent higher), infant mortality (300 percent higher), unintentional injuries (138 percent higher), tuberculosis (800 percent higher), and even car crashes — because of the limited access to care and prevalence of substance use disorders.

The health inequities the Lakota and other Native Americans face can be traced back centuries. In 1868, the Fort Laramie Treaty guaranteed health care to tribes in exchange for Native American land and resources. But by the 1880s, the Bureau of Indian Affairs offered minimal health services. Native American policy expert David H. DeJong recently told The Argus Leader, "From the start, funding for the health programs was inadequate and largely focused on preventing the spread of infectious disease." Despite its promises, the U.S. government did nothing to advocate for the wellness of Native Americans. This set the stage for poor health outcomes, for generations to come.

By the end of the 19th century, mistreatment only worsened as the U.S. government forcibly relocated Native Americans onto reservations and forced Native children into boarding schools, pressuring the loss of their language and culture. Removed from the resources of their ancestors, Native Americans had a harder time hunting their usual foods or foraging natural ingredients for traditional medicines on new land, leading to poorer diets and health outcomes. This, research suggests, most likely contributed to the higher rates of illness — such as diabetes, heart disease, cancer and mental health issues — that we see today among Native Americans.

By the 1950s, the Indian Health Service (IHS) officially took over the health care of Native Americans. An agency within the U.S. Department of Health and Human Services, IHS fulfills those treaty obligations of federally funded healthcare for Native Americans. Today, IHS is responsible for the health and wellbeing of 2.2 million Native Americans throughout the United States, but the system faces a chronic lack of funding. In 2014, IHS's per capita allocation for patient care was about one-third of health care spending nationally per person. Because Congress continues to underfund IHS, IHS hospitals continue to offer limited services. Care provided by IHS facilities is inconsistent at best, widening the health disparity gap even further. Many facilities are short-staffed, and some facilities lack the basic necessities you'd find at an average hospital — such as emergency rooms, advanced imaging machines or Wi-Fi.



SOURCE: JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION (JAMA)

All of this puts Native Americans at a disadvantage compared to non-Natives when seeking care. According to Donna Keeler, executive director at South Dakota Urban Indian Health, "a federal prisoner has more health care funding allocated for his care than an urban American Indian does." Understandably, Native Americans have conflicting feelings and wariness about the services provided by the government, not only from poor experiences of the limited services, but also due to "broken treaties, forced removal from their land and the effort to eradicate Native culture."

Other barriers to care for Native Americans include long distances to providers and insurance coverage. Most IHS facilities are located in rural settings, making it even more difficult for eligible patients to receive standardized care from IHS providers. Can you imagine waiting two hours for an ambulance? And then, there's paying for care. According to the Office of Minority Health, 43 percent of Indigenous peoples rely on Medicaid or public health coverage. As recently as 2019, 14.9 percent of Indigenous peoples in the United States had no health insurance at all — more than three times the size of the uninsured white population.

Pine Ridge is not alone in its disadvantages: The Rosebud Indian Reservation, home to Sicangu Sioux, one of the other seven tribes of the Lakota nation, is 135 miles east of Pine Ridge. When his local hospital was likely to lose federal funding, the former Rosebud Sioux President William Kindle told the press, "We're a third-world country, you know, a third-world country with our health care."

Systemic disadvantages like these contribute to chronically poor health outcomes among Indigenous peoples, classified by public health researchers as American Indian / Alaska Native (AI/AN). American Indian / Alaska Native (AI/AN) adults were nearly three times as likely to be diagnosed with diabetes in the U.S. than non-Hispanics white adults in 2018, according to the Centers for Disease Control and Prevention (CDC), and twice as likely to experience obesity. In 2019, the rate for tuberculosis was seven times higher for AI/AN individuals, and heart disease was the leading cause of death. This all adds up to Native Americans having the lowest life expectancy of all racial or ethnic groups at 71.8 years, compared to 78.8 years for non-Hispanic whites.

Whitney Fear herself describes growing up on the Pine Ridge Reservation as living in "an ocean of grief," due to all of the early and frequent loss of life in her community. Whitney is also a living, breathing example of the resilience of the Lakota Nation. Despite all of the pain and suffering, her community's support and culture also cultivated her hopeful and compassionate approach to care. It's why she's dedicated resources and her personal experiences to providing culturally sensitive care for the unique needs of Native Americans, and specifically, the Lakota people in her community of Fargo.

Depending on how nurses encourage or discourage members of different communities to interact with the healthcare system, they may contribute to structural inequities, according to the Future of Nursing report.

To make a positive impact, it's essential for nurses to practice "cultural humility." In other words: 1) first acknowledge our position of power in a healthcare interaction, 2) have an awareness of potential biases, and 3) take a learning-oriented approach to working with diverse communities. This could look like learning more about the disparities and intergenerational trauma that your patient and their community may continue to face through cultural sensitivity trainings. Studies show that the retention of cultural traditions among Indigenous populations helps heal intergenerational historical trauma and contributes to improved health outcomes. Connecting with local groups who can provide your patient with culturally appropriate social services can also build a valuable partnership in the fight for health equity.

For instance, a program called Family Spirit, out of the Johns Hopkins School of Public Health, will train providers to conduct culturally appropriate home and virtual visits for Native Americans. You can ask your workplace how to become affiliated with organizations like these and expand your patient base into more Native communities. There are also organizations actively working to increase the diversity of providers to reflect Native communities, such as Indians into Medicine. We've outlined more resources and partnerships below to help a nurse out.

DISCUSSION QUESTIONS

1. The economic and historical trauma that the Pine Ridge community has experienced continues to negatively impact its residents' health. Think of a city, neighborhood or other community near you that faces similar challenges. How have systemic issues like poverty lead to poor outcomes?
2. What social determinants affected the health of the community where you grew up? Does that help you connect with patients who may be experiencing something similar?
3. Who else do you care for at your workplace that may have experienced similar traumas to Native American populations? Does "Who Cares" or the information in this article make you reconsider how you might approach the care of various populations who experience economic disadvantages and other social determinants that contribute to poor health outcomes? How so?
4. How could more widespread education and information about the health disparities, such as those facing Native Americans, affect or change the practice of nursing in and around all communities?
5. How have you seen historical trauma play out in your community? Can you see the lingering effects on health outcomes for certain patient groups? What seems to make a difference?
6. Which community resources or organizations can you partner with to understand their cultural health priorities, history and support efforts already underway to improve quality of life and health?

For further reading and resources to make a difference, visit this article online at shiftnursing.com/articles/pine-ridge-reservation.

HIDING IN PLAIN SIGHT: HOW NURSES CAN STOP HUMAN TRAFFICKING

Healthcare workers can do something about human trafficking — if they're enabled with awareness and the resources to help victims.

Melissa Kaiser's job is not easy. As an independent consultant in the anti-human trafficking field, Melissa trains local and national groups on person-centered, trauma-informed case management of human trafficking victims and how to build multidisciplinary teams to support them. The work is not for the faint of heart. Nearly every day, Melissa faces situations that are heartbreaking.

Human trafficking is the exploitation of someone for compelled labor or commercial sex using force, fraud or coercion. Across the world, millions of human trafficking victims are exploited for sex, labor, and organs — including in the United States. According to the federal government, human trafficking is a public health concern that affects individuals, families, and entire communities. Yet the American public remains largely unaware of the crimes taking place in their towns, cities and neighborhoods. While its hidden nature makes it difficult to estimate the number of victims, human trafficking can happen in any community.

A licensed social worker who specializes in anti-human trafficking work, Melissa was hired as the first Human Trafficking Navigator for Eastern North Dakota, contracting with the North Dakota Human Trafficking Task Force. Employed by the Bureau of Criminal Investigations as a victim/witness specialist, Melissa helped create the first integrated victim services and law enforcement program in the state. With a specialization in secondary trauma, Melissa trains healthcare workers like Whitney Fear and others at Family HealthCare to identify and help victims.

It's been more than a decade since the United States passed a federal law against human trafficking. And yet, as many as 16,658 individual victims were involved in 10,583 incidents of human trafficking in the United States in 2020, according to the Polaris Project, a social justice nonprofit dedicated to tracking this issue. What's even more shocking is that victims often interact with the public while being held in involuntary servitude through fraud, violence, and coercion.

In October 2014, the Urban Institute released one of the most comprehensive reports to date on labor trafficking, based on interviews with 122 labor trafficking survivors. It revealed that victims typically come to the United States from Asia and Latin America through legal visas to work in the agricultural, hospitality, construction, and restaurant industries. Labor trafficking victims run the range of backgrounds, education, race and ethnicity, as well as fields of work — the most common being domestic service, construction, agriculture and hospitality. Unfortunately, trafficking recruitment often begins through victims' personal networks. On average, they pay their traffickers $6,150 in fees to be "recruited" to work in the United States.

The U.S. State Department estimates that the number of foreign nationals trafficked into the United States each year ranges from 14,500 to 17,500, but no government agency has published an estimated number of U.S. citizens trafficked domestically. Poverty, lack of education, language barriers, LGBTQ+ status, addiction, housing insecurity, homelessness and early childhood trauma or abuse are some of the common domestic human trafficking risk factors. Human trafficking disproportionately affects minors, especially marginalized individuals who have a history of living in abusive households, struggle with housing insecurity, or who have experience in foster care or the juvenile or criminal justice system. Young lesbian, gay, bisexual or transgender people are also disproportionately affected by housing instability and are therefore at some of the greatest risk for human trafficking.

Polaris reports that housing insecurity is a leading indicator of human trafficking and one of the greatest opportunities to prevent it. This social justice organization recommends prioritizing efforts around housing for those most vulnerable to homelessness, especially those about to age out of the child welfare or foster care systems. The coronavirus pandemic — a time which saw significant housing insecurity and economic hardship — led to a significant increase in human trafficking nationwide. Victims being recruited by a family member or caregiver also increased dramatically in 2020, to 31 percent of all victims, according to Polaris.

The types of exploitation and abuse that human trafficking victims experience vary, from withholding pay they were promised to psychological manipulation and sexual abuse. Captive workers are held against their will by their employers through threats and, all too often, physical violence. This leaves many with long-term psychological disorders, substance use disorders, and other complex health needs that can impact generations to come.

Healthcare providers can be a key ally in the fight against human trafficking, as the effects of the abuse on victims' mental and physical health can require treatment. Healthcare providers are especially a first touchpoint for trafficked women and girls, who are estimated to represent as many as 80 percent of all trafficking victims. Approximately 50 percent of victims in one study saw a healthcare professional during their exploitation. But many health professionals are unaware when those moments occur. In a 2019 survey of nurse practitioners, as many as 87 percent said it was possible that they may have encountered a trafficking victim in their practice, while 35 percent reported they were unsure. These nurses were much less confident in their ability to spot a child trafficking victim. Much of this has to do with limited data, training and research.

Public health experts have called for the healthcare system to better integrate the training of how to identify and treat victims of human trafficking into existing trainings on intimate partner violence, domestic violence and child and elder abuse. Physical indicators of trafficking can include malnourishment, dental injuries or diseases, gastrointestinal disorders, skin conditions, tuberculosis, sexually transmitted infections, sexual violence, bruises or other signs of physical abuse, a workplace injury or chronic pain. Mental health workers may also come across trafficking victims as they can present symptoms of anxiety, post-traumatic stress disorder, suicidal ideation, substance use disorders and depression as a result of the trauma they have experienced.

So, what can nurses do? Task forces across the country recommend that all healthcare workers undergo training to become aware of the signs, symptoms and solutions for human trafficking. Healthcare services, which require an intake process, are key moments to spot the signs of trafficking and implement one of the screening toolkits. Join or form a multi-disciplinary team that will work to combat trafficking in your community and contact your local task force to get involved.

Law enforcement officers and specialists like Melissa Kaiser provide trauma-informed trainings for multi-disciplinary teams just like this for continuing education credits. There are even federal resources since Congress passed the Stop, Observe, Ask and Respond (SOAR) to Health and Wellness Act in 2018, which established a federal program to train health and social service providers on human trafficking.

It's also important to be aware of the resources available for victims, in case one crosses your path. Trafficking survivors who are U.S. citizens are eligible to receive social services, including help for food, housing, healthcare, income, employment, legal assistance and interpretation or transportation services. There are visas available to qualify for these services for non-citizens, too. At the state level, there are many health services and social programs to support victims trying to escape trafficking, which range from dental, sexual and mental health services to food, clothing and housing. See if your state is one of the 22 that has established additional special funds for helping survivors, as well as training health and social professionals to assist them.

DISCUSSION QUESTIONS

1. Does it surprise you to know that human trafficking occurs to the degree that it does in the United States? Why or why not?
2. What are some ways that you can recognize the signs of human trafficking?
3. Whitney Fear describes in "Who Cares" how detrimental it can be for victims to have negative interactions with care providers. Did anything come to mind when she described moments like this from your own experience as a patient or care provider?
4. If you have been suspicious that a patient in your care was a victim of human trafficking, what specific signs or indicators caught your attention? What did you do about it?
5. In "Who Cares," Melissa Kaiser takes a phone call from someone who identified a potential victim of human trafficking at their workplace. Who could you call if a victim came into your care?
6. How does the correlation between housing instability and human trafficking make you think differently about the risks to patients who may be on the verge of losing their housing?
7. What steps could you take to increase awareness of human trafficking in your school, community or workplace? Are there protocols or community partners in place to call if a victim were to walk through your doors?

For further reading and resources to make a difference, visit this article online at shiftnursing.com/articles/human-trafficking.

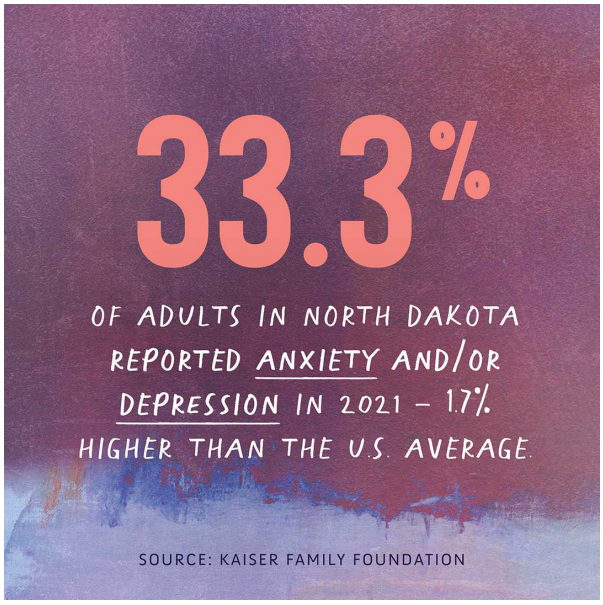
‘A MENTAL HEALTH CARE DESERT’: DISPARITIES IN NORTH DAKOTA’S MENTAL HEALTH RESOURCES

In North Dakota, the mental health crisis is compounded by limited access to care — especially for Native Americans.

Almost every state is reckoning with a mental health crisis. But for areas with underserved populations and limited resources, like where psychiatric nurse practitioner Whitney Fear grew up in Pine Ridge, South Dakota, and where she currently lives in North Dakota, treating mental health conditions presents an even greater challenge. In primarily rural states like North and South Dakota, a chronic lack of mental health resources — for both Native Americans and non-Natives — continues to set back those in need of care.

Between 2014 and 2016, mental health — including a demand for services, providers and tele-psychiatry — ranked as the second most common need across community health needs assessments conducted throughout North Dakota. This demand for mental healthcare can be linked to an increase in suicides throughout the area. Between 1999 and 2016, suicides rose by 58 percent, increasing more than in any other state. In 2017, suicide was the eighth leading cause of death throughout North Dakota; and by 2019, the state’s age-adjusted suicide rate (18.5) was significantly higher than the national rate (13.9).

Prior to the pandemic, 20.5% of adults in North Dakota suffered a mental illness. Of those who needed mental health treatment but did not receive it, 36.3% said it was due to cost. COVID-19 only further exacerbated underlying mental health struggles in the area. In 2020, 19.2 percent of North Dakota residents had been diagnosed with some form of depression. Among adults surveyed in North Dakota in fall 2021, 33.3 percent reported symptoms of anxiety and/or depression — 1.7 percent higher than the U.S. average.



Unfortunately, North Dakota is limited in its ability to meet its residents' needs. Some call the state's community-based services "inadequate or nonexistent," and jails have been compared to "warehouses" for those with untreated mental health conditions. Western North Dakota, an area that one local news article deems "a mental health care desert," is particularly desperate. The cities of Dickinson and Williston have no psychiatric inpatient beds.

But for Native Americans living in North Dakota, the mental health crisis is even more dire. In 2020, 26.1 percent of American Indian and Alaska Natives in North Dakota reported that they suffered from some form of depression. Data from the 2019 Fargo Cass Public Health Assessment revealed a suicide rate of 45.1 for Native Americans in North Dakota, compared to the national average of 13.4.

In North Dakota and beyond, societal and historical factors such as colonialism, genocide, oppression and systemic racism have contributed to a collective trauma that leads to higher instances of mental health issues among Native Americans. Research has in fact established a direct link between historical trauma and conditions such as depression, anxiety and substance use disorders. There's also an indirect link to suicidal ideation. Experts say that this "shared suffering" may be reflected in mental health disparities on a population-level. More than 10 percent of American Indians and Alaska Natives feel sad, hopeless or that "everything is an effort," all or most of the time. This is compared to 6.6 percent of non-Hispanic whites.

Although they are more likely to experience mental illness, Native Americans are also more likely to face significant barriers to mental health services. Across the country, approximately 43 percent of Indigenous peoples rely on Medicaid or public health coverage. As recent as 2019, 14.9 percent of Indigenous peoples in America had no health insurance at all — more than three times the rate of uninsured white people. They also face cultural barriers. In the United States, psychiatrists, therapists and

prescription medications are often used to treat mental health disorders, and experts note that these approach may be in conflict with Native Americans who value a more holistic approach to care. Some of the culturally based interventions used to treat mental health conditions among Indigenous peoples include traditional healers, practices for wellness, ceremonies, prayers and even storytelling. Unfortunately, most healthcare professionals trained in the United States are unaware of Indigenous traditional medicine or how to contextualize it into current clinical care.

In "Who Cares," Whitney Fear speaks to some of the cultural challenges she witnesses in behavioral health, such as prolonged eye contact. This behavior that practitioners often use to evaluate patients is actually considered impolite in the Lakota culture. Fear also describes one instance where a Native American patient was prescribed antipsychotics for having a spiritual sighting of a creature that's culturally significant to the Lakota. Each of these anecdotes speaks to the gap between available mental health resources and culturally sensitive care. The Pine Ridge Reservation, where Fear grew up, exhibits how Native American communities can struggle with the availability of mental health resources and the low life expectancy that can result from untreated behavioral and mental health disorders.

But there are steps we can all take to help overcome this gap in care. The first is to become more aware of culturally appropriate resources already available for your patients, who may need your help and support as a leader in your community's health. For instance, there are nationwide youth enrichment and empowerment programs for Native American children and families. Consider getting involved in ongoing research to help clinicians learn how to provide more effective and culturally appropriate mental and behavioral health care to Native Americans. There's research currently underway that needs partners for a screening tool in emergency departments to help Native teens at risk of suicide.

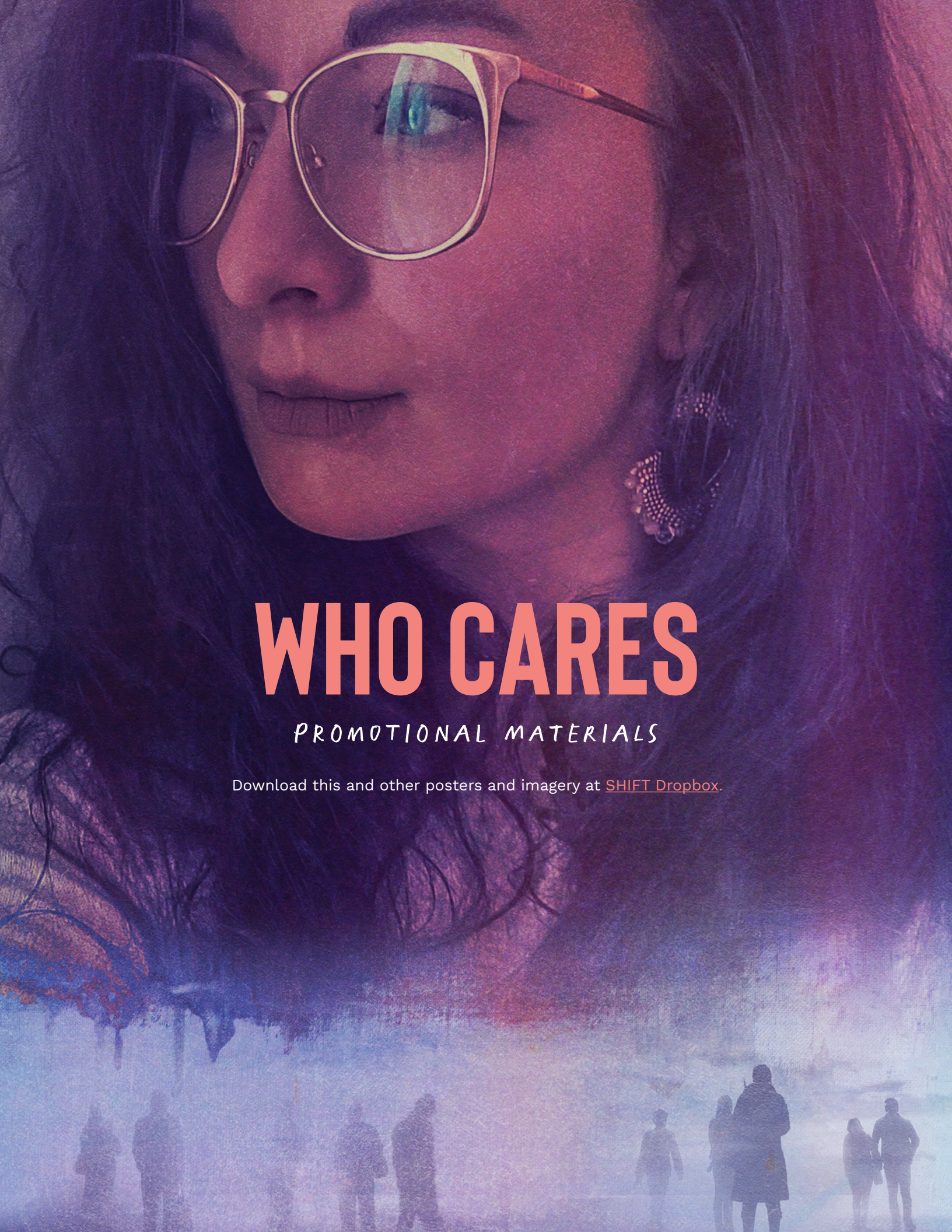
Reach out to schools of public health that provide specific resources and cultural sensitivity training for communities you're trying to reach. And don't forget the importance of diverse representation in healthcare, like Whitney Fear's role in the Fargo community. There are special resources and scholarships to encourage members of diverse communities to become leaders in their community's health and wellbeing.

We've outlined a few organizations and resources to get you started below. Never forget the difference it can make when one person cares. Especially if that person is a nurse.

DISCUSSION QUESTIONS

1. The mental health disorder statistics are high in North Dakota, and even more so for Native Americans in the area. Are there any groups in your city or state that are more at risk for mental or behavioral health disorders? If so, who? How can you better reach them?
2. In "Who Cares," Whitney shares about her Lakota heritage and values, then demonstrates her culturally sensitive approach to care. Do you come from a culture that's considered "a minority"? If so, how does that influence the way you approach your patients? If not, think of some underserved populations in your area. What can you do to become more culturally aware of care that might better serve those individuals?
3. In your opinion, why is cultural humility important in nursing? How does it impact overall health outcomes?
4. Do you know anyone who suffers from mental or behavioral health issues, either personally or professionally? How does that impact their overall health? How does it impact the way other healthcare providers treat them?

For Further Reading and resources to make a difference got to: shiftnursing.com/articles/mental-health/


WHO CARES
PROMOTIONAL MATERIALS
Download this and other posters and imagery at SHIFT Dropbox.

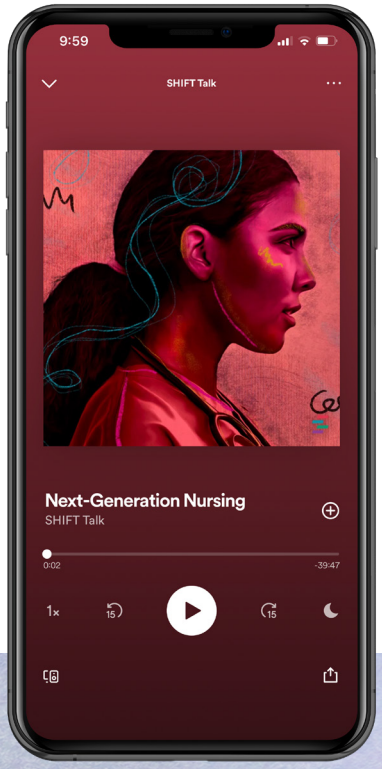
PROMOTIONAL MULTIMEDIA

SHIFT TALK

SHIFT Talk is a podcast that brings nurses together to talk about the challenges we're facing—on and off the clock. In Season 2, we interviewed nurses who are working to ensure all patients can access the resources and care they need to be healthy. In other words, it's all about health equity. That means going beyond the clinical and looking at the social factors that impact health—from a person's zip code, to their education, to their job. Even structural racism. No healthcare provider knows more about patients' lives than nurses, right? We can really make an impact here.

Listen on these platforms:

Listen on Spotify | Listen on Apple Podcasts | Listen on Google Podcasts



TRAILER:

WHO CARES: A NURSE'S FIGHT FOR EQUITY | SHIFT FILMS

As a psychiatric nurse practitioner, Whitney Fear extends the compassion, empathy and respect at the foundation of her Lakota culture to the many vulnerable populations she comes across at Family HealthCare, a federally qualified health center in Fargo, North Dakota.

Her story is one of adversity, compassion and the impact that is possible when one person cares. Especially when that person is a nurse.

Watch the trailer at: YouTube.com/@SHIFTNursing: ":60 Trailer | Who Cares: A Nurse's Fight for Equity | SHIFT Films."

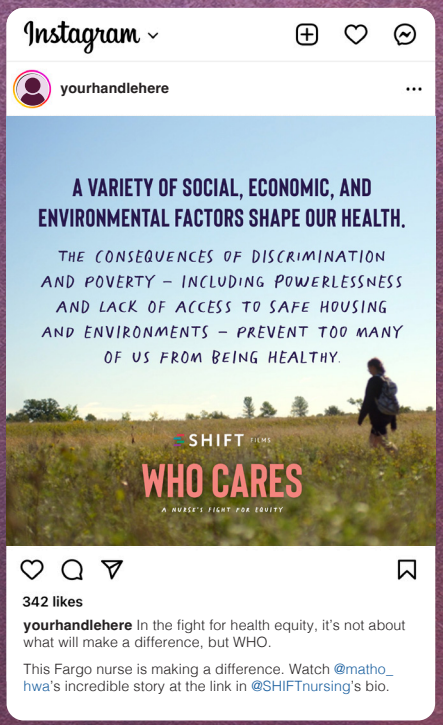
PRE-ROLL: HEALTH EQUITY ISSUES IN NORTH DAKOTA

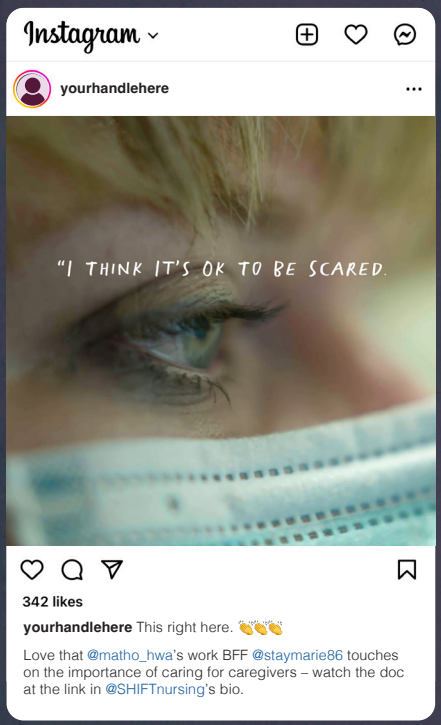
The first step to addressing a problem is understanding it. Take a look at some of the health equity issues nurse practitioner Whitney Fear is working to address in Fargo, North Dakota. Consider playing this film before the documentary during your screening.

Watch this clip at YouTube.com/@SHIFTNursing: "Health Equity Issues In North Dakota | Who Cares: A Nurse's Fight for Equity | SHIFT Films"

SAMPLE SOCIAL MEDIA POSTS TO PROMOTE SCREENINGS

Download this and other posters and imagery at SHIFT Dropbox.





POSTER

Download this and other posters and imagery at SHIFT Dropbox.


SHIFT
SHIFTNURSING.COM