

THE EXPERIENCE OF NURSING CARE FOR
FEMALE MEDICAID RECIPIENTS

by

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ABSTRACT

This phenomenological study is guided by a feminist-informed critical theory for the purpose of exploring the experiences of nursing care for female Medicaid recipients. The goals of this research were to understand how nurses' attitudes and behaviors towards female Medicaid recipients influence the ways in which these patients receive and act upon their health care, and to consider what those understandings suggest for nursing education. Semi-structured interviews with female Medicaid recipients were conducted to understand their experiences of nursing care, and a focus group interview with nurse educators was conducted to consider what those understandings suggest for nursing education.

Current health reform makes this study is timely and important, as more citizens now than ever before are eligible for Medicaid benefits. As a result, nurses will more frequently encounter members of the Medicaid population in both the public sector and community-based health care facilities. As providers of direct care, nurses play a critical role in how patients receive and act upon the health care given to them. From this research, nurses can learn what attitudes and behaviors are noted as being positive or negative for the female Medicaid population. Nurse educators can learn this as well, and can use these understandings to inform how and what students are taught regarding the female Medicaid population. Finally, understanding the experiences of nursing care for such women can assist local, state, and federal policymakers maintain population-specific considerations in the forefront of reforms.

DEDICATION

I dedicate this dissertation to my father, Gerald Thomas Duke (Jerry), who nurtured within me a thirst for knowledge and a love of learning that knows no boundaries. Who I am today is the result of his unfailing love and support for me over the years, and I am forever grateful, humbled, and honored. I love you, Daddy!

LIST OF ABBREVIATIONS AND SYMBOLS

AACN	American Association of Colleges of Nursing
ACA	Affordable Care Act
CMS	Centers for Medicare and Medicaid Services
CRS	Congressional Research Services
ED	Emergency Department
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FMR	Female Medicaid Recipient
FPL	Federal Poverty Line
HCP	Health Care Professional
HESI	Health and Environmental Sciences Institute
IOM	Institute of Medicine
LPN	Licensed Practical Nurse
NCLEX-RN	National Council Licensure Examination-Registered Nurse
NSLP	National School Lunch Program
PA	Prior Authorization
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act
RN	Registered Nurse
SCHIP	State Children's Health Insurance Program
SES	Socioeconomic Status
SNAP	Supplemental Nutrition Assistance Program

TANF	Temporary Assistance for Needy Families
US	United States
USDHHS	U.S. Department of Health and Human Services
WHO	World Health Organization
WIC	State Special Supplemental Nutrition Program for Women, Infants, and Children

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CHAPTER I

INTRODUCTION

This research explores the experiences of nursing care for female Medicaid recipients (FMRs). The researcher's goals were to understand how nurses' attitudes and behaviors towards FMRs influence the ways these patients receive and act upon their health care, and to consider what those understandings suggest for nursing education. This chapter presents a background to the study, a statement of the problem, the purpose of the study, research questions, and the significance of the study.

American women, and their duration and quality of life, are greatly influenced by their surrounding sociocultural, economic, and physical environments (U.S. Department of Health and Human Services [USDHHS], 2010a). Compared to men, women receive less education, which results in lower incomes and, ultimately, lower socioeconomic status (Nalle, Speraw, & Bushy, 2004). Women of low socioeconomic status (SES) face many challenges, including poverty, single parenthood, poor nutrition, poor housing, unhealthy lifestyles, and high-risk behaviors such as tobacco, alcohol, or drug use (Zachariah, 2009). Challenges also exist related to accessing quality health care, including lack of adequate health insurance, living in a medically underserved area, or an inability to obtain necessary services due to financial or transportation constraints (Bushy, 2001; Nalle et al., 2004).

Title XIX of the Social Security Act, a program better known as Medicaid, seeks to alleviate some of the challenges associated with low SES by providing medical and health-related services to the country's poorest people (Matthews, 2007). Often described as America's

health care program for the poor, Medicaid was first established by the federal government in 1965, but is administered and regulated at the individual state level (Grogan & Patashnik, 2003; Matthews, 2007). According to 2006 Medicaid program statistics, over 17 million low-income women aged 18 to 64 years were enrolled in Medicaid, and the program is estimated to finance 41% of all births in the United States (Kaiser Family Foundation, 2009; National Governors' Association, 2005).

In March 2010, President Barak Obama signed the Affordable Care Act (ACA) health reform into law, causing many people to wonder if government-assistance programs such as Medicaid could possibly become the norm for health care reimbursement of the future (Lee, 2010). Current health reform means more citizens are now eligible for Medicaid benefits, and the nursing community now has more frequent interactions with members of this population. As providers of direct care, nurses play a critical role in how patients receive and act upon the health care given to them.

Statement of the Problem

The primary function of bedside nursing lies within the direct delivery of hands-on care that is given by the nurse and is received by the patient. In this function, the nurse delivers not only prescribed nursing care, but also delivers to the patient his or her attitudes and behaviors, whether verbal or nonverbal, intentional or subconscious. It is the consequences of these communications that are inadequately acknowledged in nursing research, and may play a critical role in how FMRs receive and act upon their nursing and other health care. Fears of being misunderstood or disrespected by nurses and other health professionals may serve as a deterrent for FMRs and may actually keep them away from health environments during times of need.

Understanding the experiences of nursing care for FMRs can have strong implications for nursing practice, research, and education, which may preemptively influence the attitudes and behaviors of future nurses in their interactions with Medicaid patients.

Research of the Problem

Nurses and other health care professionals (HCPs) struggle when providing care to patients perceived as being “different” from themselves, whether those differences exist in gender, age, ethnicity, culture, education, or socioeconomic status (Cassata & Dallas, 2005). Low-income women are at risk of being stigmatized, stereotyped, and discriminated in health care settings (Downing, LaVeist, & Bullock, 2007). Despite research demonstrating that provider attitudes may be critical in explaining health disparities, investigation into nursing attitudes and behaviors regarding low-income women is limited (Cassata & Dallas, 2005). Also missing within the literature is research examining the role of education in the relationship between nurses’ communication of attitudes and beliefs, and the ways in which low-income women receive and act upon such messages. For example, what type of education needs to occur in order to challenge nursing students’ preconceived notions regarding low-income populations so that later, as practicing nurses, they are capable of caring for such individuals without the barriers of bias and stereotypes? As it exists today, a relatively unexplored base of nursing literature investigates the impact nurses’ attitudes and behaviors have on how FMRs receive and act upon their nursing care.

Purpose of the Study

The purpose of this study was to use a phenomenological approach to explore female Medicaid recipients’ experiences with nursing care within a feminist-informed critical

framework. The goals of this research were to understand (a) how nurses' attitudes and behaviors toward FMRs influence the ways in which these patients receive and act upon their health care and, (b) what those understandings suggest for nursing education.

Research Questions

The research and subsidiary questions that guided this inquiry were as follows:

1. How do female Medicaid recipients describe their experiences of nursing care?
 - a. What makes a nursing care experience positive or negative for female Medicaid recipients?
 - b. What do female Medicaid recipients indicate as being helpful or harmful for their future health care decisions?
 - c. In what ways do nurse-patient interactions influence how female Medicaid recipients receive and/or act upon their health care?
2. What do nurse educators need to know from these experiences?
 - a. In what ways can educators use these experiences to inform nursing education?

Research Design

A qualitative, phenomenological research design frames this research, using two separate interview approaches for data collection. Semi-structured individual interviews were conducted with FMRs for the purpose of exploring their experiences of nursing care. Following data analysis of these experiences, a single focus group interview with current nurse educators was

conducted for the purpose of understanding what these experiences suggest for nursing education.

Significance of the Study

Guided by a feminist-informed critical theory for the purpose of exploring the experiences of nursing care for FMRs, this research provided low-income women the opportunity to discuss their daily experiences, challenges, motivations, and opinions of their health and health care, which allows an underrepresented, vulnerable population to be heard. Telling one's story, and knowing that it is being heard, respected, and valued, can be an empowering process, particularly if participants feel as though sharing their story benefits the greater good. Additional significance means that nurses can learn what attitudes and behaviors this population notes as positive or negative, and offering these women an opportunity to share such experiences may serve as a catharsis. Understanding experiences of nursing care for FMRs has strong implications for nursing practice, research, and, of interest here, education.

Significance for Nursing Practice

This study informs direct-care nursing practice by acknowledging that the attitudes and behaviors of nurses influence the care and health outcomes of their patients. As a result, nurses can examine and challenge their beliefs, stereotypes, and judgments about patients of low SES, and can strive for self-awareness related to such issues. A cognitive awareness of prejudices allows nurses to better care for patients deemed "different" from themselves, particularly in regard to SES. This research can inform recommendations for more in-depth social assessments as part of standard admission assessments and plan-of-care assessments. The critical piece that this research attempts to explore is that the nurse's actions and behaviors must match what he or

she is saying. In other words, true understanding of and respect for the low SES patient is not conveyed through words, actions, or thoughts alone, but rather through a type of social awareness trinity, in which all three elements must be both present and congruent.

Significance for Nursing Research

As mentioned, the Affordable Care Act of 2010 will expand health care coverage to 32 million Americans by 2014 (White House, n.d.). As health reform allows for an increase in Medicaid eligibility, members of the nursing community will have more frequent interactions with patients coming from low SES backgrounds. This study adds to the scholarly literature of the field as it attempts to document ways nurses' attitudes and behaviors towards FMRs can influence how these patients receive and act upon their health care, so that nurses may learn what attitudes and behaviors are noted by this population as being positive or negative.

Significance for Nursing Education

The American Association of Colleges of Nursing (AACN, 2008) publishes *The Essentials of Baccalaureate Education for Professional Nursing Practice*, as an educational framework for the preparation of professional nurses, and emphasizes the expected outcomes that all baccalaureate nursing graduates should be able to achieve in order to practice nursing today. Within Essential VIII, Professionalism and Professional Values, the document states that the baccalaureate program prepares the graduate to "Recognize the impact of attitudes, values, and expectations on the care of . . . vulnerable populations" (AACN, 2008, p. 28). Nurses provide care for patients within a context of privileged intimacy; generally, the nurse is allowed into this space and, in partnership with the patient, creates a relationship with that patient that is

unique and mutually-shared (AACN, 2008). Little is known, especially from the perspective of the patient, about how nurses' attitudes and behaviors toward FMRs can have either a positive or negative consequence when this population receives or acts upon their health care. Therefore, this research may influence ways nurse educators teach nursing theory, assessment techniques, communication methods, nursing diagnoses, and nursing interventions.

Definition of Terms

To fully understand the elements of this research, the terms "nursing care" and "lived experience" must be defined. Nursing care is a plan of care that is based upon a nursing assessment and is carried out by a nurse (Como, 2002). Nursing care has four essential components: (a) identification of the nursing care issue (i.e., nursing diagnosis) and a statement of the nursing approach to address the issue; (b) statement of the expected benefits to the patient; (c) statement of the specific nursing actions that reflect the nursing approach and achieve the goals specified; and (d) evaluation of the patient's response to nursing care and readjustment of that care as required (Como, 2002). The goal of nursing care is to ensure that the patient's needs are met and to assist the individual in progressing toward self-care (Como, 2002).

Nursing care begins when a patient is admitted to a health service, and may continue long after a patient has returned home. Nursing care is performed among multiple settings such as hospitals, physician's offices, clinics, public health departments, home health care agencies, inpatient or outpatient hospice agencies, prisons, and military settings. Furthermore, these settings may be geographically located in rural, urban, or metropolitan areas, and may be private, for-profit institutions, or public, not-for-profit institutions. Within this context, nursing care

includes not only the direct delivery of hands-on care, but also words and actions performed by the nurse and directed toward the patient and/or the patient's family.

Speziale and Carpenter (2007) describe the "lived experience" or, "life history" as a research method in which the researcher listens to the telling of personal experiences, so that an understanding of a particular aspect of that individual's life may occur. For this study, anything deemed as significant by the participant, including memories, recollections, stories, and narratives were considered as part of the lived experience.

Summary

The duration and quality of life for American women is greatly influenced by their surrounding sociocultural, economic, and physical environments (USDHHS, 2010a). When seeking health care, the attitudes and behaviors of nurses and other HCPs may play a critical role in how FMRs receive and act upon their health care. Within the context of phenomenology, and as guided by a feminist-informed critical framework, this study sought to explore the experiences of nursing care for these women and to understand what these findings suggest for nursing education.

CHAPTER II

REVIEW OF LITERATURE

The central research question of this study focuses on the experiences of nursing care for female Medicaid recipients (FMRs). The goals of this research were to understand how nurses' attitudes and behaviors toward FMRs influence the ways in which these patients receive and act upon their health care, and to consider what those understandings suggest for nursing education. The purpose of this chapter is to provide a critical synthesis of the existing literature available about experiences of nursing care for FMRs, to clarify the relationship between this study and previous work conducted on the topic, and to demonstrate why this study is timely and important.

When initially reviewing the nursing literature, it quickly became apparent that information is sparse regarding the narrowly defined topic of nurses' attitudes and behaviors toward FMRs. Therefore, to broaden the view of the literature, key concepts were searched from underneath the umbrella terms of "health care professional" (HCP). While registered nurses (RNs) do make up a large portion of HCPs, the term may also be used to describe physicians, nurse practitioners, dentists, pharmacists, respiratory therapists, and other providers of professional health care.

Secondly, Medicaid--by its very definition--is a government piloted health care program for the country's poorest people. Because Medicaid seeks to serve low-income people, for the purposes of this literature review, the terms "low-income," "low-socioeconomic status (SES)," and "Medicaid" are used somewhat interchangeably. The context of this literature review, and

subsequently this research study, focuses on recipients receiving Medicaid due to low-income, and not disability or Medicare dual-eligibility. Therefore, within this context, to receive Medicaid benefits, one *must* be of “low SES” or have “low income.” It is important to note, however, that not *all* low-income people receive Medicaid, and this study describes the experiences of nursing care for low-income women with Medicaid benefits.

To effectively and holistically answer the central research questions, three major themes and several subsidiary themes from within the literature were identified. These themes include the following: (a) Medicaid, including a historical overview and its reform; (b) socioeconomic disparities in health care, including barriers to health care access, stigmas and stereotypes, health care provider attitudes, and low-income women’s experiences; and (c) the role of nursing education, including issues in nursing education, student attitudes, and service learning as a pedagogical approach.

Medicaid

Despite spending almost 15% of its gross domestic product on health, the United States’ focus on employment-based health insurance has led to a system in which one’s health insurance is linked to a job, yet this system works for only a small percentage of the population, and makes women especially vulnerable (Zdanuk, 2000). Often described as America’s health care program for the poor, Medicaid was established by the federal government in 1965, but now serves as a federal-state partnership program to provide services to low-income families and people with special health care needs and physical or developmental disabilities (Grogan & Patashnik, 2003; Matthews, 2007; Roby, Kominski, & Pourat, 2008). Eligibility requirements for Medicaid are currently based on family income, assets, number and age of children, and health needs, but

because each state is able to design its own Medicaid program, there are differences in eligibility and benefits that vary from state to state (Roby et al., 2008).

Historical Overview of the Medicaid System

During the mid-1960s in the United States, political discourse regarding universal health insurance primarily focused on the population of senior citizens who were previously bound to the state through the Social Security system (Grogan & Patashnik, 2003). To improve their access to health care, Congress adopted a three-tiered approach towards coverage: (a) Medicare Part A, a hospital insurance program modeled off of Social Security; (b) Medicare Part B, a voluntary supplementary medical insurance program funded through premiums and federal funds; and (c) Medicaid (originally called Part C), a program that extended health care not only to elderly citizens, but also to the indigent poor, the blind, the permanently disabled, and single-parent adults and their dependent children (Grogan & Patashnik, 2003). At the state level, Medicaid was originally perceived with much less significance than Medicare, and the federal government projected that its future would not lead to any dramatic expansion of health care coverage or associated costs (Stevens & Stevens, 1974). Unfortunately, this projection turned out to be poorly estimated; by 1967, 37 states had adopted Medicaid programs, and its spending rose by 57% per annum (Congressional Research Service [CRS], 1993; Grogan & Patashnik, 2003).

From an early beginning, conflict arose due to Medicaid's unexpected popularity and demand, as people either lost their private health insurance or found that their current insurance did not cover all their needs (Cohn, 2007; Grogan & Patashnik, 2003). Many states viewed Medicaid as a potential lead-in for national health care, but the federal government declined, and instead restricted program eligibility to 133.3% of the Federal poverty level (FPL), which

effectively reduced the number of potential Medicaid recipients (Grogan & Patashnik, 2003). In 1967, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) was created as a comprehensive health services benefit for all Medicaid children under age 21, and a freedom-of-choice requirement allowed low-income citizens to choose their HCPs rather than being required to use special welfare clinics or county hospitals (Centers for Medicare & Medicaid Services [CMS] n.d.; CRS, 1993; Grogan & Patashnik, 2003). By 1982, such freedom-of-choice waivers were mandated, and states became required to pay hospitals additional monies for treating a disproportionate share of low-income patients (CMS, n.d.). During the 1980s, efforts were made to expand Medicaid eligibility requirements, and in 1986 the eligibility level was adjusted to allow *all* women, infants, and children at or below 100% of the FPL to receive benefits, and by 1989, all pregnant women and children under age 6 at or below 133% of the FPL were included (CMS, n.d.).

Medicaid Reform

By the 1990s, Medicaid was characterized as an administrative failure, and attempts at welfare reform were made. While Medicaid enrollment continued to rise during this time, employer-sponsored health insurance demonstrated a marked decline (Grogan & Patashnik, 2003). In 1996, the Temporary Assistance for Needy Families (TANF) grant severed any welfare links to Medicaid and terminated its automatic enrollment for individuals receiving welfare cash assistance (CMS, n.d.). Prior to this reform, women could receive Medicaid coverage regardless of pregnancy simply because they also received cash assistance, yet once TANF was enacted, these same women were unable to obtain Medicaid coverage unless they became pregnant (Handler, Rosenberg, Rankin, Zimbeck, & Adams, 2006). Out of the Balanced Budget Act of

1997, the State Children's Health Insurance Program (SCHIP) was created to reduce the number of uninsured children, and states held the option to extend health care coverage to them through Medicaid (CMS, n.d.; Grogan & Patashnik, 2003). By 2006, over 17 million low-income women (18-64 years) were enrolled in Medicaid, which now finances 41% of all births in the United States (Kaiser Family Foundation, 2009; National Governors' Association, 2005).

In 2005, "Medicaid reform" became reality as federal budget resolutions were passed that called for reductions in Medicaid spending (Ku & Pervez, 2010). Alternate proposals for reducing Medicaid spending were created, which called for Medicaid applicants and beneficiaries to provide documentation of U.S. citizenship (Norwood, 2005). Before the House voted on the changes, though, a report was issued that warned the effects would fall not on immigrants, but on current U.S. citizens (Ku & Ross, 2006). The report also argued that many native-born, low-income citizens lack copies of birth certificates or passports, and that vulnerable populations, such as nursing home residents, the mentally ill, the homeless, or victims of disasters such as tornados or hurricanes, could have problems submitting their paperwork (Ku & Pervez, 2010). At the time, the Medicaid documentation of citizenship requirement paralleled legislative proposals to stiffen documentation guarding against undocumented aliens, and the amendment gained very little attention, as most policymakers were more concerned with overall Medicaid budget cuts. In February 2006, the Deficit Reduction Act was signed into law by President Bush (Ku & Pervez, 2010).

On March 22, 2010, President Barak Obama signed the Patient Protection and Affordable Care Act (ACA), putting in place comprehensive health insurance reforms scheduled to roll out over four years, with most changes occurring by 2014 (USDHHS, n.d.). Under the new law, SCHIP was preserved, and young adults are now allowed to stay on their parent's health

insurance plan until 26 years, unless offered personal insurance through their employer (Patient Protection and ACA, 2010; Lee, 2010). Additionally, the ACA allowed states to receive federal matching funds for covering additional low-income individuals and families under Medicaid for whom federal funds were not previously available (USDHHS, n.d.). Resulting from this health care reform, Medicaid rules and enrollment processes were simplified, allowing more people to become eligible. It was envisioned that by 2014, virtually all adults under 65 years of age with individual incomes up to about \$15,000 per year would be eligible for Medicaid coverage in every state (USDHHS, n.d.).

As one can see, Medicaid has a history full of achievements and controversy, and now once more the program is a political focal point in U.S. health policy debates as proponents feel it may serve as a pathway to a universal health care coverage system (Grogan & Patashnik, 2003; Rosenbaum, 2009). Medicaid, whose goal was once to desegregate health care by “mainstreaming” people of low-income into the health care system, now provides coverage for the very populations that a market-based health insurance system excludes: poor children, low-income pregnant women, impoverished disabled people, and the elderly indigent (Rosenbaum, 2009). While this has resulted in a demonstrated increase in access to health care, Medicaid recipients continue to remain segregated across parts of the country; to date, many citizens receiving Medicaid benefits are haunted with moral and social stigmas associated with being on “welfare” (Grogan & Patashnik, 2003; Rosenbaum, 2009).

Socioeconomic Disparities in Health Care

Social determinants--such as economic and social policies--influence an individual's ability to live, work, and function, and affect the health of low-income women (World Health

Organization [WHO], 2003). An individual's available health care resources are based upon these social determinants, and a gap in resource availability can create disparities based upon race, ethnicity, and SES (Brim, 2008). Ill health is most closely linked to low SES, and low SES results in resource marginalization, which "effectively limits people's abilities to gain access to resources and denies the opportunities to acquire capital" (Lyman, 2005, p. 36; Marmot, Ryff, Bumpass, Shipley, & Marks, 1997). Resource marginalization is associated with the disproportionate delivery of health care treatments, and can lead to feelings of hopelessness and lack of control over one's health (Brim, 2008; Browning, Ferketick, Salsberry & Wewers, 2008; Fiscella, Franks, Gold, & Clancy, 2000; Gornick et al., 1996; Schneider, Zaslavsky, & Epstein, 2002).

Access to health care is a major concern for consumers, HCPs, and policymakers alike. It is defined as having a usual source of health care or a regular site of care that serves as a point of entry into the health care system (Litaker, Koroukian, & Love, 2005). Such a source of care can provide the individual with prevention measures and management for chronic conditions (Brim, 2008). Generally, it is more difficult to access health care under Medicaid than other forms of insurance, although Medicaid *does* provide more access than being completely uninsured (Rocha & Kabalka, 1999).

Socioeconomic disadvantage significantly impacts women and minorities, and often the point of entry into the health care system is because of gender-related issues such as contraception or pregnancy (Zdanuk, 2000). The multiple roles of women can produce overload, conflict, and stress, but FMRs and single mothers experience even higher levels of physical, emotional, and financial stress, ultimately affecting their abilities to provide healthy living environments for themselves and their children, and resulting in higher risks for mental illness

(Jones, Darroch, & Henshaw, 2002; Keating-Lefler & Wilson, 2004; Zdanuk, 2000). Single mothers are at particular risk for poverty because often they become unemployed after childbirth, have unequal earning capacity, and lack paternal child support (Keating-Lefler & Wilson, 2004).

Despite many of its flaws, Medicaid *does* provide more health-related benefits than being completely uninsured. Low-income women with Medicaid prior to pregnancy are more likely to initiate early prenatal care than those women who are uninsured (Rosenberg, Handler, Rankin, & Adams, 2007). Some Medicaid-eligible women, including those who are pregnant, are automatically eligible for the State Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which provides assistance in securing nutritious foods and prevents future health problems related to nutrition, ultimately resulting in reduced health care costs, enhanced education for children, and a more productive workforce (Laraia, Siega-Riz, Gundersen, & Dole, 2006). Low-income women receiving WIC before and during their pregnancies are more likely to receive adequate prenatal care, thereby placing them at less risk for preterm delivery, low birth weight, and fetal death (El-Bastawissi, Peters, Sasseen, Bell, & Manolopoulos, 2007; Johnson et al., 2007).

Barriers to Health Care Access

Medicaid beneficiaries are primarily women, children, and people with disabilities or special health care needs. Medicaid recipients are more likely to be minorities than the general population, and tend to use public clinics, which can result in barriers such as long wait times, a lack of continuity in care, discomfort with providers, and missing work for appointments (Diamant et al. 2004; Gleason & Kneipp, 2004; Lowe et al., 2005; MacLean et al., 1999; Roby et al., 2008; Rocha & Kabalka, 1999). Medicaid recipients are more likely to lack telephone lines,

valid phone numbers, or reliable addresses, and frequently experience “churn” when issues with eligibility causes them to occasionally be uninsured for periods of time (Short & Graefe, 2003; White, Fisher, Mendelson, & Schulman, 2005). Additional barriers include difficulty finding HCPs that accept Medicaid, lack of knowledge about Medicaid eligibility, Medicaid’s stigmatic link to welfare, the complexity of the enrollment process, and language issues (Feinberg, Swartz, Zaslavsky, Gardner, & Walker, 2002; Perry, Kennel, Valdez, & Chang, 2000; Roby et al., 2008).

Communication issues play a major role in describing barriers between Medicaid recipients and HCPs, and Medicaid recipients are more likely to have troubles communicating with HCPs because of language barriers, literacy, or disability (Roby et al., 2008). Feinberg et al. (2002) identified language as an enrollment barrier, as one-third of families with enrolled children were limited English proficient. Low-income populations also tend to be dissatisfied with their communications with HCPs; this is of concern because they may disregard health advice or reject the health care system in its entirety (DeVoe, Wallace, & Fryer, 2009; DeVoe, Wallace, Pandhi, Solotaroff, & Fryer, 2008; Fiscella, Franks, & Clancy, 1998; Fiscella, Franks & Gold, 2000; Hussey et al., 2008; Jensen, King, Guntzviller, & Davis, 2010). Research suggests physicians are less likely to encourage interaction or provide feedback when communicating with lower SES patients (Willems, De Maesschalck, Deveugele, Derese, & De Maeseneer, 2005).

In discussing the socioeconomic disparities that exist in the U.S. today, as well as the barriers and challenges Medicaid recipients face, the image of a “totem pole” comes to mind. Within this health care totem pole, those individuals privately insured through their employee-based insurance programs are on top, those insured privately through individual group plans and those with federal Medicare plans are somewhere in the middle, those insured through state

Medicaid programs are somewhere in the high bottom, and the uninsured are on the very bottom, bearing heaviest weight.

Stigmas and Stereotypes

When talking about stigma, one should first differentiate “public” stigma and “perceived” stigma. Public stigma is external, generally reflecting the attitudes or reactions that the general population may hold toward the individual being stigmatized, whereas perceived stigma is internal, referring to an individual’s anticipated fear of societal attitudes and potential discrimination (Kinsler, Wong, et al., 2007). Perceptions of stigma from HCPs can deter individuals from health care environments and the disclosure of sensitive personal information. Kinsler et al. (2007) found examples of perceived stigma identified among low-income, HIV positive women as HCP discomfort with patients, HCPs treating them as inferior, avoiding them altogether, or refusing them service. Perceived stigma, therefore, can actually be an additional barrier to health care access for low-income populations needing routine or urgent care.

Low-income women are stereotyped as “dishonest, dependent, lazy, disinterested in education, and promiscuous” (Bullock, 1995, p. 125). These stereotypes negatively affect how low-income women interact with people who are not poor, especially since many Medicaid recipients encounter classism when seeking housing, WIC benefits, health care, public transportation, educational opportunities, and any other social situation in which their Medicaid status becomes identified (Bullock, 1995; Downing et al., 2007; Lott, 2002; Lott & Bullock, 2007; Reed, Collinsworth, & Fitzgerald, 2005; Seccombe, James, & Walters, 1998). Many FMRs are haunted with moral and social stigmas associated with being on “welfare,” and are especially vulnerable to discrimination when seeking reproductive care (Downing et al., 2007; Grogan & Patashnik, 2003). Such women, especially those with multiple children or who are

pregnant, are stigmatized as contributing to welfare costs; historically, they even have been encouraged to limit their reproduction through family caps on Medicaid benefits, Medicaid-provided contraception, community-based family planning clinics, sterilization options, and abortion allowances (Benson-Smith, 2005; Blank-Libra, 2004; Downing et al., 2007; Jensen & Bute, 2010; King & Meyer, 1997; Personal Responsibility and Work Opportunity Reconciliation Act [PRWORA], 1996; Thomas, 1998). Low-income women of color more frequently report being advised to limit their childbearing than middle-class White women (Downing et al., 2007).

When HCPs hold negative stereotypes regarding low-income populations, the result is an intentional or unintentional health disparity. Smoking cessation education may serve as an example, as smoking is currently the leading preventable cause of death in the United States. Yet individuals who are White, more educated, and have greater socioeconomic advantage are more likely to receive smoking cessation assistance (Browning et al., 2008; Goldstein et al., 1997; Quinn et al., 2005). Browning et al. (2008) suggest that this disparity might be explained by provider bias related to “certain sociodemographic characteristics of the patient” (p. 58). In elaborating, the authors note that smoking is most prevalent in people who are poor, less educated, and already in poor health; but based upon certain sociodemographic characteristics, HCPs may perceive the low-income population as having a low probability of quitting, and therefore are less likely to offer smoking cessation assistance (Browning et al., 2008; Parnes, Main, Holcomb, & Pace, 2002; Pollak et al., 2002).

Critics of the U.S. health care system suggest that stereotyping is related to the current system being predominantly a medical (as opposed to *health care*) system, in which the paradigm’s focus is on the *individual* rather than the community (Hoff, 1994). In biomedical research, an individualistic model is essentially victim-blaming in its emphasis on individual

health-related behaviors such as smoking and drinking (Dressler, 1993; Hoff, 1994). Victim-blaming is alive not only in medical research, but also within the “lifestyle” or “personal responsibility” discourse within health care reform, as it is easier to place responsibilities on individuals than to change an unjust system (Hoff, 1994; Jackson, 1993). For example, HCPs were found to perceive low SES patients as less likely to actually quit smoking, and therefore they did not bother spending time on smoking cessation education (Browning et al., 2008). Here, the HCPs’ focus (and root cause for stereotyping) was on the characteristics of the low SES individual(s), and ultimately ignored the larger social context in which that individual lives, works, and functions. Instead of maintaining an individualistic model toward health and health-related research, Hoff (1994) proposed a social-structural analysis, with emphasis on the “*interactive* relationships between race, gender, and class as an explanation” for health issues (p. 97). This emphasis would also assist consumers of research in acknowledging the social factors that contribute to one’s health.

Health Care Provider Attitudes

Nurses have more direct, hands-on contact with low-income women than any other HCP, yet there is a significant gap in the literature about their attitudes and behaviors toward their low-income patients, or toward Medicaid recipients. An even larger gap exists regarding the impact nurses’ attitudes and behaviors have on how FMRs receive and act upon their health care. Slowly, however, the focus on HCPs’ attitudes is shifting, particularly as they relate to the type and quality of provider-patient interactions, care, and treatment protocols across patient groups (Cassata & Dallas, 2005).

An *attitude* is a hypothetical construct representing an individual's positive or negative views toward an entity, which can range from shallow, changeable opinions to deeply held convictions, and generally dispose people to behave in certain ways (Wade & Tavis, 1998). The attitudes of nurses are shaped by personal, educational, and professional experiences, along with their political, social, and religious or spiritual views (Cassata & Dallas, 2005). Of particular concern is the attitude of nurses or HCPs when they provide care for patients perceived as "different" from themselves in regard to gender, age, ethnicity, culture, education, or SES; this is concerning because research suggests that attitudes are significant predictors of behavior (Ajzen, 2001; Cassata & Dallas, 2005; Sword, Reutter, Meagher-Stewart, & Rideout, 2004).

Nursing is not as diverse a profession as some would believe; most nurses are Caucasian (83%), middle class (87%), middle-aged (46 years old), female (90%) and have attended community college, a baccalaureate program or higher (USDHHS, 2010b). The racial and ethnic profile of the RN is substantially different from that of the U.S. population; only 16.8% of RNs identify themselves as being a part of a minority group, whereas the general population in the U.S. is about 34% (USDHHS, 2010b).

Congress charged the Institute of Medicine (IOM) to assess the extent of racial and ethnic differences in health care, including the role of bias, discrimination, and stereotyping at all levels within the health care system (IOM, 2003). As a result, several research studies were produced and indicate that race and SES play a large role in how HCPs perceive patients (Browning et al., 2008; DeVoe et al., 2008; DeVoe, et al., 2009; Fiscella et al., 1998; Fiscella et al., 2000; Hussey et al., 2008; Jensen et al., 2009; O'Malley, Forrest, & Miranda, 2003; Roter & Hall, 1992; Willems et al., 2005). As one can see, the variables of race/ethnicity, SES, gender, and education are well researched within the nursing literature as means for attempting to explain health

disparities; only recently has the focus on provider attitude come under scrutiny (Cassata & Dallas, 2005).

Akers et al. (2010) explored HCPs' perspectives on the challenges to contraceptive counseling in primary care clinics. The participants--all physicians--perceived a woman's contraceptive preference as being influenced by her previous experiences, family and peers, and dislikes of another method's administration route. The participants also reported that they perceived patient discomfort when holding contraceptive conversations with their patients, with one saying, "I think [the patients] feel uncomfortable answering. I don't feel uncomfortable asking, but sometimes you get some hesitation . . ." (p. 1165). In this example, however, one has to wonder about the role HCP attitude plays into how they perceive their patients' lives, how these attitudes are nonverbally communicated to and received by the patient, and how these attitudes impact the ways in which patients act upon their health care. This study's design was based upon "barriers" perceived by people in a relative position of privilege; of the 41 highly educated participants, 93% were White primary care physicians (Akers et al., 2010). Bearing this in mind, the participants make no mention of any type of consideration of the socioeconomic factors related to their patients' decisions regarding contraception, such as the costs associated with the various methods, or how they may affect their daily lives. Are patients uncomfortable during contraceptive conversations with their HCPs because they recognize a power imbalance or hold fears of perceived stigma? Is it possible that the attitudes of these HCPs are being nonverbally communicated and received by the patient as encouraging them to limit their reproduction, based on the stereotype that low-income women with multiple children are "burdens to society"? Surely a replicated study would hold more significance if the actual

population of contraceptive-using women were allowed to join the conversation, rather than merely asking the HCPs to contemplate perceived barriers *for* them.

Low-Income Women's Experiences

Humbert and Roberts (2009) sought to qualitatively gather perspectives of maternal and child health care from individuals with diverse backgrounds. Participants identified that certain health behaviors recommended by HCPs were difficult to follow, conflicted with the reality of their lives, and were not culturally relevant or congruent with generational family traditions. The authors also found that if participants felt they were treated badly by HCPs, they would sometimes interpret that behavior as discriminatory or racist. In fact, participants frequently shared both their positive and negative experiences with health care to family, friends, and community members, and would also make their personal health care choices based off of experiences shared by others. This “ripple effect” illustrates the powerful role that positive or negative experiences of health may have in instilling health care beliefs and behaviors among individuals within low-income communities (Humbert & Roberts, 2009).

In regard to mental health, Medicaid offers specific guidelines mandating HCPs to individually assess women for psychosocial problems, and, if identified, referrals for counseling or additional resources are made (Korenbrodt, Wong, & Stewart, 2005). Low-income minority women are less likely to initiate care in a mental health setting, and instead tend to seek help from primary care settings; the unfortunate irony, however, is that these physicians are less likely to diagnose depression among poor, minority women (Borowsky et al., 2000; Kessler, Zhao, Blazer, & Swartz, 1997; O'Malley et al., 2003; Wang, Berglund, & Kessler, 2000). Respectful and dignified treatment by HCPs is an important attribute of care identified by low-income

women, and even appears to outweigh logistical factors such as wait times (Humbert & Roberts, 2009; O'Malley et al., 2003). HCPs who tactfully inquire about areas of psychosocial concern, such as mood disorders, money, food, housing, parenting, and domestic abuse have also been identified by low-income women as important (Korenbrodt et al., 2005).

The Role of Nursing Education

As mentioned, an additional missing piece within nursing literature is research that examines the role of education in the relationship between nurses' communication of attitudes and beliefs, and the ways in which low-income women receive and act upon such messages. For example, what type of education is needed to challenge nursing students' preconceived notions regarding low-income populations so that later, as practicing nurses, they are capable of caring for such individuals without the barriers of bias and stereotypes? If nursing students are to transition into effective care providers, they must understand the challenges of those who are economically disadvantaged and maintain a positive attitude toward them; likewise, nursing education programs have a responsibility to provide students with opportunities to gain the knowledge, skills, and attitudes that will enable them to work with low SES populations (Sword et al., 2004). This section of the literature review offers a discussion on current issues influencing nursing education, the role of student attitudes in nursing education, and service learning as a pedagogical approach used within nursing education.

Issues in Nursing Education

Leaders from industrialized countries around the world agree that the global economy has transformed into an innovation- and knowledge-based economy, and for societies to successfully manage this transition, education must also change (Sawyer, 2006). As this nation advances in

size, age, and diversity, the needs and demands of its citizens revolutionize, and many look to the health care system and policymakers for solutions. The health care system and policymakers adjust based on these demands, which directly influence health care reform and nursing education (Myrick, 2005). Nursing education responds by developing current and applicable curriculum, and to produce graduate nurses capable of caring for patients. Nursing practice, therefore, is directly influenced by nursing education, as the next generation of nurses brings new skills, knowledge, and attitudes that influence the delivery of patient care. Health care reform also directly influences nursing practice through new laws and regulations. Finally, the discipline of nursing has a direct effect on society (Myrick, 2005); if the discipline is meeting the nursing needs and demands of society, all is well. However, if society's nursing needs are not met, the process begins all over again until a satisfactory outcome is met.

As one can see, our current health care system demands more now from its nurses than ever before, and nursing education is challenged with keeping current on technological advances, changes in health care policy, and practice standards. Doing so ensures that the next generation of nurses will be flexible and capable of delivering skilled nursing care in an ever-changing health care system. Influenced by the greater society, nursing education is at risk of reflecting the Euro-American culture and values of empowerment, independence, and the continued focus on the individual, which can result in nurses who have been educated to care for individuals rather than families (Cassata & Dallas, 2005). Instead, nursing education must transcend the traditional areas of anatomy and biology, and strive for students to gain a deeper understanding of health promotion, disease prevention, screening, genetic counseling, and immunization (Amos, 2005).

Girot (1995) describes the educational philosophy in nursing as shifting away “from the doing of nursing [and instead] toward the thinking behind the doing” (p. 388). The goals of

education today place less emphasis on the transmission of knowledge and skills, and instead accentuate students' interest-driven learning experiences. Students seeking information based upon personal interests will ultimately generate for themselves the desired levels of knowledge and competence (Scardamalia & Bereiter, 2006).

Student Attitudes

Nursing students' knowledge of poverty is little more than stereotypical, as few students are exposed to low-income populations (DeLashmutt, 2007). Very little research addresses nursing students' attitudes toward low-income populations, although research from social work and family medicine reveal that students hold negative perceptions of the causes of poverty, of people living in poverty, and often overestimate the incomes of people who are poor (Price, Desmond, Snyder, & Kimmell, 1988; Rosenthal, 1993; Sword et al., 2004).

Although attitudes tend to be relatively stable, evidence suggests nursing students' attitudes can be influenced by curriculum content (Azjen, 2001; Fox & Wold, 1996; Sheffler, 1995; Sword et al., 2004; Thompson, Emrich, & Moore, 2003; Valois, Turgeon, Godin, Blondeau, & Cote, 2001). For example, students report positive attitude changes toward older adults when exposed to additional gerontological theory content and clinical placements while in nursing school (Fox & Wold, 1996; Sheffler, 1995). Students who have frequent contact with low-income populations are more likely to hold positive attitudes towards those populations (Sword et al., 2004). Placing students in clinical situations involving direct contact with poor people will likely enable them gain the personal knowledge about poverty that is crucial to providing compassionate care to low-income populations. This concept of influencing attitudes by interacting with low-SES populations is consistent with social interaction theory, which suggests that attitudes emerge from and are embedded in interactions and with others and the

cues that others provide (Wood, 2000). Therefore, if students are given the opportunity to critically reflect upon relevant information that challenges their preconceived notions, prejudices, stereotypes, and attitudes, they are more likely to modify or reject existing attitudes and consider adopting new ones (Clarke, 1999; Sword et al., 2004; Wood, 2000).

Service Learning as a Pedagogical Approach

According to educational philosopher John Dewey, the role of education is to serve as a miniature society by giving students opportunities to act out, mimic, and practice the occupations and activities of the larger society (Maxcy, 2002). Dewey holds firm to the tenet that students learn best with direct exposure to unique learning experiences. Active participation and hands-on learning is more beneficial than a passive exchange of information from the teacher to the learner. Service learning, as a pedagogical strategy, is experiential learning that relates real-life experiences to theoretical learning, allows students to be active in contributing to meaningful social change for vulnerable populations, and prepares graduates for continued citizenship throughout their careers (Gillis & Mac Lellan, 2010). A key feature to service learning involves critical reflection, whether in the form of journaling, small group discussion, or reaction papers, which enables students to connect the dots between the service they provided, their academic goals, and meeting the needs of the community (Gillis & Mac Lellan, 2010).

Service learning allows students to reflect upon assumptions, stereotypes, and preconceptions about populations of individuals with different life experiences from themselves. After discovering that students were lacking in awareness and exposure of poverty-stricken populations, DeLashmutt (2007) created intentional clinical learning opportunities in which student nurses provided care for single mothers at a crisis center for the area's poor and

homeless. The author describes how this clinical experience fostered poverty awareness and activism among her students, with one student responding, “[The poor] aren’t milking the system. They are not lazy and unmotivated. They don’t want to be poor. They are just like you and me” (p. 185). Hunt (2007) described a similar service learning opportunity; students found the experience eye-opening, and identified a disconnect between the priorities of the HCPs and the homeless clients. One student observed, “Homeless people are not really all that concerned about their health. They are concerned about their basic needs, where the next bed is, where the next meal is, so preventive health care is swept under the carpet” (Hunt, 2007, p. 279).

Barriers to successful service learning do exist for students, such as intense anxiety over the poverty of clients and feelings of depression or helplessness in participating within the clients’ environment of vulnerability (Gillis & Mac Lellan, 2010). Debriefing sessions following each service learning experience can help break down such barriers. Students may experience intense emotions, due in part to the vulnerability of the population they were working with, as well as the level of development and life experience of the student (Gillis & Mac Lellan, 2010; Hunt, 2007).

Summary

This research attempted to fill a gap in the literature related to the experiences of nursing care for FMRs, and the attitudes/ behaviors of nurses that bear consequence on how these women receive and act upon their health care. Both topics are relatively unexplored areas within nursing literature, and the understandings of these experiences may inform nursing education, because educating the nursing students of today directly influences the nursing practice of tomorrow. Research similar in nature focuses more on the HCP’s perspectives and perceptions, rather than

that of the patient. Additionally, nurses are lumped together with others underneath the umbrella term of “health care professional” rather than examined as one collective group; this is significant because nurses do more hands-on direct care with patients than any other profession. Finally, while evidence exists regarding nurses’ attitudes and beliefs, the focus of this study is not the attitude or belief itself, but rather how the patient receives the spoken and unspoken messages communicated by the nurse, and how health decisions are made based upon those messages.

This study is timely and important because current health reform means that more citizens now than ever before are eligible for Medicaid benefits. As a result, nurses will have more frequent interactions with members of this population in both the public sector and community-based health care facilities. As providers of direct care, nurses play a critical role in how patients receive and act upon the health care given to them. From this research, nurses can learn what attitudes and behaviors are noted by this population as being positive or negative. Nurse educators can glean meaning from the understandings of these experiences, which may inform how and what students are taught regarding this population.

CHAPTER III

METHODOLOGY

This chapter explains the research methods that were used to explore the experiences of nursing care for female Medicaid recipients (FMRs). The goals of this research were to understand the following: (a) how nurses' attitudes and behaviors toward FMRs influence the ways in which these patients receive and act upon their health care; and, (b) what those understandings suggest for nursing education. The research questions that guided this inquiry were as follows:

1. How do female Medicaid recipients describe their experiences of nursing care?
2. What do nurse educators need to know from these experiences?

Given the research questions central to this study, a feminist-informed critical theory was chosen within a phenomenological qualitative design to promote social awareness of FMRs and to challenge stereotypes about them.

Theoretical Framework

Theoretical perspectives provide both researchers and readers alike with an orienting lens; in addition, they assist the researcher with the development of research questions, and inform how data will be collected and analyzed (Creswell, 2009). This study utilized feminist-informed critical theory as a theoretical framework for understanding the experiences of nursing care for FMRs.

Critical Theory

Critical theory originated in the 1920s for the purpose of incorporating subjective human experience into the realm of science. An interdisciplinary group of Frankfurt School of Marxist-oriented German scholars, specifically Jürgen Habermas, Max Horkheimer, Herbert Marcuse, Theodor Adorno, and Walter Benjamin, have been credited with its conception (Campbell & Bunting, 1991; Falk-Rafael, 2005). It involves a thorough critique of society, societal processes and its structures, and is “designed to involve and inform people, especially marginalized or oppressed populations, about actions necessary to promote their emancipation” (Fontana, 2004, p. 95; Polit & Beck, 2008). As a social theory, it is concerned with critiquing society as a *whole*, rather than trying to merely understand and explain parts of the society. The ultimate goals of critical theory are (a) to empower human beings to rise above the restrictions placed upon them by race, class, and/or gender; (b) envision new possibilities and affect social change; and (c) politicize social problems by placing them within historical and cultural contexts (Fay, 1987; Lindlof & Taylor, 2002; Polit & Beck, 2008). Critical theory aims to promote critical consciousness and to break down oppressive institutional structures that perpetuate cycles of oppressive ideologies and social inequities (Van Manen, 1990). Science informed by critical theory is action-oriented as it seeks to integrate both theory and practice, so that people may become aware of contradictions in their beliefs and social practices, and become inspired to make changes (Polit & Beck, 2008).

Feminist Theory

Feminist theory aims to understand women’s diverse situations and the institutions that frame those situations by examining women’s social roles and lived experiences, providing a

critique of social relations, analyzing gender inequality, and promoting women's rights, interests, and issues (Olesen, 2005). Approaches to feminist research actually share several parallels to those of critical theory research so much, that the issue of finding an appropriate methodology for feminist research has given way to the thought that any method may be made feminist (Deem, 2002; Moss, 2006).

Within feminist theory, the primary emphasis is on gender domination and discrimination within patriarchal societies (Creswell, 2007; Polit & Beck, 2008). When integrated into other theories, "gender is employed as a specific unit of analysis, not in an additive sense, but as an intersecting system of categorization through which power relations unfold to systematically advantage some and disadvantage others" (Kirkham & Browne, 2006, p. 334). Embedded within feminist theory is the notion of intersectionality, which seeks to understand how gender, class, and cultural/social positioning are co-constructed in particular sociopolitical and historical contexts to create conditions for injustices and inequities (Kirkham & Browne, 2006).

Feminist-Informed Critical Theory

Neither critical theory, nor feminist theory that adds a gendered lens, are nursing theories in and of themselves, yet both still have much to offer nursing (Falk-Rafael, 2005). Incorporating critical and feminist theory into existing and philosophically-congruent nursing theories allows for such theories to be expanded and enriched while still being rooted within nursing science (Falk-Rafael, 2005). Examples of this include exploring the commonalities and tensions between Rogers' Science of Unitary Human Beings and critical feminist theories, or creating a hybrid concept of "empowered caring" drawn from Watson's Theory of Human Caring and critical feminist theories (Cowling & Chinn, 2001; Rafael, 1996).

Both critical and feminist theories hold elements of liberation and emancipation, as marginalized or oppressed populations become more involved and informed (Fontana, 2004). The main difference between the two theories, however, is that feminist theory is specifically concerned with ending the unequal social position of women (Lather, 1991). Here, every woman is unique and different; therefore, feminist-informed researchers avoid searching for a unified voice to represent the population (Stewart, 1994). Instead, through recognition and participation, the voices and experiences of those who have been marginalized are used to inform discussions about social justice, thereby creating space for alternative perspectives that have historically been silenced in social and health care contexts (Kirkham & Browne, 2006).

Critical theory promotes social awareness, advocacy, and change through the challenging of stereotypes imposed by power imbalances within social structures; similarly, feminist theory *also* promotes social justice, just specifically as it relates to women and within specific contexts (Creswell, 2007; Fay, 1987; Fontana, 2004; Olesen, 2005). From a critical perspective, some situations are considered to be more just than others, but injustices, such as poverty and homelessness, are simply unacceptable; a feminist perspective would take injustices such as these and shed light on the prevalence of underlying themes of patriarchal gender domination (Creswell, 2007; Fontana, 2004).

A feminist-informed critical perspective guided the framing of this study, and informed data collection methods that involved listening and inquiring about the lives and experiences of women in a collaborative and non-exploitative manner (Fontana, 2004; Opalinski, 2006; Polit & Beck, 2008). This perspective rejects the typical neutrality of the objective, and argues that an observer cannot remain fully objective and unbiased (Im, 2010). This research involved a thorough analysis of the research problem, critiqued underlying assumptions, examined the

language used to depict the situation, and documented the biases of the researcher prior to investigating the problem (Polit & Beck, 2008).

This research sought to look critically at the structure of nursing care through the experiences of FMRs, and to explore the factors framing those experiences. Rather than seeking a unified voice from which to represent *all* FMRs, this study asked women to describe experiences of nursing care and interactions with nurses that were unique to the participant. During the interview process, FMRs were asked to describe their sense of trust in their nursing care, including influential factors in how that trust was built and/or lost. They were asked about the role of Medicaid in the patient-nurse interaction. For example, do FMRs feel equal to nurses, or are there perceived stigmas attached to Medicaid that cause them to feel self-conscious, embarrassed, angry, or inferior? The notion of intersectionality may be applied to consider how a Medicaid recipient's gender, class, and social position are co-constructed to create conditions of injustices and inequalities within a nursing environment.

Guided by this theoretical perspective, this study also attempted to explore the role race and gender play in the FMR-nurse interaction. For instance, this research sought to investigate if the race and/or gender of both the patient and nurse influenced the chemistry, mood, or tone of the interaction between those two individuals. If so, how did they affect the outcome of that interaction? Understanding these influences on patient-nurse interactions could inform nurses, nurse educators, and others, and promote emancipatory thinking that stems from both feminist and critical traditions.

Additional Theoretical Perspectives

Additional theoretical approaches also were considered for use in this study, and may be beneficial for future research to provide unique perspectives on the experiences of nursing care for FMRs. As a sociological theory of knowledge, social constructionist theory is one example that looks at how social phenomena and humans develop within social contexts. A focus of this theoretical perspective is to uncover ways in which individuals and groups create, institutionalize, interpret, and reproduce social concepts or practices (Kim, 2001). On the larger nature versus nurture debate continuum, social constructionist theory falls toward the nurture end, suggesting that while a biological basis for human behavior or culture may exist, much of society's perceptions of that behavior/culture is socially construed (Kim, 2001).

In exploring the research questions, a social constructionist perspective could suggest that nursing care is a socially construed tradition in which care is given by the nurse, and received and acted upon by the patient. From this perspective, the entire patient-nurse interaction is a set of social constructs in which both the nurse's and the patient's behavior is influenced by various factors. For example, the patient may bring to the interaction a set of socially construed beliefs about who nurses are and what they do, and this social reality is either challenged or confirmed as the patient interprets and acts upon the knowledge of what it means to receive nursing care. Similarly, the nurse also brings a set of socially construed beliefs to the patient-nurse interaction. When the two individuals interact, the belief set of each person carries potential for influencing that interaction either positively or negatively. A future recommendation for this study may include utilizing alternative theoretical perspectives such as social constructionist theory to frame a similar study.

Qualitative Research Design

Qualitative research refers to research about the lives, lived experiences, behaviors, and emotions of individuals (Strauss & Corbin, 1998). It is viewed as being beneficial for “unstudied or understudied areas” (National Institute of Health, 1999, p. 4), and the experience of nursing care for FMRs is an underrepresented area within nursing literature. Therefore, a qualitative design was applicable for this study. Within qualitative research, the researcher is the primary data collection instrument, and data may be gathered in multiple forms, such as observations of participant behavior, interviews, documents, or audio-visual materials, and the data are analyzed inductively by the researchers (Creswell, 2007, 2009).

Phenomenological Methodology

Phenomenological methodology allows the researcher to identify the “essence of human experiences about a phenomenon as described by participants” (Creswell, 2009, p. 13). In this study, the phenomenon of interest was the experience of nursing care for the specific population of FMRs. Moustakas (1994) described phenomenology as what one perceives, senses, and knows within the immediate awareness and experience; it is the building block for human science and the basis for all knowledge. In regard to experiences, phenomenology relates to the *reflection* of the experience, as it is not possible to reflect on an experience while actively living it. Therefore, lived experiences are not immediately manifested, but are instead grasped from retrospective reflections of past presences (Van Manen, 1990).

Within phenomenology, the role of the researcher is to receive knowledge about the experiences of others, and to convey these stories to others. Several approaches have developed for the analysis of phenomenological data. Some argue that the researcher must set aside, or

bracket, his or her own experiences in order to offer a full and unbiased understanding of the participants (Creswell, 2009; Gearing, 2004; Husserl, 1962; Nieswiadomy, 1993). Others argue, however, that in interpreting data, researchers cannot separate themselves from the meanings and must instead strive to understand all the possibilities that may be revealed (Gadamer, 1975; Im, 2010; Polit & Beck, 2008; Ricoeur, 1981).

Theory involving the study of interpretation is known as hermeneutics; during the 20th century, hermeneutics shifted away from emphasis on interpretation and focused instead on existential understanding, which has been described as a more authentic way of being in the world (Heiddeger, 1962; Ruoppo, 2011). Advocates of Heideggerian hermeneutics claim that texts, and the authors producing the texts, cannot be studied using the same scientific methods as the natural sciences (Ruoppo, 2011). These advocates argue that such texts reflect the expressions of the experience of the author; therefore, interpreting such texts should reveal something about the social context in which they were formed, and provide the reader with the opportunity to share in the experiences of the author (Ruoppo, 2011). Central to analyzing data in an interpretive--or hermeneutic--study is the notion of the hermeneutic circle, in which there is reciprocal and continual movement between the parts and the whole of the text being analyzed, and the surrounding context of the text (Polit & Beck, 2008; Ruoppo, 2011).

Given the research questions central to this study, a qualitative phenomenological research design was applicable for exploring the experiences of nursing care, but from the perspective of the person actually receiving the care--the patient. With this population being understudied among nursing literature, this study sought to inductively analyze reflections on nursing care deemed significant and meaningful for the women who experienced them, and to convey these experiences to others through participant profiles and stories. The researcher drew

upon a hermeneutic approach to data interpretation, feeling that the finished product of the research reflects upon both the experiences of the researcher and the surrounding social context within which the study occurred. This study was conducted during a time of active health reform, which holds significance for how the stories of FMR participants were formed, as well as how these stories were interpreted and written by the researcher.

Qualitative Interview Approach

Two separate interview approaches were utilized for data collections within this research: semi-structured interviews with the population of FMRs, and a focus group interview with current nurse educators.

Semi-structured Interviews

In qualitative research, interviews “may be used as a means for exploring and gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of a human phenomenon” (Van Manen, 1990, p. 66). The process of interviewing gives access to the observations of others, permits inquiry about people’s interior experiences, opens up a window on the past, allows for learning about settings otherwise forbidden, and rescues events that would otherwise be permanently lost (Weiss, 1994). A semi-structured, almost conversational, interview allows the researcher to prepare in advance general topics or questions to be covered with each participant (Kahn, 2000; Polit & Beck, 2008). Participants are then encouraged to talk freely about the topics, to tell stories in their own words, and to provide as much detail as they wish. Semi-structured interviews are structured to be flexible rather than stiff and formal. If participants veer the conversation away from what the researcher has

prepared, it may indicate an area of particular importance for the participant, and the researcher is encouraged to help the participant explore further meanings for such experiences. Probes may be used by the researcher to elicit more detailed information (Kahn, 2000; Polit & Beck, 2008).

Focus Group Interviews

Focus group interviews consist of a group of four or more people assembled for the purpose of discussing a specific topic, and take advantage of group dynamics to access rich information in an efficient manner (Polit & Beck, 2008). The interviewer, commonly referred to as the moderator, is responsible for guiding the discussion according to pre-established topics or questions, just as in a semi-structured interview. Moderators are critical to the success of a focus group interview, as their job is to encourage input from all group members rather than allowing one or two people to dominate the conversation (Polit & Beck, 2008).

A major advantage of a focus group interview is its efficiency, as researchers are able to collect information from many individuals within a short timeframe. Within focus groups, participants react to what is being shared by others, oftentimes leading to a deeper expression of opinion or meaning for the participants (Polit & Beck, 2008). This type of interview works best when participants are similar and cooperative with one another (Creswell, 2007). Sometimes, however, people in a group setting may be uncomfortable about expressing their views and may inhibit their individual expressions, contributing to a “group think” culture dynamic (Polit & Beck, 2008, p. 395).

Participants

Participants for this study included 11 FMRs, each interviewed individually for the purpose of exploring their experiences of nursing care, and five current nurse educators, who participated in a focus group interview for the purpose of understanding what those experiences suggest for nursing education.

Female Medicaid Recipients

The specific population of FMRs was chosen for this study because they live complex and diverse lives. The experience of receiving Medicaid benefits generally has no racial or geographical boundaries; women of all cultures, races, and educational backgrounds may be eligible for Medicaid benefits, depending on their individual or family income. Low-income does not distinguish among rural, suburban, or metropolitan populations, nor does it favor healthy women over those with risky lifestyle behaviors. Women receiving Medicaid benefits are diverse in regard to race, educational level, and health state; whereas one female Medicaid recipient may live in a rural area with little access to health care, another may temporarily receive Medicaid while pursuing a higher education degree that prevents her from working full-time.

Purposive sampling. After obtaining IRB approval for this research, the next step was to gain entry into the settings from which potential participants were recruited. Female Medicaid participants were recruited from an urban southeastern area. A purposive sample was used to select a group of women who responded to flyer advertisements and/or electronic announcements posted around the community.

Qualitative research must purposefully select participants to best aid the researcher in understanding the problem and the research question; within phenomenological research, it is essential that all participants share the experience of the phenomenon being studied (Creswell, 2009; Polit & Beck, 2008). Purposive sampling assists the researcher in narrowing down the pool of potential participants to a manageable and workable number of individuals that represent people who have experienced the phenomenon. For this study, a purposive sample was sought for female Medicaid participants located within an urban area of the southeastern United States.

Number of participants. For the first part of this study, 11 female Medicaid participants were selected. Weiss (1994) suggested that the researcher stops interviewing participants when encountering “diminishing returns” (p. 21), or data saturation, which occurs when the information obtained is redundant and adds little new knowledge to what is already known about the phenomenon. By the seventh interview, data saturation had begun to occur in a few areas; additional interviews were continued, however, to elicit richer data in areas not yet saturated. Data saturation was met by the 10th interview, yet one final 11th interview was conducted just to be certain.

Characteristics of the sample. Characteristics of the participants consenting to be in the study included that they (a) were female of 19 years or older, (b) received Medicaid due to low income, (c) spoke and understood English, and (d) were cognitively able to understand the study, and give informed consent to participate. All participants ranged between 22 years to 34 years of age. Six participants described their ethnic background as “Black,” three as “White,” and two as “Other,” with “Other” being described as “Mixed” and “Lebanese.” Five participants were

enrolled in college, with one working on a Bachelor's degree, three on Master's degrees, and one on a Doctorate degree. Of the remaining six participants, three had "some college" as their highest level of education, and three others held high school diplomas. Eight women were employed on a part-time basis (two participants reported having two part-time jobs); one participant was employed full-time, another was a full-time student, and only one participant was unemployed, but reportedly was seeking employment. Seven participants rented (alone or with a spouse/significant other) a house or an apartment, three lived with a family member, and one lived in subsidized housing. Out of the 11 participants, 5 reported receiving some type of nutritional assistance, such as WIC, Supplemental Nutrition Assistance Program (SNAP), or National School Lunch Program (NSLP). None of the participants was pregnant. All participants had children, with four having one child, one with two children, three with three children, and three with four children. The characteristics of this sample are summarized in Table 1.

The inclusion and exclusion criteria for this study were intentionally established, as all participants had to have met the age of majority in order to give their consent to participate. Secondly, all participants had to receive Medicaid due to low-income. This research was open to women receiving Medicaid benefits solely because of the event of pregnancy; however, this affected none of the participants. Finally, this research, the informed consent, and the interview questions were conducted in English; therefore, it was necessary for a participant to speak and understand English in order to understand the study and give consent to participate. Participants were excluded from this study if they were not a citizen of the United States, received Medicaid benefits due to disability, or received Medicare benefits (e.g., Medicaid dual eligibility). While Medicaid does cover individuals with certain disabilities, FMRs with a disability may have different experiences than women who receive benefits solely due to low-income; therefore, this

area fell outside the scope of this research. Similarly, women receiving both Medicaid and Medicare benefits may also have different experiences; therefore, Medicaid dual eligibility recipients were excluded from this study.

Table 1

Characteristics of the Sample of Female Medicaid Recipients

FMR	Age	Ethnicity	Work status ^a	Highest education	Housing status	# of children ^b	WIC benefits	Health rating ^c
Nia	28	Black	PT/ PT-ST	Associate/Working on Bachelors	Lives with Family	4	Yes	VG
Melanie	31	White	PT	Some college	Subsidized housing	3	No	G
Rhonda	29	Black	FT/ PT-ST	Bachelors/ Working on Masters	Rent house/ apartment	3	No	VG
Melissa	31	White	FT-ST	Bachelors/ Working on Masters	Rent house/ apartment	4	No	G
Danielle	26	Other: “Mixed”	PT/ FT-ST	Bachelors/ Working on Masters	Rent house/ apartment	1	Yes	VG
Nada	31	Other: “Lebanese”	PT/ FT-ST	Masters/ Working on Doctorate	Rent house/ apartment	1	No	VG
Yvette	27	Black	PT x 2	HS Diploma/ GED	Rent house/ apartment	2	Yes	G
Gina	22	White	Unempl., SE	HS Diploma/ GED	Rent house/ apartment	1	Yes	G
Nancy	33	Black	PT x 2	HS Diploma/ GED	Lives with Family	1	No	VG
Alisha	32	Black	PT	Some College	Lives with Family	4	No	G
Vanessa	34	Black	PT	Some College	Rent house/ apartment	3	No	G

^a PT = Part-time; PT-ST = Part-time Student; FT = Full-time; FT-ST = Full-time Student; Unempl, SE = Unemployed, Seeking Employment

^b Number of children under the age of 18 living in the household

^c VG = Very Good; G = Good

Current Nurse Educators

Five current nurse educators were also chosen to participate in this research, and were recruited by electronic mail from a convenience sample of nursing faculty within the southeast.

The focus group interview with nurse educators occurred 2 months following data collection

from the female Medicaid population, after the data were analyzed and meanings were summarized. A brief background of the FMR participants and their experiences with nursing care were presented during a focus group discussion in order to discuss what the essence of these meanings might suggest for nursing education. The significance and implications of this research for nursing education were also explored more deeply at that time.

Convenience sampling. A convenience sample was sought for recruiting nurse educator participants. Such a volunteer sample is used when researchers need to easily have potential participants come forward and identify themselves (Polit & Beck, 2008). Within focus group interviews, the participants selected are a fairly homogeneous group who generally express their views with other group members of a similar background (Polit & Beck, 2008). In this study, the bond shared by all focus group participants was their teaching of nursing to students. An inclusion criterion was that they had to be currently teaching undergraduate students at an accredited nursing program.

Number of participants. The optimal group size for focus groups is 6 to 12 people; too many risks not allowing every member an opportunity to voice their opinions, but too few risks not generating sufficient interaction (Polit & Beck, 2008). For the second part of this study, five current nurse educator participants were selected.

Characteristics of the sample. Characteristics of the nurse educator focus group participants include that they all were currently teaching undergraduate students at an accredited nursing program. All five participants were female, and ranged between 31 years to 56 years of

age. Three participants described their ethnic background as “White,” and two described their ethnic background as “African American” or “Black.” All participants taught full-time in Baccalaureate nursing programs; two had 5-7 years of teaching experience, two had 10 years, and one had 20 years of teaching experience. Three nurse educator participants had Doctorate degrees; one was working on a dissertation, and one was enrolled in doctoral coursework.

Ethical Considerations

The researcher recognizes that a major portion of this study involved conducting research about a population of women who are vulnerable because they are low-income. As a result, every step was taken to ensure minimal harm to them as a result of this research, including research activities during the course of the study, after the study’s conclusion, and even after the publication of the study’s results.

Risks

There was minimal risk of physical or psychological harm to both groups of participants within this study. As an ethical concern for their wellbeing, FMR participants were screened either in person, by phone, or through e-mail (Appendix A). To assure that they were healthy enough to participate in the research, potential participants were asked to rate their general mental and physical health as being *very good*, *good*, *fair*, *poor*, or *very poor*. Those reporting their health as *very good* or *good* were eligible for recruitment. While this did not occur, had a potential participant reported her health as *fair*, she would have been asked to consult with a physician and to provide documentation of this visit prior to participating in the research study. Those reporting their health as *poor* or *very poor* would have been ineligible for recruitment, and

would have been encouraged to contact one of the numbers listed on a provided copy of the Community Resource Directory (Appendix B).

The questions asked during the interviews with FMRs were personal in nature, and had the potential for triggering unpleasant emotions for participants; however, none of the 11 FMRs indicated any such unpleasant emotions. Although highly unlikely of its need, a plan of intervention was created in the event a participant became distressed. This plan included stopping the interview, allowing the participant to take a break, and/or withdrawing the participant from the study altogether without penalty or question. In the unlikely event of an emergency (e.g., if a participant became highly agitated, or expressed an intent to harm oneself or others), the researcher was prepared to remain with the individual and activate emergency services (i.e., 911). Upon reestablishment of safety, the researcher was to follow IRB protocol by notifying her dissertation chair and reporting the event to a Research Compliance Specialist and the IRB.

IRB Approval

IRB approval from The University of Alabama's Institutional Review Board was sought and received to ensure that this study was consistent with the safe and ethical treatment of humans as subjects of research (Appendix C). Prior to submitting an application to the board, the researcher completed and passed the required Social and Behavioral Human Subject Training.

Informed Consent

Informed consent was obtained from all participants prior to the conduction of any individual or focus group interviews (Appendix D). Information regarding the study and the

participant's rights were provided both verbally and in writing. All participants gave consent in writing by signing and dating the informed consent.

Confidentiality

Confidentiality refers to how information disclosed by a participant is treated, with the expectation that it will not be used or divulged without permission in ways other than which it was originally disclosed (Rudestam & Newton, 2007). Confidentiality of all data collected from FMRs and nurse educators was maintained through pseudonyms to ensure that specific information could not be traced back to any individual. At the time of the interview, during the verbal review of the informed consent document, participants were informed of procedures to ensure confidentiality, as well as procedures for the maintenance of digital audiotapes, transcripts and other confidential information. Participants were also informed of local laws requiring disclosure of specific events (e.g., abuse, threats to harm oneself or others) as an exception to maintaining confidentiality.

Female Medicaid recipient interviews. Individual interviews with FMRs were conducted in a private room, and a random pseudonym was assigned to each participant. The researcher recorded these pseudonyms in three places: the interview guide, the digital audio file, and the transcript file. This allowed the researcher to navigate easily among the various files whenever clarification on data content was necessary. Only the researcher had access to these files, and all documents were kept in secure, password-protected electronic formats on the researcher's personal computer. After pseudonyms were assigned, from that point forward, in all transcriptions and analyses of data, participants were referred to by pseudonym only.

Transcription of interviews occurred one at a time, as soon as possible after the interview, to avoid contamination of the data or errors between two or more sources. During transcription, if a participant ever referred to herself by name, brought up the name of another person (e.g., her spouse, children), or mentioned a specific location that could be traced to her identity (e.g., the road she lives on, the name of her employer), the data would be de-identified by omitting the name, and a general description of the word would be substituted in italicized brackets (i.e., *[name of son]*; *[name of doctor]*).

Nurse educator focus group interview. The focus group interview with current nurse educators was conducted in a private room, and random pseudonyms were assigned to each participant by the researcher. These pseudonyms were recorded in two places: the interview guide and the transcript file. This allowed the researcher to identify easily the five different voices during the interview. Again, only the researcher had access to these files, and all documents were kept in secure, password-protected electronic formats on the researcher's personal computer. After the pseudonyms were assigned, from that point forward, in all transcriptions and analyses of data, participants were referred to by their pseudonym only. Transcription of the focus group interview also occurred as soon as possible following the conclusion of the interview.

Data management. Copies of all transcriptions will be kept in hard format in a locked filing cabinet inside the researcher's office for a minimum of 7 years. Digital copies of the transcriptions were saved as PDF files and will be kept on the researcher's personal computer and as a backup copy on a jump drive. Each digital copy of the transcriptions has been password

protected to ensure the confidentiality and security of the transcript and the participants. No one may access these digital files without first typing in the correct password, which is known only to the researcher. All audio recordings will be destroyed following the completion of data analysis.

Validity

In qualitative research, validity refers to what a researcher does to ensure accuracy of the research findings, and reliability indicates that the researcher's approach is consistent across different researchers and projects (Creswell, 2009; Gibbs, 2007). Additional terms used to describe qualitative validity may also include *trustworthiness*, *authenticity*, and *credibility* (Creswell, 2009; Lincoln & Guba, 2000).

This study used Gibbs (2007) suggested qualitative reliability procedures as guidance to increase the reliability of this research. Each transcription was reviewed for accuracy by simultaneously listening to the interview and reading the transcript to catch obvious mistakes made during the transcription process. During coding, continuous comparisons of data and codes were done to make sure a shift in the meaning of codes did not occur. Memos about the codes were documented in a research notebook, and definitions for each code were created. An external reviewer was also employed to cross-check codes, ensuring that they were independently derived.

To increase the validity of this research, methods of member checking, peer review, and clarification of researcher bias were done (Creswell, 2007). Member checking is considered "the most critical technique for establishing credibility" (Lincoln & Guba, 1985, p. 314), and solicits participants' views of the credibility of the findings and interpretations (Creswell, 2007; Ely,

Anzul, Friedman, Garner & Steinmetz, 1991; Erlandson, Harris, Skipper & Allen, 1993; Glesne & Peshkin, 1992; Merriam, 1988). Preliminary analyses containing a description of themes were sent to participants, who were asked to reflect on the accuracy of the account and to consider if anything was missing.

Peer review and debriefing were also utilized as sources for external checks of the research process (Creswell, 2007; Ely et al., 1991; Erlandson et al., 1993; Glesne & Peshkin, 1992; Lincoln & Guba, 1985; Merriam, 1988). The role of the peer debriefer was to play “devil’s advocate” in order to keep the researcher honest, and to ask difficult questions regarding methodology, meanings, and interpretations (Creswell, 2007; Lincoln & Guba, 1985). Aside from the researcher’s dissertation chairperson, four peer reviewers were also enlisted, with two being male, and two being female. Two reviewers came from backgrounds outside of nursing, whereas the other two have extensive backgrounds in emergency nursing, clinical education, and management. One reviewer is a current doctoral student. Each peer reviewer received a background of the research participants, a preliminary description of their experiences, and a description of themes that emerged from the data. Peer reviewers were asked to read and review the content for accuracy and to consider alternative meanings or interpretations. All feedback received from both member checking and peer reviews was reflected upon and documented in a research notebook. Frequent consults with the chairperson of the researcher’s dissertation committee also assisted in decreasing potential for researcher bias.

Protecting against researcher bias. Clarification of researcher bias alerts the reader in understanding the researcher’s position and of any biases or assumptions that may impact the inquiry (Creswell, 2007; Merriam, 1988). The researcher has worked as a Registered Nurse (RN)

for 6 years. During that time, she has been employed at a not-for-profit regional hospital as a staff nurse and at a major southeastern university as a nursing instructor in both the classroom and clinical settings. Her nursing background is primarily trauma/surgical critical care and clinical education. Employment at both the hospital and academic institutions developed her interest in exploring the experiences of nursing care for female Medicaid women. This interest has been further developed through her participation in various volunteer organizations and opportunities throughout her community. She felt that her work and service experiences with FMRs would be an asset to understanding and exploring the setting and context for this research.

Issues of social justice and feminist perspectives are areas of close interest and passion for the researcher. Her professional nursing experiences inspired this research project, and it is recognized that she does maintain specific biases. Prior to beginning each interview, she documented through journaling any personal biases related to the topic being studied or the person being interviewed. Every effort was made to create a safe, nonjudgmental position during the interviews and throughout the course of the study. During the introductory phase of the interview process, the researcher alerted participants of the fact that she is a nurse, and that she recognized the potential that they might be uncomfortable sharing negative experiences about nurses to a nurse. To confront this issue, she emphasized again that her goal for this research was to help nurses learn from their experiences so that better care may be provided in the future. Participants were encouraged to share as much or as little information as they desired. The researcher recognized she might hear comments, opinions, attitudes, expressions, or thoughts that directly conflicted with her own personal belief system or professional code of conduct, and

she attempted diligence in withholding my personal judgments or voicing my personal beliefs to participants.

Instruments

Three instruments for data collection were used in this study: a screening tool for potential female Medicaid participants and two separate interview guides. During the initial point of contact with female Medicaid recipients, a screening tool (Appendix A) was used to ensure participants met the study's inclusion criteria. FMRs were asked for their age, ethnic background, work, educational, and housing statuses, number of dependents, whether or not they were currently pregnant or receiving WIC benefits, and to rate their general mental or physical health status. A semi-structured interview guide was used to facilitate discussion during these interviews (Appendix E). For the nurse educator focus group interview, an interview guide was also used to facilitate discussion (Appendix F).

Data Collection

Prior to any contact with potential participants, The University of Alabama's Institutional Review Board (IRB) completely and thoroughly reviewed the study to ensure that it was consistent with the safe and ethical treatment of humans as subjects of research (Appendix C). Upon IRB approval, recruitment for female Medicaid participants was initiated, and data collection began with the conduction of 11 interviews. As is often the case with qualitative research, data collection and analysis occur concurrently; therefore, coding began with the first data collection (Merriam, 1998).

After analysis and interpretation of data from the female Medicaid population, recruitment began for current nurse educators. This data collection process involved a five-member focus group interview to explore what these experiences might suggest for nursing education.

Female Medicaid Recipients

The research activities of this study took place in an urban area of the southeastern United States. Female Medicaid participants were recruited using flyer advertisements (Appendix G) and electronic announcements (Appendix H). Flyers were posted in public locations throughout the local community in areas targeted towards FMRs, such as bulletin boards at the public library, grocery stores, and thrift stores. Electronic announcements were e-mailed to potential research participant gatekeepers, such as leaders of local communities of faith, and an academic student listserv. Both methods for recruitment contained the researcher's phone number and e-mail address, so that individuals interested in the study could contact the researcher.

When potential participants did make contact, the researcher briefly described the aims of the study and its involvement. A screening tool was used to ensure that participant met the study's inclusion criteria. As part of the tool, FMRs were asked to report their health status; only those reporting their health as "very good" or "good" were deemed eligible for the study. Actual female Medicaid participants were selected on a first-come basis after successfully completing the inclusion criteria screening process. Interviews were conducted at mutually agreed upon dates and times, with individual interviews spanning the course of two months. The research site included a private, reserved room located inside a public library, which was chosen because it

was neutral, accessible, easy to find, and suitable for audio-taping. Upon participant arrival, the researcher offered an introduction of the interview process, verbally reviewed the informed consent document and answered questions as needed. Verbal emphasis was placed on confidentiality of data as it related to audio-taping, and written permission of this was included in the informed consent.

Interviews ranged from 45 minutes to 1.5 hours in length, and were semi-structured and conversational in style. Open-ended questions were asked using the interview guide, and participants had the chance to respond and control the direction of the conversation. The goal of this interview approach was to allow participants an opportunity to construct their experiences in relation to the research questions, and this allowed the researcher flexibility to deviate from the interview guide. At the conclusion of the interview, participants could add or clarify information shared, and were given a packet containing a copy of the informed consent, a list of Community Resources Directory and a \$25.00 gift card as compensation for her time and effort. After the interview, the researcher documented her own subjective experience of the interview through memos written into the margins of the interview guide.

Nurse Educators

A recruiting e-mail (Appendix I) was sent to educators from several area nursing programs, inviting them to join in the focus group discussion. Participants were selected among those educators who responded to the e-mail. The focus group interview was conducted in July 2012, on a date mutually agreed upon by the five participants and the moderator. The research site was a private, reserved room on campus of a major university, and was selected because it was well recognized, easily accessible to participants, and also suitable for digital audio-taping.

Once all five participants arrived, the researcher offered an introduction of the focus group process, verbally reviewed the informed consent document, and answered questions as needed. Verbal emphasis was placed on confidentiality of data as it related to audio-taping, and written permission of this was included in the informed consent.

The semi-structured focus group interview lasted 90 minutes and was conversational in style. As moderator, the researcher asked questions using the interview protocol as a guide, and made sure all group members had the opportunity for input. A flip chart visible to all participants was used to record themes and help maintain focus on the content. Participants were encouraged to view, add, or clarify themes or comments written by the researcher. At the conclusion of the interview, participants were given a \$25.00 gift card as compensation for their time and effort. Following completion of the interview, the researcher documented her own subjective experience of it through memos written into the margins of the interview guide for later examination and analysis of tacit biases and assumptions. The focus group interview later was transcribed verbatim.

Data Analysis

The purpose of data analysis is to impose order on large quantities of information so that the data can be synthesized, interpreted, and communicated to others (Polit & Beck, 2008). Multiple approaches to phenomenological data analysis exist. Huberman and Miles (1994) offered a data analysis process that details steps such as writing marginal notes, drafting summaries of field notes, and noting relationships among categories. Madison (2005) advocated for the need to create a stance that signals the theoretical perspective utilized within the study; Wolcott (1994) argued for the importance of forming a description from the data and relating that description to the literature. Van Manen (1990), using a combined approach of descriptive

and interpretive phenomenology, also emphasized the description or essential meaning of the experience being studied, but called for thematic descriptions to be gleaned from artistic sources such as literature, music, and art. Colaizzi (1978) proposed a seven-step method, in which one distinguishing step involves returning to study participants the essence of the description to ensure that it is accurate and valid. Giorgi's (1985) method, on the other hand, places sole responsibility of validating results on the researcher.

Because data collection and analysis occur somewhat concurrently in qualitative research, each individual interview with FMRs built upon the previous interview, as identified issues began to emerge. Some of these issues were anticipated, by either personal experience or through the review of the literature; however, some were not. Ziebland and McPherson (2006) recognized that researchers do not solely analyze data related to the issues that were initially deemed significant, but rather, researchers seek to examine unexpected themes that emerge in addition to those probable themes. Therefore, topics that were not originally asked about during one interview with a participant were brought up and mentioned to subsequent participants for exploration, confirmation, and clarification.

Marshall and Rossman (2006) described the phases of typical analytic procedures, which were used to guide data analysis for this study. In this process, data are first organized, and the researcher becomes immersed in the data. During immersion, categories and themes become generated, and the researcher codes the data accordingly. Interpretations of the data are offered through analytic memos, and the researcher searches for alternative understandings. Finally, the researcher writes the final report in order to present the research study and findings (Marshall & Rossman, 2006). To begin the analytic process, however, audio-recorded raw data first had to be transcribed.

Transcription

Transcription refers to the process of converting spoken word into another representation, such as written text; data that have been transcribed are no longer considered raw data, but rather “processed data” (Wengraf, 2001, p. 7). Transcription of interviews occurred singularly as soon as possible after the interview, to avoid contamination of the data or errors between two or more sources. In transcribing, the researcher identified the speaker in the written text by designating “S” as the researcher and “P” as the participant. Additional conventions noted in the transcript were added by bolding, italicizing, or writing in all caps whenever the participant emphasized certain words. Nonlinguistic utterances such as sighs or laughter were also transcribed.

The 11 interviews produced a large amount of data, which ended up being roughly 70 hours of recorded interviews and approximately 265 pages of transcribed data. Following this data collection, the next step was to organize the data in order to make it more manageable to work with.

Data Organization

Organizing data involves developing a method for classifying and indexing data (Polit & Beck, 2008). For this to occur, data must be converted to small, manageable units that can be quickly retrieved and reviewed without having to take the whole transcription into consideration (Polit & Beck, 2008). At this point, immersion in the data occurs as the researcher reads and rereads the data in an effort to become intimately familiar with the content (Marshall & Rossman, 2006). The researcher questions and reflects upon the data, and eventually categories become generated as patterns expressed by participants are noted. Such categories of meaning should be internally consistent but distinct from one another (Guba, 1978; Marshall & Rossman,

2006). Once categories begin to emerge, they then serve to act as baskets into which segments of text are placed for organization, also referred to as coding (Marshall & Rossman, 2006).

The researcher's first step in organizing the data was to reduce the text of each transcript to what was important and meaningful. The researcher carefully analyzed each transcript and bracketed data into smaller, workable chunks of information that highlighted significant statements, sentences, or quotes that provided an understanding of the participants' experiences (Creswell, 2007; Moustakas, 1994). Each data chunk was judged for its importance and relevance to the study by providing answers to the research questions, or by reoccurrence in each participant's interview transcript. All remaining transcript was removed. For each transcript, the researcher created an electronic table of these data chunks, with each cell containing a sentence or paragraph of meaning for the participant. This bracketing process succeeded in reducing the text of each transcript from approximately 24 pages to six or seven pages, each divided into manageable data chunks.

Coding Data

Coding is a process of qualitative data analysis that involves reducing data into meaningful segments, assigning names for those segments, and combining the codes into broader categories or themes (Creswell, 2007; Huberman & Miles, 1994; Madison, 2005; Wolcott, 1994). Once data were bracketed into data chunks, the researcher began a process of open coding for major categories of information. Each code was assigned a color, and as the researcher immersed herself in the data chunks from each transcript, she highlighted the selected text with the color assigned to that code. In doing so, it was not uncommon for data chunks to contain multiple color-coded elements. For example, a two-sentence data chunk might contain three

colors, each representing a different code, such as purple (trust), bright yellow (communication), and red (negative HCP attributes). When data chunks held multiple color codes, duplicate copies were made so that each code had its own copy; in the previous example, three duplicated copies of the data chunk were made, one each for the codes of trust, communication, and negative HCP attributes.

Interpretation of Data

The goal of interpretation is to bring meaning and coherence to the themes, patterns, and categories, and to develop linkages and a story line that makes sense and is engaging to read (Marshall & Rossman, 2006). This process occurs after categories and themes have been developed and coding is well under way as the researcher begins to reflect and interpret what has been learned. It involves evaluating the usefulness of the data as they relate to the research questions and the unfolding story about the phenomena of interest.

Throughout the coding process, the researcher engaged in interpretation of the data as she pondered what potential meanings were and how they related to one another; these were recorded in her research notebook as analytical memos or reflective notes. Occasionally, there were instances where the researcher identified personal biases related to the data, and documented these as well, so that they could be shared with her dissertation chairperson. When this occurred, the researcher documented her thoughts and feelings related to the topic, and reflected upon what the participant's true meaning might have been.

Once the data chunks were coded, the researcher began a visual process of generating "clusters of meaning" from these significant statements (Creswell, 2007; Moustakas, 1994). The researcher hung large, easel-sized Post-it notes to the walls of her personal office, with the more

frequently identified codes as headings for each. From there, color-coded data chunks were taped underneath the appropriate category, and were clustered with data chunks of similar color codes. In doing this, many of the initial codes became clustered due to similarities between the two groups, and by the end of the clustering process, most of these groups became merged into one major thematic category. For example, initially the open codes for authority (aqua blue) and submission (baby pink) were separate and distinct, but in interpreting and generating clusters of meaning, the two became merged into the larger thematic category of Authority and Submission. Despite merging, however, the researcher opted to keep the two separate colors on the data chunk to serve as a visual reminder of which textual components pertained to authority versus those that that involved submission.

Some initial codes, when clustered together for meaning, began to emerge as sub-sets of major themes. For example, the initial open code of feeling invisible (light green) was originally clustered with issues of self-identity (hot pink); however, in working with and interpreting the data chunks, the researcher began to sense that invisibility was one of many smaller subsets that comprises the FMR's overall subjectivity; therefore, the sub-theme of Invisibility was generated.

The process of clustering also assisted with further reducing the data. Once the data chunks were organized into clusters of color-coded themes, duplicate and redundant data chunks were compiled and set aside. There were occasions when a data chunk simply didn't "fit" into any major category, theme, or sub-theme. When this occurred, the researcher attempted to reflect and interpret its true meaning, and considered its applicability to the research question related to the experience of nursing care for FMRs. If the data chunk did not appear to offer applicability to the research question, it was set aside. If it had potential for applicability, but the researcher was not yet sure how or why, it was set aside in an "un-clustered" pile, through which the researcher

went back additional times to search for themes or codes that may have previously been missed or overlooked. A conceptual map was created as a visual example of how the major themes and sub-themes were organized (see Appendix J).

Making connections. During the final stages of interpretation, the researcher is to evaluate the understandings that were developed, and explore the data again for the purposes of challenging those understandings and seeking negative instances of the patterns (Marshall & Rossman, 2006). In searching for alternative understandings, the researcher must identify and describe them, and must further demonstrate why the explanation offered is the most plausible.

The final stage of interpretation and data analysis is writing the report that summarizes the findings of the research. Marshall and Rossman (2006) considered this to also be a highly interpretive process, as one chooses carefully the words that summarize and reflect upon the complexity of the data. The authors noted that the researcher must consider her positionality, ethics, and political stance when writing the report, as each has the potential to influence the overall tone of the report. The feminist-informed critical framework of this study assisted the researcher in writing the final report, as it is recognized that writing *her* truth about others' lives is an assertion of power (Lather, 1991; Marshall & Rossman, 2006; Tierney & Lincoln, 1997).

The researcher began by creating participant profiles of the female Medicaid recipients (Table 2). Profiles allowed the researcher to present the participants to others in order to share what was learned through narratives (Seidman, 1998). Secondly, textural descriptions of the participants' experiences of Medicaid and of nursing care were created as the result of the analyzed data obtained through interviews (Creswell, 2007). From these textural descriptions, four major shared themes and four sub-themes emerged, which are defined in Appendix K and

discussed more in depth in Chapter IV. Understandings from these themes and sub-themes allowed the researcher to create a composite description, in an effort to present the “essence” of experiences of nursing care for female Medicaid recipients, which is discussed in Chapter V. A timeline of research activities is presented in Appendix L.

Table 2

Participant Profiles of Female Medicaid Recipients

Participant ^a	Textual description
Nia	Nia is 28-year-old Black woman with four boys, including a set of twins, ranging between 4 and 12 years old. She is unmarried, and she and her sons live with Nia’s mother. Nia holds an associate’s degree, and is currently a part-time student, working on a bachelor’s degree in business, in addition to working in the retail industry part-time. Nia and her children receive WIC benefits, and her children receive NSLP meals. Nia’s oldest son was diagnosed with asthma in infancy, and her youngest son has been diagnosed with cerebral palsy.
Melanie	Melanie is a 31-year-old White mother of three. She and her kids live in subsidized housing with Melanie’s longtime boyfriend and father of her youngest child. Melanie has some college education, and is currently working part-time.
Rhonda	Rhonda is a 29-year-old Black mother of three children, ages 6, 10, and 12. She and her husband rent a house. Rhonda holds a Bachelor’s degree, works full-time doing “office work,” and attends school on a part-time basis, working on a master’s degree in business.
Melissa	Melissa is a 31-year-old White woman with four girls, ages 2, 3, 6, and 8. She is a full-time student, working on a master’s degree, and receives a small monthly stipend as a graduate teaching assistant. She rents her home, and her husband is a “stay at home dad” to their younger children. Melissa’s family receives SNAP benefits, and her older children receive NSLP meals.
Danielle	Danielle is a 26-year-old female who describes herself as being of a “mixed” ethnicity. She is a single mother of one 4-year-old girl, and together they live in a rented apartment. Danielle attends school full-time, working on a master’s degree, and works part-time in the evenings at a restaurant. Danielle relies on a family friend for childcare while she is at school and work; she also receives WIC benefits.
Nada	Nada is a 31-year-old married mother of a 4-year-old boy. She describes her ethnic background as being “Lebanese.” She works in retail part-time, and attends school full-time, working towards a doctorate degree. Her family lives in a rented apartment, and her son attends daycare. Nada’s son was diagnosed with asthma and colic in infancy.
Yvette	Yvette is a 27-year-old Black woman. She is a single mother of 2 children, and lives in a rented apartment. Yvette’s highest level of education is a high school diploma, and she is currently working 2 part-time jobs. Yvette receives WIC benefits.

(table continues)

Participant	Textual description
Gina	Gina is a 22-year-old White mother of a 1-year-old girl. She and her boyfriend, who is the father of her child, rent an apartment. Gina has a high school diploma; she is unemployed, yet seeking employment. She receives WIC benefits and unemployment benefits.
Nancy	Nancy is a 33-year-old single Black mother of one 4-year-old girl. She lives with her mother and grandmother, and works two part-time jobs: one at a church daycare program, and the other at a chain drug store. Her highest level of education is a high school diploma. Nancy does not own a car, and relies on her mother, neighbors, and friends (such as Alisha) for her transportation needs.
Alisha	Alisha is a 32-year-old Black woman, with four children ranging in age from 2 to 15. She and her children “temporarily” live with her sister and her sister’s family, which also consists of 3 additional children. Alisha has some college education, and currently works at a church daycare program with Nancy, whom she describes as “a close friend.” Because she owns a vehicle, Alisha often provides transportation to work for herself and Nancy.
Vanessa	Vanessa is a 34-year-old Black mother of three. She and her husband rent a house. Vanessa has some college education, and works part-time evenings/ nights at a fast food restaurant.

Note: NSLP= National School Lunch Program; SNAP= Supplemental Nutrition Assistance Program (formerly Food Stamps); WIC= Women, Infants, and Children supplemental nutrition program.

^aThese names are pseudonyms. All names were randomly assigned to protect the identity and confidentiality of the actual participants in this study.

Nurse Educator Focus Group Data Analysis

The focus group interview with nurse educators produced 75 minutes of recorded data, which were transcribed immediately upon completion, resulting in nine pages of transcribed data. In transcribing, speakers were identified in the written text by designating “S” as the researcher and the first one or two letters of the participants’ pseudonyms. Additional conventions noted in the transcript were added by bolding, italicizing, or writing in all caps whenever a participant emphasized certain words. The transcript was then reduced, through bracketing, into workable data chunks, which were then coded. From the interpretations of these coded data chunks, two categories emerged: Reactions to the Experiences of FMRs and Socioeconomic Diversity Training in Nursing Education. Chapter IV presents in depth these results as textual descriptions.

Summary

This chapter describes a method of phenomenological research design, data collection, and data analysis used to understand the experiences of nursing care for FMRs. The specific goals of this research were to understand how nurses' attitudes and behaviors towards FMRs influence the ways in which these patients receive and act upon their health care, and to consider what those understandings suggest for nursing education.

Qualitative research offers a pragmatic and humanistic method of exploring phenomena. Here, the researcher described a feminist-informed critical theory framework and the phenomenological methodology. Semi-structured interviews with FMRs assisted me in understanding their experiences of nursing care, and a focus group interview with nurse educators assisted me in considering what these understandings suggest for nursing education. Through these different interviews, the researcher engaged participants in conversations that allowed them to share their experiences and opinions from various worldviews. This study not only provided me, as the researcher, an opportunity to view the world through the lens of FMRs, but also allowed an opportunity for educators to consider the experiences of these women as important and worthy of attention.

CHAPTER IV

FINDINGS

The purpose of this study was to use a phenomenological approach to explore female Medicaid recipients' (FMRs) experiences with nursing care within a feminist-informed critical framework. The goals of this research were to understand (a) how nurses' attitudes and behaviors toward female Medicaid recipients influence the ways in which these patients receive and act upon their health care; and, (b) what those understandings suggest for nursing education. The research and subsidiary questions that guided the researcher in gathering subjective data for this study were as follows:

1. How do female Medicaid recipients describe their experiences of nursing care?
 - a. What makes a nursing care experience positive or negative for female Medicaid recipients?
 - b. What do female Medicaid recipients indicate as being helpful or harmful for their future health care decisions?
 - c. In what ways do nurse-patient interactions influence how female Medicaid recipients receive and/or act upon their health care?
2. What do nurse educators need to know from these experiences?
 - a. In what ways can educators use these experiences to inform nursing education?

This chapter is divided into three sections. The first section describes the FMR participants used in this study, and offers a brief summary of how they were recruited, their

characteristics, and a summary of how their experiences were analyzed. The second section discusses the themes and sub-themes that were formulated, including an in-depth description of each. The third section describes the nurse educator participants used in this study, summarizes how they were recruited, their characteristics, and the results of their focus group interview.

Participants: Female Medicaid Recipients

The data presented in this section comprises interviews with 11 women, each of whom completed a single, individual interview. Using pseudonyms, the FMRs who participated in the study are “Nia,” “Melanie,” “Rhonda,” “Melissa,” “Danielle,” “Nada,” “Yvette,” “Gina,” “Nancy,” “Alisha,” and “Vanessa.” A background description of these women, including their age, ethnic background, work and education status, and their family composition was presented in Table 2.

Recruiting Participants

Potential participants were recruited through flyer advertisements posted throughout the local community and electronic announcements e-mailed to potential participant gatekeepers (Appendices G and H). Participants contacted the researcher by telephone or by e-mail, and a screening tool was used to ensure participants met the study’s inclusion criteria (Appendix A). Actual participants were selected on a first-come basis after successfully completing the inclusion criteria screening process.

Characteristics of the Sample

After 100 flyer advertisements were dispersed locally, and 25 e-mail announcements were sent to potential participant gatekeepers, 22 women contacted the researcher for additional information regarding the study. Of this group of women, 11 actually participated in the research. Of the remaining women, 3 declined to be in the study after further information was given related to participation, and 3 others did not respond back to the researcher's e-mails or phone calls. During the screening process for the study's inclusion criteria, 4 women were excluded from recruitment; one female misunderstood the study, thinking it involved women receiving Medicare, and three others had a time lapse of greater than two years since receiving Medicaid. One female agreed to participate, and scheduled an interview date, location, and time with the researcher, but did not show up for her scheduled interview and was eliminated from the study.

Characteristics of these FMR participants included that they (a) were female, and at least 19 years of age, (b) received Medicaid benefits due to low income, (c) spoke and understood the English language, and (d) were cognitively able to understand the study in order to provide consent for participation. The specific characteristics of the sample are summarized in Table 1. All interviews were conducted in private between March and May 2012.

Female Medicaid Recipient Data Analysis

Guided by Moustakas' (1994) phenomenological data analysis strategies, the interviews with FMRs were transcribed upon completion and analyzed by hand through bracketing, horizontalization, and generating themes. After the data were reduced through bracketing and judged for its importance and relevance toward the study, codes were generated based upon

concepts from the literature and the theoretical framework. These codes consisted of words or phrases that were used to represent information contained within the bracketed lines of text, and were clustered with similar categories. Examples of some of these codes included patient-initiated health actions, competing roles/stressors, self-identity, positive and negative health care provider (HCP) traits/actions, and care. In addition to codes referenced from the literature, Seidman (1998) described that themes may also develop from interesting passages of texts, patterns within the transcripts, and excerpts of similar experiences shared among participants. Four themes and four sub-themes were generated from the data, based on the number of times participants' referred to them within the transcripts, their references within the scholarly literature, and how they provided answers to the research questions. These themes include (a) The Shuffle, (b) Authority and Submission, (c) Subjectivity as Mothers, and (d) Expectations of Nursing Care. Four sub-themes shared among all or most participants were also identified, including: (a) Telling of One's Story, (b) Invisibility, (c) Role Confusion, and (d) Stigma and Stereotype. A conceptual map of themes and related sub-themes is presented in Appendix J, and definitions of them are presented in Appendix K.

Themes Generated from the Research

FMRs live complex lives that are often exasperated by socioeconomic constraints. Nia and Nancy described experiences with unreliable transportation, and almost everyone discussed experiences involving demanding school or work schedules, challenging childcare arrangements, or "struggling to make ends meet." These challenges were especially difficult for Nia and Nada, who have children with chronic illnesses (e.g., asthma, cerebral palsy) requiring frequent hospitalizations or doctor's visits.

FMRs described their experiences of Medicaid with mixed emotions, and while there were some reported advantages to Medicaid, there were also multiple reported disadvantages associated with Medicaid. Advantages of Medicaid included positive feelings related to enrollment or re-enrollment, no windows for enrollment periods, no co-payments for doctor's visits or prescriptions, and the security of knowing health care was available for them and their children. As Yvette stated, "Medicaid is a savior for those of us who are single mothers."

The Shuffle

There were several reported disadvantages associated with receiving Medicaid, and in many of these experiences, FMRs described feeling shuffled or "lost in the system" that is Medicaid. Therefore, the term "The Shuffle" is used here to describe experiences where FMRs felt an overall sense of jumble, carelessness, disorganization, or "system"-related inconveniences. It is recognized that many non-Medicaid patients may share similar experiences related to The Shuffle. However, it is felt that Medicaid in and of itself may make one more susceptible to being "shuffled," since often such patients are limited in their choice of health care provider (HCP) and end up left with HCPs most likely contributing to The Shuffle.

"Assignment: Limited choice. Upon initial enrollment into the Medicaid program, FMRs reported being "assigned" to a HCP; for Vanessa, this major drawback of the program was "having no choice of who you want [for a HCP], as far as who does and doesn't accept Medicaid." FMRs were unhappy with their limited choice in HCPs, and because Medicaid limits their selection of available HCPs, those who *were* available were described as "not good," "sub-par," "awful," or "not that great." FMRs felt "stuck" and shuffled with these HCPs, yet felt they

could not do anything about their situation. Nia experienced this somewhat frantically when her young son experienced an active asthma attack. She elaborated:

I took him to the doctor, and they said, “We can’t see him until next Tuesday, go to the emergency room.” And when I got to the ER, the nurse said, “It’s daytime! Why didn’t you go to your doctor?” That was a problem for me! I just wanted someone--anyone--to see my son, rather than punting him off on someone else!

Alisha and Rhonda described being “assigned to practicing doctors” whose bedside manner was “uncomfortable,” “uncaring,” “uncertain,” and “clueless about women’s bodies.” If unhappy with a HCP, the process of changing to a different one was described as being quite complex, as Nancy described:

If you have a provider that you don’t particularly care for, [Medicaid] says... that I can change . . . but first I have to get a referral from my doctor. I have to have permission . . . to go to another doctor. But, if I tell my current doctor that I want a referral to go to a different doctor, he’s gonna refuse, and that is an uncomfortable conversation to bring up with your doctor. And if he refuses . . . well, I still have to continue to be seen by him.

For some participants, this limited choice in HCPs resulted in anger and resentment, and some women reported assertiveness in standing up to or changing HCPs with whom they were unhappy. Other participants felt impassive or indifferent about the whole situation, and avoided primary health care altogether. For example, Melanie once went without a routine Pap smear for several years, stating, “I hated to go to the health department; it was the worst thing . . . but it was my only option.” Melissa thought the only way her current HCP received any clients at all was because Medicaid assigned them to him, since she felt that individuals with private insurance, who could choose to go elsewhere for care, would not tolerate his rude personality and poor bedside manner.

System-related shuffling. Sometimes, The Shuffle was not necessarily related to individuals or groups of HCPs, but instead related to “systems” (e.g., Medicaid system, the

health care system) or “institutions” (e.g., a hospital, health center). Nia and her son struggled with this when encountering conflicting statements from her HCP’s office and the ED. Nada experienced system-related inconveniences when she tried to get a Prior Authorization (PA) form completed for her son’s asthma medication. From Nada’s understanding, Medicaid requires PA forms for more expensive medications, and the process requires her to obtain a completed form from her prescribing physician and take it to the pharmacy, so that Medicaid will reimburse the pharmacy for filling the prescription. She mentioned that occasionally, however, Medicaid has refused to pay for certain medications, in which case she had to either return to her prescribing physician for an alternative medication, or simply go without the medication. Once, Nada’s prescribing HCP forgot to complete the PA, resulting in her pharmacy being unable to fill the medication. When Nada called her HCP’s office, she was told it would take several days for them to prepare a copy for the pharmacy. Nada was forced to wait, all the time praying her son did not have an asthma attack.

FMRs reported face-to-face interactions with HCPs that were “rushed,” “hurried,” and impersonal. They felt HCPs’ main concerns were not on the individuality of patients, but rather on “herding” all patients in and out hurriedly, because there were so many to see in a fixed amount of time. Melissa compared this to a “little [factory], where everybody comes in and goes back out like a revolving door.” Because these interactions were hurried, FMRs felt as though they were not given the opportunity to tell their story or have it heard. They reported feeling like “just another patient,” “just another number on the list,” “just the one o’clock appointment,” or “just a bed number,” which resulted in them feeling invisible, frustrated, resentful, and distrustful. To make matters worse, FMRs’ primary care settings often involved large numbers of different HCPs, including physicians, interns, “practicing doctors,” RNs, LPNs, and office staff.

Because of this, FMRs felt they lacked a personal relationship with their HCPs, since they saw so many different people and rarely ever visited with the same nurse or doctor. Every time she visited her HCP, Rhonda felt like she had to repeat her story over “from the beginning” so that whatever HCP she saw that day could understand where she was coming from.

Lengthy waits and crowded waiting rooms. FMRs also described busy, “jam-packed” waiting rooms, where wait times ranged from 45 minutes to 2.5 hours past scheduled appointment times. Melissa and Alisha had to bring their young children with them to appointments, which made the wait especially tedious whenever they were not updated on delays. Nada described “never knowing” how long a scheduled appointment might last, which only added to her schedule-related stress. When FMRs visited health care settings, many had to take time off work or school, keep children out of school, or plan the feeding or toileting routines of small children. Alisha admitted to avoiding routine, preventative care for herself because she did not like not knowing how long an appointment might last and would rather spend her time earning money at work. Nada also described avoiding health care for herself, unless absolutely necessary, since lengthy waits and long appointments interfered with her entire day. When it comes to health care for their children, however, FMRs described that they would “suck it up,” “bite the bullet,” or “just clear [the] day” in order to attend to their child’s health needs.

Lengthy wait times also existed in urgent care settings, such as the emergency department (ED). During their experiences in the ED, Danielle and Yvette felt their time between arrival and triage was quick, which made them feel like appropriate attention was being given, and made them optimistic about their treatment times. The time spent between triage and examination, and then examination and discharge or admission, however, proved to be the most tedious and

frustrating. Yvette recalled, “. . . they’re just playing with you. You get seen real quick . . . then they take you to the exam room, and that’s where you end up waiting for forever.” Lengthy wait times without updates on delays resulted in FMRs feeling “forgotten about,” kept “out of the loop” or “in the dark.” Nia recalled thinking, “I must not be as important as [someone] down the hall.”

In acute care settings, FMRs described feeling confined to a hospital bed or room, and frustration occurred when met with a lengthy wait after using the call bell system to alert their nurse of a need. This also contributed to feeling “invisible” or “not as important” as other patients, and had negative effects on FMRs’ trust in nursing staff. Nia felt nurses’ shift change often was to blame, with the culprit being poor communication between the person answering the call bell and the nurses. Yvette blamed lengthy waits on nurses who didn’t care about her as a patient. Regardless of the causes, FMRs described feeling uninformed about their conditions, treatments, and rights as patients.

Invisibility. This sub-theme was identified among experiences in which participant interactions with HCPs were so impersonal, the FMRs felt invisible. FMRs indicated that the behaviors of the people “at the front desk” contributed to the problem of invisibility. Danielle once waited a significant length of time before someone at the desk acknowledged her, yet that person sat right in front of her. Gina once perceived that the staff behind the desk were talking to each other about her like she was not even there, and recalled thinking, “If [they] were talking about me right in front of me, what were they going to say about me when I wasn’t there?”

While in the hospital, Yvette listened to two nurses talk over her without including her in their

conversation, and recalled, “I was just lying there, listening to them gossip; it was like I wasn’t even there.”

Sometimes, HCPs contributed to feelings of invisibility by undermining FMRs’ feelings or by assuming their actions were in the best interest of the patient. Rhonda felt like an invisible, passive player in her health care choices, because she knew her HCPs would ultimately do whatever they wanted. Nia felt invisible when her HCPs brushed off her concerns regarding the progression of her labor, as did Vanessa when, after the birth of her son, “the doctor left... and that was it.”

Authority and Submission

Authority and Submission also emerged as a theme from the descriptions of FMRs’ experiences with nursing and other health care. Many of these experiences revolved around maternity settings, but regardless, HCPs were viewed as positions of authority, as they generally may decide what care treatments are to be done and how. Furthermore, FMRs felt that clear distinctions of Medicaid versus Private Insurance exist in health care settings. Four participants had previous experiences with private insurance and compared them with those of Medicaid. They felt the physical care given by HCPs was similar, in that the checkups, tests, procedures and treatments were the same regardless of their insurance status, but felt that the quality in which the care was delivered by nurses and other HCPs was different. These participants felt that people with private insurance were better treated, and that a general lack of respect for people on Medicaid existed within health care settings. Danielle recalled the following:

The first thing I noticed when I got on Medicaid was that [people] treat you odd when you show that Medicaid card. . . . When you hand over a good insurance card . . . you get more positive social feedback, like smiles and facial expressions. But when you pull out

the government card, things get testy. . . . It's totally different when you put the Medicaid card out there.

Conflicts over health decisions. FMRs often drew upon their previous knowledge of health care and their bodies when articulating their concerns to HCPs, and occasionally they experienced times when their personal beliefs and interests conflicted with those of their HCPs. For example, Melissa tried to discuss homebirth as an option for her, but her HCP told her to “go see someone else who believes in that sort of thing.” When bringing up needs or concerns with HCPs, many FMRs reported feeling met with resistance, “frustration,” and “annoyance.” This tended to cause internal conflicts for FMRs, who struggled with what they wanted versus what their HCPs wanted, and such HCPs were described as being “closed-minded” or “resistant” to talking about their concerns. Often, these HCPs were quick to “argue” their opinions based on the underlying assumption that they were working “in the best interest of the patient.” Experiences like these negatively affected FMRs’ trust, which then influenced how they acted upon their care. Withdrawal and avoidance were frequently reported coping mechanisms used by FMRs.

FMRs described times when HCPs scheduled inductions or cesarean sections, despite their desires for natural initiations of labor, and felt HCPs ended up “winning” since the babies were delivered in the manner chosen by the HCPs. During labor with her first-born, Nia felt something was wrong with her progression of labor, but her HCPs undermined her concerns. She recalled:

I tried to be very patient, because I did understand that it was my first child, and I didn't know what I was doing . . . but I felt like something was wrong. . . . The doctor . . . the nurses... kept saying, “You're just panicking. It's your first child, calm down. First babies are normally a little bit harder than the next.” Well, what did I know? I just knew that [the baby] wasn't coming out.

Nia's c-section made her feel like she had "lost," since she had really wanted to deliver her twins naturally. Rhonda, too, described feeling passive in her health care choices, knowing that her HCP was ultimately going to do whatever he or she wanted. Vanessa also felt dehumanized, as she recalled, "The doctor left, the nurses cleaned [my son] up . . . and that was it. It was like wham, bam, thank you ma'am. I mean, I'd only just given birth to a baby!" Many FMRs described feeling "beaten down" by these types of interactions, and over time, learned to speak only when spoken to, and answered only those questions asked. Sometimes, their true concerns were never really addressed.

Sometimes, either intentionally or unintentionally, HCPs assumed their actions were in the best interest of FMRs, and did not offer much room for their input. Nancy described a time when a nursing student did things to her without apparent consideration of Nancy's feelings regarding the situation. "I really wasn't given a choice. It was just expected that I let her do things to me," she recalled. Nia recalled a time when a HCP prescribed an asthma inhaler for her 6-month-old child, which did not make sense to her at all, yet she didn't say anything. She quietly accepted it, thinking "the doctor knew what he was doing . . . and so it must be right," and consulted with her friends and family about how to give the medicine to her child. Ultimately, however, she recalled that her son "probably went without much of the medication," as she "tried to hold the inhaler in front of his face, and hoped he got at least some of it." She felt resentful toward the doctor, who--in her opinion--had written an inappropriate prescription "without paying attention to the actual patient."

Confusion about patient rights. FMRs experienced times when they were unsure about their rights as patient. Yvette was hospitalized following a surgery, and recalled not knowing

“what my rights were, as far as being able to get out of bed or not.” With her IVs with long tubing, she had to get help just to go to the bathroom, and stated, “It was just kind of unspoken, you’re really not supposed to get up out of this bed.” Her uncertainty resulted in an unfortunate nursing interaction that left a negative lingering impression. She said a nurse “got on” to her for *not* getting up to the bedside chair, and elaborated:

I felt like a kid in trouble . . . like I needed to ask [her] permission to [get out of bed], but I was afraid [she’d] say no. So I didn’t ask . . . and I got in trouble! It was just a lose-lose situation . . . I’m sure [the nurse] was thinking I was the dumbest brick on earth, and lazy, too . . . her face and . . . her hand on her hip said it all. Like, “You are so stupid. Did you think we were gonna let you just lay around in bed all day?” It didn’t feel fair . . . [she] made me feel stupid, then [she] made me feel like a criminal. . . .

Melissa echoed this uncertainty in describing the conclusion of a nursing interaction, and said, “I couldn’t tell if the nurse was finished with me . . . I waited . . . for her to come back, but finally I got up and left.” Danielle was met with hostile resistance when leaving because she felt “forgotten about,” and had an altercation with an ED security guard who told her she could not leave “without the doctor’s permission.” Each of these was described as negative experiences, and had negative effects on the participant’s trust. Yvette never wanted to see her offending nurse again, which ended up being unavoidable, and when the nurse did return, Yvette responded by making minimal eye contact and submitting to the nurse’s tasks so she would “hurry up and get out of the room.” Nia tried to “be good” for her nurses in an attempt to “not make [the nurse’s] life any harder.” Nada also tried to promote positive interactions with nurses, and described, “I try to be the easy patient . . . I’m not a nagging person . . . I joke with [the nurses] when they come in so that they’ll feel comfortable.”

Role confusion of HCPs. This sub-theme of role confusion was identified as a result of FMRs being unclear about which HCPs they interacted with, and being unable to differentiate

nurses from other HCPs. Yvette best summarized her time in the hospital, and said, “I [saw] so many people, I [couldn’t] keep everyone straight!” FMRs had vague ideas about who nurses were, what nurses did, and how to differentiate “Nurses” [i.e. Registered Nurse] from physicians, nurse practitioners, LPNs, or nursing assistants. Many participants thought there was a hierarchy among doctors and nurses, with doctors on top. Nada noted that the first person to assess her was not a doctor, but rather “the nurse, or the practitioner . . .,” and thought that this person’s job was to “make up a report, and then, if need be, a doctor will come in and see me.”

FMRs’ role confusion may stem from common gender and role stereotypes that influenced their perceptions of nurses and doctors, which appeared most prevalent in urgent care settings where a greater number of male nurses existed. In these settings, FMRs described interacting with several different HCPs during a relatively short amount of time (“a flurry of activity”), followed by long waits that often transcended the ED staff’s change of shift. Danielle recalled her experience:

In the [ED], I’m not sure we saw a doctor at all. We saw [a lot] of people. . . . A guy came in. I guess he would have been the doctor . . . he looked like a doctor, with more stuff around his neck . . . but he had to have been the doctor, because he was there for like, 2 minutes, and left, and the next thing I knew he had someone scurry in to start my IV.

FMRs viewed doctors as authority figures “in charge” of nurses who had the final say in the health care decisions of patients. Rhonda thought that “doctors give work for nurses to do,” in that doctors were in charge of nurses, yet felt that nurses did “everything else” or “all the work.” FMRs felt that doctors were “too busy,” and viewed the nurse’s role as stepping in whenever doctors were unavailable. Many participants felt like nurses tried to “hold off” doing things or “tide [the patient] over” until doctors were able to get to the bedside. Whenever Nia asked about where her doctor was, her nurses tried to distract her and would not give her a direct

answer. During her labor, Melanie felt her nurse was “there to help the doctor,” yet noted that her nurse was “knowledgeable” and somewhat autonomous in that she wasn’t “there just to fill in for the doctor.”

Poverty-related submission. In primary care settings, Danielle felt the overall office environment played a role in how patients were treated. She said, “If the doctor has a certain personality . . . and is an ‘in-and-out’ doctor . . . the nurses are going to take on that personality . . . and be ‘in-and-out’ too.” She noted that nurses and doctors fed off one another, but was unsure about who was actually in charge, and pondered, “Of course, you see the nurses first, [and] you observe their behavior . . . and then the doctor comes in, and it’s the same behavior.” For Melissa, the culture of health care settings is best identified at the front desk, and she found that if the office staff were warm and welcoming, so too would be the nurses and doctors. Conversely, if they were cold, distant, and “just [going] through the motions of doing their job,” she found that the nurses and doctors were equally “uncaring” or “burned out.” Rhonda felt like her HCPs could not relate to her, which explained why they treated her the way they did. She explained it the following way:

When you have places [where] the [HCPs] have not experienced [hardship] for themselves, they don’t have a clue about it . . . what [the patients] are going through, or the mental turmoil. They probably see the same issues, but really don’t understand [them]. I feel like the patients are taken advantage of; they’re not getting the care that they need because the [HCPs] don’t understand where [the patient] is coming from.

Many FMRs felt it was not their place to stand up to authority figures such as doctors or nurses. For Alisha, this related back to being raised in poverty, as she recalled, “Growing up, everybody was poor . . . if somebody gave you something, you were expected to be grateful, whether you wanted it or not. You just take it, nod your head, keep your mouth quiet, and go

with the flow.” For many, this history of poverty-associated submission influenced how they received their nursing and other health care. Nancy recognized her position of vulnerability, since she could not afford either out-of-pocket health care expenses or private insurance. Nia admitted that because she did not pay for Medicaid, she felt “expected to keep our mouths quiet and just go along, because at least we’re getting some kind of care, rather than none at all.”

Gina was unsure if her response to HCPs’ authority was the result of her role as a patient, being unknowledgeable about health care in general, or because she was poor and on Medicaid. She explained, “Sometimes, [I] sense that [HCPs] expect me to follow what they’re saying, because they . . . know more than me, and I’m supposed to just take it.” Alisha described accepting health treatments despite having concerns because, “[I feel] like I don’t deserve anything more. How can I ask for more, if they’ve already given me this?” Nancy responded by feeling indifferent and “stuck,” and said, “At the end of the day, what can I do? When you’re poor, you don’t have the . . . knowledge to stand up. I can’t do anything. . . . I just try to make the best of it.” For Melissa, this was especially frightening, because she feared HCPs might abuse their authority by telling her incorrect information in order to persuade her into doing something she did not want.

Subjectivity as Mothers

The FMRs interviewed regarded their role as Mothers and primary caregivers to their children with vehemence. Several participants felt their number one job was to care for their children, and went to great lengths to do so. As Nada described, “I’m a mom, and it’s my job to fix him . . . to put a Band-Aid on it or to give him something to fix it. . . . If he is sick, my world stops. . . .” These participants felt no one was more knowledgeable about their child’s health than

they, which made it imperative to tell their stories whenever that story involved their child; many became anxious if unable to do so because of interactions with HCPs that were too rushed or hurried. Other times, however, FMRs felt HCPs were not listening to them or did not care about hearing their story.

Feeling silenced. FMRs felt HCPs were not listening to them. This most frequently occurred during initial contact with HCPs--commonly nurses--who began interactions with open-ended questions, yet interrupted FMRs' narratives with a set of predetermined, fixed-response questions. Melanie and Rhonda described these interruptions as the nurses' attempt to "out talk" or "rush" them into telling their story. Nia felt discredited when HCPs directed their attention to her child, rather than including her in the assessment. For Gina, when nurses write on their clipboards, it meant they were not listening to or caring about her story. Such interactions were negative for these women, and harshly affected their trust. Nada feared something about her child's health would be overlooked because her HCP did not know "the full story," and rebuffed, "I'm [emphasis added] the mom. I live with this person night and day; you only see him for 10 minutes . . . let me just tell you my observations as the mom."

Nia experienced frequent hospitalizations with her young son, and mentioned that nurses who were able to relate with her were those that gave the best advice and information. She recalled being able to sit down and talk with them about things going on at home. Nada recalled a similar experience, and took comfort in nurses who related to her as a mother and recognized her worry. She mentioned how they also sat down with her and made sure she understood what was going on, and recalled, "They helped me with my worries by keeping me informed."

Telling of one's story. This sub-theme was identified among many FMRs, who expressed a desire to tell their story when interacting with nurses and other HCPs. This “story” often included their reason for seeking care, any course of illness, associated symptoms, and treatments or responses to treatments. It was told from the FMR’s perspective of the situation, and used words and orders of events that were meaningful for her. As personal narratives of her health, FMRs found it important to share their stories with HCPs, and doing so brought them meaning to the interaction. Unfortunately however, because of rushed or impersonal interactions, FMRs were not always given that chance to tell their stories. FMRs described feeling frustrated, distrustful, and invisible whenever they were unable to tell their story to HCPs.

“Standing up” with knowledge. When it came to the care of children, some FMRs were more likely to stand up to HCPs and question their actions than others. Nia equated advocating for her child with her job as a mother, and said, “If you have a child, and that child is suffering . . . it’s just a matter of being persistent [with HCPs] . . . to get to the root of the problem.” For her, “standing up” to HCPs was challenging, yet her motivations stemmed from her concern about her son’s life and wanting to know more about his asthma. To confront these challenges, Nia underwent a process of information-seeking health behaviors about her son’s asthma that ultimately resulted in her feeling empowered. She said, “[I felt] equal to the doctors and nurses . . . [I] knew as much about asthma . . . and even more about my son . . . [than] they did.” She educated herself on asthma by reading old textbooks and articles on Google. She created charts about when his attacks occurred and what his triggers were, and adjusted her family lifestyle, such as how she cleaned their home. Nia mentioned that talking to other parents in the waiting rooms of hospitals and doctor’s offices was another avenue of support and information for her.

As she grew in her knowledge of asthma, she began to notice a shift in how other parents interacted with her, which further added to her sense of empowerment. She recalled the following:

Sometimes it seemed like I was the only parent asking the [doctors and nurses] the hard questions; other parents didn't know enough [about asthma] to even know what to ask . . . I remember a few moms [who were] glad to see me walk in so they could ask me questions... I didn't mind sharing [with them], because I wish somebody had taken the time to educate me.

Rhonda also equated her duty as mother with advocating for her children's health, yet described her role in HCP interactions as "slightly passive-aggressive." She, too, had been active in information-seeking health behaviors, but her motivations stemmed from a general sense of distrust in what her HCPs did and told her. She described the following:

The [doctor or nurse] can tell me something, and I'll say "Oh okay." But then I go home and research it on my own, because I don't trust what [they] are telling me. I [want] to make sure that what I hear, and what I read . . . all have a common ground. . . . Things that don't match up, I put on the back burner. . . . But from the things that did match up, I gather what [must be] the truth.

Rather than finding empowerment in doing these things, Rhonda instead expressed sentiments of growing distrust, resentment, and avoidance of health care settings and HCPs.

Melissa also described how she would prepare herself with knowledge prior to visiting her HCP, and while this helped her feel "equal" to them, it influenced her trust. For example, she described how she would research vaccination guidelines for getting her kids into school, and would know these going into her appointment. If her HCP were to tell her something different from what she had researched, however, or would recommend something "outside the guidelines," Melissa would feel like she was trying to be coerced into doing something she did not want. When this occurred in the past, she relied on her maternal intuition for health care decision-making by mentally assessing her child and her knowledge of her child's health; often

she decided to “err on the side of caution” by going without the treatment. As soon as possible though, Melissa would research the issue, and while she often concluded that the problem was not as bad as she had originally thought, she did find a sense of empowerment in knowing she had control over the decision-making process. She said, “When you just don’t know . . . that’s a very scary position to be in . . . it’s a mountain in my mind until I can find out what the problem is or become more educated about it.”

Expectations of Nursing Care

FMRs interacted with nurses in a variety of settings and for a variety of reasons. Of those interviewed by the researcher for this study, the most frequent FMR-nurse interactions occurred in the primary care setting at either doctor’s offices or public health departments. Most commonly, the FMR’s child was the direct recipient of care, not themselves, and the reasons for visits included routine well-child checkups, scheduled immunizations, or illness care. FMRs visited public health departments for illness care, WIC services, and family planning services. In acute care settings, most FMR-nurse interactions occurred during the birth of a child, or if a FMR brought her child to the emergency department (ED).

FMRs viewed nursing as a profession in which nurses constantly interacted with people, and described that the best nurses were those who were friendly and understanding. From their perspective, professional nurses are respectful, knowledgeable, and able to work with all different types of patient populations, regardless of insurance or socioeconomic status. FMRs indicated that “customer-service” actions were important in establishing and maintaining positive nursing care experiences. These actions included acknowledging the patients, greeting them with smiles, making eye contact, and using their names during conversation. FMRs felt nurses were

responsible for creating positive interactions and that nurses should strive to create environments that are open, accepting, and unbiased. Alisha noted that when patients come to nurses, “[they are] already suffering . . . [they] don’t need the extra stress from nurses who don’t understand that the nature of their job is acceptance.”

Positive interactions of care and respect for patients. For Melissa, a nurse’s respect for individuals was the keystone of good nursing care, as she explained, “If a nurse is respectful . . . the patient will be forgiving. But if the nurse was disrespectful . . . the patient will think the nurse doesn’t care.” FMRs indicated that nurses demonstrate care and respect through positive communication skills such as active listening, displaying interest in them, and attempting to understand situations from their perspectives. Nancy spoke of a time during one of her pregnancies when she was late for an appointment because of car troubles. She described the subsequent interaction with her nurse, which left a positive impression on her:

[My nurse] didn’t get on to me or act like I had messed up her schedule. . . . She listened to me when I mentioned my car problems, then asked me what I was going to do if I had car problems when I went into labor. I hadn’t thought of that! [Together] we came up with a backup plan, sitting right there. It was nice to know she cared about me.

FMRs described professional nurses as being respectful of their time, and those nurses who provided updates on delays or wait times were most favorable. Gina recalled a time when her appointment ran late, but her nurse updated her of the situation as soon as it arose. She said, “[The nurse] gave me the chance to decide if I wanted to stay or not . . . gave me control . . . rather than just not knowing.” When her nurse became busy, Yvette still felt in good hands because, “[my nurse] sent someone else in to bring me what I needed, then later [apologized] and said, ‘Did you get everything you needed?’ . . . She followed up on me.” To her, this follow-up demonstrated that her nurse cared about her. For Nia, it took a nurse who made personal phone

calls to follow up with her about her son's asthma symptoms. She recalled, "When this nurse would call me at home to check on me, it really meant a lot. . . . I felt like she really cared about me, and not like it was her job to *take* [emphasis added] care of me."

FMRs expected nurses to be knowledgeable about medications, nursing skills, and patient education topics. Gina remembered feeling scared as a new, young mother, yet found comfort in a nurse who taught her how to feed and care for her baby. Nurses demonstrated credibility to Nada by being knowledgeable; she said, "[The nurse] doesn't have to know all the answers . . . but at least share with me what she knows, and make me feel like she understands." Vanessa found it easier to trust the information given by nurses when they appeared confident and knowledgeable about what they were telling her. She described not only wanting her nurse to understand the topic, but to take the time to make sure she understood it, too. Melanie echoed this desire for information from nurses, saying, "I want [nurses] to tell me things . . . even things [they] think I might not be interested in, like my vital signs. Keep me informed." The tone used during such conversations also carried a heavy message, as it might convey that the nurse is patient and caring, or impatient, irritated, and stereotyping the patient as "dumb."

Negative impersonal and unprofessional interactions. FMRs indicated that the most negative interactions occurred with nurses who appeared burned out, overworked, tired, and dissatisfied with their jobs, and these nurses contributed to interactions that were impersonal and meaningless to FMRs. FMRs viewed such nurses as unprofessional, and equated them with being disrespectful of their time and hurried when interacting with them. Danielle recalled once waiting in the lobby of her doctor's office for over an hour, only to later find out her nurse was on lunch break. Poor communication skills were viewed as unprofessional and contributing to

negative interactions. Nancy described, “It really bugs me when a nurse’s body language implies that you don’t want to be there with me. What makes you think I want to be there too?”

Sometimes FMRs felt like nurses sent subliminal messages, and blamed it on the nurses’ lack of eye contact and tone of voice. Nia said, “If a nurse can’t look at me, why should I trust her?”

Alisha agreed, saying, “If a nurse is talking to me but looking at the clipboard, I’m trying to figure out if what she’s saying is really important or not.” Melissa found herself straining to listen to a nurse whose speech was monotone, and said, “I didn’t know if what she was saying was good or bad or what.” Because of a lack of eye contact, Danielle felt her nurse judged her for accepting condoms.

FMRs found it negative when nurses did not provide ample amounts of knowledge or education. Rhonda had a problem with a nurse who could not answer her questions satisfactorily, and said, “The nurse is supposed to know this information; I don’t know it! But if my nurse doesn’t know it, I lose confidence.” She reiterated that tone and body language were important to a nurse’s overall message, and said, “If the nurse didn’t know the answer to my question, and acted like she didn’t care, I would be upset, like she was blowing me off.” It was important for Nada to understand the justifications behind HCPs’ actions, and while she wanted to know why certain medications were being given, what she really wanted was for nurses and HCPs to talk to her like an educated person. She said, “Don’t just give me the medicine and say, ‘Take this for two weeks.’ I need to know why.”

Sometimes, FMRs were uncertain about the roles and responsibilities of various HCPs, which led to uncomfortable and negative experiences. Many were unclear about the titles or roles of the people they interacted with, and were unable to differentiate nurses from doctors, or nursing assistants from RNs. As a result, they often didn’t know to whom they should tell their

story. For example, Nada once was unsure if the person checking her child's height and weight and asking health history questions was actually her nurse, or just a member of the office staff. She recalled waiting for the "right person" and the "right time" to tell her story, which unfortunately was never identified. Yvette also described not knowing to whom to talk when she needed something or had a question, and recalled, "One person didn't mind going to get me [things]. But . . . the next person . . . was rude and told me to have my family go get [them] . . . Well, I didn't know." Danielle suggested it would be helpful to know the name and title of everyone who came in and out of her hospital room, yet stated that not many HCPs actually introduced themselves to her in this manner.

Stigma and stereotype. FMRs described that the major drawbacks of Medicaid were its associated sub-theme involving stigmas and stereotypes. Many lived with the effects of these stigmas and stereotypes daily, and perceived them from sources such as the media, politicians, employees of grocery and retail stores, law enforcement agencies, and HCPs. Rhonda thought it was doctors' and nurses' frustration with Medicaid that "[affected] their attitudes and how they treat [Medicaid] patients." She felt HCPs were more likely to stereotype when they only worked with Medicaid patients, and summarized Medicaid recipients' most common general stereotype: "You never work . . . so you're poor. You don't work because you're lazy; you have no motivation. You just get pregnant so you can get food stamps for more kids and get a bigger [government] check."

FMRs felt being poor and receiving Medicaid often went hand-in-hand, and that HCPs treated all Medicaid patients as if they were "dumb," "stupid," or "uneducated." The five FMRs enrolled in higher education programs were most offended by this, yet this stereotype was hurtful to all participants, because they did not view themselves as any of these labels. Gina said, "If

you're not in the medical field, that stuff is just different to you. . . . [HCPs] take advantage of [that] fact . . . and assume 'Well, it's Medicaid people; they're just ignorant,' when really, it's any average person." Yvette experienced this during her hospitalization, and felt uninformed by her doctors and nurses altogether. Whenever she asked questions, she felt her HCPs gave her "dumb[ed] down" answers. She also felt uninformed about her HCPs' postoperative expectations, and subsequently experienced a negative encounter with a nurse who "got on to" her.

FMRs also felt stereotyped as "freeloaders" who "know how to work the system." Many described feeling sensitive, embarrassed, or even ashamed about "handing over that Medicaid card," and felt it was necessary to "prove" that their need for Medicaid was not related to laziness or stupidity. Many also worried that their HCPs grouped them "in the category of people who abused the system." For example, Vanessa said, "I think [nurses] see me as a young Black woman with three kids . . . they assume I'm not married, and . . . on Medicaid." She continued, "I can feel [nurses] size me up. . . . [Their] face tells it all . . . I feel like I have to prove something. I mean, I dress okay; [they] don't see my car . . . I work hard, but I don't get it. . . ." When she brought up her issues of anxiety and depression with her HCP, Nancy felt she was viewed as "drug-seeking." Melissa described being most sensitive to stereotypes when she hands her food stamp card to the grocery store clerk, and mentioned, "I think [people are] thinking they would never let themselves get in my position . . . of being poor . . . on Medicaid."

Danielle described a time when she went for her routine birth control injection and, as was customary, her nurse asked if she needed any condoms. When she agreed to take some, she felt like the nurse judged her, and said, "I could tell by her whole body language. She didn't make eye contact; she wasn't really looking at me." She was confused by the nurse's reaction,

and thought, “Why would that make you uncomfortable? You’re a nurse!” The situation made Danielle frustrated, and she too described struggling with shame about receiving Medicaid and WIC; she defended herself, however, by saying, “I have taxes taken out of my paycheck, too. . . . I contribute to the tax pool. . . . I see it as a way of me getting my tax money back.” She was aware of the assumptions society and HCPs had for Medicaid recipients, and claimed that these assumptions were based upon how Medicaid recipients physically looked or talked. She felt that HCPs treated Medicaid recipients based off these assumptions, and related it to discrimination, and described the following:

Difference in treatment because of Medicaid is . . . discrimination in the end. I see that, I feel that. And it’s not racial, because if I go in as a dark person, I get the same feedback from the workers that are dark. It doesn’t matter if the person at the desk is Black or White; it’s [more of] a money versus no money [discrimination].

FMRs described coping mechanisms for challenging stereotypes. Danielle tried to dress professionally and brought her college textbooks to her appointments. Nancy felt stereotyped as “drug-seeking” by her HCP, and felt “stuck” as a result. Melissa described researching her symptoms prior to appointments so that she might sound more educated when talking to HCPs. Melanie described avoiding and rescheduling her children’s appointments if they had bruises on them from playing outside, and said, “I’m just afraid [the HCP] will automatically assume my kid is being abused, just because we’re poor.”

Most FMRs felt they could not do anything to overcome or challenge stereotypes. Vanessa said, “It’s like [HCPs’] minds are already set, and no matter how you dress, how you talk, they still look at you as the Medicaid cardholder.” Nia felt that challenging stereotypes too much would only contribute to further stereotyping, since people might judge her even more if she drove a nicer car or owned her home while on Medicaid. Danielle did not foresee these stigmas and stereotypes changing anytime soon, despite current health reform that made more

people eligible for Medicaid. Instead, she thought that because such stereotypes were discrimination against poor people, health reform would only mean that a greater number of people would suffer the effects of these stereotypes.

The Roles of Race, Gender, and Age

The FMRs interviewed found that neither race nor gender played much of a role in their interactions with nurses and other HCPs, and instead indicated that it was personal characteristics or attributes of individual HCPs that made interactions meaningful or not. FMRs wanted their nurses and other HCPs to relate with them, and while Rhonda felt a Black HCP might better relate with her at times, she said that sharing race did not play into her determination of whether the interaction was meaningful or not. FMRs felt they could have meaningful interactions with nurses and HCPs of varying races and cultures. Danielle thought Medicaid played a role in the racial diversity of her HCPs, and reflected, “I think I’m less likely to see a [HCP] of a minority background at places that cater to private insurances. But at the health department, where everybody is mostly Medicaid, the nurses are diverse and the patients are diverse.”

Additionally, FMRs indicated that gender also played a minor role in their interactions with nurses and other HCPs. Most FMRs reported preferring female HCPs, but many stated that “it really doesn’t make a difference,” and again looked at the personal characteristics of a HCP when determining the meaningfulness of interactions. Many FMRs interviewed did not have experiences with male nurses, yet for those who did, the experiences were described as positive. Some participants preferred female nurses and HCPs for gender-related experiences, such as labor and delivery, birth control, or pediatric care. Nada felt that female nurses were more relatable to her and her son, and said, “I think [female] nurses with kids do better than [male]

nurses . . . [because] they know how to interact more with my kids.” Danielle was more comfortable discussing birth control with female nurses, and thought they were “more familiar with the different types of birth control because they’ve probably used it themselves.”

The Role of Health Care Provider Age

The age of HCPs was found to potentially influence interactions with FMRs, who tended to equate the age of their doctors and nurses with their years of experience. Interactions with doctors who were older, male, and of a different race were described as negative, and such doctors were viewed as “old-fashioned,” “unable to relate,” and more likely to do “what [they] want, when [they] want” without regard for the patient. Nia’s twins were delivered by an older, White male physician, and she recalled, “[He] automatically said I’d be getting a C-section, without even knowing how [the babies] were laying. . . . And, [he] pushed for me getting my tubes tied, without a question. . . . He wouldn’t even hear me out.” Yvette described her older, male surgeon as being “from a different country” and unable to relate with her. When making rounds, he told her, “Well, your surgery went well! Let’s see how you do tomorrow, and then maybe we’ll let you go home.” Yvette remembered thinking, “Okay . . . what else? I mean, you took an organ out of my body; all you’re saying is ‘it went well?’” Rhonda did have a positive experience with an older, Black female doctor who saw only Medicaid patients, and she thought that her doctor’s race and gender were what made her more relatable to her patients. Her doctor’s age was beneficial to Rhonda, “because she’s older [and] used to dealing with younger women. . . . She knew how to handle me!”

The Role of Nurses' Age

FMRs indicated that a nurse's age also played into the meaningfulness of interactions. FMRs described "younger nurses" as being mid-30s and under, and "older nurses" as being 40 and up. Some participants found it easier to talk with younger nurses closer to them in age about issues related to contraceptives or sexual health. Vanessa thought younger nurses were more knowledgeable about technology and nursing tasks because they were more recently in school. Melissa found younger nurses to be more open-minded in conversations about alternative therapies, but thought that this was related more to the nurse's personality rather than age. Conversely, other participants felt that younger nurses were lacking in experience, and Melissa also noted that they appeared to try and prove themselves to other people, such as doctors.

Some FMRs viewed older nurses as carrying more experience, which was at times comforting, especially in the labor and delivery setting. Alisha preferred to discuss personal issues with older nurses because she felt they "have probably heard it all before," and were less likely to judge her. Other times older nurses were viewed as "tired, burned out, and unhappy with their jobs." Some participants described older nurses as "set in their ways" and closed-minded to discussing ideas that conflicted with their own. FMRs least preferred older nurses in primary care and public health settings, where, according to Danielle, "It seems . . . like older nurses go . . . to dry up and die."

Participants: Nurse Educators

The second set of data presented in this research is comprised of a single focus group interview with five current nurse educators. Using pseudonyms, the nurse educators who

participated in the study were “Audra,” “Amy,” “Sharon,” “Tammi,” and “Kerri.” A brief profile and background description of these participants is presented in Table 3.

Table 3

Participant Profiles of Nurse Educators

Participant ^a	Textual description
Audra	Audra is a 31-year-old White female who teaches in a large Baccalaureate nursing program. Her clinical background is in trauma-surgical critical care and home health care. She is currently enrolled in doctoral coursework, seeking a Doctorate of Philosophy (Ph.D), and has 5 years of teaching experience.
Amy	Amy is a 32-year-old White female, and teaches in a large Baccalaureate nursing program. Her clinical background is in cardio-thoracic critical care and the operating room. She is currently working on her dissertation for a Doctorate of Education (Ed.D) degree, and has 7 years of teaching experience.
Sharon	Sharon is a 47-year-old African American female who teaches in a “medium-sized” Baccalaureate nursing program. Her clinical background is in the Emergency Department and critical care, and she is a licensed Nurse Practitioner. Sharon holds a Doctorate of Science in Nursing (DSN), and has 10 years of teaching experience.
Tammi	Tammi is a 41-year-old Black female who is faculty in a smaller, rural Baccalaureate nursing program. Her clinical background is in mental health and geriatric care. She holds a Doctorate of Philosophy (Ph.D), and has 10 years of teaching experience.
Kerri	Kerri is a 56-year-old White female who is faculty at a large Baccalaureate nursing program. Her clinical background is in labor and delivery and neonatal care, and she also works as a Family Nurse Practitioner. Kerri holds a Doctorate in Nursing Practice (DNP) degree, and has 20 years of teaching experience.

^a These names are pseudonyms. All names were randomly assigned to protect the identity and confidentiality of the actual participants in this study.

Recruiting Participants

Current nurse educators were recruited by electronic mail from a convenience sample of nursing faculty of southeastern nursing programs. A recruiting e-mail was sent to educators from several area nursing programs, and actual participants were selected among those responding to the e-mail. An inclusion criterion was that they had to currently be teaching undergraduate students at an accredited nursing program.

Characteristics of the Sample

Ten e-mail announcements, initially, were sent to educators from area nursing programs. Seven nurse educators responded to the researcher by e-mail stating their interest in participation. Of this group, only five actually participated in the focus group interview. Of the remaining educators, one was unable to attend due to scheduling conflicts, and another did not respond to the researcher's e-mail regarding scheduling of the interview. The focus group interview was conducted in July 2012.

Characteristics of the nurse educator participants included that they were currently teaching students at an accredited nursing program. All participants were female, and ranged between 31 years to 56 years of age. Three participants described their ethnic background as "White," and two described their ethnic background as "African American" or "Black." All participants taught undergraduate Baccalaureate nursing students full-time, with two participants with 5-7 years of teaching experience, one with 10 years of teaching experience, and one with 20 years of teaching experience. Three nurse educator participants had Doctorate degrees, one participant was currently working on her dissertation, and the fifth participant was enrolled in doctoral coursework.

The focus group interview with nurse educators was transcribed upon completion, and the transcript was reduced through bracketing into workable data chunks, which were then coded. From these coded data chunks, two categories emerged: Reactions to the Experiences of FMRs and Socioeconomic Diversity Training in Nursing Education. This section presents the results of the analyzed data as textual descriptions of the categories.

Reactions to the Experiences of Female Medicaid Recipients

During the introductory phase of the focus group interview, nurse educators were given a brief background of the FMR participants and an overview of their experiences. When asked to describe their initial reactions to this information, several nurse educator participants expressed surprise that FMR participants were relatable, valued their role as mothers, and that many were enrolled in college-level education. This information served as an “eye-opener” for some, and challenged the educators’ preconceived notions about FMRs. Amy was surprised at “how normal [FMRs were]” and how much she had in common with them. Audra was most surprised to hear about Medicaid’s assignment of HCPs and the complex process that occurs if FMRs wished to change. One thing that *did not* surprise Sharon was FMRs’ expectations for nurses, as she explained, “I think [those are] pretty much everyone’s expectations for nurses, to be treated with respect, for nurses to care about you . . . that’s what makes up professional nursing.”

None of the nurse educator participants were surprised that FMRs experienced stigma and stereotype, and many described witnessing these stereotypes played out by physicians, nurses, and students. All agreed that both nurses and students alike hold various forms of stereotypes associated with Medicaid and low-income populations. The educators felt students and nurses perceived low-income Medicaid populations as unmotivated in self-care tasks and more interested in pain medications, and that Medicaid patients viewed nurses as waitresses.

The educators identified potential factors contributing to nurses’ stereotypes: (a) the clinical setting where the nurse worked, (b) the types of patients the nurse interacted with, and (c) the workload of the nurse. Sharon echoed FMRs’ description of nurses as being busy and sometimes impatient, but explained it was because there was much focus on the accomplishment of certain tasks during a shift in order to provide safe and effective patient care. She explained:

[Nurses] really only take . . . time out to give . . . extra [care] when it's convenient for us. . . I [don't] mind loving on the families and giving them a little bit extra, but only when [I'm] not slammed. If I [am] slammed, then those [extra] things . . . become prioritized. ABC's: Airway, Breathing, Circulation! And [those extra things are] way down the alphabet!

The educators identified additional factors as potentially contributing to students' stereotypes, including the following: (a) the students' race and age, (b) their lack of nursing and/or "real-world" experience, (c) a lack of confidence in their nursing abilities, (d) a lack of exposure to diversity, and/or (e) fears of interacting with "different" people.

Instructional Strategies to Promote Socioeconomic Diversity Training

The nurse educator participants of this study expressed belief that students could benefit from learning about the essence of experiences shared by FMRs within this research. The group dubbed the term "socioeconomic diversity training" to describe instructional strategies that might be used within current, existing nursing curricula to address the role that socioeconomic status has on a person's health and health outcomes, with the goal being to promote learning environments that allow students to explore the various perspectives of people from different socioeconomic backgrounds. The inclusion of such instructional strategies might serve several areas: (a) increasing student exposure to various socioeconomic perspectives, (b) combating stereotypes by offering "real-world" experiences in caring for socioeconomically diverse populations, (c) recognizing the social causes behind disease or illness, and (d) focusing consideration onto social aspects of care.

The nurse educator participants described instructional strategies that might be utilized to implement socioeconomic diversity training into existing nursing curriculum, and identified related disadvantages/barriers and advantages/benefits of each. Examples of these ideas are

summarized in Table 4, and include instructional strategies such as case study, role-play, reflective journaling, group discussion, service-learning pedagogy, narrative pedagogy, and lecture, among others. The educators believed these strategies could challenge and combat students' stereotypes through intentional interactions with socioeconomically diverse populations, which is consistent with the premises of Social Interaction Theory. The educators believed that through these techniques, students stood to gain alternative perspectives, empathy, life skills, and real-world experience that otherwise could not be taught through lecture or book readings.

Table 4

Instructional Strategies for Including Socioeconomic Diversity into Nursing Curriculum

Case Study, Role Play, Reflective Journaling		
<p>Description:</p> <p>One student assumes the role of patient; another student assumes the role of nurse. The “patient” is assigned a socioeconomic background and disease or a condition, and must research both to become familiar with any associated symptoms, health history information, and physical assessment findings. The “nurse” is given a set of orders to complete within a set timeframe, and must rely upon the patient for subjective and objective data. The “patient” is allowed to make requests for needs, such as PRN medications or assistance ambulating to the bathroom.</p>	<p>Advantages/ Benefits:</p> <p>The “nurse” learns skills in:</p> <ul style="list-style-type: none"> • Communication • time management • prioritization • delegation (if applicable) <p>The “patient” experiences:</p> <ul style="list-style-type: none"> • alternative perspective of the patient • being dependent on a nurse for needs (i.e., pain relief, ambulation, feeding) 	<p>Disadvantages/ Barriers:</p> <ul style="list-style-type: none"> • Requires additional supplies and a simulated hospital environment • Time intensive for faculty to plan

(table continues)

Guest Speakers, Panel Discussions, Group Discussions (Large or Small)		
<p>Description:</p> <p>Guest speakers are invited into the classroom to discuss aspects of their lives. Using female Medicaid recipients as an example, a participant could talk with students about her life, any events that contributed to her receiving Medicaid, her experiences with it, and her experiences with the care she has received from nurses or other HCP while on Medicaid.</p>	<p>Advantages/ Benefits:</p> <p>The guest speaker may experience:</p> <ul style="list-style-type: none"> ● empowerment ● feeling involved ● feelings of influencing the future of nursing <p>The students may:</p> <ul style="list-style-type: none"> ● Have stereotypes or preconceived notions challenged by putting a face to them ● Have a better understanding about the reasons behind the individual's health actions ● Learn an alternative perspective by listening to the speaker's story 	<p>Disadvantages/ Barriers:</p> <ul style="list-style-type: none"> ● May be challenging to find speakers willing to talk to nursing students about sensitive issues ● Time intensive for faculty to plan
Service- Learning Pedagogy		
<p>Description:</p> <p>Enable community-service clinical partnerships, or allow volunteer hours to count toward some clinical hours. Create learning experiences that have a focus on the nurse's role in community service, with emphasis on patient advocacy, social aspects of care, and social causes of illness. <i>(Examples may include: soup kitchens, women's shelters, teenage pregnancy centers, low-income schools)</i></p>	<p>Advantages/ Benefits:</p> <p>Students:</p> <ul style="list-style-type: none"> ● Gain "real world" experience ● Interact with different populations and environments <p><i>(Consistent with premises of Social Interaction Theory)</i></p>	<p>Disadvantages/ Barriers:</p> <ul style="list-style-type: none"> ● Time intensive for faculty to plan ● May have legal aspects to consider
Narrative Pedagogy, Reflective Journaling		
<p>Description:</p> <p>Students read personal narratives about the lives of individuals from diverse and varying backgrounds. Students reflectively journal their thoughts related to the narrative.</p>	<p>Advantages/ Benefits:</p> <p>Narratives:</p> <ul style="list-style-type: none"> ● Are read at the flexibility of the student's schedule ● Don't take time away from the classroom or clinical ● Are often interesting and easy to read ● Offer exposure to the perspectives of people with whom students may not regularly interact ● Easy for faculty to incorporate into existing lectures 	<p>Disadvantages/ Barriers:</p> <p>None identified in focus group discussion.</p>

(table continues)

Mentoring (formal or informal), Faculty Role Play, Case Study, Group Discussion (Large or Small)		
Description: Faculty role-play a case study or clinical scenario in front of students in order to mentor professional language and actions. Two scenarios can be given—one professional, one unprofessional—and students may be asked to compare/contrast the scenarios, consider the patient’s perspective of each scenario, and create alternative actions within the unprofessional scenario.	Advantages/ Benefits: • Mentoring may occur across multiple settings (e.g., classroom, clinical, professional, community service)	Disadvantages/ Barriers: Time intensive for faculty to plan
Lecture		
Description: Include socioeconomic diversity considerations into applicable lectures throughout the nursing curriculum, much as one might do for older adult considerations or cultural considerations.	Advantages/ Benefits: • Easy for faculty to incorporate into existing lectures	Disadvantages/ Barriers: • Requires faculty buy-in
Intentional Clinical Patient Assignments, Reflective Journaling		
Description: In clinical, faculty assigns students a diverse range of patients. Students complete reflecting journaling such as, “What challenges did you have in caring for your patient today? What did you learn about your patient from these challenges? What did you learn about yourself?”	Advantages/ Benefits: • Easy for faculty to incorporate into existing lectures	Disadvantages/ Barriers: None identified in focus group discussion.

Note: These instructional strategies were derived from a focus group interview whose identified purpose was to understand how female Medicaid recipients’ experiences with nursing care might inform nursing education. The advantages/ benefits and disadvantages/ barriers of each instructional strategy were identified among participants within the focus group interview, and are based upon personal opinions, perspectives, and experiences, and therefore may or may not be consistent with identified advantages or disadvantages of pedagogies documented within nursing education literature.

Disadvantages and barriers. The nurse educators identified disadvantages or barriers associated with the implementation of instructional strategies used to promote socioeconomic

diversity training. Some of these were unique to the specific instructional strategy, such as the extensive faculty planning time involved with preparing service-learning opportunities, panel discussions, or complex case studies. Faculty buy-in was identified as a general barrier for implementing these socioeconomic diversity training strategies into existing nursing curriculum. Amy felt a challenge associated with faculty buy-in was an existing curriculum that was very content-heavy and focused on preparing students to successfully pass their graduation or licensing exams (known as the HESI and the NCLEX-RN, respectively). She explained, “I feel like [educators are] so focused on our NCLEX pass rates, and if content isn’t on the NCLEX, it’s not important . . . students can learn it after they graduate.” Sharon related this to another barrier associated with faculty buy-in, which was a lack of social awareness among nurse educators. She described the following:

If [faculty] don’t realize that social awareness is important, they aren’t going to buy-in to the need for teaching it . . . you’ve got to educate the faculty on *why* [emphasis added] this is important enough to include in their teachings . . . they [need] to see the bigger picture that goes beyond the NCLEX.

Tammi defended that socioeconomic diversity training would transcend into the “bigger picture” beyond exit and licensing exams, and added, “If [the] goal is to give [students] tools . . . to [care] for different people . . . then it’s worth the extra time and effort, even though it’s not going to be on the NCLEX.”

Advantages and benefits. The nurse educators also identified the advantages and benefits associated with the implementation of instructional strategies used to promote socioeconomic diversity training. The group felt that such strategies might provide students with opportunities to understand the various perspectives of people within different socioeconomic categories. Amy said, “If we put ourselves in the patient’s shoes . . . would we have a different perspective of the

situation? Maybe nurses are misinterpreting a ‘lack of motivation’ when really . . . the patient is feeling self-conscious, or isn’t sure what’s expected of her?” The educators also felt that such strategies might offer students “real-world” experience in caring for people different from themselves, which would then lead them to better understand the social causes behind disease or illness. These instructional strategies might also help students focus consideration onto social aspects of care, such as the inclusion of a patient’s methods for transportation into discharge teaching.

Combating stereotypes. The group of nurse educators expressed belief that instructional strategies aimed at promoting socioeconomic diversity education for undergraduate nursing students would assist these students with combating stereotypes they held towards individuals from diverse socioeconomic backgrounds. In Tammi’s opinion, students could not only confront their stereotypes, but could also learn to decipher between nursing assessments, personal judgments, and alternative causes in the process. She explained:

Nurses are trained to assess a person . . . by assessing their appearance, [but] we need to teach students to not judge [based] off those assessments. . . . Nurses assess [to] create a plan of care, but [when they] judge . . . that can cloud the accuracy of their assessments.

As an example, Tammi recalled a time when she once assessed a middle-aged man who appeared unkempt, disheveled, and confused, and her nursing assessment led her to believe mental illness. She admitted that her personal judgments, or even prejudices, led her to believe drugs were involved, yet after a few days, the patient became worse and underwent a head CT. Tammi recalled, “Come to find out, this man actually had a slow intracranial hemorrhage! We need to be teaching our students how to decipher between nursing assessments, personal judgments or prejudices, and alternative considerations, like brain bleeds!”

Promoting patient advocacy. For Sharon, socioeconomic diversity training could actively involve students in patient advocacy by teaching them to view the world from a nurse's lens. She argued:

We [teach] that our number one role as nurse is to advocate for our patient . . . but do students truly know what that means? . . . Nurses walk around the world viewing it from nursing lenses . . . [and] we need to [teach] students that, yes . . . you may clock in and clock out, but you don't ever really leave your nursing hat at work. . . . Getting students involved . . . in the community, and teaching them to look at that through a nurse's lens . . . is how they get that real-world experience.

To implement this, Sharon described a service-learning approach that would allow certain community-service hours to count as clinical hours, and offered examples of clinical placements such as soup kitchens, women's shelters, teenage pregnancy clinics, low-income schools, or even clinical sites in which the "typical" Medicaid patient was not easily identified, such as university-based student clinics. In her opinion, students would gain real-world experience through working with different types of people and in different contexts, which would allow them to draw upon those experiences when caring for similar patients within a health care context. Audra felt service-learning opportunities would also allow students to gain alternative perspectives of situations, and added, "[Being] the patient sometimes is a humbling experience . . . students could learn from that, from the perspective as a patient."

Combating issues of authority. Kerri agreed that greater exposure to different types of people would lead to increased student comfort in interactions with diverse populations, but she also believed students could benefit from intentional training in communication skills designed to address issues associated with the theme of Authority identified among the experiences of FMRs. She elaborated, "We could eliminate some of those authority issues [by focusing] on the collaboration [skills needed for the] patient and nurse [to] work together towards a

mutually-agreed-upon, patient-centered goal.” Kerri was concerned that educators inadvertently transferred communication skills to their students that were inconsistent with the drastic change of the nursing role over the years. She suggested that educators “better prepare [students] on ways to [combat] Physician Authority [emphasis added] assertively.” She viewed these skills as “life skills” rather than nursing skills, yet felt they could not be taught through lecture alone, but rather through repeated practice, sometimes spanning the course of years.

Summary

This chapter described the experiences 11 female Medicaid recipients discussed during individual interviews with the researcher, and explored the themes that emerged from the analysis of those interviews. These experiences assisted in providing an understanding of what nursing and other health care is like for female Medicaid recipients. Participants discussed issues such as limited choice, rushed and impersonal relationships, and lengthy wait times, all of which contributed to them feeling “shuffled,” “invisible,” or “lost in the system.” They described instances of HCP Authority, including times when their expectations conflicted with those of their HCPs, and times when HCPs assumed their actions were in the best interest of the patient. FMRs talked about how these interactions influenced ways they received their nursing or other health care, as well as how they influenced their future health actions, which for many FMRs involved withdrawal and avoidance. They reflected upon their role as mothers, and described the importance of being able to tell their stories and advocate for the health of their children. They discussed their expectations for professional nurses, and described influential aspects in their trust-building, including the communication skills of HCPs, experiencing role confusion, and

perceiving stigma or stereotypes. Finally, FMR participants considered ways race, gender, and age played into their interactions with nurses and other HCPs.

A few participants discussed experiences that were not shared by others, and therefore were not used in this study. The themes from these experiences were coded a fewer number of times than the major themes and sub-themes. Examples included feeling like a burden (mentioned by three participants) and challenges associated with Medicaid and Complementary and Alternative Medicine (CAM) techniques (discussed by two participants). Although not used in this particular study, these themes were unique to the experiences of the women who discussed them, and may warrant exploration in future research.

A focus group interview of five nurse educators was conducted to explore what educators need to know about the essence of experiences described by FMRs. The educators described their reactions to FMRs' experiences, including things that challenged their preconceived notions and things that did not surprise them. They identified potential factors contributing to nurses' and students' stereotypes, and described how offering instructional techniques to promote socioeconomic diversity training in undergraduate nursing students might assist them in combating those stereotypes. These strategies were described as offering students "real-world" experience in caring for people different from themselves, assisting students in understanding social causes behind disease or illness, helping them focus consideration onto social aspects of care, and involving them in patient advocacy. Additionally, educators felt students would also benefit from intentional training in communication skills designed to address issues associated with the theme of authority.

Nurse educator participants discussed methods for implementing socioeconomic diversity training into existing nursing curriculum, and identified the related advantages and benefits of

each. Challenges associated with implementing the instructional strategies were also discussed, and included extensive faculty planning time, faculty buy-in, a focus on graduation or licensing exam content, and a lack of social awareness among nurse educators.

CHAPTER V

DISCUSSION

This chapter provides an overview of this research study, summarizes its findings, responds to the research questions that guided this work, and considers the findings in light of existing research. A discussion of the implications for nursing practice, education, and research are included. Finally, limitations of the study are discussed, with recommendations for further research offered.

Overview of the Study

American women are greatly influenced by their sociocultural, economic, and physical environments (USDHHS, 2010a). Compared to men, women often receive less education, resulting in lower incomes and socioeconomic status (SES), and therefore making them more vulnerable to poverty, single parenthood, and poor access to health care, nutrition, and housing (Nalle et al., 2004; Zachariah, 2009). Medicaid is a government-funded program that seeks to alleviate some of these challenges by providing health care services to the country's poorest (Matthews, 2007). As current health care reform progresses into 2014, more citizens will begin to receive Medicaid benefits, and nurses of the future will interact with members of the Medicaid population more frequently. As providers of direct care, nurses play a critical role in how patients receive and act upon the health care given to them.

The purpose of this study was to explore the experiences of nursing care for female Medicaid recipients (FMRs) within a feminist-informed critical framework. The study further

explored ways nurses' and other health care providers' (HCP) attitudes and behaviors towards FMRs influence how these patients receive and act upon their health care, and what these understandings suggest for nursing education. The research and subsidiary questions that guided this inquiry were as follows:

1. How do female Medicaid recipients describe their experiences of nursing care?
 - a. What makes a nursing care experience positive or negative for female Medicaid recipients?
 - b. What do female Medicaid recipients indicate as being helpful or harmful for their future health care decisions?
 - c. In what ways do nurse-patient interactions influence how female Medicaid recipients receive and/or act upon their health care?
2. What do nurse educators need to know from these experiences?
 - a. In what ways can educators use these experiences to inform nursing education?

To achieve this goal, a qualitative, phenomenological research design was used to frame this research within a feminist-informed critical framework. This study asked women receiving Medicaid to describe their experiences of nursing care and their interactions with nurses that were unique to them. The notion of intersectionality was applied to consider how the FMRs' gender, class, and social position were co-constructed to create conditions of injustices, inequalities, and submissions within an authoritative nursing or other health care environment.

Eleven FMR participants completed individual interviews during which they provided information about past experiences with nursing care. These experiences provided information about shared factors that contributed to FMRs being "shuffled," the role HCP authority played

into interactions, the concept of Mother that played into the subjectivity of FMRs and their HCP interactions, and FMRs' expectations for professional nurses. After analysis of these interviews was completed, the researcher met with five nurse educators and presented a brief background of the FMR participants and an overview of their experiences. The educators described their reactions to the FMRs' experiences, and identified potential factors contributing to nurses' and students' stereotypes of them. They brainstormed instructional techniques that might be implemented into existing nursing curriculum that would promote socioeconomic diversity training and challenge the stereotypes and preconceived notions undergraduate nursing students hold about low-income populations. The educators identified the related advantages and benefits of each instructional strategy, as well as the challenges associated with implementing them, including extensive faculty planning time, faculty buy-in, a focus on graduation or licensing exam content, and a lack of social awareness among nurse educators.

In analyzing the data collected from interviews with FMRs, four major themes emerged that were shared among all participants, and included the following: (a) The Shuffle, (b) Authority and Submission, (c) Subjectivity as Mother, and (d) Expectations of Nursing Care. Additionally, four sub-themes shared among all or most participants were also identified: (a) Telling of One's Story, (b) Invisibility, (c) Role Confusion, and (d) Stigma and Stereotype.

The experiences reported by these participants assisted in providing an understanding of the experience of nursing care for female Medicaid recipients. FMR participants discussed how issues such as limited choice in HCPs, rushed and impersonal relationships with HCPs, and lengthy wait times contributed to feeling "shuffled," "invisible," or "lost in the system" that is Medicaid. Further, FMR participants described experiences in which HCPs came across as authoritative, such times when the interests of FMRs and HCPs conflicted, or whenever HCPs

assumed their actions were in the best interest of the FMR. FMRs described the effects that such interactions had on how they received and acted upon their health care, which often involved coping mechanisms such as withdrawal and avoidance. They reflected upon their role as Mothers, and described the importance of telling their story to HCPs and advocating for their children's health care. For many of these women, information-seeking behaviors were identified as beneficial coping mechanisms for challenging the barriers associated with The Shuffle or HCP Authority.

FMRs also discussed their expectations that professional nurses would be respectful, knowledgeable, and able to work with diverse populations. They described influential aspects in their trust-building, including the communication skills of HCPs, experiencing role confusion, and perceiving stigma or stereotypes. FMRs found that neither race nor gender played much of a role in their interactions with HCPs, and instead indicated that it was personal characteristics of individual HCPs that made interactions meaningful or not. FMRs described how a HCP's age might potentially influence the interaction, as FMRs appeared to equate HCP age with years of experience.

The analyzed data collected during the focus group interview with nurse educators revealed useful information about ways the essence of experiences described by FMRs might inform nursing education. The educators described their reactions to FMRs' experiences and identified potential factors contributing to nurses' and students' stereotypes. They discussed instructional techniques to promote socioeconomic diversity training in undergraduate nursing students for the purpose of assisting them in combating those stereotypes. The educators described methods for implementing these socioeconomic diversity training strategies into existing nursing curricula, and identified related advantages and benefits of each. Challenges

associated with implementing these instructional strategies were also discussed, including extensive faculty planning time, faculty buy-in, a focus on graduation or licensing exam content, and a lack of social awareness among nurse educators.

Discussion

This section discusses the findings from this study as they related and responded to the research questions that guided this work, as well as a consideration of those findings in light of existing research.

Research Question 1

How do female Medicaid recipients describe their experiences of nursing care?

In general, the FMRs interviewed by the researcher of this study described experiences of nursing care that were common, ordinary, and unexceptional. While there were a few experiences of nursing care that stuck out in FMRs' memories as being especially positive or negative, these were generally explained by FMRs as being related to the individual nurse's personality characteristics or attributes. Therefore, the personality of a nurse, as well as his or her attitudes and attributes expressed through behaviors, is what made a nursing care experience good or bad for FMRs.

FMRs most frequently interacted with nurses in primary care settings, in which the direct recipient of the nursing care was usually the FMR's child. Most FMRs interviewed in this study reported that they have at one time or another avoided primary care for themselves, often resulting from repeated negative experiences associated with The Shuffle (limited choice, rushed and impersonal interactions, lengthy wait times), or with individual HCPs. In acute care settings,

FMRs' most common interactions with nurses occurred during the labor and delivery of a child, including post-partum care.

Often, FMRs were better able to recall broader experiences of health care, in which nursing care comprised a smaller part. These experiences involved people other than nurses, such as physicians, LPNs, nursing assistants, and office staff. FMRs recalled these experiences somewhat harshly, and described experiences of health care that were impersonal, rushed, hurried or disorganized. FMRs described feeling “stuck,” “invisible,” “forgotten about,” and “brushed off.” In these experiences, nurses were described as being very task-oriented and less “customer-service” oriented. Therefore, the findings of this study demonstrate how important it is that nurses are fully engaged in their role as patient advocate in order to offset many of the negative aspects of care associated with system-related Shuffling.

Subsidiary question 1. What makes a nursing care experience positive for female Medicaid recipients?

A nursing care experience was made positive for FMRs when a nurse was able to convey care and compassion. FMRs believed this stemmed from a nurse's satisfaction with his or her job and choice of profession. In these experiences, nurses were described as friendly, caring, approachable, respectful, and personable. A positive nursing care experience was created through meaningful interactions with such nurses, and was demonstrated whenever a nurse took his or her time interacting with FMRs and their families, and subsequently was able to make personal connections with them. These personal connections included the nurse remembering FMRs from previous visits and recalling smaller details of their lives. Nurses who could relate and empathize with FMRs during times of stress, such as a new diagnosis or a time of uncertainty, also added

positivity to a nursing experience. FMRs described that during these times, the best nursing care experiences involved nurses who took the time to sit down with them and offered advice, information, or simply presence.

A nurse's use of positive communication skills played a large role in how personable, open, and accepting their interactions were with FMRs. FMRs expected their nurses to be effective communicators, and felt it was the nurse's responsibility to create a positive tone for the interaction. Some FMRs were more comfortable initiating conversation with nurses than others, but for those who were not, it was meaningful when a nurse assisted in bringing up sensitive topics. Nurses with strong active listening skills, such as introducing themselves, sitting down at eye level, using eye contact, and giving FMRs their fullest attention, allowed FMRs to become more comfortable and better able to open up and talk. Therefore, nurses demonstrated care and respect to FMRs through these positive communication skills, in addition to communicating knowledge about medications and patient education topics.

Subsidiary question 2. What do female Medicaid recipients indicate as being helpful for their future health care decisions?

FMRs indicated that being informed about treatment delays or health-related information was helpful for future health care decisions. Adequate types and amounts of information allowed FMRs to feel involved and in control of their health care. The type and delivery of health information made a difference, however. For example, FMRs generally wanted to know more about their health than HCPs realized. They wanted to know how diagnoses were made, the causes and contributing factors behind diseases and illnesses, and ways to manage their symptoms and health that were feasible and applicable to their lifestyles. In discussing

treatments, medications, or procedures, FMRs wanted to know they had options, and desired accurate, nonbiased information on those options. In short, FMRs wanted actual control of their health care decisions, rather than simply being “informed” of predetermined decisions made by their HCPs. The delivery of health information was also influential, as FMRs desired ample amounts of time for information to be delivered, questions and concerns to be addressed, and an understanding of content ensured. FMRs wanted “sit down” discussions with nurses where the flow of conversation was open, mutual, equal, and applicable to the unique aspects of their lives. FMRs wanted nurses to talk naturally and comfortably with them, and to provide trusted resources where further information might be sought.

Another aspect that was influential to FMRs’ future health care decisions was follow-up from a nurse or other HCP. Many FMRs also wanted nurses to inquire about socioeconomic aspects of their lives. They wanted their nurses to be knowledgeable, to share information with them, and to make time for them. When nurses or HCPs followed up with FMRs on treatments, concerns, or just to simply see how they were doing, FMRs felt more involved in their actual health care process. They felt the HCP cared about them, were comforted or reassured in their personal health actions, and were less likely to slip back into lifestyle habits that were incongruent with their health care treatment decisions. In primary care settings, follow-up occurred in person during subsequent office visits, but the most positively influential follow-up experiences occurred when nurses make personal telephone calls. In acute care settings, the most positively influential experiences of follow-up occurred when nurses routinely checked in with FMRs to update them on treatment delays and/or results, and to provide opportunity for FMRs’ input into their plans of care. As discussed, meaningful patient-nurse interactions like these led to positively received health care experiences for FMRs. Furthermore, such interactions empowered

FMRs to make health care decisions and actions that were within their control, were feasible, and were applicable to the unique aspects of their lives.

Subsidiary question 3. What makes a nursing care experience negative for female Medicaid recipients?

FMRs indicated that a nurse's bad attitude was the most significant contributing factor of negative nursing care experiences. In this sense of "attitude," FMRs referred to the physical posture (either conscious or unconscious) the nurse held while interacting with them. FMRs believed a nurse's bad attitude stemmed from job dissatisfaction or burnout, demonstrated through actions that were flat, monotone, or even downright angry. In these experiences, nurses were described as tired, indifferent, uninterested, and just there to do a job without full engagement. FMRs were at times intimidated by such nurses, and indicated that interactions with them were not meaningful, because they did not feel comfortable opening up to discuss questions or concerns with them. Without meaningful interactions with nurses, FMRs perceived their nursing care experience as unconstructive, which then negatively influenced how they acted upon their health care.

Role confusion about the titles and/or roles of nurses and other HCPs contributed to negative nursing care experiences for FMRs. This was complicated in health care settings where FMRs interacted with different types of HCPs, such as RNs, LPNs, physicians, physician assistants, and so on. FMRs reported uncertainty about the type or amount of information to give to certain HCPs, and ended up withholding information until they were able to identify the "right person" and the "right time" in which to talk, which often never truly occurred. FMRs thought the doctors were "too busy," and felt it was the nurses' responsibility to step in whenever doctors

were unavailable. This was frustrating, however, as FMRs perceived nurses as trying to tide them over until the doctor was available.

The stereotypes nurses hold toward FMRs also contributed to experiences of nursing care that were negative for FMRs. FMRs felt nurses viewed them as ignorant and uneducated, and reported receiving information that was “watered down” based on the assumption that FMRs were unable to understand it due to ignorance. Additionally, FMRs felt HCPs stereotyped them as “freeloaders” who “knew how to work the system” because they did not make direct payments for Medicaid services. FMRs felt HCPs made assumptions about who received Medicaid based off how individuals physically looked or talked, and felt that the Medicaid population received substandard treatments of care simply because the care they received was “free.”

Subsidiary question 4. What do female Medicaid recipients indicate as being harmful for their future health care decisions?

FMRs indicated that poor communication between themselves and their nurses had a detrimental effect on their future health decisions and actions. Within verbal communication, a nurses’ tone of speech that reflected “watered down” content was indicated as harmful, since FMRs felt the nurses were stereotyping them as ignorant, and caused them to become angry, frustrated, and lose trust. Within nonverbal communication, a lack of eye contact from the nurse or HCP was described as being most harmful for future health care decisions, as it made FMRs feel like they had to read a subliminal message. FMRs viewed nurses with poor communication skills as unprofessional and contributing to negative patient-nurse interactions.

Feeling uninformed and lacking in control over conditions, treatments, and/or medications was also harmful to the future health care decisions of FMRs. These participants

wanted to have active involvement in their health care and decision-making processes, but unfortunately were often not given that opportunity. Because of rushed, impersonal, and authoritative interactions with HCPs, FMRs did not feel as though they had the chance to share their stories and know that they were being heard by HCPs.

The participants viewed their role as Mothers and primary caregivers to their children with vehemence, and felt upset when nurses or other HCPs did not include them in the assessment or treatment decision process involving their children. They described feeling angry, distrustful, or undermined whenever nurses or HCPs did not show interest in listening to their knowledge of their child's health story. Additionally, FMRs found that HCPs were quick to stereotype them as "ignorant" or "free-loading," undermined their concerns involving their personal subjectivities, and made assumptions that their actions were in the best interest of the FMR. These HCPs actions contributed to interactions with FMRs that were unconstructive and not meaningful for the patient, which, in turn, held harmful implications for the future health care decisions of FMRs.

Subsidiary question 5. In what ways do patient-nurse interactions influence how female Medicaid recipients receive and act upon their health care?

The findings of this study indicated that when nurses fashioned routinely meaningful nursing care experiences for FMRs, the patients came to rely and depend upon them, and the patient-nurse interaction was constructive. These interactions empowered FMRs in making health care decisions and actions that were within their control, were feasible, and were applicable to the unique aspects of their lives. From their position, FMRs brought to the interaction different coping mechanisms for interacting with HCPs, such as trying to "be good"

for nurses, or trying to be an easy patient. To combat the intimidation associated with telling their story, many FMRs wrote down questions, symptoms, and narratives ahead of time. They also reported investigating symptoms and learning about health topics or actions on their own, which was also empowering as it helped them feel equal to HCPs.

Without meaningful interactions with nurses, FMRs received nursing care experiences as unconstructive, which negatively influenced how they acted upon their health care. FMRs used coping mechanisms to deal with these negative interactions between nurses or HCPs. For example, when conflict arose between their personal beliefs and those of their HCPs', many FMRs reported that they shut down and minimized eye contact, spoke only when spoken to, and answered only those questions asked by their HCP. Perhaps most concerning was FMRs' use of avoidance as a coping mechanism for negative interactions and experiences. FMRs reported relying on their intuition about health decisions, and tended to abstain from health care unless necessary for emergent treatments or for their children's health.

FMRs coped with the stereotypes of HCPs by dressing professionally, reading college textbooks while waiting, or researching material beforehand. When nurses or HCPs talked to FMRs in a "dumb" or "watered down" manner, FMRs felt disrespected and lost a sense of credibility towards the HCP. Some FMRs refrained from asking questions out of fear they might confirm the HCP's stereotype that they were uneducated, and instead would nod their heads in agreement with whatever the HCP said, despite conflicting inner opinions. These illustrated circumstances resulted in negative effects on FMRs' trust, who felt angry, manipulated, or at a loss of control. This was harmful to their future health care decisions, because they were less likely to actively participate in current health actions and were more likely to avoid future interactions with HCPs.

Research Question 2

What do nurse educators need to know from these experiences?

Through these conversations with FMRs, the researcher identified the essence of their shared experiences as common, ordinary, unexceptional, and “shuffled” care experiences. The repeated, negative experiences associated with The Shuffle (limited choice, rushed and impersonal interactions, lengthy wait times, feeling invisible) contributed to the avoidance of health care by many FMRs. In understanding this essence of shared experiences, nurse educators need to recognize a disconnect exists between the *actual* quality of nursing care being delivered to FMRs, and the *recommended* quality of patient-centered care expected by the Institute of Medicine (IOM, 2001a, b).

As a potential cause of this disconnect, nurse educators also need to recognize that students, educators, nurses, and other HCPs hold a variety of stereotypes and prejudices towards patients under their direct care, including patients of low-income or Medicaid status. In discussing the essence of shared experiences of FMRs with current nurse educators, the group suggested that a lack of social awareness may contribute to a nurse’s stereotypes or prejudices, and that implementing instructional strategies to promote socioeconomic diversity training in existing nursing education might serve as a tool for combating or challenging such stereotypes and prejudices.

Subsidiary question. In what ways can educators use these experiences to inform nursing education?

The educators of this study expressed the shared belief that students could benefit from teaching strategies aimed at promoting socioeconomic diversity training in current, existing

nursing curricula. The group discussed how such instructional strategies might be designed to address the role of socioeconomic status on a person's health and health outcomes, and would have a goal of promoting learning environments that allow students to explore the various perspectives of people within different socioeconomic categories. Including instructional strategies to promote socioeconomic diversity awareness into existing undergraduate nursing education might serve several areas: (a) assist students in combating their stereotypes by offering "real-world" experiences in caring for diverse populations, (b) teach about social causes underlying disease or illness, and (c) focus on social aspects of care unique to the patient. The group agreed that promoting socioeconomic diversity training in baccalaureate nursing curricula would equip graduate nurses with the knowledge, communication skills, and real-world experience necessary for becoming leaders of change in achieving the aim of patient-centered care for individuals of *all* backgrounds.

Nurse educator participants identified several instructional strategies for teaching socioeconomic diversity training into existing nursing curricula, as well as any advantages or disadvantages of each (Table 4). Examples of instructional strategies discussed by the group included the following: (a) case studies, (b) role-play, (c) reflective journaling, (d) group discussion, (e) service-learning pedagogy, and (f) narrative pedagogy, among others. The educators believed that through these instructional techniques, students stood to gain alternative perspectives, empathy, life skills, and real-world experience that otherwise could not be taught through lectures or readings from a book.

Contributions to the Scholarly Literature

When considering the research findings of the scholarly literature, the results of this study were found to support some areas of the literature and yet were inconsistent in other areas. Additionally, some of the findings from this study were new to the literature, and extended new meanings and recommendations for further study.

Literature in Support of Research Findings

The literature supported several of the identified themes and sub-themes of this research. Congruent with what the participants in this study described in their experiences, Patrick et al. (2011) recognized the following as aspects of care that can be reported and measured by patients: (a) access to care, (b) timeliness of care, (c) communication, (d) office staff, and (e) health plan customer service. The Shuffle, as it related to FMRs' experiences with limited choice, rushed and impersonal interactions, and system-related inconveniences, had been described within the literature as "churn" associated with eligibility determination, the complex enrollment process, and difficulty in finding HCPs that accept Medicaid (Feinberg et al., 2002; Perry et al., 2000; Roby et al., 2008; Short & Graefe, 2003). From the nursing perspective, challenges associated within acute care settings that contributed to the Shuffle included a high turnover of nursing staff, an increase in the acuity and complexity of patients' needs, inefficient care processes, and burdensome documentation (Rutherford, Moen, & Taylor, 2009). The literature supported the findings that low-income populations and FMRs were dissatisfied in their communications with HCPs, which could lead to withdrawal, avoidance, or rejection of health advice and care (DeVoe et al., 2008; DeVoe et al., 2009; Fiscella et al., 1998; Fiscella et al., 2000; Hussey et al., 2008;

Jensen et al., 2010). FMRs in this study also described being unable to tell their story or provide feedback when interacting with HCPs (Willems et al., 2005).

FMRs in this study identified that a major drawback to Medicaid was its associated stigmas and stereotypes, and were especially haunted by the stereotypes of ignorance and free loading (Bullock, 1995; Downing et al., 2007; Grogan & Patashnik, 2003; Rosenbaum, 2009). Participants described instances of feeling judged or stereotyped by HCPs (Browning et al., 2008; Parnes et al., 2002; Pollak et al., 2002), and some interpreted HCPs' delivery of poor-quality care as discriminatory (Humbert & Roberts, 2009). FMRs responded to perceived stigma and discrimination by either challenging them through their dress and behaviors, or by withdrawing and avoiding interactions with HCPs altogether (Kinsler et al., 2007).

The nurse educator participants of this study agreed that both nurses and nursing students hold various forms of stereotypes associated with Medicaid and low-income populations. These stereotypes are documented within nursing education literature, and suggest that a lack of exposure to low-income populations contributed to students' limited and stereotypical knowledge of poverty (DeLashmutt, 2007). In considering instructional strategies for promoting socioeconomic diversity training in nursing education, the educators described methods that centered on the theme of increasing students' exposure to individuals within different socioeconomic categories. These methods of teaching placed less emphasis on the transmission of knowledge and skills from the teacher to the student, and instead utilized a social interactional approach to service-learning to assist educators in creating interest-driven, active learning experiences that relates real life to theoretical learning (Gillis & Mac Lellan, 2010; Girot, 1995; Wood, 2000).

Literature Inconsistent with Research Findings

The Institute of Medicine considers patient centeredness a dimension in the assessment of quality health care delivery, and recognizes that it can only be assessed through patient reports of care (IOM, 2001b). Patient-centered care includes establishing partnerships between HCPs and patients, including their families, and involves improvements in health care design, delivery, and communication (IOM, 2001a, b; Patrick et al., 2011). The research findings presented by the researcher of this study indicated that the IOM's dimension for patient-centered care is inconsistent with the actual experiences of FMRs. The participants of this study described interactions with HCPs that were rushed, impersonal, and led to their feelings of invisibility. They spoke of times when their expectations of care conflicted with those of their HCPs, and described accepting that care out of intimidation of challenging the HCPs' Authority, or because a lack of health literacy led them to believe that HCPs knew best. In this sense, the findings presented within this study supported the literature in that low socioeconomic status is a potential source of health care disparities (Brim, 2008; Browning et al., 2008; Fiscella et al., 2000; Gornick et al., 1996; Schneider et al., 2002).

In some areas, the findings of this qualitative study were inconsistent with findings of similar, quantitative studies. For example, Barry, Kaiser, Lopez, and McNulty (2009) used a quantitative approach to explore the satisfaction outcomes for Nebraska's Medicaid Managed Care participants. The authors analyzed the results of 3,042 telephone and mail surveys administered over a period of 5 years. In response to the question, "I knew I had choice of doctor/health plan," 97% of respondents reported to *Agree/Strongly Agree* (Barry et al., 2009). This was inconsistent with the results of this qualitative study, in which FMRs reported that they were "assigned" to HCPs and had limited choice in HCPs who accepted Medicaid patients.

Furthermore, 93% of the authors' participants reported to *Agree/Strongly Agree* to the question "I know I have a right to change provider/plan," and 85% of participants reported to *Agree/Strongly Agree* to the question "I know I have a right to voice a complaint" (Barry et al., 2009). This was also inconsistent with the results of this study, in which FMRs reported that the Medicaid process of changing HCPs was complex, intimidating, and held thematic elements of Authority and Submission. Recall Nancy's summarized description, in which she said that in order to change doctors she first had to obtain a referral from the very doctor with whom she was unhappy. And if that doctor refused to refer her, Nancy described being "stuck" with that doctor or else going without care at all.

There may be a few potential explanations for these inconsistencies, and quantitative versus qualitative methodologies may serve as an explanation in the differences of the results. Quantitative surveys are fixed-response and are unable to fully account for the realities of human experience, whereas qualitative approaches consider the holistic, individual aspects of that experience (Pollit & Beck, 2008). Therefore, the individual aspects that played into a Medicaid recipient's satisfaction might be more likely to be elicited during a qualitative interview rather than a fixed-response quantitative survey. Secondly, the data from Barry et al. (2009) was collected in Nebraska, and because Medicaid programs are state-managed, it is possible that program quality--and therefore participant satisfaction--varies among different states. Finally, the data in the authors' study were collected between 2000 and 2005, whereas the data collected in this study occurred in 2012, during a time of active discourse in national health reform.

New Findings

From a feminist perspective, women in traditionally subordinate roles (e.g., woman's submissive role to men, a patient's submissive role to doctors, and a poverty-stricken individual's submission to government welfare or Medicaid) are expected to receive authority unquestioningly (Kirkham & Browne, 2006; Lather, 1991; Racine, 2009). Regardless of the gender of the nurse or the HCP, the medical field exerts a paternalistic, male-like authority over patients, as those in need of health care find themselves with limited alternatives, other than accepting the health care or going without it altogether (Broyles, Colbert, & Erlen, 2005; Racine, 2009). While it is common for many individuals in need of unexpected health care to seek "second opinions" from different HCPs, FMRs typically are not granted this luxury, because Medicaid limits their availability of HCPs altogether. This limited choice exemplifies that powerlessness is the defining element in the establishment of interactions that hold negative influences for the future health decisions of FMRs (Brown, 2006; Kirkham & Browne, 2006; Racine, 2009).

FMRs in this study described the importance that their role as Mothers played in their interactions with nurses and other HCPs. When also considering the themes of HCP Authority, Patient Submission, and the Shuffle, the women in this study--both as Medicaid patients and as Mothers--were thrown into nursing and other care experiences in which they were rendered powerless and invisible. In fact, the language used by several FMRs (e.g., "coerced," "dehumanized," "helpless") hints at elements much deeper than HCP "Authority" and patient "Submission," and suggest something even more violent, such as HCP bullying or an abuse of power. Many FMRs coped with this by arming themselves with medical and health-related knowledge or by altering their outward appearances through dress or accessories such as

textbooks. For these FMRs, such behaviors served as a means for challenging the authoritative stance of the traditionally male medical field, and gave these women the opportunity to empower themselves so that their personal identities were not solely dependent upon their motherhood and femaleness.

The racial and ethnic profiles of nurses (16.8% minority) are substantially different from that of the U.S. population (34% minority; USDHHS, 2010b), and there is concern regarding the attitudes of nurses who provide care for patients perceived as “different” from themselves (Cassata & Dallas, 2005). Literature exists that indicates a patient’s race and SES play roles in how HCPs perceive them, which may serve as an explanation for health disparities (Browning et al., 2008; DeVoe et al., 2008; DeVoe et al., 2009; Fiscella et al., 1998; Fiscella et al., 2000; Hussey et al., 2008; Jensen et al., 2009; O’Malley et al., 2003; Roter & Hall, 1992; Willems et al., 2005). The researcher of this study considered how the roles of race, gender, and aged played into FMRs’ interactions with nurses and other HCPs; however, the researcher approached the issue from the perspective of the patient.

The FMRs interviewed in this study found neither race nor gender to play much into their interactions with HCPs, and instead indicated that it was the personal characteristics of nurses and other HCPs that made interactions meaningful or not. While they did want their nurses and other HCPs to be able to relate with them, they felt they could have meaningful interactions with HCPs of different races and cultures. They did indicate, however, that the age of their nurses and other HCPs somewhat influenced their interactions, and the participants discussed advantages and disadvantages of interacting with both older and younger HCPs. As this was a relatively new finding, it certainly warrants deeper exploration with future research.

The nurse educator participants in this study expressed the shared belief that students could benefit from learning about the essence of experiences shared by FMRs within this research. The group dubbed the term “socioeconomic diversity training” to describe instructional strategies that might be used within current nursing curricula to address the role that socioeconomic status has on a person’s health and health outcomes. Goals of such instructional strategies would be the following: (a) increasing student exposure to various socioeconomic perspectives, (b) combating stereotypes by offering “real-world” experiences in caring for socioeconomically diverse populations, (c) recognizing the social causes behind disease or illness, and (d) focusing consideration onto social aspects of care. Social education--including socioeconomic diversity--is sparse within nursing education literature, and what *does* exist does not relate to nursing alone, but rather to an interdisciplinary approach that often does not involve nursing research occurring within the United States (Araujo & Sanna, 2011; Chan, Chi, Ching, & Lam, 2010; Chan, Mok, Po-ying, & Man-chun, 2009; Hirst, Lane & Stares, 2012).

Limitations of the Study

Because this study used a phenomenological approach, the results are not generalizable to the larger population of *all* female Medicaid recipients; however, the results do provide a greater understanding of the lived experiences of such women through the voices of the research participants’. The sample size for this study was relatively small. Although interviews were conducted until data saturation was met, a larger sample might better ensure a fuller, more accurate representation of the population. In addition, the racial demographics of this sample of FMRs consisted of White, Black, Mixed, and Lebanese women of various work and educational statuses. Black women, however, were primarily represented in this study; therefore, caution is

suggested in attempts to generalize these findings to unrepresented ethnicities, such as Hispanics or Asians.

Despite efforts to explore experiences solely related to nursing care, FMRs instead described broader experiences of care that involved nurses and other HCPs. This may be explained in that, when seeking health care, FMRs actually interacted with a team of HCPs, and therefore may reflect on that experience as a whole rather than on parts specific to nursing care. FMRs may also be more likely to recall experiences of care that are especially positive or negative, and therefore may forget the more common, everyday experiences. This could be compared to what is known as “proxy variables” seen within quantitative research, in that one variable (nursing care) involved in a significant correlation seems inadequate for explaining the full impact on the other variable (positive/negative experiences; Shaha, 2010).

There was little prior research on experiences of nursing care from the perspective of FMRs, and even less existed regarding ways attitudes and behaviors of nurses affected how FMRs received and acted upon their health care. This lack of prior research resulted in this study being more exploratory in nature, as opposed to explanatory. Further, the data collected through interviews with participants was self-reported, and therefore unable to be independently verified. The examination of lived experiences in and of itself is self-reporting, and the researcher notes that a limitation exists in being unable to verify the factuality of the data. Additionally, the researcher of this study only considered ways baccalaureate nurse educators might utilize its findings, and not associate degree or LPN educators; therefore, the findings of the nurse educator focus group cannot be generalized to community colleges or other non-baccalaureate nursing programs.

A final limitation of this study was the profession of the researcher. Because I am both a nurse and a nurse educator, my profession had the potential to influence the responses of both the female Medicaid recipient participants and the current nurse educator participants. While I implemented the actions to protect against research bias, as discussed in Chapter III, it is possible that some participants may have been concerned about discussing their experiences of nursing care with a nurse, particularly negative experiences.

Implications and Recommendations

The results of this study leave several implications for nursing practice, education, and research in regard to promoting quality treatment and care for FMRs. However, these implications may also hold meaning for the benefit of greater populations as well. The conclusions drawn from the descriptions of experiences and their implications have also allowed the researcher to make recommendations in areas of nursing practice, education, and research. These recommendations were informed through an increased understanding of the participant's experiences with nursing and other health care.

Nursing Practice

This research described how meaningful patient-nurse interactions led to health care experiences that were received positively by FMRs. The consequences of these interactions empowered FMRs to make health care decisions and actions that were within their control, were feasible, and were applicable to the unique aspects of their lives. However, for these meaningful interactions to occur, the elements of HCP Authority and FMR Submission must first be eliminated to allow open, mutual, and equal conversation to develop. Additionally, nurses must

recognize the impact FMRs' Subjectivity has on their health actions, and must accept responsibility in creating care experiences that include time for FMRs to tell their stories, ask questions, share concerns, and explore alternative ideas.

The results of this study also acknowledged that the role of the nurse is paramount in the establishment of an overall experience of care for FMRs. As these findings document, the type and quality of care given by a nurse can make a health experience positive and meaningful for FMRs, or can leave a lasting, negative impression. Based upon these findings, the author recommends that nurses involved in direct patient care seek opportunities that allow them to examine and challenge their beliefs, stereotypes, and judgments about patients of low SES. This could be accomplished through attendance at continuing education offerings, conferences, in-services, or professional development offerings that are intentional in addressing the unique needs of individuals spanning various socioeconomic levels. A cognitive awareness of prejudices allows nurses to better care for patients deemed "different" from themselves, particularly in regard to SES. While this may be as simple as conveying to the patient, through words and actions, "I don't know where you're coming from, but I'd like for you to help me to understand," it takes practice for nurses to become truly comfortable in providing culturally and socioeconomically sensitive care.

By taking into account the perspectives of FMRs, this research holds implications for how nursing actions (i.e., assessments, interventions) can best be conducted to ensure patient-centered care. Incorporating an in-depth social assessment into the larger admission or plan-of-care assessments may assist nurses in identifying the social roots behind underlying illness processes. Examples of social elements for assessment include the patient's mode of transportation, method for securing food, type and location of housing, access to utilities such as

water and electricity, type of family unit (e.g., married, divorced, single-parent) and number of dependents in the household. Each of these elements hold influence into ways low-income patients make health decisions.

Nursing Education

This research described contributing factors for meaningful patient-nurse interactions that led to positively received health care experiences for FMRs. Understanding ways nurses' attitudes and behaviors influenced patients may be helpful to educators seeking to implement teaching strategies for promoting socioeconomic diversity training into existing nursing education. From the focus group with nurse educators, this research identified that students may benefit from safe learning environments that would allow them to identify and address their stereotypes and prejudices about patients of diverse socioeconomic backgrounds. Such learning experiences may promote students' personal and social awareness, open-mindedness, and acceptance as they interact with patients different from themselves in regard to race, class, ability, or sexuality.

This research recommends that nurse educators become intentional in engaging students in professional or community-based organizations that promote social awareness and advocacy. It also recommends that educators consider implementing strategies for teaching nursing theory, knowledge, and skills that heighten students' awareness about social causes underlying disease and illness, as well as social aspects of care that may be unique to patients of diverse socioeconomic backgrounds.

Nursing Research

Several implications for future research are generated by the results of this study, which can further increase the literature on the experiences of nursing care for FMRs. This study attempted to explore experiences solely related to nursing care, yet FMRs instead described broader experiences of care that involved nurses and other HCPs. Therefore, a study examining nursing's role in positive or negative health care interactions may offer an additional perspective. Approaching the research problem from alternative methodologies (e.g., mixed-methods or grounded theory) and theoretical perspectives (e.g., social constructionist theory) may assist in providing better understandings of ways nurses' attitudes and behaviors might influence how FMRs receive and act upon their health care.

The findings of this study generate many ideas for future research, including examinations into how nurse educators teach students about low SES populations and how to interact with them. Exploration into ways current nurses interact with low SES populations might serve as a comparison of the perspectives of nurses and FMRs. Research centered on ways the education of current nurses prepares them for interactions with patients of low SES might hold implications for nursing education. Future research could also revolve around the following potential research questions: What is the difference in nursing attitudes and behaviors among new graduate nurses and seasoned nurses when interacting with patients of low SES? What discrepancies exist between the educational preparation of the nurse and the actual attitudes and behaviors of the nurse when working with patients of low SES? (What factors contribute to these discrepancies?) What barriers exist that prevent the nurse from achieving patient-centered interactions with patients of low SES? (Are these nurse-patient interactions satisfactory for the nurse? Are these interactions satisfactory for the patient?)

The findings of this study indicate that neither race nor gender play much of a role from the FMRs' perspective of interactions with HCPs, but did find that HCP age may be an influential factor in those interactions. A study further examining the role of HCP age in the experiences of care for FMRs might also add to the scholarly literature of the field. The possibilities for future research are endless, especially if the focus shifts from the population of FMRs to other areas of social vulnerability, such as immigrants, the disabled, individuals with addictions, individuals within the criminal justice system, or members of the gay, lesbian, bisexual, or transgendered community.

Conclusion

This research study provides the reader with a deeper understanding of female Medicaid recipients' experiences of nursing and other health care. Participation in this study provided these women an opportunity to tell their stories, and sheds insight into their lives and interactions with nurses and other health care professionals. The participants expressed hope that the telling of their stories might help nurses and others better understand their perspectives, which might lead those nurses in providing respectful nursing care to low-income populations.

The results of this study also provide the reader with a vantage point for understanding how the essence of the experiences shared by these female Medicaid recipients might be utilized in nursing education. The nurse educator focus group participants had an opportunity to reflect upon that essence and to consider ways for implementing instructional strategies within existing undergraduate nursing education classroom and clinical experiences in order to emphasize socioeconomic diversity training. Several educator participants expressed a desire to go ahead and implement some of these strategies into their current teachings, in an effort to prepare

current nursing students in providing respectful nursing care for socioeconomically diverse populations.

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APPENDIX A

SCREENING TOOL FOR POTENTIAL PARTICIPANTS:
DEMOGRAPHIC DATA QUESTIONNAIRE

**Screening Tool for Potential Participants:
Demographic Data Questionnaire**

1. What is your current age? _____
2. Ethnic Background:
 - White, non-Hispanic
 - Black, non-Hispanic
 - Hispanic
 - Asian/Pacific Islander
 - Native American
 - Other (please specify) _____
3. Work status:
 - Employed Full-time
 - Employed Part-time
 - Unemployed, seeking employment
 - Unemployed, NOT seeking employment
 - Full-time Student
 - Part-time Student
 - Other (please specify) _____
4. Highest level of education:
 - Some high school
 - High school diploma/ GED
 - Some college
 - College degree (Associate/ Bachelor)
 - Post-graduate degree (Master/ Doctorate)
 - Other (please specify) _____
5. Do you:
 - Own a house
 - Rent a house/apartment
 - Live in subsidized housing (e.g., government housing, Section 8 Housing, public housing)
 - Live in campus-based housing (e.g., dormitory, campus apartments)
6. How many children under the age of 18 live in your household? _____
7. Are you currently pregnant?
 - Yes No Unsure
8. Do you receive WIC benefits? (Women's Infant and Children Nutritional Supplement Program)
 - Yes No Unsure
9. How would you rate your general mental and physical health?
 - Very Good
 - Good
 - Fair
 - Poor
 - Very Poor

APPENDIX B
COMMUNITY RESOURCE DIRECTORY

Community Resource Directory

Medical Resources

DCH Regional Medical Center
809 University Boulevard East, Tuscaloosa, AL 35401
(205) 759-7111
<http://www.dchsystem.com>

The University of Alabama Student Health Center
Located at the corner of University Boulevard and 5th Avenue East
(205) 348-6262
<http://cchs.ua.edu/shc/>

Tuscaloosa County Health Department
2350 Hargrove Road East
Tuscaloosa, AL 35405
(205) 562-6900
<http://www.adph.org>

Mental Health Resources

Alabama Psychiatric Services
825 Rice Mine Rd N, Tuscaloosa, AL 35406
(205) 391-3099
<http://www.apsy.com>

The University of Alabama Counseling Center
South Lawn Office Building
1101 Jackson Ave., Tuscaloosa, AL 35487
(205) 348-3863
<http://counseling.ua.edu/>

Additional Resources

Alabama State Medicaid Agency
907 22nd Avenue
Tuscaloosa, AL 35402
(205) 391-6767
<http://medicaid.alabama.gov/>

The University of Alabama Women's Resource Center
South Lawn Office Building, Suite 2000
1101 Jackson Ave., Tuscaloosa AL 35487
(205) 348-5040
<http://wrc.ua.edu/index.cfm>

APPENDIX C
IRB APPROVAL LETTER

February 28, 2012

Office for Research
Institutional Review Board for the
Protection of Human Subjects

THE UNIVERSITY OF
ALABAMA
R E S E A R C H

Sara Kaylor
ELPTS
College of Education
The University of Alabama

Re: IRB # 12-OR-075 "The Experience of Nursing Care for Female
Medicaid Recipients"

Dear Ms. Kaylor:

The University of Alabama Institutional Review Board has granted
approval for your proposed research

Your application has been given expedited approval according to 45 CFR
part 46. Approval has been given under expedited review category 7 as
outlined below:

*(7) Research on individual or group characteristics or behavior
(including, but not limited to, research on perception, cognition,
motivation, identity, language, communication, cultural beliefs or
practices, and social behavior) or research employing survey, interview,
oral history, focus group, program evaluation, human factors evaluation,
or quality assurance methodologies.*

Your application will expire on February 27, 2013. If your research will
continue beyond this date, complete the relevant portions of the IRB
Renewal Application. If you wish to modify the application, complete the
Modification of an Approved Protocol Form. Changes in this study
cannot be initiated without IRB approval, except when necessary to
eliminate apparent immediate hazards to participants. When the study
closes, complete the appropriate portions of the IRB Study Closure Form.

Please use reproductions of the IRB approved informed consent form to
obtain consent from your participants

Should you need to submit any further correspondence regarding this
proposal, please include the above application number.

Good luck with your research.

Sincerely,



358 Rose Administration Building
Box 870127
Tuscaloosa, Alabama 35487-0127
(205) 348-8461
FAX: (205) 348-7189
TOLL FREE (877) 823-3066

[Redacted Signature]
Carpantato T. Myles, MSM, CIM
Director & Research Compliance Officer
Office for Research Compliance
The University of Alabama

APPENDIX D
INFORMED CONSENT

AAHRPP DOCUMENT #192

**UNIVERSITY OF ALABAMA
HUMAN RESEARCH PROTECTION PROGRAM**

Informed Consent for a Non-Medical Study

Study title: The Experience of Nursing Care for Female Medicaid Recipients

Sara Kaylor, Ed.D Candidate, Educational Leadership, Policy, and Technology Studies

You are being asked to take part in a research study.

This study is called The Experience of Nursing Care for Female Medicaid Recipients. The study is being done by Sara Kaylor, who is a graduate student at the University of Alabama. Ms. Kaylor is being supervised by Professor Becky Atkinson, PhD, who is a professor within the College of Education at the University of Alabama.

What is this study about? What is the investigator trying to learn?

This study is being done to learn about the experience of nursing care for female Medicaid recipients. The investigator is trying to understand how women with Medicaid describe their experiences with nursing care, including things that make the experience either positive or negative for them. The investigator seeks to learn what female Medicaid recipients indicate as being helpful or harmful for their future health care decisions, as well as the ways nurse-patient interactions influence how these women receive and/or act upon their health care. Finally, the investigator hopes to learn what the understandings of these experiences might suggest for nursing education.

Why is this study important or useful?

The purpose of this study is to use a phenomenological approach to explore female Medicaid recipients' experiences with nursing care within a feminist-informed critical framework. This research aims to understand how nurses' attitudes and behaviors towards female Medicaid recipients influence the ways in which these patients receive and act upon their health care, and what those understandings suggest for nursing education. The results of this study will help nurses learn what attitudes and behaviors are noted by female Medicaid recipients as being positive or negative. The results may also help nurse educators understand better ways of teaching students about this population, while also adding to the scholarly literature of the field during a time of current health reform.

Why have I been asked to be in this study?

You have been asked to be in this study because you responded to an advertisement and expressed interest in this study. You are a person over the age 19 who either (a) receives Medicaid benefits due to low-income, or (b) currently teaches students in an accredited nursing program.

How many people will be in this study?

About nine to fifteen female Medicaid recipients will be in this study, and about four to eight current nurse educators will be involved in this study.

What will I be asked to do in this study?

If you meet the criteria and agree to be in this study, you will be asked to do these things:

- Participate in an audio-taped individual interview with the investigator (*for female Medicaid recipient participants only*), or
- Participate in an audio-taped focus group interview with the investigator and a group of other nurse educators (*for nurse educator participants only*)

How much time will I spend being in this study?

Individual interviews should take approximately 60-90 minutes to complete.

The nurse educator focus group interview should also take approximately 60-90 minutes to complete.

Will being in this study cost me anything?

The only costs to you from this study are your time and your mileage to the interview location.

Will I be compensated for being in this study?

In appreciation of your time, you will receive a \$25.00 Visa gift card upon completion of your interview.

What are the risks (dangers or harms) to me if I am in this study?

There should be very little or no risk to you as a participant in this study, however potential risks have been identified. The main risk for you for being in this study is that you will be asked questions that could potentially be uncomfortable. You can control this potential by not being in the study, by not answering any questions that make you feel uncomfortable, or by stopping your participation in the study at any time. There is no penalty or consequence for choosing to stop your participation. Because agreeing to be audio-taped is necessary for participation in this study, your confidentiality may also be at an increased potential risk. To decrease this risk, you will be identified in this study by pseudonym, and the audio-tapes will be destroyed upon completion of this study.

What are the benefits (good things) that may happen if I am in this study?

There are no direct benefits to you for participating in the study. However, sharing your experiences of what you felt was positive or negative about nurses' actions or attitudes towards you may offer potential future benefits to other female Medicaid patients in your community. Additionally, you may benefit indirectly from a sense of closure that sharing these experiences might bring.

What are the benefits to science or society?

This study will help nurses learn what attitudes and behaviors are noted by female Medicaid recipients as being positive or negative. The results of this study may also help nurse educators understand better ways of teaching students about this population, while also adding to the scholarly literature of the field during a time of current health reform.

How will my privacy be protected?

Your privacy will be protected by conducting the interview in a reserved, private room. You have the right to refuse to answer any question(s) that you do not wish to answer. However, the investigator is required to report any signs of spousal, child, or elder abuse, or threats of harm to self or others, to the police and/or other protective services.

How will my confidentiality be protected?

Confidentiality refers to the data that you offer and how it will be safeguarded. Data from your interview will be transcribed by the investigator and kept in the sole possession of the investigator. No other person will have access to the recorded interview or transcription. Interviewees and/or their affiliated institutions will be de-identified through the use of chosen and/or assigned pseudonyms. Audio-recordings will be destroyed at the conclusion of the research project, and all hard-copy transcriptions will be shredded. Electronic copies of transcriptions will be kept as a password-protected document on the investigator's personal computer for a period of seven years. Only the investigator will know the password.

During the nurse educator focus group, the investigator will request members of the focus group to keep the discussion confidential; however, the investigator cannot guarantee that this will happen.

What are the alternatives to being in this study? Do I have other choices?

The alternative to being in this study is not to participate.

What are my rights as a participant in this study?

Taking part in this study is voluntary. It is your free choice. You can refuse to be in it at all. If you start the study, you can stop at any time. There will be no effect on your relations with the University of Alabama, or with your Medicaid benefits.

The University of Alabama Institutional Review Board ("the IRB") is the committee that protects the rights of people in research studies. The IRB may review study records from time to time to be sure that people in research studies are being treated fairly and that the study is being carried out as planned.

Who do I call if I have questions or problems?

If you have questions about the study right now, please ask them. If you have questions, concerns, or complaints about the study later on, please call the investigator, Sara Kaylor at 205-239-5533.

If you have questions about your rights as a person in a research study, call Ms. Tanta Myles, the Research Compliance Officer of the University, at 205-348-8461 or toll-free at 1-877-820-3066.

You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach website at http://osp.ua.edu/site/PRCO_Welcome.html or email us at participantoutreach@bama.ua.edu.

After you participate, you are encouraged to complete the survey for research participants that is online at the outreach website or you may ask the investigator for a copy of it and mail it to the University Office for Research Compliance, Box 870104, 152 Rose Administration Building, Tuscaloosa, AL 35487-0104.

I have read this consent form. I have had a chance to ask questions. I agree to take part in it. I will receive a copy of this consent form to keep.

Signature of Research Participant

Date

Signature of Investigator

Date

Audio Taping Consent

As mentioned above, the individual qualitative interview will be audio recorded for research purposes involving the collection of a large volume of verbal (spoken) data. This spoken data then will be transformed into written data through a process known as transcription. All audio tapes will be stored in a locked file cabinet in a locked room and only available to the research staff consisting of Ms. Kayor, the Principle Investigator, and her doctoral research supervisor, Dr. Atkinson. We will only keep these tapes for no more than six months, and we will destroy them after they have been transcribed.

I understand that part of my participation in this research study will be audiotaped and I give my permission to the research team to record the interview.

Yes, my participation in this interview may be audiotaped.

No, I do not want my participation in this interview to be audiotaped.

APPENDIX E

INTERVIEW GUIDE FOR FEMALE MEDICAID RECIPIENTS

Interview Guide for Female Medicaid Recipients

Introduction

My name is Sara Kaylor. I am a doctoral student in at the University of Alabama. The purpose of my research is to examine the experiences of nursing care for female Medicaid recipients. Before we begin, we will read and review an informed consent document together. You will need to sign the document, agreeing to participate in this research, before we begin the actual interview. If you have any questions, feel free to ask them at any point. *(Read Informed Consent aloud, offer time for individual review of the document, witness participant sign the document, provide a copy for participant to keep, allow participant to choose pseudonym, or assign a random one).*

Reflection

Now I will begin audio-taping our interview. I want to ask you to take just a moment to reflect on an experience you've had in the past as a Medicaid recipient in which you interacted with a nurse or nurses.

Interview Questions and Probes

Probe 1: Think of a time when **you** needed health care (e.g., doctor's office visit, hospital).

1. Please describe what happened, who was involved, and the outcome.
2. What about this situation made it a good experience for you? What made it a bad experience for you?

Probe 2: When thinking about that situation, describe your interactions you had with a nurse(s).

3. Please describe what happened, who was involved, and the outcome.
4. What about this situation made it a good experience for you? What made it a bad experience for you?
5. How would you describe the level of trust you had in the nurse(s)? What things did the nurse do or say that helped you build trust? Lose trust?
6. What was the nurses' attitude towards you? How did this make you feel about the things the nurse was telling you?
7. Did the nurses' behavior(s) match his/her attitudes? Were they genuine or fake?

Probe 3: When thinking about these, how does being a Medicaid recipient play into them?

8. What are your feelings about the type of health care you receive with Medicaid?
9. What are the advantages of having Medicaid? Disadvantages?

Probe 4: When thinking about these examples, how does race or gender play into them?

10. How does your race play into your interaction with nurses? Your nurses' race?
11. How does your gender play into the interaction? Your nurses' gender?
12. Do you prefer nursing caregivers of your own race and/or gender?

Conclusion

Thank you for your time and participation in this interview. In appreciation of your time, here is a \$25.00 Visa gift card for you. If you have questions, concerns, or complaints about this study later on, you may reach me using the information listed on your copy of the informed consent. If you have questions about your rights as a person in a research study, you may contact Ms. Tanta Myles, the Research Compliance Officer of the University, whose information is also located on the informed consent.

APPENDIX F

INTERVIEW GUIDE FOR NURSE EDUCATOR FOCUS GROUP

Interview Guide for Nurse Educator Focus Group

Introduction

My name is Sara Kaylor. I am a doctoral student in at the University of Alabama. The purpose of my research is to examine the experiences of nursing care for FMRs, and to gain understanding as to what those experiences might mean for nursing education.

Before we begin, we will read and review an informed consent document together. Each one of you will need to sign the document, agreeing to participate in this research, before we begin the actual focus group. If you have any questions, feel free to ask them at any point. *(Read Informed Consent aloud, offer time for individual review of the document, witness participants sign the document, provide a copy for participants to keep, assign participants pseudonym).*

Reflection

Now I will begin audio-taping our focus group interview. I want to share with you an overview of the meanings and experiences of nursing care for FMRs. During this focus group interview, we will further discuss these experiences. *(Share with nurse educators a 5-7 minute narrative overview of findings from the female Medicaid participants)*

Interview Questions

1. What are your initial thoughts, reactions, and feelings related to the experiences I've just shared with you?
 - a. What surprises you the most? What doesn't surprise you at all?
2. What stereotypes or prejudices do you think nurses/ nurse educators have about the low-income female Medicaid population? What about your students?
 - a. How do the experiences shared challenge/confirm those stereotypes or prejudices?
3. What do you think the essence of these experiences might mean for nursing education?
 - a. What do you think students stand to gain from learning about them?
4. How do you think the essence of these experiences can be used in your curriculum or teaching techniques?
 - a. What challenges or barriers exist for implementing them?
 - b. What additional resources are needed to implement them?
 - c. Is it worth incorporating these changes/techniques, or can students gain similar knowledge in a different way?

Conclusion

Thank you for your time and participation in this focus group interview. In appreciation of your time, here is a \$25.00 Visa gift card for you. If you have questions, concerns, or complaints about this study later on, you may reach me using the information listed on your copy of the informed consent. If you have questions about your rights as a person in a research study, you may contact Ms. Tanta Myles, the Research Compliance Officer of the University, whose information is also located on the informed consent.

APPENDIX G

RECRUITMENT FLYER FOR FEMALE MEDICAID RECIPIENTS



Female Volunteers Needed for Research

Female volunteers are needed for a research study on the **experiences of nursing care as a Medicaid recipient**.

Why should I volunteer? What you share will help the researcher and others know what nursing care is like from your perspective. This is important so that nurses can learn what makes for a good or bad nursing experience.

What do I have to do? You are being asked to volunteer for a **private**, 60-90 minute individual interview to talk about your experiences and interactions with nurses.

Location: Interviews are held at the **Tusc. Public Library**, at a mutually-agreed upon date and time between you and the researcher.

To be eligible, you must:

- * Be 19 or older
- * Get Medicaid benefits due to **low income**
- * Speak/understand the English language
- * Give informed consent to participate

You will be compensated for your time with a \$25.00 gift card.

NOTE: No healthcare or Medicaid goods or services are being offered in this study. If you need health care resources, please contact the Tuscaloosa. Co. Health Department at (205) 562-6900 for more information.

Contact person:

Sara Kaylor, RN, MSN

sarakaylor@gmail.com

Box 870358, Tuscaloosa, Alabama 35487

205-239-5533

Sara Kaylor, RN
(205) 239-5533
sarakaylor@gmail.com

Sara Kaylor, RN
(205) 239-5533
sarakaylor@gmail.com

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sarakaylor@gmail.com

Sara Kaylor, RN
(205) 239-5533
sarakaylor@gmail.com

APPENDIX H

ELECTRONIC ANNOUNCEMENT TEMPLATE FOR RECRUITING
FEMALE MEDICAID RECIPIENTS

From: Sara Kaylor, RN
sarakaylor@gmail.com

To: Recipient's Name
Recipient's e-mail address

Date: Date and time of e-mail

Dear _____:

I am writing to let you know of a volunteer opportunity for participation in research. I am working on my doctoral dissertation entitled *The Experiences of Nursing Care for Female Medicaid Recipients*, and was hoping you might pass the attached informational flyer to anyone you feel might be interested.

As you'll see on the attached flyer, I am seeking women 19 years of age or older who receive Medicaid benefits and would be interested in participating in a 60-90 minute interview about their experiences with nursing care.

Thank you for your time, and please consider sharing this flyer with anyone you feel might be interested in speaking with me.

Sincerely,

Sara Kaylor

Attachment (Recruitment Flyer for FMRs)

APPENDIX I

ELECTRONIC ANNOUNCEMENT TEMPLATE FOR
RECRUITING NURSE EDUCATOR PARTICIPANTS

From: Sara Kaylor, RN
sara.kaylor@gmail.com

To: Recipient's Name
Recipient's e-mail address

Date: Date and time of e-mail

Dear _____:

I am writing to let you know of a volunteer opportunity for participation in research. I am working on my doctoral dissertation entitled *The Experiences of Nursing Care for Female Medicaid Recipients*, and was hoping you might consider participating in a focus group interview with fellow nurse educators for the purposes of discussing what my research findings might suggest for nursing education.

For this 60-90 minute focus group interview, I am seeking nurse educators that currently teach students at an accredited nursing school. If you are interested in participation, please respond back to me potential dates and times your schedule will allow for your involvement in the focus group.

Thank you for your time and consideration, and please feel free to share this information with additional nurse educators you feel might be interested in participating as well.

Sincerely,

Sara Kaylor

APPENDIX J

THEMES AND SUB-THEMES CONCEPT MAP

Themes and Sub-Themes Concept Map

Theme 1: The Shuffle

- Sub-theme: Telling of One's Story
- Sub-theme: Invisibility
- Sub-theme: Stigma and Stereotypes

Theme 2: Authority and Submission

- Sub-theme: Telling of One's Story
- Sub-theme: Invisibility
- Sub-theme: Role Confusion
- Sub-theme: Stigma and Stereotypes

Theme 3: Subjectivity as Mother

- Sub-theme: Telling of One's Story
- Sub-theme: Invisibility
- Sub-theme: Stigma and Stereotypes

Theme 4: Expectations of Nursing Care

- Sub-theme: Telling of One's Story
- Sub-theme: Role Confusion

APPENDIX K
DEFINITION OF THEMES AND SUB-THEMES

Definitions of Themes and Sub-Themes

The Shuffle: Theme

Definition: “The Shuffle” is used to describe situations or experiences in which the overall sense felt by FMRs is one of jumble, carelessness, disorganization of HCP interactions, or “system”-related inconveniences. This sense may be caused in part by being limited in their choices of HCPs, impersonal interactions with HCPs, and lengthy wait times.

Authority and Submission: Theme

Definition: For the purposes of this discussion, the term “authority” is used to describe HCPs, Systems, and Institutions, and the term “submission” has been used to describe the positionality of the FMR patient. In the sense of HCP as Authority, the “Authority” is an individual who has power (either perceived or actual) over someone or something else, and may command that power by enforcing rules or giving orders (“Authority,” n.d.). In the sense of “System” or “Institution” as Authority, the “Authority” is an official body that administers a form of rule that is seen as legitimate. In the sense of Submission as the positionality of the FMR patient, “Submission” refers to the act of yielding or surrendering to somebody or something that, in this sense, holds some element of power (“Submission,” n.d.).

The theme of Authority and Submission describes situations or experiences where FMRs felt their beliefs and opinions conflicted with their HCPs’, when they felt undermined by their HCP, when their HCP assumed their best interest, or when they were uncertain of their role as patient.

Subjectivity as Mother: Theme

Definition: For the purposes of this discussion, the term “Subjectivity as Mother” refers to the individuality of the FMR and her unique perspectives, feelings, beliefs, and desires related to motherhood (Solomon, 2005). This theme describes situations or experiences where FMRs reflect upon their role as Mother and share their stories from the perspective as Mother.

Expectations of Nursing Care: Theme

Definition: For the purposes of this discussion, “Expectations of Nursing Care” refers to the standards of conduct or performance that FMRs anticipate receiving through their interactions with nurses. Including both positive and negative attributes, this theme describes situations or experiences in which FMRs express their impressions of nursing professionalism. It also explores FMRs’ suspected role confusion surrounding HCPs, and considers how race, gender, and age factor into interactions with HCPs.

Telling of One’s Story: Sub-theme

Definition: For the purposes of this discussion, the sub-theme “Telling of One’s Story” refers to the personal narrative FMRs share with their HCPs. It involves the FMR’s subjective vocabulary, order of events, and flow of thought, and often revolves around their reason for seeking health care and their observations.

Invisibility: Sub-theme

Definition: For the purposes of this discussion, the sub-theme of “invisibility” refers to FMRs’ feelings of being hidden, not readily noticed, unacknowledged, or “forgotten about.”

Role Confusion: Sub-theme

Definition: For the purposes of this discussion, the term “role” refers to the set of expected functions or behaviors that society places upon somebody, such as a doctor, nurse, patient, or FMR. The term “confusion” refers to a misunderstanding or uncertainty about something, and in this case, about the role of somebody. Therefore, the sub-theme of “role confusion” or “role uncertainty” describes situations or experiences in which FMRs have either difficulty in understanding the role of patient, or in differentiating roles among various HCPs.

Stigma and Stereotype: Sub-theme

Definition: For the purposes of this discussion, “stigma” may be external, reflecting the attitudes the general population holds towards FMRs, or may be internal, referring to the FMR’s anticipated fear of society’s attitudes and potential discrimination (Kinsler et al., 2007). The term “stereotype” refers to the act of reducing FMRs into a standardized image, idea, or category (“Stereotype,” n.d.). This sub-theme describes situations where FMRs express being treated like they are dumb, uneducated, or free loading, explores thoughts related to stigmas and stereotypes, and looks at coping mechanisms for dealing with them.

APPENDIX L
TIMELINE OF RESEARCH ACTIVITIES

Timeline of Research Activities

	Month	Activity	
2010	June	Complete Comprehensive Exams	
	July	Final Draft of Dissertation Prospectus	
	August	Submit Dissertation Prospectus to Chair	
	September	Complete Revisions to Prospectus	
	October		
	November	Present Dissertation Prospectus to Committee	
	December	Draft Dissertation Proposal	
	2011	January	Draft Dissertation Proposal: Write/Revise Chapter 1: Introduction
February		Write/Revise Chapter 2: Review of Literature	
March			
April		Write Chapter 3: Methods	
May			
June		Meet with Chair, discuss dissertation topic change	
July		Write and Revise Chapters 1-3 to reflect dissertation changes	
August		Submit Chapters 1-3 to Chair for revisions	
September		Submit document of dissertation changes to committee for approval; Work on IRB proposal and informed consent to have ready upon dissertation proposal defense	
October		Defend Dissertation Proposal	
November		Submit UA IRB Proposals for approval by the 15 th of the month. Allow 4 weeks for review and decision.	
December		Begin Recruitment of participants and scheduling of interviews	
2012	January	Recruit participants, conduct Interviews (9-15) Allow time for one interview/ week; Data analysis is concurrent with data collection, Transcribe interviews: allow for approx. 6 hours/ interview for transcription	
	February		
	March		
	April	Write/Revise Chapter 4: Data Analysis and Findings	
	May	Conduct focus group interview with nurse educators; transcribe and analyze data Write/ Revise Chapter 5: Implications	
	June		
	July	Submit manuscript to committee Chair: allow 2-4 weeks to read	
	August	Complete Revisions to manuscript based on what committee Chair recommends	Set defense date for end of September/ early October
	September	Submit Application for Degree	
	October	Submit approved dissertation to the Graduate School 6 weeks prior to graduation	
	November		
	December	Commencement	