Sharing Our Stories with the Future Healthcare Workforce: Perspectives of Low-Income Poverty Simulation Volunteers

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Abstract

Practitioner attitudes about low-income patients may impact clinical care and outcomes. Poverty simulation, employing low-income community volunteers, is an effective teaching tool in improving attitudes toward poverty among health professions students. This study explores the experiences of these essential simulation volunteers who share their stories with student participants. Focus groups were conducted with low-income community members who staff resource tables during poverty simulations. Data were audio-recorded, transcribed, and analyzed using a grounded theoretical approach. Participants spoke of the systemic nature of poverty and identified multiple barriers to healthcare access. Perceived lower quality of care, mistrust in health professionals, and a lack of continuity of care were discussed. In regards to the simulation, participants were empowered through sharing their stories with students, and offered suggestions for program improvement. Simulation provides a forum for community members to educate the future healthcare workforce on systemic barriers faced by low-income populations.

There are clear links between poverty and disparities in healthcare access, utilization of health services, and health status, risk factors, and outcomes (Adler & Newman, 2002; Fiscella, Franks, Gold, & Clancy, 2000; Fiscella & Williams, 2004; Meyer, Yoon, Kaufmann, Centers for Disease, & Prevention, 2013). U.S. adults living below the poverty threshold are 2.5 times more likely to suffer from depression, have greater risk for heart disease, hypertension, and stroke, and have reduced life expectancy compared to those above the poverty line (Blackwell, Lucas, & Clark, 2014; Crimmins, Kim, & Seeman, 2009; Pratt & Brody, 2014). The intersectionality of race/ethnicity, geography, educational attainment, and other social statuses may further exacerbate health inequities in low-income populations (Bowleg, 2012). Even with expanded access to health insurance, patients living in poverty face additional barriers to care and treatment compliance, such as transportation, time, and other competing priorities (Hall & Lord, 2014; Jacob, Arnold, Hunleth, Greiner, & James, 2014; Syed, Gerber, & Sharp, 2013). With more than 45 million Americans living in poverty, 40 percent of which reside in the South, it is essential that the future healthcare workforce training in this region understand the challenges faced by low-income patients (Beach et al., 2005; United States Census Bureau, 2013; Wear & Kuczewski, 2008).

The Community Action Poverty Simulation (CAPS) is an experiential tool used to educate groups about the day-to-day realities, struggles, and stresses faced by low-income Americans (Missouri Community Action Agency, 2015). The ultimate goal of the program is to change attitudes toward poverty and the poor. During the simulation, participants are assigned to role-play the lives of low-income individuals, and are tasked with attaining, food, shelter, and basic necessities throughout four 15-minute weeks. Participants must navigate and access services from various community agencies and social services, which are staffed by low-income volunteers.

The University of Louisville Health Sciences Center Office of Diversity and Inclusion offers the simulation to health sciences faculty, staff, and student groups, with an adapted emphasis on the role poverty plays in healthcare processes and outcomes. Working with community partners, low-income volunteers with first-hand experiences of poverty, homelessness, and accessing social services are recruited to staff the simulated community agencies and businesses. The agencies represented in the simulation are broad and include a community health center, police department, pawn shop, school, grocery, bank, quick cash center, daycare center, community action agency, interfaith center, homeless shelter, employer,

mortgage company, utility company, and department of social services. Volunteers are instructed to treat the participants in the simulation the way they were treated when seeking help from these agencies in the real world. Following the simulation, many of the volunteers share their stories with the participants during a debriefing period, which is a critical and powerful component of the program.

Current literature on poverty simulation demonstrates that the exercise is effective in changing attitudes and beliefs about poverty among participants, including health professions students (Menzel, Willson, & Doolen, 2014; Noone, Sideras, Gubrud-Howe, Voss, & Mathews, 2012; Patterson & Hulton, 2012; Steck, Engler, Ligon, Druen, & Cosgrove, 2011; Strasser, Smith, Pendrick, Denney, Jackson, & Buckmaster, 2013; Vandsburger, Duncan-Daston, Akerson, & Dillon, 2010). However, the perspectives of these essential volunteers are yet to be explored. Qualitative studies have provided a valuable forum for low-income population to have a "voice" while providing insight into the challenges they face in accessing community resources and services (Bender, Thompson, McManus, Lantry, & Flynn, 2007; Canvin, Jones, Marttila, Burstrom, & Whitehead, 2007; Edin & Lein, 1997; Newman, 1999). Such studies have generated an understanding of poverty as it is experienced and of the complex web of ideas and practices that surround policies designed to eradicate it. Within community engagement activities, universities are called to gather feedback from community partners to monitor satisfaction, assure equitable benefits for the community, and avoid the potential for community exploitation (Bringle & Hatcher, 2002). The purpose of this study was to explore the perspectives of these essential simulation volunteers who share their stories with student participants.

Methods
Design and Sample
The study utilized a qualitative descriptive research design and an analytic inductive method of data collection and analysis to assess the experience of low-income volunteers who serve as resource providers during a poverty simulation. This study fit well within the qualitative research paradigm, as this is the first to explore the perspectives of simulation volunteers (Creswell, 2013).

Participants were recruited to focus groups from a convenience sample of 19 volunteers who participated in a November 2014 simulation. Poverty simulation volunteers are referred through community agencies and non-profit centers that provide services for low-income individuals. The following criteria were required for enrollment into the focus groups: minimum age of 19 (no maximum age), prior experience as a volunteer in a CAPS simulation, and the ability to speak and understand English. Eighteen of the 19 adults who served as volunteers in the preceding simulation participated in the study. Of the focus group participants 13 (72 percent) were male, and 5 (28 percent) were female, and were mostly African American (89 percent). Written informed consent was obtained from participants. The University of Louisville Institutional Review Board approved this study.

Focus Groups
Three focus groups were conducted immediately following a November 2014 CAPS simulation. The authors developed a semi-structured interview guide comprised of open-ended questions with built in flexibility for the moderator (Gillham, 2000). This ensured consistency across multiple focus groups, assuring that the moderators would ask the same questions in the same sequence (Morgan, 1997). Questions centered on experiences living in poverty, utilization of community resources and healthcare services, personal strengths, and their experience serving as staffers within a poverty simulation.

The interviews were held in private rooms near the location of the preceding simulation. Three of the authors served as facilitators, as the data were collected simultaneously. The focus groups lasted between 60 and 90 minutes and were captured through digital audio recording devices and transcribed verbatim by an outside agency. Participants used pseudonyms so that no names or personal identifiers were attached to audio files or transcripts. Participants received lunch and a $20 gift card for their time and effort.

Data Analysis
Analysis of focus group transcripts employed a grounded theoretical approach. Grounded theory identifies patterns and themes, then builds concepts and connects them together into a theoretical explanation that accounts for the lived experiences of those studied (Charmaz, 2006). The primary and secondary authors performed independent initial line-by-line open coding analysis in QSR NVivo 10. The coding authors then met to resolve any discrepancies in open codes, and jointly

performed axial and selective coding for theory development. As themes and patterns emerged, the transcripts were again reviewed to code any relevant data that were previously overlooked.

Results

Four main conceptual findings emerged from the data analysis: the systematic nature of poverty, barriers and mistrust in the health system, empowerment through simulation involvement, and suggestions for simulation improvement. A discussion regarding the findings within each theme and contextual statements from participants is provided.

Systematic Nature of Poverty

When asked about experiences with poverty, participants spoke of major gaps in systems, and described the difficulty in accessing social services. It was perceived that systems were developed by persons with no experience of poverty with policies derived from political considerations. They felt as though current policies create an inescapable, defined class system. In discussing poverty, one participant defined it as:

> Poverty is, first of all, not having anything. Then, through continually trying to be responsible and productive member [of society], what I'm able to obtain, there's so many obstacles to get it and then once I get it, the expenses of living takes it all away. I'm right back on step one… …They enact laws or rules and regulations to prevent us from having enough to just survive. …That's what poverty is to me. I have to be honest. It's a systematic demise of people.

Participants identified multiple flaws in the "system" of social services and community agencies. Within the system there are unclear and undefined processes that must be learned. Service agencies and their employees do not teach one how to navigate the network of agencies, applications, and processes. These hidden processes are learned by experiences of failure or through other members of the community. The processes are often lengthy and impractical given the circumstances of the clients they are intended to serve. Participants felt like the system is designed for them to fail as agencies place unnecessary barriers that create an inescapable, vicious cycle of poverty. A formerly homeless African American man illustrated this point in the process of applying for food stamps:

> Trying to get food stamps is very hard for a homeless person. I know because I dealt with it. First off you have to have a letter stating that you're homeless. Some homeless people do not stay inside, they stay outside, so it's rough. They go through trying to get a letter or proof of them being homeless on anything out here that you try to get. Any type of services that you need to get if you are homeless they want to see some type of documentation.

Another formerly homeless man discussed a similar impractical documentation practice required for him to enter into a housing program:

> I've been homeless for the last three years and it took me three years to obtain a place of residence again. It didn't come easy. They want you here at a certain time, then they want to actually come... If you say you're homeless they want to actually see you outside sleeping on a piece of cardboard. The night that the guy that came and did the assessment on me, I told him I slept over there… I stayed at my buddy's house that night, but I was down here at 5:30 in the morning when he rolled up… I grabbed a couple pieces of cardboard and a blanket and laid it out… Had I not shown up that morning I could very well be one of the guys that's walking down the street with two, three backpacks with all my possessions in it right now. I could still be in that situation.

However, participants identified several strengths that aid in navigating systemic challenges. They continue to live their lives despite poverty and its many challenges. Many discussed their own spirituality, and described how faith motivates them to persevere, aiding in resiliency. Participants also discussed the sense of community and helping others as a source of strength. They described friendships and teaching and assisting others in the navigation of social services and community agencies.

Barriers and Mistrust in the Health System

Experiences accessing healthcare were described as largely negative. Similar to other agencies they must navigate on a daily basis, participants felt that accessing medical care required them to navigate yet another complex system. Common experiences were long wait times for appointments and a lack of continuity of care. One participant summarized that the lack of continuity of care among providers and agencies:

> If they can get around to you and learn what the problem is, some of these places will do that, you know. [They] try to help you…but you just wonder how will I [get] this and that. You have to be examined and everything but then again just put on [another] waiting list.

In addition to systemic problems, participants felt like the majority of healthcare professionals merely "tolerated" them, and did not necessarily care about them. They perceive that they are provided unequal treatment and a lower quality of care. An African American female explained:

> My experience with the doctors and the dentists, once they perceive that you are poor or you're on Medicaid or something they're not as forthcoming with the medical care that they would give somebody else…the wait time is longer, the treatment plan is different.

A white male concurred:

> I feel like if you don't have a whole lot of money and you're just someone like me, they're just trying to get you in and out. They don't really care. They treat you differently. They look at you funny."

In addition to the general lack of trust for healthcare professionals, participants also commented on the lack of diversity within the healthcare system.

Moreover, simulation volunteers indicated that medical care was often not a major priority when compared to other competing financial and temporal priorities such as finding food and shelter. Monetary costs associated with copayments for visits and prescriptions and the cost of time have an impact on the utilization of medical care.

Participants indicated that, similar to clinicians they've seen in practice, the health professions students in the simulation lacked in knowledge of health insurance systems. An African American female described how she observed this lack of knowledge among simulation participants:

> Another thing that I was a little in awe of is the fact that the people who are coming to us, their lack of knowledge that it costs. They had this look like, "I have to pay a copay with Medicaid or Medicare?" Or how much they had to pay with their insurance. The experience was that a lot of people didn't know or weren't versed on how much money it really costs to go to the doctor.

Overall, participants felt like they were an afterthought in the healthcare system, and longed for a forum to voice their concerns.

Empowerment through Simulation Involvement

In discussing their experiences as volunteers in the simulation, the response was unanimously positive. This was the first time many were provided with the opportunity to share their story and have a voice. The volunteers enjoyed serving as teachers and being the experts during the simulation process. Their hope is that their contribution will impact change on campus as well as have an impact on the practice of health care. An African American male described the mutual benefit to both health professions students and community volunteers:

> Let me say, these students are receiving something and we are receiving something that we never had before. It was talked about in circles, but to be put out in an open forum like this, you know. They are able to hear and be concerned, a little bit more concerned, they lend a little bit more of an ear to us because we are interacting with each other. Which is the beginning of change… This is a smile for us. This is encouragement for us.

Many expressed gratitude for the opportunity to share their narratives with the simulation participants during the debriefing. An African American male described his experience sharing his story:

I did something I didn't even think I was going to do. I didn't know I was going to come in here and get up and share with anybody. Usually mum's the word… [but] something came over me, go here, share your experience with some people that never had the experience of any of this. Maybe this'll prevent them in the long from shunning and looking different at [patients] that are homeless or not in the best of situations when they see them.

Overall, the volunteers felt valued and respected, with all volunteers wanting to come back to serve and share their stories in future simulations.

Suggestions for Simulation Improvement

While they enjoyed the experience, the volunteers did have several insightful suggestions for improvement. They perceived that participants lacked exposure to poverty and had a limited understanding of systemic issues in poverty and health care. They viewed the simulation as an important first step for health professions students to learn about and gain empathy for the poor. However, more education is needed. One volunteer described poverty as something you truly have to live to understand:

It's almost like picking cotton. I can tell you about picking cotton, but until you cut your hand, until you reach in and stick your hand and you get pricked, you have no knowledge of that. I could say I picked 100 pounds a day. But [you won't understand] until you have the cuts on your hand.

Recommendations were made to include real life experiences as student curricular requirements such as taking the bus, staying in a shelter, walking to all appointments, spending the day without money or a phone, and standing in a social services line.

Some volunteers felt that students perceived the simulation as just another class or a game. Very few students took the opportunity to engage in further conversation with the volunteers after the completion of the debriefing. Participants suggested that more time be spent with the students to share their stories. An African American female explained:

They probably would have gotten more out of it if they had an opportunity to have a one on one with the actual people who had [shared] their story, to actually sit and be within the same vicinity with this person rather than being in a big group and hearing somebody telling their story over on that side of the room and on the other side, because they get up and leave en masse [at the end].

It was recommended for students to have additional time to talk in small groups for further discussion and deeper engagement with the volunteers. They also acknowledged that the impact of the simulation on students may not be fully evident today, as these stories and experiences may change the way they see, approach and care for low-income individuals in the future.

Discussion

This study contributes to the limited literature on poverty simulation, providing insight into the perspectives of low-income volunteers who serve as pillars for the exercise. Participants spoke of the systemic nature of poverty and shared barriers they experienced in accessing healthcare and other social services. This was the first time many were provided with the opportunity to share their story, particularly with an audience of future healthcare professionals. The volunteers enjoyed serving as teachers and experts during the simulation process. Thus, this served as an empowering experience for the volunteers. The volunteers also provided several important suggestions for program improvement which will aid in future simulations.

Participants identified perceived gaps in knowledge regarding poverty, health care, and social services among health professionals and health professions students. This underscores the importance of exposure to low-income populations for health professions students. Participants recommended more time for in-depth discussions with health professions students in small groups as an enhancement to the simulation. While health professions students may have exposure to low-income populations in clinical settings, further dialogue is needed to foster compassion and understanding (Wear & Kuczewski, 2008). Future simulation programs may be more effective in instilling empathy for the poor among students if they are more realistic, require dialogue, and allow more time for critical reflection.

Several limitations in the study should be considered. Because of the qualitative nature of the study, data were comprised of self-reported experiences. This study utilized a convenience sample because of the focus on the experience of low-income poverty simulation volunteers. As a result, participants were primarily African American and male, which may not be representative of the experience of all low-income populations. In addition, the sample size was small, which also limits the generalizability of the findings. Furthermore, several of the participants knew each other, which may have impacted the information that they were willing to share about themselves with other participants.

Overall, the conceptual findings that emerged from the data demonstrate both a benefit for low-income volunteer participation in poverty simulation and identify areas for program improvement. Poverty simulation provides both a learning experience for students and a forum for community members to educate the future healthcare workforce on systemic barriers faced by low-income populations. This study contributes to the poverty simulation literature in confirming that serving as a volunteer is an empowering experience for low-income community members.

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