

# Examining Student Preparation for Advancing Care in a Diverse Society: A Qualitative Study on Curricular, Clinical, and Cocurricular Alumni Experiences

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**NLN Education Summit 9/29/2023, Washington, D.C.**

**Disclosures:** This study was supported by a seed grant from MGH IHP School of Nursing, Office of Research, Charlestown Navy Yard, Boston MA.



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# Background

- ▶ Race and bias have been shown to be contributing factors of racial health disparities.<sup>1</sup>
- ▶ In 2008, the American Association of Colleges of Nursing (AACN) challenged nursing institutions to develop curricula to reduce health disparities for minoritized populations.<sup>2</sup>
  - ▶ More specifically, to achieve goals of eliminating health disparities and achieve health equity, the AACN has charged schools of nursing to “improve the quality of education by enhancing the capacity of academic nursing to maximize learning opportunities and experiences for students and faculty, alike, which depend in significant ways on learning from individuals with diverse life experiences, perspectives, and backgrounds.”<sup>3</sup>



# Purpose

- ▶ To understand the preparedness of Nursing graduates of a school in the Northeast United States, to advance care in a diverse society, and to address the American association of College of Nursing (AACN) mandate of 2017 on enhancing diversity and inclusion.<sup>3</sup>
- ▶ To better understand the strengths and gaps in their educational preparation as health professionals and use these data to inform policy and practice for preparing nursing students to work effectively with diverse patient populations.



# Research Questions

- ▶ What are the curricular, clinical, and cocurricular experiences of nursing alumni in relation to preparation for advancing care in a diverse society?
- ▶ How do nursing alumni make sense of their curricular, clinical, and cocurricular education experiences as it relates to advancing care in a diverse society?



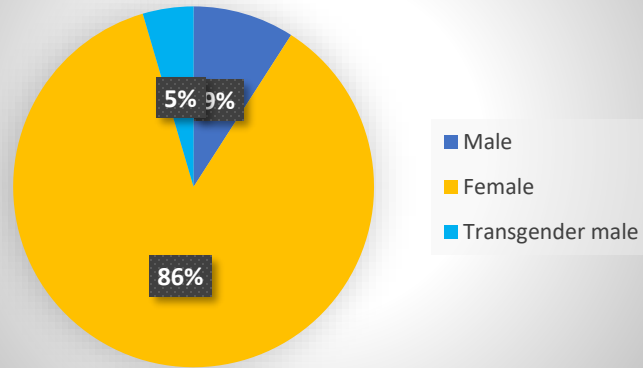
# Research Methods

- ▶ Qualitative research methods
- ▶ Criterion sampling<sup>4</sup>
- ▶ Semi-structured interviews (30-90 minutes)
- ▶ Interviews transcribed using Microsoft Express Scribe
- ▶ Analyzed using Nvivo
- ▶ Audit trail and peer debriefing

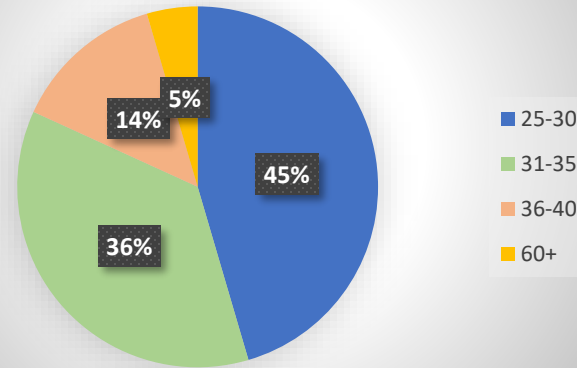


# Sample Descriptives, N=22

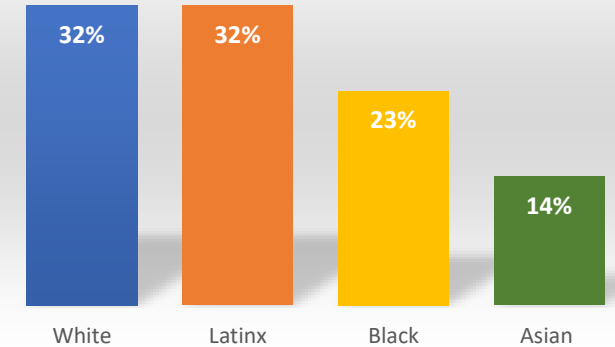
## Sex



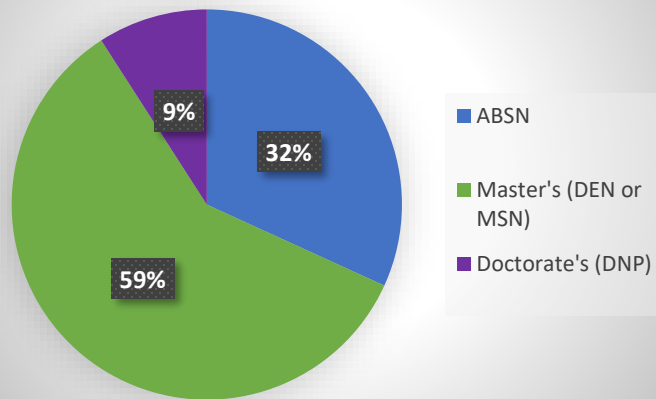
## Age



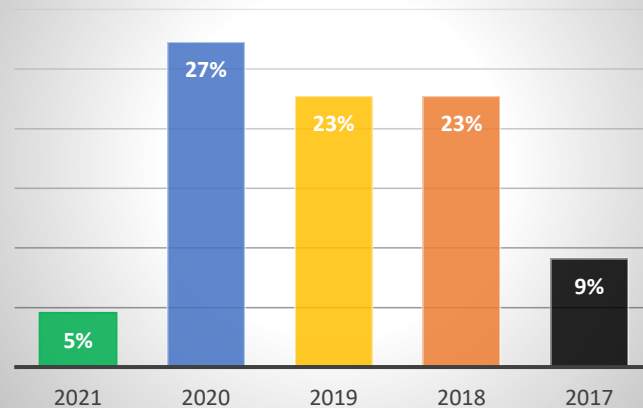
## Race



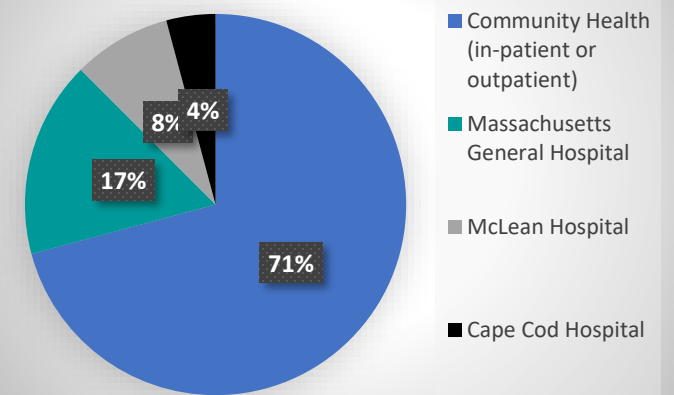
## IHP Degree Program



## Graduation Year



## Location of Current Work



# Sample Descriptives

Demographics	N= 22
<b>Sex</b>	
Male	9%
Female	86%
Transgender	5%
<b>Race</b>	
White	32%
Latine	32%
Black	23%
Asian	14%
<b>Age</b>	
25-30	45%
31-35	36%
36-40	14%
60+	5%

Demographics	N=22
<b>IHP Degree Program<sup>a</sup></b>	
ABSN	32%
Master's (DEN or MSN)	59%
Doctorate's (DNP)	9%
<b>Graduation Year</b>	
2021	14%
2020	5%
2019	23%
2018	23%
2017	9%
<b>Location of Current Work<sup>b</sup></b>	
Community Health(in/out- patient)	77%
Massachusetts General Hospital	18%
Local Non-diverse Hospitals	14%

<sup>a</sup> Rounding approximation may not add to 100%; <sup>b</sup> multiple responses possible

# Findings: Major Themes

- ▶ Diversity representation
- ▶ Diversity training
- ▶ Mental health
- ▶ Language competency & interpreter services
- ▶ Pros and Cons of IMPACT
- ▶ Pros and Cons of co-curriculars





# Diversity Representation

## Need more minority representation across the institution and healthcare field:

- “Nursing is also a very White dominant profession... presenting themselves like in that community as a school that’s... more welcoming or presenting more opportunities for like students of color.”
- “I feel like a lot of our diversity classes are taught like from White people to White people.”
- “I was one of three people that were Indian and maybe one of ten Asian students in a program of over 100. That sometimes was a bit jarring.”
- “I am not saying White men make bad leaders... I am saying that there are other types of leaders out there as well, so we should be open to diversifying the leadership.”
- “There have been studies that prove like when your healthcare provider looks like you, there are better health outcomes, and so I think that’s important on to recruit, and make students of color feel like, you know this is a place that they can be and feel welcome.”

## Diversify simulation lab and case studies:

- “More diversity with the simulation mannequins... it was always the same type of patients during sim... If not in actual clinicals, at least in sim class, switch it up a little better.”
- “Case studies that incorporated more diverse populations, so you know, on LatinX families, or African American families, including cultures into these case studies.”

## Diversify clinical placements:

- “I feel like I was in the hospital the entire time, and I knew I was never going to do bedside nursing. It was helpful I think maybe just to pass the NCLEX, but it wasn’t necessary to do so many clinicals in the hospital.”
- “A lot of clinical placements were at MGH...its not a community health center so you don’t often see patients of underserved or minority backgrounds.”
- “More community health clinicals or more or try to get more patients from different backgrounds where we may need to use an interpreter or address the cultural barriers that might be one of the things we need to address. The IHP could have probably done better in that sense.”



# Diversity Training

## Implicit bias training:

- “How do you deal with instances where like the patient, didn’t want you as a nurse, and how do you, like how you were asking, how do you deal with your own personal biases, how do you deal with, what is the right way to process that if something happens in that way?”
- “I think it’s a challenge for each individual professor to challenge their own thinking around it because if you grew up and were educated in the US, to some extent, you were taught White as default, and especially White male as default. And you just have that initial bias about how you think about things.”
- “I am like many White people... “I am a completely unbiased person”, and you know, I really had to kind of think through things in a very different way. We can’t just look through this White lens... They may need something totally different that we haven’t thought of so how do we bring that into treatment.”
- “I think it’s more like the implicit biases and racism, and kind of like treating the students the same. And that goes for the students too, I think important to have those types of trainings for students to.”

## Clinical preceptor training:

- “I think just maybe finding some additional resources for preceptors.”
- “There was a psych clinical instructor the first semester who wouldn’t even pronounce my classmate’s names. Oh, that’s too hard.”

## Training built around cultural competency and cultural humility:

- “I don’t even know that I am 100% culturally competent in the culture that I grew up in because we are in the United States, but I think that having cultural humility, and just being able to recognize that everyone who you come across, has a different way of dealing with their own culture. Even if two people from the same exact place in the same exact same household, they identify their culture differently.”
- “I feel like you learn it in a power point...but then what you actually do with? How do you put that into practice? So, I think there could have been more effort definitely made to address cultural competency and see it in practice.”
- “I am White girl from rural America. I didn’t see a lot for a long time, so I am catching up, but it’s a steep learning curve, and it feels really uncomfortable sometimes.”
- “You’re going to be treating a variety of people. You are going to be encountering a variety of situations, and some maybe uncomfortable, and [learning] how to get comfortable with uncomfortable situations.”



# Mental Health

## Mental health training for all:

- “I got an hour or an hour and a half lecture on what is trauma informed care. I struggle with where I meet new patients every single day, and 95% of them have a very significant trauma history, and it’s essential for a psychiatric diagnostic evaluation to assess that trauma history.”
- “I think it would have been helpful to have maybe a little bit more cross pollination between psychiatry, which is kind of like it’s on discipline, and more of like the medical and primary care... knowing how to work with patients who are like very seriously mentally ill.”
- “They got a grant for us to do buprenorphine training... they taught us how to prescribe it to different populations of people, but not the types of people you run into, and like what situations you know, you, come across when you are prescribing to people who need buprenorphine. These are people who have a lot of trauma, and they don’t actually give you a sit down about like this is how you can do this visit appropriately.”

## Increased need for mental health services:

- “COVID has made mental health access, just as everyone knows, just horrific...what we’re finding is, you know, everyone is in crisis rightfully so right now, or just dealing with their mental health issues that they had pre-COVID, and we as PCPs are being asked to act as what, a [psych NP’s job is] which I am not qualified to do.”
- “I think COVID has added a layer or trauma for at least our patients, for everyone, not just our patients.”
- “The social workers that we do have... they’ve been overwhelmed, especially with the pandemic, the need is a lot higher, so it’s a work in progress, but that’s still like the biggest barrier, and that’s causing an increase in depression, and anxiety in a lot of patients that originally had it or had it under control or new anxiety, and depression.”
- “Because that’s the real-world example of the patient who gets admitted to the hospital for X, Y, Z, and then it ends up being psych related, and I have to prescribe the medications until we can find them a psychiatrist. So, I am not prepared for that.”



# Language Competency and Interpreter Services

## Interpreter services training:

- “When you need to use an interpreter, it is going to take longer to provide good care because of that. Like, how are you going to plan for that in your day when you’ve got 20 patients on your list, and you have to see everyone? Like how do you handle that and still give good care, not in a theoretical sense where here we have all the time in the world to debate what this is, but when it’s real?”
- “I feel like a lot of people don’t use the interpreter; it adds a lot more work or adds more to my workload already. It’s hard when you are a patient that does not understand the language, or what’s being done, it can be scary, and it shouldn’t be hard for us to use interpreter services or find ways to really communicate with the patient to understand them.”

## Importance of basic language competency:

- “I think what would be amazing is to somehow build it into the curriculum... taught us some of the words... that are medically inclined... pain, safety... and the person came in and only spoke Swahili, you can say “hello, or I am here to help you, are you okay?” I think that could go a really long way.”
- “I wish that I learned a second language a long time ago. We have a fair amount of Spanish speaking patients, and we have a fair number of Brazilian, Portuguese patients. It would have been helpful if I had, you know, and again, I wouldn’t have to be fluent, but just have some like basic medical words or phrases, that I think would have gone a long way to help build rapport, especially in the beginning with patients.”
- “I learn one Portuguese word and I go in, and I tried my best at saying it, they’ll laugh at me, they will definitely laugh at me. “ Oh wow, she tried,” you know what I mean?”



# Pros and Cons of IMPACT

## Provided multi-perspective training:

- “IMPACT yes, it wasn’t the most impactful, but I think the most important aspect for me at least being able to communicate with the other members and talk about what they were doing... how if we work collaboratively on one patient, what we can do to together, how we can work together, how we can use each other’s skillset. That was extremely important.”
- “I think it was good for practicing how to coordinate care. That the patient is not just dealing with medical issues from my perspective, it’s from a variety of different perspectives.”
- “I remember there being an emphasis on interprofessional [collaboration], and working with other doctors, and PTs, and that has been a big part of what I have to do as a nurse. I think emphasizing that is obviously a good thing.”
- “We had people from the community come in who were affected by aphasia either through a stroke or something like that, and it was local people in the community. I really liked that because you got to engage with people from different backgrounds who were all coming together because of one reason.”

## Poorly integrated into the curriculum:

- I felt like IMPACT was a lot of busy work. I think there is value in it, and I am not really sure how you do it without it feeling so forced, especially in the first semester. “Oh, you’re supposed to talk about what you can bring, what your discipline can bring to the table.” I am like, “I am just learning what my discipline is, and I am trying to figure out what nursing is, I don’t know how this all fits together”, I don’t think we had enough context for it.”
- I also don’t think I got a good sense of like what the other disciplines really do through IMPACT. Like I kind of know what a PA is, and I kind of had a sense of what a PT was, but like I didn’t understand that I would have a lot of interaction with occupational therapist in in-patient mental health. That would have been good to know, but I didn’t know what a lot of SLP did either, and I don’t think that I learned in IMPACT.”
- “IMPACT was, we knew we had to do it. We checked the box, and no one took it seriously. It needs to be thoughtful in terms of how it’s integrated, the central part of it, not ancillary.”





# Pros and Cons of Co-Curriculars

## Crimson Care Collaborative, Interprofessional Dedicated Education Units (IPDEU), and health disparities lectures helpful for diversity training:

- “I was also part of Crimson Care Collaborative or CCC, which was also extremely valuable for my knowledge base and my experience to be able to work in the diverse population that I am in right now.”
- “Crimson Care Collaborative... I feel like getting experience through that helped me easily transitioned into working in community health.”
- “I was involved in IPDEU. For example, a nursing student would pair up with speech language pathology, or a medical student, or an OT or PT student, and we would go to MGH, and like, you would spend time with someone from a different profession who is working there, and shadow them, and see what they do. I really liked that because it shows you how these different professions can rely on each other and work together.”
- “I have a deeper understanding of like, okay, if I have, if this is happening to my patient, what services are available, and like speech language pathology is more than just a swallow test.”
- “I remember one where a lady came in and she was talking how African American women die at significantly higher rates... African American women don’t have like pleasant experiences with healthcare in terms of childbirth... You know the statistics, but then how she was able to present it, and I was like, “this could happen to me.” So, that was, like wow!, and I think that started a lot of conversations about, “okay, how do we interact with people really as healthcare providers?”
- “You go into clinical practice and then you still see, GFR adjusted for African Americans. I think that just reflects there is still not a good, still don’t have good answers for these. Um, I remember that lecture being transformative.”

## Low student engagement:

- “Opportunities, groups to join, none of that so it was a real disconnect in our [DNP] program with that because we didn’t really know anything that was going on. My husband happened to be in the PA program at the same time that I was in the doctorate program so that’s how I knew about things that were happening but otherwise, I mean, it wasn’t mentioned to us at all.”
- “I did a lot of studying, and I didn’t live like close so when they were doing things, I had a class or something... I knew they were there, but I did not participate.”
- “There was absolutely no way that I could have extended myself beyond what we were already doing to get involved with anything outside of what I already had, you know, kind of on my plate.”
- “It was harder for me; it was harder to make a connection with school because you know it’s so fast.”



# Limitations

- ▶ In terms of participant outreach, we received a stronger interest in participating in the study from White alumni as compared to minoritized alumni.
- ▶ We did not interview current students after we have made some changes to the curriculum and academic preparation as it relates to racial equity, though their insights may be useful.



# Discussion & Recommendations

- ▶ Our research outcomes guide the following recommendations to design a culturally appropriate curriculum, teaching and learning that addresses issues of racism, justice, equity, diversity, and inclusion (JEDI):
  - ▶ Recruit more students, faculty, and staff, including leadership staff of color at the IHP
  - ▶ Provide adequate diversity, implicit bias, and mental health training to faculty, staff, and students and require recertifications annually
  - ▶ Ensure all students obtain a diverse set of clinical placements, including those encompassing the Mass General Brigham network, community health hospitals (e.g., Shattuck, Cambridge Health Alliance, Boston Medical Center, Spaulding, etc.) as well as outpatient community health centers (e.g., Roxbury, Charlestown, Chelsea, etc.)
  - ▶ Shift IMPACT to later semesters will serve to be more impactful to prepare students to advance care in a diversity society as students will have had adequate exposure to their respective fields of study.
- ▶ This study has implications for policy, curriculum innovation and clinical practice to better prepare students to advance care for a diverse society.



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