

Perspectives of Community Partners Involved in an Academic Training to Address Clinicians' Implicit Bias

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ABSTRACT

Background: Community-academic partnerships are increasingly used in interventions to address healthcare disparities. Little is known about motivations and perceptions of participating community members.

Objectives: To elicit community members' perspectives of involvement in a community-academic partnership to address implicit bias in healthcare.

Methods: With our partnering community organizer, we conducted one-on-one semi-structured interviews and a follow-up group interview with participating community members to solicit experiences about involvement in an NIH-funded clinician training; responses were organized using content analysis.

Results: Community members revealed that: their participation was motivated by trust in our community organizer; they derived personal pride from participation in clinician training; the power differential between community members and clinicians in the training environment needed to be levelled. Our community organizer noted that the benefits of community-academic partnerships propagate to the larger community via community members' experiences.

Conclusions: Community members note trust, pride, and power as important elements in community-academic partnership.

KEYWORDS: Community Engagement, Simulation Training, Healthcare Disparities, Implicit Bias, Participatory Action Research

BACKGROUND

Community-academic partnerships can give voice to marginalized stakeholders in programs to address healthcare disparities. Such partnership can integrate their unique knowledge into efforts to increase the relevance and potential impact of interventions meant to ultimately improve outcomes for vulnerable communities.^{1,2} Despite the benefits of community-academic partnerships to both community stakeholders and researchers, concerns about the challenges and burden of community participation exist.³ Little is known from the perspective of community participants about motivation and impact of participation partnerships,⁴ particularly from persons of color communities.

To give voice to community partner perceptions about engaging in a community-academic partnership to address healthcare disparities, we invited community members and our partnering community organizer in a NIH-funded clinician training program to address implicit bias in healthcare to provide reflections about their participation experience. These reflections will be of interest to academic researchers and educators interested in understanding, from the point of view of partnering community members, the motivations and benefits of forming partnerships to address healthcare disparities.

METHODS

Study Setting

This study took place at an academic medical center that is a safety net provider in Massachusetts with ~63% public-payer mix; ~43% of the medical centers' primary care patients are low income and ~27% non-white. In this setting, investigators formed a community-academic partnership to develop and implement a 3-part 'awareness, exposure and skill-building' simulation-based, intervention training to equip clinician learners (i.e. internal and family

medicine residents and DNP students) with implicit bias mitigation skills. The program was called Community-Engaged Simulation Training for Blood Pressure Control (CONSULT-BP). A key component of the training was the opportunity for clinical learners to practice communication and bias mitigating skills in case simulations with standardized patients (SP) drawn from the community who reflected the sociodemographic characteristics of the medical center's surrounding population. Simulation cases depicted hypertension management in an African American woman, a Latinx man from Puerto Rico, a Ghanaian immigrant, and a White lower socioeconomic status woman with a history of substance use disorder. **Table 1** presents a summary of the cases. Details about the training, clinical trial, and approach to community-academic partnership are reported elsewhere.⁵

Community-Academic Partnership

Role of Community Organizer. We partnered with a local community organization, the Center for Health Impact (CHI), to lead community member recruitment and advise all aspects of community involvement in the project. CHI was chosen because of their long-standing relationship with the academic medical center and community, and their deep commitment to health equity and enhancing healthcare access through education, workforce development, and language access services (e.g., medical interpretation).

Role of Community Members. Community members played two roles. First, they were paid advisors who informed the development of clinical case simulations. Second, they were paid SPs trained to portray the cases in the simulation center. SPs received training on how to act, evaluate and provide feedback to clinical learners in both one-on-one encounters and in group feedback sessions facilitated by clinical faculty. This manuscript focuses on community members' perspectives about their role as SPs.

Data Collection

To give voice to our community member partners, we used a collaborative, exploratory method that included several informal feedback meetings, one-on-one semi-structured interviews, and two formal manuscript-focused group meetings that allowed community partners to discuss their experiences with and perceptions of participation in this effort. One-on-one interviews allowed for personal reflections, while the group meetings (via teleconference due to COVID-19) allowed group discussions that were guided by the following prompts: What were your initial hopes and/or goals in joining CONSULT-BP? Were there any insights gained? What did you notice about being part of this project? Recordings and field notes allowed the research team to accurately capture the community members' voices. Responses were organized and coded using content analysis. An early draft of the results and manuscript were presented to the community members for review, validation and revision. Finally, the community organizer's team wrote reflections reacting to the community members' responses in order to contextualize and fill out the presentation of the community perspective in this manuscript. Results mostly focus on experiences of community members as SPs.

RESULTS

COMMUNITY MEMBER REFLECTIONS

Trust and Relationships Drive Community Participation

In response to the prompt "What were your initial hopes and/or goals in joining this program? ", community members discussed recruitment. Recruitment occurred through word of mouth; existing community relationships were popular methods used for recruitment. Community members' motivation for participation centered on their trust and relationship with the community organizer. Many community members and SPs joined the effort because they were a friend of one

of the community organizers. Some SPs participated because of their existing relationship with the medical center's simulation center.

Most of the community members hoped to contribute to the training of clinical learners with the goal of improving patients' experiences with medical providers. Community members from the African American case group said, "during the feedback and debrief session, we were able to teach them how to be more observant in order to provide better bedside manner and treat people from different backgrounds." A community member from the Latinx case group noted, "We were helping new providers figure out how to deal with difficult or complicated patients... From our work we can give the necessary feedback to help learners enhance their skills." Community members from the White lower socioeconomic SP case group stated, "We hope that our feedback forces doctors to reevaluate the ways their patient encounters are conducted." Community members noted the lack of diversity within the SP workforce and felt that a diverse SP group representative of the local population would better serve clinical learners.

The Community-Academic Partnership had a Personal Impact on Community Members

In response to the prompt, "*Were there any insights gained?*", community members discussed the positive impact of the program on their lives personally. Through the SP training and simulations, they expressed they had gained tools and skills that enabled them to take agency of their own health, particularly around blood pressure management, which was the clinical focus of the training. The African American case community SP group provided this sentiment: "Because of our roles as SPs, we have this newfound agency to hold nurses and doctors accountable about blood pressure taking." The Latinx SP group mentioned that they closely related to their character, and this helped them realize how important it was to listen to, and work closely with, their clinical providers to formulate a treatment plan. "Through this work we have

realized that both the patient and doctor ‘need to learn to dance together.’ The communication needs to flow effortlessly between both parties to ensure a quality and enriching encounter.”

Additionally, the community members as a whole became more aware of the nature of their interactions with their own clinical providers. They began asking more questions and felt they got more out of their appointments. They believed this would help improve their health. For the African Immigrant SP group, the concept of being able to ask questions of a clinician was a somewhat new concept due to cultural differences. Specifically, in Ghana, they expressed this notion that clinicians must have all the right answers due to their extensive schooling, so there was no need to question their treatment plan. However, “there’s this new level of thinking where a conversation needs to be had about treatment.” As a result of their partnership, the community members of the African Immigrant group realized the importance of going back into their own communities to share the skills and knowledge they acquired, particularly with recent immigrants.

Community members were proud to be part of a project geared toward helping the next generation of clinicians interact with patients from different backgrounds. They felt value in bringing their experiences and unique perspectives to their SP role. As a community member SP of the Latinx case group said, “All of us play Juan Gonzalez [SP case patient name], but we each play the character differently. Although learners may be seeing ‘Juan Gonzalez,’ they engage with each ‘Juan’ in a way that is personal and specific to the individual acting him out.” That statement reflects real-life encounters because some providers may have similar patients but interact with each one in a crucially individualized manner.

Power Dynamics Needed Intentional Levelling for Community Members to Feel Heard

In response to the prompt “What did you notice about being part of this project?”, community members provided insights into strengthening their role in the training intervention by addressing power dynamics. There was some disappointment and frustration. For example, the African American SP case group were disappointed that some learners treated their encounters as simulations and not valuable learning opportunities. One community member of the African American SP case group candidly said, “If the learners [at the time] are not trying, then why should I?” The White lower socioeconomic case group shared similar concerns, “Sometimes it seems as if learners just see Linda Roberts [SP case patient name] as a case, but they need to understand that this is real life. There are Linda Roberts out there.” According to one member of the African Immigrant case group, the hope was that practicing “on real humans with feelings will build much confidence for their work.”

Further, community members wanted to embrace the role as a teacher who provided valuable feedback to learners, but recognized the power differential between them and the clinician learners. They felt that their personal experience and information were important, but potentially missed by the learners at times. They understood the dynamic between faculty and learners and suggested that support from faculty during the group debriefing session would help drive the community members’ points home.

COMMUNITY ORGANIZER REFLECTIONS

CHI, our partnering community organizer, anchored the academic-community partnership. The CHI team led the front-line effort serving to build a crucial bridge between the community and academia by leading community engagement and driving (and informing) the work forward. Joanne Calista, CHI Executive Director and Jaenia Fernandez, Program Coordinator and Community Health Worker, described the importance of this initiative: "This work addresses

critical inequities in our community. It activates community voices and impacts not only the current and future practice of nursing and medical students, but also enhances self-reflection of learners. The PI and academic team were also open to addressing systemic barriers, and racism, in the clinical systems.”

“There were so many pivotal moments for us...particularly in hearing the feedback from the SPs. Hearing that this work has strengthened their voices and those of their families was powerful. It speaks to the additional benefits that occur in authentic, respectful academic partnerships. One of the SP's statements particularly resonated, ‘When there were problems...., Jen [the PI] and you stepped up and addressed the situation.’ *Stepping up* was not easy to do, but with the strategic intervention of the whole team, we brought the issue to light and addressed it...it was personal and professional learning for all of us.”

Nancy Esparza, former CHI Director of Health Equity and key team member, noted that “An important point of this project is that the involvement of community members [i.e. SPs] were thought of from the start as critical to the success of the project; it was not an afterthought. This project has immense potential to transform how medical professionals are trained, and to move toward enhancing the well-being of patients and our health care system.”

CONCLUSION

As the importance of community-academic partnerships grows in clinical research, it is important for investigators to understand that the success of partnerships depends on several key factors. First, inclusion of community members needs to happen from the beginning of the project and not as an afterthought. Second, trust is essential for community members to be willing to enter into partnership. Third, academic partners need to be willing to receive and respond to community feedback and to address power dynamics. When successful, community members garner personal

benefit from the partnership that extend into their local circles. Taken together, there is much to be gained at the individual, project, and scientific levels through thoughtfully executed community-academic partnerships.

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DISCLOSURES OF CONFLICT

The authors have no competing interests to disclose.

CONTRIBUTORS

JT, NE: Conception and design of study, acquisition of study data, drafting and critically revising the manuscript; JC, JF, GP, VD, JT: Acquisition of study data, drafting and critically revising the manuscript; AB, JB, AC, SD, CF, BK, LM, LN, CP, CP, LT, ST, KW, SW, PZ: conception and design of study, critically revising the manuscript.

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DISCLAIMER

The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

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Table 1. Summary of Standardized Patient Cases in the CONSULT-BP Project

| Standardized Patient Case Profile | Brief Case Summary |
|--|---|
| <p>“Juan Gonzalez” 55-year-old Latino Male with poorly controlled hypertension</p> | <p>Case profile describes patient with history of non-adherence to medication due to side effects, persistent elevated blood pressure with occasional headaches.</p> |
| <p>“Kwame or Ama Amoah” 34-year old Ghanaian man or woman with hypertensive urgency</p> | <p>Case profile describes patient with a history of elevated blood pressure and headaches concerning for hypertensive urgency. In addition, they recently immigrated from Ghana and new to the healthcare system. Treatment options include possible referral to the emergency department.</p> |
| <p>“Phyllis Jones” 70-year-old African American woman previously diagnosed hypertension</p> | <p>Case profile describes patient who believes that the blood pressure medication is not working despite strict adherence to medication regimen. She is concerned that the generic medication is not as effective as the brand name medication.</p> |
| <p>“Linda Roberts” 50-year-old White woman receiving Medicaid with a history of hypertension</p> | <p>Case profile describes patient with a history of a history of hypertension but has not seen her provider for several years. She had recently lost consciousness at work, was evaluated in the emergency department, and requires medical clearance from her primary care provider to return to work. There are several social stressors that affect Linda’s life and ability to adhere to visits, including work, finances, and family issues. She also has a prior history of drug use.</p> |