Surmounting the Unique Challenges in Health Disparities Education: A Multi-Institution Qualitative Study

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BACKGROUND: The National Consortium for Multicultural Education for Health Professionals (Consortium) comprises educators representing 18 US medical schools, funded by the National Institutes of Health. Collective lessons learned from curriculum implementation by principal investigators (PIs) have the potential to guide similar educational endeavors.

OBJECTIVE: Describe Consortium PI's self-reported challenges with curricular development, solutions and their new curricular products.

METHODS: Information was collected from PIs over 2 months using a 53-question structured three-part questionnaire. The questionnaire addressed PI demographics, curriculum implementation challenges and solutions, and newly created curricular products. Study participants were 18 Consortium PIs. Descriptive analysis was used for quantitative data. Narrative responses were analyzed and interpreted using qualitative thematic coding.

RESULTS: Response rate was 100%. Common barriers and challenges identified by PIs were: finding administrative and leadership support, sustaining the momentum, continued funding, finding curricular space, accessing and engaging communities, and lack of education research methodology skills. Solutions identified included engaging stakeholders, project-sharing across schools, advocacy and active participation in committees and community, and seeking sustainable funding. All Consortium PIs reported new curricular products and extensive dissemination efforts outside their own institutions.

CONCLUSION: The Consortium model has added benefits for curricular innovation and dissemination for

cultural competence education to address health disparities. Lessons learned may be applicable to other educational innovation efforts.

KEY WORDS: education, professional; cultural competency; health status disparities; health care disparities.

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INTRODUCTION

Increasing recognition of well-documented disparities in health status, health care access and health care service delivery by race, ethnicity, socioeconomic status, gender, age, sexual orientation and other sociodemographic characteristics in the US has fueled calls to better prepare future health professionals to address these challenges^{1–3}. One approach to address such disparities suggested by the *Unequal Treatment* report is to integrate cross-cultural education into the training of current and future health professionals to improve the quality of health care and health care communication³.

In 2000, the accrediting body for US and Canadian medical schools set standards that “faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.”⁴ Elements of cultural competency were addressed by two of the six core competencies for physicians identified by the Accreditation Council for Graduate Medical Education (ACGME): interpersonal and communication skills, and professionalism⁵. In addition, medical and graduate schools have been encouraged by organizations such as the American Medical Association⁶, the Society of General Internal Medicine Health Disparities Task Force⁷ and the American Public Health Association⁸ to provide training in culturally competent health care and health disparities.

In response to these recommendations, in 2004 the National Heart Lung and Blood Institute of the National Institutes of Health (NIH) established a competitive training award program (K07) for US medical schools to develop, implement and evaluate curriculum in health disparities and cultural competence. The goal was to increase the overall knowledge, awareness and skills of medical students, residents and practicing physicians of ethnic, cultural, religious, socioeconomic, linguistic and other

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factors that contribute to health disparities, and on culturally competent approaches to mitigating these disparities. The National Consortium for Multicultural Education for Health Professionals (Consortium) was established by the 18 medical schools ultimately funded by this initiative, with an overarching vision to embrace and enact the principles of high quality, equitable and culturally responsible care, and to eliminate health and health care disparities. The principal investigators (PIs) engaged individually and collectively in curriculum development, implementation, evaluation in health professional education, dissemination of curriculum to health professionals in training and practice, support and leadership to health professional education programs, and advocacy for the Consortium's vision and principles. Consortium schools included eight public, eight private and two historically black college and university medical schools representing all regions of the US. Individual awards were for 5 years.

The consortium approach to educational development is not new. For example, in the 1990s the Robert Wood Johnson Foundation's Generalist Physicians' Initiative consisted of a group of endowment-funded medical schools that designed and implemented curricula to increase the exposure of students to primary care education⁹. More recently, an NIH-funded consortium on Integrative Medicine reported the processes and products of educators from 21 medical schools working collaboratively to integrate complementary and alternative medicine (CAM) content into their schools' existing curriculum^{10,11}. We posit that lessons learned from our own Consortium's work would be of value to other educators engaged in similar endeavors. We encountered many of the usual challenges to new curricular efforts, but also encountered challenges unique to this topic area and kind of endeavor. The lessons learned individually and collectively may be of significant strategic and tactical value to educators tasked with developing or expanding curriculum in health disparities and cultural competence in their own institution.

This paper describes the study we conducted to explore in depth the individual and collective experiences of faculty from the 18 schools in the Consortium, with the goal to derive

critical information applicable to implementation of cultural competence curricula to address health disparities. Using data obtained from this inquiry, we then identified unique challenges to curricular implementation in health disparities and cultural competence and approaches we collectively identified to overcome these challenges, with the aim of informing other educators engaged in similar processes.

METHODS

Study Participants

Participants for this study consisted of faculty PIs at each of the 18 Consortium schools (see Fig. 1).

Process of Survey Development

We used a qualitative, descriptive study approach to develop a questionnaire, collect data and interpret the information derived from PIs at the 18 schools. By the start of 2008–2009, 4 years after the establishment of the Consortium, awards had been ongoing for 4 years for eight schools, 3 years for six schools and 2 years for four schools. At the 2008 annual Consortium meeting, the 18 PIs noted shared challenges in developing and integrating cultural competency curriculum into their own medical schools' existing curricula. During a facilitated small group session, 16 PIs brainstormed about ways to systematically identify these shared experiences and to learn from strategies adopted to address the challenges. Based on emergent themes from this meeting and driven by group consensus, three Consortium PIs (OCP, SB, CB) developed a new, structured 53-item "Measures of Success" questionnaire to catalog accomplishments and to identify common barriers and challenges during development and implementation of cultural competency curricula, and ways to overcome these challenges, because no existing validated instrument for this purpose was available based on a literature review. These three PIs also identified themes from the meeting discussion that eventually informed the analytic approach to qualitative questionnaire responses.

Figure 1. Consortium map.

Questionnaire

The detailed 53-item “Measures of Success” questionnaire contained various types of questions in three parts. The “Demographics” section consisted of ten demographic or background questions of the PI including their primary discipline and personal career descriptions. The “Challenges, Solutions, Resources Used” section contained five open-ended questions that addressed barriers and challenges for curricular implementation, strategies to overcome them and use of existing curricular resources. The “Curricular Efforts” section contained questions that combined binary as well as open-ended responses related to details of curricular development and products such as the number and type of learners taught, types of learning activities, development of new or revised curricula and other information pertinent to the NIH award objectives and curricular evaluation methods (complete questionnaire available from corresponding author by request).

Data Collection

The same questionnaire was used to collect data from all members of the Consortium. PIs were given the option to respond to the questionnaire as an e-mailed Word© document, an online web survey, or by in-person or telephone interviews by SB. Offering an alternative mode for response is a common approach that is used by other studies to maximize the response rate. Oral interviews were typed and transcribed. All responses were collected as individual typed documents in preparation for analysis and interpretation.

Data Analysis

Questionnaire responses for all 53 questions were collated and entered into a spreadsheet. Quantitative data were entered in Excel and descriptive statistics calculated. Qualitative narrative responses were extracted for each question and analyzed by the specific open-ended question. For this study, our qualitative analysis focused mainly on narrative responses to the question (from the “Challenges, Solutions, Resources Used” section): “Please describe any personal, institutional or other challenges that you have encountered in developing or implementing your cultural competency and health disparities curriculum. Were you able to overcome this/these challenge(s)? If yes, please describe what worked to overcome the challenge(s).” Two coders with previous qualitative and quantitative experience, OCP (epidemiologist) and SB (anthropologist), independently coded responses using a grounded theory approach and six previously identified consensus-driven themes after discussing each response and verbally agreeing on each of the assigned codes, using a previously reported method¹². No additional themes were identified during our review of individual responses. Disagreements were resolved by discussion. This process was iteratively repeated until final agreement for all themes was reached. This iterative approach is one that has been used by other researchers¹³.

We also extracted information from the “Curricular Efforts” section of the questionnaire to catalog examples of successful completed curricular products and their dissemination. The “Curricular Efforts” section of the survey asked whether a particular type of curricular material was developed, such as case vignettes, with an open-ended follow-up question asking

about the type. This way, we were able to quantify how many materials were developed as well as generate a list of these materials. The coders (OCP, SB) systematically reviewed these responses to generate quantitative data, and when applicable, matched results for all the responses. Some narrative responses to questions in the “Curricular Efforts” section added greater depth to support themes derived from the analysis of the “Challenges, Solutions, Resources Used” section responses and are thus included in the Results.

The Institutional Review Boards of the University of Maryland and Stanford University approved the study.

RESULTS

Participants and Responses (from the “Demographics” Section)

The final 53-item questionnaire was completed by all 18 PIs. Thirteen responded via e-mail/Word© document, three by online survey and two by in-person interview for a 100% response rate over a 2-month period. Ten of the 18 PIs were female, and ethnicities represented by all PIs were: Hispanic (7), non-Hispanic White (6), African-American (4) and Asian (1). The most commonly reported primary discipline was internal medicine (9) followed by family medicine (4), medical education (2), epidemiology (1), pediatrics (1) and psychology (1).

Obstacles and Solutions (Qualitative Analysis of Responses to “Challenges, Solutions, Resources Used” and “Curricular Efforts” Section Questions)

We identified six dominant themes with regard to unique challenges in implementing curriculum in health disparities and cultural competence. These were (1) finding administrative and leadership support for curriculum, (2) sustaining the momentum, (3) continued funding support, (4) finding curricular space for curriculum, (5) accessing communities and skills to engage communities, and (6) lack of sophistication in rigorous education methods. Table 1 provides quotations from PI respondents that were drawn from questionnaire responses to support each theme. Also provided in Table 1 are suggestions on how to overcome these challenges that were drawn from questionnaire responses and further developed in Consortium meeting discussions.

For the theme ‘finding administrative and leadership support for curriculum,’ three PI respondents described the challenge of finding administrative support or changing leadership by noting “another challenge for me will be the retirement of the Dean of Education who has been a steadfast supporter of me, as a mentor and my go-to person.” Additionally, one PI observed “the difficulty of working with course leaders who undermined activities proposed and who sought to discredit me” was a barrier to educational innovation.

For the theme ‘sustaining the momentum,’ two PI respondents described challenges, one PI noting a challenge in the process of “developing a core group of faculty to facilitate small group discussions. This is an issue that we continue to struggle with given the many other obligations that our staff have.”

As part of the continued funding support theme, PIs’ times for curricular innovations are supported by the grant; therefore, ‘continued funding’ after grant support ends was a concern; one

Table 1. Six Themes from Principal Investigator Questionnaire and Suggested Solutions, National Consortium for Multicultural Education for Health Professions (NCME)

Challenges	In their own words	How to overcome challenges
Finding administrative and leadership support for curriculum	<ul style="list-style-type: none"> ○ <i>"Another challenge for me will be the retirement of the Dean of Education who has been a steadfast supporter of me, as a mentor and my go-to person"</i> ○ <i>"Trying to foster/encourage true inter-institution collaboration"</i> ○ <i>"Access to faculty data base has been difficult despite open sharing from me I have discussed with internal powers regarding resolution"</i> ○ <i>"...the difficulty of working with course leaders who undermined activities proposed and who sought to discredit me"</i> 	<ul style="list-style-type: none"> ○ Chair committees responsible for reviewing the curriculum and making recommendations to the education deans, course directors and clerkship directors ○ Involve others (i.e., develop a diversity plan with advisory boards or advocacy committees) ○ Network, develop a critical mass for support ○ Support colleagues in order to stay focused ○ Alter approach to determine what is important to them ○ "Go up"—involve higher administration (i.e., deans) ○ "Go around"—advocate for implementation (i.e., curriculum committee) ○ Reorganize action plan to solidify partners' interest
Sustaining the momentum	<ul style="list-style-type: none"> ○ <i>"Have had two changes in personnel—first, a change in co-investigator, and secondly, a more recent change in curriculum evaluator"</i> ○ <i>"Developing a core group of faculty to facilitate small group discussions. This is an issue that we continue to struggle with given the many other obligations that our staff have"</i> 	<ul style="list-style-type: none"> ○ Foster true intra- and inter-institution collaboration ○ Positive reinforcement for team members and partners (i.e., public recognition, thank you in newsletter) ○ Broad-based approach to faculty development to create an environment and culture of inclusiveness toward curricular innovations ○ Think "outside the institution" and seek collaborative efforts with colleagues ○ Leadership at institution to write letters of support
Continued funding support	<ul style="list-style-type: none"> ○ <i>"Sustaining the [grant-funded] center in post-grant era"</i> ○ <i>"Continued funding is the biggest challenge"</i> 	<ul style="list-style-type: none"> ○ Aligning strategies for stakeholders ○ Review existing cases/lectures to incorporate cultural competency (published and unpublished)
Finding curricular space for curriculum	<ul style="list-style-type: none"> ○ <i>"Integration of new material into a curriculum that is perceived as already full (subsequent resistance by faculty)"</i> ○ <i>"Scheduling new content within the already full curriculum with exceptionally busy basic science and clinical faculty continues to be the biggest challenge"</i> ○ <i>"As a course director and clerkship director, I've been able to implement components of the curriculum in the courses and clerkships that I run; however, outside of these areas I've been unsuccessful gaining access to other courses"</i> 	<ul style="list-style-type: none"> ○ Attend curriculum steering committees to advocate for the new curricular elements ○ Develop curricular work-around for cultural competency issues (i.e., nested in another topic) ○ Watch/edit how to talk about the need for cultural competency education and training to reflect strong belief that is essential to achieving professionalism
Accessing communities and skills to engage communities	<ul style="list-style-type: none"> ○ <i>"Difficult to have a local steering committee, hard to maintain interest and participation [with communities]"</i> 	<ul style="list-style-type: none"> ○ Identify: ○ Access to the communities served by medical school ○ Recognizable leaders in the community not just those who have high educational levels ○ Spend time in the community (e.g., attend church, volunteer) ○ Connect with others doing community-based participatory research ○ Identify cultural brokers with necessary research skills who can help translate community health needs, etc.
Lack of sophistication in rigorous education methods	<ul style="list-style-type: none"> ○ <i>"I was relatively junior when I received this award. I did not have the experience of running a research team and did not receive mentorship around doing so"</i> 	<ul style="list-style-type: none"> ○ Apply to medical educator training program (i.e., Harvard Macy Institute Program for Educators in Healthcare Professions)

PI noted that "continued funding is the biggest challenge" for them.

A resonating challenge for all PI respondents (even among those who were course directors and curricular leaders) was 'finding curricular space for curriculum.' The biggest challenge occurred when "integrat[ing] new material into a curriculum that is perceived as already full (subsequent resistance by faculty)."

One PI attempted to incorporate local community advocates into their curricular planning and found it "difficult to have a local steering committee, hard to maintain interest and participation [with communities]," addressing the theme 'accessing communities and skills to engage communities.'

Another emergent theme relative to the granting mechanism, 'lack of sophistication in rigorous education methods,'

was remarked upon by one PI: “I was relatively junior when I received this award. I did not have the experience of running a research team and did not receive mentorship around doing so.”

In their responses, PIs described some successful solutions to overcome challenges encountered. For example, some PIs noted that aligning strategies for stakeholders and leadership, both at the intra- and inter-institution level, best addressed sustainability issues (one PI suggested the need to “think ‘outside the institution’ and seek collaborative efforts with colleagues”). Some PIs noted that finding support in the curriculum by aligning with key stakeholders or chairing curricular committees addressed the problem, while others suggested creating a critical mass for support such as utilizing committees and advisory boards. Working within their respective institutions, some PIs reported that they “came across difficult or obstructive people.” These PIs found that by working directly with key leaders, involving administrative resources, or working with the curriculum committee they were able to address some of these challenges. As an example, one PI respondent reported that he/she had to “alter [their] approach to determine what is important to [the administrator]” in order to effect change. Respondents consistently noted a need for sustainable funding and described efforts to seek future funding for their curricular work.

Despite the challenges to curriculum implementation, 13 of the 18 PI respondents reported (in “Curricular Efforts” section responses) that they successfully advocated for, or participated in, institutional changes to help support cultural competency education with examples such as creation of a new administrative unit or committee, changes in administration statements about cultural competency curriculum objectives, or dean’s letters. Seven of the 18 PI respondents reported collaborating on Association of American Medical College products related to health disparities education (e.g., Tool for Assessing Cultural Competence Training or TACCT)^{14–19}, participated in expert literature review panels, and/or created Liaison Committee on Medical Education (LCME) faculty and student admission statements of diversity. One PI respondent reported working with the National Board of Medical Examiners to include cultural competency and health belief questions in the USMLE Step 3 Board examination.

Cultural competency was successfully embedded into curriculum by incorporating it into current cases or existing content, such as professionalism, and advocating for cultural competency with curriculum steering committees. Identifying cultural brokers and community leaders helped improve community access and participation in the curriculum. Once cultural competency content was integrated into the curriculum, continued faculty development and fostering inter- and intra-institution collaboration helped address the challenges of developing core faculty and changes in personnel. Some members mentioned acquiring research skills as a personal challenge and found support in medical educator training programs. One unanticipated finding (derived from responses to “Curricular Efforts” section questions) was the use of inter-school collaborative projects as a solution to some of the identified challenges. Twelve Consortium PIs reported joining with one or more member institutions to participate in multi-site studies. Eleven Consortium PIs provided technical assistance to other PIs to share their experiences about developing and implementing cultural competence curriculum. PI respondents reported that participation in the Consortium allowed them to have a broader impact than within their own

institution, and provided a “safe” place to discuss barriers and challenges and how best to address them.

Examples of Curricular Products and Dissemination (from Responses to “Curricular Efforts” Section Questions)

Each school focused on slightly different curricular approaches. PI respondents reported the use of existing videos, websites, online curricula and written materials in their cultural competency education and training activities. All PI respondents reported creating new curricular products. For example, 13 of the 18 respondents reported creating cases or case vignettes including a textbook of cases²⁰ and an online self-study CME activity²¹. Seven of the 18 Consortium PIs developed videos or other educational tools available in MedEdPORTAL^{17,18,22–29}.

Assessment tools or performance checklists were developed, modified or validated by 13 Consortium members including those published in the peer-reviewed literature^{16,18,30}. Standardized patient (SP) formative and evaluative cases were implemented by ten Consortium PIs. Experiential learning opportunities such as in-clinic visits, community-based practicums or learning abroad programs were implemented by 13 Consortium PIs. Twelve Consortium PIs also implemented evaluations of their curricular products. Several of these products, as well as an online training module, have been highlighted on the Consortium’s (<http://culturalmeded.stanford.edu/>) and NHLBI websites (<http://www.nhlbi.nih.gov/training/>).

For example, new discussion guides were developed to accompany the PBS series “*Unnatural Causes: Is Inequality Making Us Sick?*” to better tailor the series on “upstream factors” (e.g., social, employment and civic factors) for health disparities to medical and other health professional learners (available at <http://culturalmeded.stanford.edu/teaching/unnaturalcausesresource.html>). Several PI respondents reported implementing new reflective practice and self-reflection approaches through their professionalism course content, such as the online Implicit Association Test as a trigger for self-reflection and discussion about unconscious bias and its effects on patient care (see <https://implicit.harvard.edu/implicit/>).³¹

In responses to “Curricular Efforts” section questions, PIs also reported a wide range of approaches to disseminate their curricular innovations. Six of the 18 PIs reported presenting results at international conferences, 13 at national or regional meetings, 10 reported poster presentations, and 15 gave presentations at their own institutions or as continuing medical education (CME) grand rounds. Nine of the Consortium PIs reported submitting or publishing a manuscript in the peer-reviewed literature, and 11 reported publishing other materials such as books, book chapters, casebooks or magazine articles. As a further demonstration of successful dissemination beyond their home institutions, six respondent PIs reported contributing to changes in state and local policies regarding the future of cultural competency training for health professionals by participating on committees or through consultation.

DISCUSSION AND CONCLUSIONS

Through a qualitative, descriptive inquiry among members of a national education consortium, we were able to identify the

unique barriers/challenges of curriculum development and implementation in health disparities and cultural competence. We were also able to identify successful strategies to overcome these barriers, and how a national consortium approach can help individual educators tasked with developing curriculum in these areas leverage their individual skills and experience to achieve a larger local and national impact. The insights, strategies and tactics we identified may prove useful for future efforts by these educators, and to motivate further exploration of ways to develop and support educational consortia.

Many of the usual challenges to new curricular efforts were encountered^{9-11,32,33}, including: integrating new material into a curriculum that is perceived as already full, adding curriculum work to existing duties and sustaining the new curriculum. These challenges were addressed using a variety of approaches with common principles: engage stakeholders, advocacy through participation on committees and in communities, identify funding sources and develop sustainable products.

One unique challenge to this topic area and kind of endeavor was the theme of “accessing communities and skills to engage communities.” Community connections are crucial to professional multicultural education efforts.

Traditional measures of success were reported by PIs, such as peer-reviewed publications and presentations. Importantly, with the Consortium mechanism PIs noted added positive impact from their individual and collective curricular work that included both internal and external recognition for their educational work in cultural competence through national presentations and publications, and participation on policy-making committees and as invited consultants. A surprisingly high number of shared collaborative projects across Consortium schools was identified as being one solution to some of the challenges of institutional implementation. Our study also identified key curricular products that were shared by Consortium PIs and that further exemplified the added benefits of the collaborative model.

Strengths of our current study are firstly a 100% response rate to the questionnaire, thus representing all Consortium PIs; secondly, a comprehensive and detailed approach combining quantitative and qualitative methods to collecting, analyzing, and interpreting data and curricular products. Our questionnaire, although long, was inclusive and permitted thoughtful analysis of PI responses and careful cataloging of the curricular products of the Consortium. However, this study has to be interpreted in the light of several limitations. Although a self-study, the same standard questionnaire was used to collect data from all members of the Consortium. All members were provided the questionnaire in the same manner, and all were provided the opportunity to complete the questionnaire over the telephone rather than in writing. Two respondents chose to complete the questionnaire over the telephone because of time constraints or reluctance to document challenges that they were encountering in writing. However, use of alternative modes of response eliminated non-response bias. Two coders with different backgrounds and experiences and from different institutions were used to minimize observer bias in interpreting the narrative responses. The coders adjudicated disagreements by discussion and consensus building. Using this approach we believe that the results would not have been substantially different if external coders had been used to code the themes.

The questionnaire maintained integrity and captured the desired information on the PIs experiences (face, content and construct validity); however, we did not assess reliability (repeatability), perform factor analysis or compare results to an outside source of information. Our goal was not to develop an instrument to evaluate the success and failure of the curriculum, but to assess individual and collective Consortium members' experiences developing and implementing cultural competency and health disparities curricula as a result of this training grant. Consortium members are using different curricula approaches; there is no one single curriculum to be evaluated.

Our findings are limited to institutions specifically funded to pursue curricular innovations, and represents individual and collective PI respondents' views. Thus, challenges identified may not generalize to institutions without the benefit of external funds to initiate curriculum. The 18 schools were in three different stages of implementation, and lessons learned may reflect developmental progression of curriculum implementation. We anticipate continuing data gathering to test the robustness of our findings when all 18 schools have completed their awards in 2011. It remains to be seen whether solutions derived from the lessons learned from the Consortium model promote sustainability of cultural competence curricula beyond the period of external funding and the support of individual PIs associated with such efforts.

Since 2004, state legislation mandating cultural competency education and training of physicians and other health professionals was signed into law in the states of California [CA Chapter 514 (2005 AB1195)], New Jersey (NJ 2005 SB144), New Mexico (NM 2007 SB0600) and Washington (WA 2006 SB6194). In addition, legislation recommending such education and training was signed into law in Maryland [MD Chapter No. 414 (2009 HB756)]. Other states are considering similar legislation (e.g., Arizona, Kentucky, Ohio, New York, Georgia) (see https://www.thinkculturalhealth.org/cc_legislation.asp for an update). So, in addition to federal support for cultural competency education for health professions training such as that provided by the NIH for our Consortium, policy change at the state level continues to expand to support the educational approach to addressing health disparities.

Lessons learned from a multi-school Consortium with the common goal of educational development to address health disparities in medical schools have common themes and have the potential to guide other schools engaged in similar endeavors. We conclude that the national Consortium model is a viable method for introducing educational innovation in medical schools. Among the many advantages, we have shown how the Consortium was able to provide enhanced support for individual educators and to expand the scope of impact of their individual work. This observation alone may fuel increasing interest in supporting and developing the consortium approach to medical education in this and other areas.

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