Global Advances in Integrative Medicine and Health
Volume 14: 1–8

DOI: 10.1177/27536130251315079
journals.sagepub.com/home/gam
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Advancing Health Equity in Integrative Health: The Role of Collaborative Educational Partnerships in Addressing Structural Racism

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Abstract

Background: Integrative Health (IH) professional organizations are responsible for advancing health equity and addressing structural racism.
Objective: The Academy of Integrative Health and Medicine (AIHM) partnered with the University of Miami Miller School of Medicine to co-create a longitudinal curriculum for its board and staff to address structural racism and health equity in IH.
Methods: We administered a 2-phase curriculum addressing health equity in IH. We evaluated the curriculum with pre & post-surveys of knowledge, attitudes, skills, and behaviors and conducted a qualitative analysis of open-ended questions and personal reflections.
Results: Thirty one respondents took the pre-training survey. The mean knowledge scores for each seminar improved. Qualitative analysis revealed that participants grappled with the pervasiveness of racism and bias engrained within health care.
Conclusion: This curriculum serves as a valuable model for IH professional organizations aiming to address their role in disrupting the effects of racism on health outcomes.

Keywords

health equity curriculum/education, cultural humility, cultural appropriation, structural racism, integrative health

Received September 11, 2024; Revised December 3, 2024. Accepted for publication January 2, 2025

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Introduction

Health care professional organizations are responsible for advancing health equity and educating their leadership and constituents on the impact of structural racism. Structural racism, the normalization and legitimization of historical, cultural, institutional, and interpersonal dynamics that consistently benefit White individuals, has led to cumulative and chronic adverse outcomes for people of color.[1] This responsibility also holds for integrative health (IH) professional organizations.

Integrative Health (IH) aims for well-coordinated care among providers and institutions by combining conventional and complementary approaches to care for the whole person. IH fosters healing environments, offering a unique opportunity to address health disparities by prioritizing whole-person care, empathy, and trauma-informed approaches.[2] The growing demand for integrative therapies, from 19.2% to 36.7% between 2002 and 2022,[3] underscores the need for providers to deliver equitable care to an expanding patient population. To fully realize this potential, IH providers must actively combat structural racism and address their implicit biases and their impact on health care delivery. Furthermore, IH professional organizations must also be united in their organizational responsibility to deliver on this goal.

The Academy of Integrative Health & Medicine (AIHM) is a unique organization because it supports organizational membership and individual members. At the organizational level, it supports the member institutions in advancing integrative and whole health globally. The board and staff at the AIHM play critical and complementary roles in shaping the organization's mission, strategic direction, and operational priorities. Staff members are responsible for implementing the organization's vision and policies in day-to-day operations and programs.

In 2021, AIHM developed institution-wide strategic priorities placing health equity at its center, with an initial goal to train the board and staff in understanding and addressing racism and championing health equity. Existing training in racism often focus on the interpersonal level without adequately addressing structural racism and its impact on traditional practices most applicable to IH.[4,5] These programs usually do not describe the organizations' engagement in co-creating and implementing the curriculum. Alberti et al. (2018) suggested that academic health centers integrate their local community health needs into their curricula to enhance the effectiveness of their initiatives to promote social justice and health equity.[6] Racial equity training is likely more effective when the academic institution works collaboratively with the organization and individuals receiving the training to understand their needs and incorporate suggestions.

AIHM partnered with the University of Miami Miller School of Medicine (UMMSM) to co-design and implement a longitudinal training program in racial and health equity in IH. This paper outlines the design of a health equity curriculum explicitly developed for the IH community and discusses the program outcomes from its first cohort. Through this training, specific efforts are made to decolonize and improve health equity with an integrative lens.

Methods

Study Design

Leveraging our team's expertise in adult learning, clinical care, community engagement, organizational change, and anti-racism, we applied Kern's six-step model[7] to design the curriculum in 2022 (Figure 1). As an interprofessional organization, AIHM is uniquely positioned to advocate for health equity within the broader IH community. AIHM hosted virtual listening sessions to engage community voices and develop key topics for educational development. The domains of the training objectives included cognitive (knowledge), affective (attitudinal), and psychomotor (skill/behavior). The graphic below lists the goals and objectives for the overarching health equity within the integrative health curriculum. Objectives 1 & 2 are dedicated specifically toward understanding structural racism and colonialism as these are foundational to understanding the landscape of the current environment. Objectives 3 & 5 are designed to foster personal transformative change to support health equity. Objectives 4 & 6 are more specific to the Integrative Health community. Each session included multiple sub-objectives. The sub-objectives specific to Integrative Health include:

- Recognize the role of colonialism and imperialism in shaping and exploiting traditional health practices within IH.
- Understand the significance of interprofessional equity and the negative impact when not all disciplines in IH are afforded the same recognition within the IH community (resources funding, certification, etc.).
- Acknowledge the negative impact of requiring certification and licensure of traditional practices, which can present additional obstacles for community and cultural practitioners.
- Become familiar with the consequences of the Flexner report on narrowing the breadth and opportunity of Medical Education for Black, Indigenous, and communities of color.
- Realize that cultural appropriation is widely present across multiple integrative practices within the wellness and health care industries and actively strive to address the erasure and theft of Traditional Knowledge for profit.
- Recognize the exploitive and extractive practices of the nutraceutical and supplement industry.

The curriculum involved synchronous and asynchronous learning using the structural competency approach to explore potential topics and teaching methods.[8] We tailored our teaching strategies to adult learners, including problem-solving cases, real-life application of ideas, and collaborative learning opportunities.[9] We also include personal reflection and exploration as a component of this learning journey.[10]

The curriculum consisted of 2 phases: The Learning and Exploration Phase and The Real-World Application

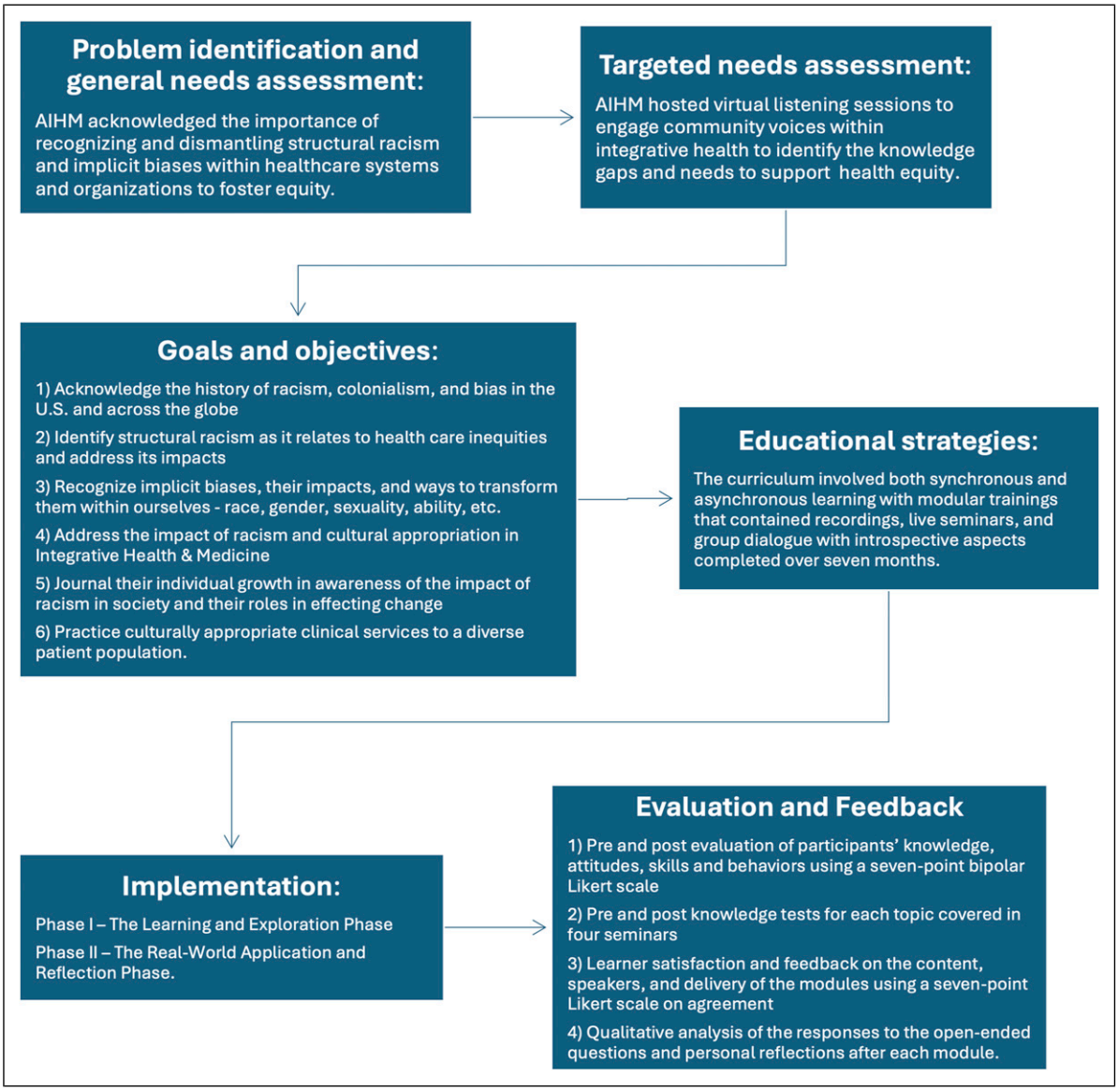

Figure 1. Kern's six-step model applied to the racial equity curriculum.

and Reflection Phase. During Phase I, 4 subject experts from UMMSM led 4 50-minute live seminars with pre-reading, followed by a 40-minute circle dialogue. Phase II comprised 2 monthly Zoom sessions led by the project leaders and 1 final in-person session with article discussion, case study, and circle dialogue. The evaluation of the curriculum included:

1) Pre- and post-evaluation of participants' knowledge, attitudes, skills, and behaviors related to racism and implicit biases using a seven-point bipolar Likert scale ranging from strongly disagree (1) to strongly agree (7)–Kirkpatrick level 2 (learning) and level 3 (behaviors).
2) Pre- and post-knowledge tests for each topic covered in 4 seminars–Kirkpatrick level 2 (learning).
3) Learner satisfaction and feedback on the modules' content, speakers, and delivery using a seven-point Likert scale –Kirkpatrick level 1 (reaction).
4) Qualitative analysis of the responses to the open-ended questions and personal reflections after each module–Kirkpatrick level 4 (results)

Data Analysis Approach

We collected data using Qualtrics, a secure, web-based application managed by our university. Our mixed methods approach included (1) quantitative analysis using R software for reporting descriptive statistics and results of the paired t-tests for pre- and post-comparisons and (2) qualitative analysis using NVivo software based on best practices in

grounded theory examining emergent themes from the data. The University of Miami Institutional Review Boards approved the study as exempt.[a]

Results

Thirty-one respondents took the pre-training survey, with a higher proportion of female respondents (80.6%, n = 25) than males (19.4%, n = 6). Most participants identified as White (58.1%, n = 18). 64.5% (n = 20) of the respondents reported having taken diversity training previously, and 64.3% were practitioners (n = 18 out of 28 valid responses).

The mean knowledge scores for each seminar improved; however, from paired t-tests, only the May session showed significant improvement in participants' scores (N = 15, P = .008, t = −3.108). Except for the question, "I am confident in my ability to deliver equitable care to diverse patient populations," participants demonstrated significant improvements in each curriculum evaluation statement (Table 1).

The participants' mean level of satisfaction with each live seminar facilitated by subject experts ranged from 6.00 to 6.95 (1 = strongly disagree, 7 = strongly agree). The participants' mean level of satisfaction with the 2 Zoom sessions ranged from 5.83 to 6.50 (Appendix 1).

Qualitative Results

After each session, participants were asked to take a Qualtrics questionnaire with 5 open-ended questions. They also answered reflection questions at the end of each phase of the curriculum (Appendix 2). Five themes emerged:

1. **Training Effectiveness**: A common theme throughout the qualitative data was participants' perceptions that the training was effective, with the following emergent subthemes: "Increased understanding of racism and the implicit biases they unconsciously possess," "Confronting racism and bias," and "Tools and resources." Participants indicated that the training renewed their commitments to anti-racist and anti-bias work. They mentioned that they would apply the information provided during the training to their practices, teaching, and daily lives.
2. **Concepts Learned**: Participants were asked to list concepts learned during the training. The most common concepts learned were cultural appropriation (n = 23), racism (n = 18), and bias (n = 10). Participants described cultural appropriation as pervasive in the field of IH. Often, participants expressed a desire to engage with diverse cultural practices in respectful and valuable ways.
3. **Racism and Bias in Society**: Participants grappled with the pervasiveness of racism and bias engrained in society in the United States. Participants recognized that structural racism is the result of past and present policies creating systems that reinforce harmful biases and outcomes. They commented on the pervasiveness of these issues in the U.S. health care system and their impact on health outcomes. Bias, mainly implicit or unconscious bias, was discussed as capable of adversely affecting patient outcomes.
4. **Confronting Racism and Bias**: Participants expressed increased commitment and awareness of the need to end racism and bias in the health care system. Certain participants believed that this work begins with the individual. Others noted that collective voices in the medical community are equally important. Participants gained insight into ways to confront racism and bias and desired to evaluate their implicit bias as a starting point. Participants also highlighted the necessity and difficulty of taking this work from a personal to a structural level.
5. **Common Needs**: Throughout the training, participants reflected on their work within settings (eg, health care systems, classrooms, research labs, and medical practice) that have historically and currently been rooted in racist, biased, and culturally appropriative norms and environments, particularly within the field of IH. Three common needs were expressed: do the hard work, promote dialogue and conversation, and cultivate empathy.

Discussion

Participants in the racial health equity curriculum noted heightened awareness of systemic racism and implicit biases. They gained knowledge and tools learned to combat structural racism at both individual and institutional levels. They felt "inspired to do more," became more aware of critical issues of racism and bias, and expressed optimism about receiving concrete strategies, language, and toolkits for addressing these societal and interpersonal issues. Participants intended to apply the training content to their practices, teaching, and daily lives.

We found no published study on a longitudinal racial health equity curriculum related to IH health care professional organizations. The multimodal nature of the curriculum, which includes pre-reading, didactics, circle dialogues, small-group activities, and reflections, is unique and appeals to various learning styles. Our curriculum guided participants from awareness to knowledge and to take ownership in creating an anti-racist environment of learning, working, and living.[13] We attribute these positive outcomes to our focus on the history and current impact of racism, colonialism, and bias, as well as content relevant to IH, including cultural intelligence and cultural appropriation. Opportunities for circle dialogue, breakout discussions, real-life applications, and self-reflections further enriched the experience. The close partnership between AIHM and UMMSM ensured content relevancy and participant engagement.

Limitations of this study include the need for a control group and the reduction in participation and survey

Table 1. Curriculum Pre and Post Evaluation and Knowledge Pre and Post Test.

Variable	Pre-curriculum/session M (SD)	Post-curriculum/session M (SD)	Difference M	*P*	95% CI
Overall curriculum evaluation (n = 10)					
1. I know what to say when interacting with people from different races and cultures	5.3 (1.2)	6 (0.67)	.7	.04*	−1.4 to −.02
2. I am aware of the specific obstacles that many patients from underrepresented groups have in accessing equitable health care	5.3 (1.3)	6.2 (0.6)	.9	.04*	−1.8 to −.04
3. I am able to recognize biases and stereotypes towards patients in integrative health and medicine	5.2 (1.4)	6 (1.2)	.8	.04*	−1.5 to −.06
4. I have a sufficient knowledge about implicit biases	4.1 (1.7)	5.8 (0.6)	1.7	.008*	−2.8 to −.58
5. I understand the impacts of implicit biases on health care disparities	4.7 (1.3)	6.2 (0.4)	1.5	.003*	−2.3 to −.66
6. I am able to integrate my knowledge of bias into my work/clinical practices	4.9 (1.4)	6.4 (0.8)	1.5	<.001**	−2.0 to −.10
7. I am confident in my ability to deliver equitable care to diverse patient populations	5 (1.4)	6.3 (0.5)	1.3	.08	2.1 to .15
8. Personal reflection and journaling help me grow as an inclusive informed person	-	6.7 (0.7)	-	-	-
Knowledge test scores					
Mar (n = 21)	2.8 (0.5)	2.9 (0.4)	0.1	.16	−.23 to .04
Apr (n = 16)	4.12 (0.7)	4.38 (0.7)	0.3	.10	−.56 to .06
May (n = 15)	1.13 (0.8)	2.07 (1.0)	0.9	.008*	−1.58 to −.29
Jul (n = 17)	1.59 (0.6)	1.71 (0.7)	0.1	.43	−.43 to .19

Notes:
1. * indicates $P < 0.05$, **$P < 0.01$ for a two-tailed test.
2. Abbreviations: M, mean; SD, standard deviation.
3. The pre and post curriculum evaluation was rated based on a seven-point bipolar Likert scale ranging from strongly disagree (1) to strongly agree (7).
4. The knowledge test scores were based on the correct answers the participants provided. Four seminars have knowledge test questions with a number ranging from 3 to 5 questions.
5. In addition to paired-sample *t* test, we also ran Wilcoxon rank-sum tests in case the data were not sufficiently parametric due to the small sample size, but the findings were consistent across both methods.

completion over time as it occurs in longitudinal studies. Two key factors influenced the reduction in survey response rates over time: (1) personnel changes and (2) survey reminder frequency decreased over time. This likely contributed to fewer participants completing all surveys, as the lack of follow-up may have led to a decline in engagement with the survey process. Allocating time at the end of each session to complete evaluations could mitigate this issue. Notably, some participants required additional time and space outside the formal curriculum to process the emotional gravity surrounding the subject matter. Only 1 session showed significant improvement in participants' knowledge scores. However, we noted that the mean scores for the March and April sessions were high at baseline. This may be due to many participants (64.5%, n = 20) receiving relevant training elsewhere.

The IH community represents a broad network of practitioners facing varying structural barriers, challenges, and biases regarding health equity within their healing traditions. Dedicated and ongoing efforts are required to support equity within IH. While the virtual format enhanced participation, allowing attendees from across the United States to join the final session in person facilitated a successful conclusion.

Lessons Learned and Future Goals

Lessons learned from this pilot project may be used to improve the dissemination and adoption of a health equity curriculum specific to IH. These include:

1) Prioritizing a community-building exercise in the first session to build trust and psychological safety among participants. This is vital in all equity work to support deep, meaningful discussion and reflection.
2) Prioritizing small-group discussion and reflection segments over didactic time, as our participants found these highly valuable.
3) Providing a more conversational summary of academic papers and case studies to improve accessibility and retention of the concepts taught in the pre-session readings.
4) Offering separate sessions for practitioners and administrative staff members to ensure each group can engage in conversations relevant to their roles and challenges within the organization.
5) Setting aside extra time for participants to process how the material relates to their own lives and to engage in the deep emotional work of antiracism.

Given the mission and vision of AIHM, it is uniquely positioned to advance racial health equity within the broader IH community through innovative curricula. Ongoing reinforcement is essential for significant knowledge gains on this complex topic. Future implementations could incorporate additional brief, frequent check-ins to reinforce key learning points. This health equity curriculum serves as a valuable model for health care professional organizations aiming to reflect on and address their role in identifying and disrupting the effects of racism and implicit bias on health outcomes.

Going forward, this training would incorporate updates based on the lessons learned and participant feedback. We envision the larger IH community members, clinicians, administrators, educators, and patients/clients benefiting from this training. The broader impacts we hope to achieve through this training are multi-layered:

A. Organizational Transformation: A deeper awareness of structural racism among the board and staff will lead to meaningful changes in AIHM's policies, programs, and practices.
B. Improving Health care Outcomes: By equipping AIHM's leaders with this knowledge, the aim is to influence how the organization promotes integrative health practices, ensuring they are accessible, culturally responsive, and attuned to the needs of diverse populations.
C. Sector-wide Influence: As a leading organization in Integrative Health, AIHM has a unique platform to set an example and advocate for equity across the industry. Training the board and staff in structural racism gives them the language, understanding, and commitment to engage in dialogues and initiatives that challenge inequitable practices within the larger health care landscape.
D. Sustained Engagement and Accountability: Finally, this training is just the beginning of a sustained journey for AIHM in pursuing anti-racist work. By building this foundation, it is better positioned to hold itself accountable, measure progress over time, and continuously improve its commitment to equity, diversity, and inclusion.

Appendix

Appendix 1 Additional Tables

1. Participant Demographics (n = 31)

	% (n)
Gender	80.6% (25)
Female	19.4% (6)
Male	
Ethnicity	
White	58.1% (18)
Black or African American	3.2% (1)
Hispanic/Latino	12.9% (4)
Asian	9.7% (3)
Other	16.1% (5)

2. Session Evaluation Results

Variable	Mar M(SD) (n = 27)	Apr M(SD) (n = 21)	May M(SD) (n = 22)	Jul M(SD) (n = 22)	Aug M(SD) (n = 12)	Sep M(SD) (n = 8)
The presenter has a strong fund of knowledge	6.89 (0.32)	6.95 (0.22)	6.73 (0.70)	6.64 (0.58)		
The information presented was very helpful	6.59 (0.64)	6.90 (0.30)	6.50 (0.86)	6.68 (0.65)		
The facilitators created a comfortable space for conversation	6.63 (0.63)	6.48 (1.17)	6.27 (0.94)	6.73 (0.88)		
Overall, the learning module was excellent	6.37 (0.84)	6.90 (0.30)	6.09 (1.15)	6.59 (0.96)		
This training is an effective way to teach people about racism/bias	6.37 (0.74)	6.29 (1.19)	6.09 (1.15)	6.50 (0.80)		
Overall, I enjoyed the training	6.48 (0.64)	6.71 (0.46)	6.27 (1.20)	6.59 (0.96)		
I would recommend this training to a colleague	6.37 (0.88)	6.52 (0.98)	6.00 (1.27)	6.64 (0.66)		
The facilitators created a comfortable space for conversation					6.42 (0.67)	6.50 (0.76)
The group reflection/circle dialogue was helpful for your personal exploration and growth					6.00 (0.74)	6.38 (0.92)
Listening to the implementation experiences of the participants was helpful for your personal exploration and growth					5.83 (1.04)	6.25 (1.04)
The presenter has a strong fund of knowledge					6.42 (0.67)	6.50 (0.76)

Notes: M, mean; SD, standard deviation.

Appendix 2

Five open-ended questions (after each speaker seminar and each facilitated Zoom call session)

1. What is the single most important concept that you learned today?
2. How will the discussion from today inform your thinking about racism/bias?
3. How will the discussion from today inform your practice of integrative health and medicine?
4. What specific feedback do you have for the presenters/facilitators (for Zoom call sessions)?
5. Other comments?

Reflection questions (at the end of phase I and phase II of the curriculum)

1. Please list 2-3 important concepts that you learned so far
2. So far, how have the training program impacted your thinking about racism/bias? Can you share some specific examples?
3. So far, how have the training program impacted your practice of integrative medicine?
4. How do you anticipate this training program will impact your work/practice of integrative health and medicine?
5. How do you foresee the knowledge gain from this training to impact your future work/practice of integrative health and medicine?

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by the Academy of Integrative Health and Medicine.

Ethical Statement

Ethical Approval

This study was approved by the University of Miami Institutional Review Boards (IRB Number: 20220131) on March 3, 2022.

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Note

a. For the qualitative component, the July subset of data were independently coded by 2 trained coders,[11] with an initial ICR of 0.68 denoted 'substantial reliability'.[12] Next, the coders came to a "negotiated agreement" leading to an increase in ICR to 0.91.[11] With high agreement established in the coding frame, the remaining data were coded by a single coder, and the final codes were reviewed by both coders.

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