

**UNIVERSITY OF COLORADO SCHOOL OF MEDICINE**

**DIVERSITY PLAN**

Steven R. Lowenstein, MD, MPH  
Professor of Surgery, Medicine and Preventive Medicine and Biometrics  
Associate Dean for Faculty Affairs

Gwen Hill, MA  
Director, Office of Diversity and Inclusion

Regina Kilkenny, PhD  
Associate Dean

For the Council on Diversity, University of Colorado School of Medicine

**Revised May 30, 2007**

I have been concerned by the evidence of inequalities that exist among the states as to personnel and facilities for health services. There are equally serious inequalities of resources, medical facilities and services in different sections and among different economic groups. These inequalities create handicaps for the parts of our country and the groups of people which most sorely need the benefits of modern medical science.

Franklin D. Roosevelt  
*Message to Congress on the National Health Program*  
January 23, 1939

## TABLE OF CONTENTS

	<b>EXECUTIVE SUMMARY</b> .....	4
I.	<b>Introduction</b> .....	14
II.	<b>Approval of New Diversity Mission Statement</b> .....	15
III.	<b>Definitions</b> .....	16
IV.	<b>Rationale: Why the School of Medicine Seeks Diversity</b> .....	17
	Enhancing Medical Education.....	17
	Reducing Health Disparities.....	19
	Informing the Research Agenda.....	22
	Summary: Why We Need Diversity.....	22
V.	<b>Student Diversity</b> .....	23
	National Perspective.....	23
	CU School of Medicine: Current Data and Recent Trends.....	23
	Rationale for Diversity Efforts in Medical School Admissions.....	24
	Admission Goals.....	25
VI.	<b>Graduate Medical Education</b> .....	26
VII.	<b>Faculty Diversity</b> .....	27
	National Perspective.....	27
	CU School of Medicine: Current Data and Recent Trends .....	27
	Faculty Diversity Goals.....	28
VIII.	<b>Curriculum Reform</b> .....	30
IX.	<b>Recommendations</b> .....	31
	1. Enhance the visibility of SOM diversity programs and strengthen ties to the community and to community leaders .....	32
	2. Strengthen recruitment and retention programs for minority students, housestaff, faculty and administrative leadership.....	36
	3. Establish systems of accountability for School and departmental diversity efforts.....	38
	4. Establish a Center for Health Disparities Research.....	39
	5. Create a School of Medicine Office of Diversity and Inclusion .....	42
	<b>SUMMARY</b> .....	44
	<b>APPENDIX A: SOM Diversity Mission Statement</b> .....	45

<b>APPENDIX B: Medical Student Admissions Diversity Policy.....</b>	<b>46</b>
<b>APPENDIX C: Diversity and Inclusion Initiatives and Activities.....</b>	<b>47</b>
<b>REFERENCES.....</b>	<b>49</b>

## EXECUTIVE SUMMARY

*Mitigating disparities in health and eradicating disparities in health care will bring us closer to the ideals at the foundation of our profession.*<sup>\*</sup>

This document outlines a new diversity plan for the University of Colorado School of Medicine (SOM). The primary goal of this plan is to achieve a diverse and representative student body, house staff, faculty and administrative staff. The plan also seeks to: (1) promote the academic advancement and success of minority students, house staff and faculty; (2) enhance cultural, bilingual and diversity instruction throughout the curriculum; (3) promote an institutional climate of inclusiveness, respect and understanding; (4) promote unexplored research agendas and new areas of scholarship related to cultural and racial disparities in health and health care; and (5) improve access to quality health care for poor, minority and underserved populations. The students, faculty and administration of the SOM believe that diversity is a core value that is central to the educational, research, community service and health care missions of the School.

The Diversity Plan begins with an introduction and a review of the 2002 LCME accreditation visit to the School of Medicine, which prompted the writing and approval of a Diversity Mission Statement (Sections I and II). In July, 2004 the Executive Faculty of the School of Medicine added a formal Diversity Mission Statement to its Rules; this Statement articulates the School's commitment to diversity among its students, residents, faculty, staff and administration.

Section III of the Plan outlines the SOM's definitions of "diversity" and "under-represented in medicine" (URM). As outlined in the Diversity Mission Statement, the School of Medicine has adopted a definition of diversity that embraces race, ethnicity, gender, religion, socioeconomic status, sexual orientation and disability. The definition of diversity also includes life experiences, record of service and employment and other talents that enhance the scholarly and learning environment.

Section IV presents the rationale for a diversity plan, addressing the question, "Why do we want diversity in the School of Medicine?" Citing recent peer review publications and national consensus documents, this section summarizes the evidence that a diverse student body, faculty and administration will enhance the scholarly and learning environment of the School of Medicine. There is compelling evidence that achieving diversity within a medical school has a strong, positive effect on the quality of medical education that is provided, helps to advance student, resident and faculty achievement, strengthens the

---

<sup>\*</sup> King TE, Wheeler MB. Inequality in health care: Unjust, inhumane and unattended. *Ann Intern Med.* 2004;141:815-817.

School's ties to nearby communities, informs and broadens the research agenda and contributes in measurable ways to improving the community's health. Increasing diversity among medical students and other trainees will lead to greater representation of minorities, not only among practicing physicians, but also among medical educators, scientists, public health officials, health services researchers, health insurance executives and health care policy makers. There is also strong evidence that achieving diversity of the health care workforce translates directly into improved delivery of health care services to underserved and minority populations.

Sections V, VI and VII present additional background information pertaining to medical student, house staff and faculty diversity, respectively. These sections include information from national sources, as well as data from the School of Medicine student, graduate medical education and faculty data bases. Section VIII provides information about cultural competency training in medical education. There is a discussion of the SOM's recently revised curriculum, which includes a cultural competency "thread" throughout all four years of the MD training program.

The final section (IX) of the Diversity Plan focuses on specific recommendations to achieve the goals outlined in the School's Diversity Mission Statement. There are five broad recommendations, and each is accompanied by one or more specific implementation tasks. These recommendations were selected by members of the SOM Diversity Council from among more than sixty recommendations and actions steps originally considered. Council members selected these five key recommendations because they are important and feasible, even during a time of limited resources. The recommendations focus on action steps that can be taken over the next 12 - 18 months. They also suggest defined and measurable outcomes. Taken as a whole, Council members believe these recommendations and the accompanying implementation tasks, summarized below, will help the SOM demonstrate its commitment to diversity and successfully implement its new Diversity Mission Statement.

### **RECOMMENDATION #1**

**Enhance the visibility of the School of Medicine's diversity programs and strengthen ties to the community and community leaders.**

#### **Rationale**

The Institute of Medicine has recommended that medical schools seek public and private support for their diversity efforts. The University of Colorado School of Medicine must be proactive in seeking such support. Efforts should be made to strengthen dialogues with legislators, business leaders, philanthropists, alumni and other community stakeholders. Communication efforts should stress

the importance of developing a diverse health care workforce that is optimally prepared to care for the people of the state. Building coalitions with community stakeholders can help develop awareness of health disparities and create advocacy for change. The Diversity Plan also emphasizes the importance of participation in community-based “pipeline” activities; these activities, which include K-12, pre-collegiate, collegiate and post-baccalaureate programs, mentoring and outreach, seek to identify and encourage promising URM high school and college students to pursue careers in medicine. In addition, over the past decade, the Kellogg Foundation and other organizations have recommended that medical schools emphasize “community engagement” and community-based scholarship as an essential strategy to improve health professional education, achieve a more diverse health care workforce, increase access to health care and eliminate racial and ethnic disparities in health. The SOM Diversity plan also calls for efforts to expand and strengthen partnerships with state, community and religious organizations, invest in recruitment of community-engaged faculty, advocate for extramural support of community-based research and revise faculty review, promotion and tenure criteria to recognize community-based service and scholarship.

### Implementation Tasks

- Reorganize the School of Medicine Diversity Council to include community, education, political, business and health agency leaders and other stakeholders.
- Distribute and publicize the SOM Diversity Plan and related activities.
- Compile a roster of faculty members who are willing to participate in “pipeline” activities or serve as contacts for high school, college or post-baccalaureate students.
- Assist SOM education leaders to identify URM community physicians who are willing to serve as preceptors or small-group discussion facilitators for medical students.
- Take steps to educate community stakeholders regarding the importance of diversity at the SOM; emphasize the importance of a diverse physician workforce (and the large gaps that remain in achieving the School’s diversity objectives); and publicize the SOM’s ongoing diversity initiatives.
- Develop formal working relationships with the new Office of Health Disparities at the Colorado Department of Public Health and Environment, the Colorado Medical Society and Colorado Physicians of Color; also identify other inter-institutional and community partnerships.
- Invite speakers on diversity, cultural competency and health disparities to participate in the Dean’s Distinguished Seminar series.
- Sponsor an annual Diversity Research Exchange, which should include invited speakers, abstracts and plenary presentations.
- Add language to faculty letters-of-offer that highlights the importance of diversity and professionalism in the SOM.

- Develop strategies to recognize and reward departments, centers and individual faculty for noteworthy diversity achievements (for example, recruitment activities, successful mentoring programs, cross-cultural initiatives, education innovations, research or service to diverse populations).
- Create annual diversity awards.
- Review and revise the SOM web site to highlight diversity and diversity efforts, partnerships, collaborations and opportunities (especially for minority and women faculty). The web site should include information and links designed to enhance minority recruitment and retention activities.

## **RECOMMENDATION # 2**

**Strengthen key recruitment and retention programs for minority students, house staff, faculty and administrative leadership, while monitoring the outcomes of these programs.**

### Rationale

There is strong evidence that recruiting a diverse student body, house staff and faculty has a strong, positive effect on the learning environment and quality of medical education that is provided to learners. A diverse community of teachers and learners leads to a more enlightened curriculum and educational environment, vital role models and better-trained physicians. According to the 2004 Sullivan Commission Report, *Missing Persons: Minorities in the Health Professions*, increasing the diversity of medical students, residents and faculty is also “an indispensable tool in efforts to improve access to health care for underserved populations.” There is a similar, compelling rationale to increase the production of qualified minority physicians who will become future leaders of medical schools, hospitals, public health agencies, health care organizations and health-related businesses. Finally, increasing the diversity of the academic medical faculty will inform and promote unexplored research agendas and accelerate the pace of scientific discoveries that bear directly on health disparities and other health concerns of under-served populations.

### Implementation Tasks

#### *General*

- Conduct a SOM climate assessment in order to identify areas of need with regard to the working and learning environment, particularly for minorities and women.

### *Medical Students*

- Develop an orientation and training program to ensure that Student Admissions Committee members are prepared to implement the admission goals outlined in the Diversity Plan.
- Continue to support and strengthen, with appropriate outcome monitoring, key URM medical student recruitment, “pipeline” and preparation programs, including the current post-baccalaureate and pre-matriculation programs.
- Support the current Student Ambassador Program and develop other activities to encourage the matriculation of URM students who are offered admission to the School of Medicine.
- Develop a mentoring program for incoming URM medical students, with participation by minority and non-minority faculty and community physicians.
- Identify resources and funding to enhance academic support for URM students (for example, tutoring and preparation for residency applications and interviewing).
- Encourage and support leadership activities by minority students in local, regional and national minority health and medical organizations, such as the National Hispanic Medical Association, National Medical Association, Association of American Indian Physicians and others.
- Annually, collect and distribute data about student diversity and diversity-related activities.
- Develop programs to support URM and other medical students who demonstrate an interest in an academic medical career.

### *Graduate Medical Education*

- Develop an orientation and training program to ensure that Residency Selection Committee members are prepared to implement the goals outlined in the Diversity Plan.
- Expand programs that seek to recruit new URM house officers (interns, residents and fellows) from national pools of applicants, through attendance at meetings, brochures, an enhanced web site, welcoming communications and other outreach efforts.
- Develop programs to increase recruitment of URM house staff from existing University of Colorado pools of URM medical students.
- Annually, collect and distribute data about resident and fellow diversity and diversity efforts.

### *Faculty and Administration*

- Ensure that participation in pipeline activities, public service and community-engaged scholarship are recognized and rewarded (for example, during annual performance reviews and at the time that promotion and tenure decisions are made).
- Distribute a quarterly “Tips for Successful Faculty Searches” to all departments, chairs and administrators (for example, advertising strategies, preparation of effective job descriptions, interviewing strategies, etc.).

- Ensure that a commitment to diversity is considered in the search processes for department chairs, division heads, assistant and associate deans and other leadership positions.
- Develop brochures, an enhanced web site and other outreach and information tools that will aid in recruitment of URM faculty.
- Conduct a needs assessment survey to assess the current academic climate for URM minority faculty, barriers to retention and academic success and mentoring needs;
- Conduct systematic exit interviews of departing faculty to identify barriers to academic and social success and retention of URM faculty; data should be shared with departments and administrators and used to improve the climate and support systems for URM and other faculty.
- Develop a collaborative mentoring system for URM and other new faculty, focusing on initial orientation to academic life, teaching skills, research methods, mentored research opportunities, grant-writing, promotion and tenure information, gaining national exposure and other career-building skills.

### **RECOMMENDATION # 3**

**Establish systems of monitoring and accountability for school-wide and departmental diversity efforts.**

#### Rationale

As discussed in the *Sullivan Commission Report*, the mandate to increase diversity and cultural competency will not be achieved unless institutions hold themselves accountable and are held accountable by others. The Commission also noted that diversity and cultural competence are measurable; data collection is a prerequisite for measurement and accountability. The Commission specifically recommended gathering data to assess institutional progress in achieving racial and ethnic diversity among students, faculty, administration and health services providers, as well as monitoring career patterns of graduates. Further, the Commission suggested that the “Department of Labor and the Department of Health and Human Services should ensure that the appropriate accrediting bodies hold medical residency and health professional training programs accountable for promulgating and implementing standards for diversity and cultural competence.”

## Implementation Tasks

- Improve the system for collecting faculty diversity statistics, and distribute these statistics to faculty, department chairs, Dean, Chancellor and Faculty Senate.
- Regularly measure and report the representation of URM faculty in key leadership posts and on major institutional committees and governing boards.
- Ensure that all search committee members receive training and assistance in conducting searches that include efforts to increase the number of minorities and women in applicant pools.
- Ensure that departmental search committees adopt uniform procedures, and comply with all SOM and University policies, to facilitate effective faculty searches.
- Enhance the faculty and residency search committee databases to include race, ethnicity and gender of search committee members as well as new faculty applicants, finalists and hires.
- Require that each department submit an initial diversity plan, plus annual updates.
- Ensure that each department's diversity plan and record are considered in annual evaluations of the chair and during regular departmental reviews.
- Develop a procedure for review and critique of departmental diversity plans by the SOM Council on Diversity.

## **RECOMMENDATION # 4**

### **Establish a Center for Health Disparities Research.**

#### Rationale

There are at least five compelling reasons to establish a Center for Health Disparities Research at the School of Medicine: a) to respond to the growing disparities in health and health care in Colorado and across the nation; b) to broaden and strengthen the research programs of the SOM; c) to help recruit and train a diverse investigator faculty; d) to strengthen the connections between the academic programs of the SOM and community and public health stakeholders; and e) to advance our understanding of health disparities and develop new knowledge to reduce and ultimately eliminate such disparities. Effective health disparities research will bridge theory and application, will emphasize collaborative and inter-disciplinary programs and will include investigations in basic sciences, educational methods, behavioral sciences, epidemiology, health services and health outcomes. The most successful research initiatives are likely to be "action-oriented" with a focus on collaborations with community organizations and local and state governments.

The expected advantages of such a research initiative extend beyond grant acquisition and scholarly output. Other benefits may accrue, including strengthening student and faculty recruitment, encouraging URM students and trainees to enter research careers, strengthening faculty mentoring programs and enriching the medical curriculum.

**Establishing a strong, well-funded Center for Health Disparities Research is one of the most important recommendations in this Plan.**

#### Implementation Tasks

- The Dean should appoint a committee to examine the feasibility of, and funding opportunities for, creation of a Health Disparities Research Center. The focus should be on collaborative and multicultural research programs, which build on existing SOM programmatic strengths.

### **RECOMMENDATION # 5**

**Create an Office of Diversity and Inclusion to oversee implementation of the School's Diversity Plan and to serve as the central point of responsibility for coordinating, developing and evaluating the School's diversity initiatives and programs.**

#### Rationale

In 2004 the Sullivan Commission recommended that all medical schools “should have senior program managers who: a) oversee diversity policies and practices; b) assist in the design, implementation and evaluation of recruitment, admissions, retention and professional development programs and initiatives; c) assess the institutional environment for diversity; and d) assist in developing curricula for students, faculty and staff on key principles of diversity and cultural competence.”

#### Implementation Tasks

- Create a position for an Assistant or Associate Dean for Diversity and Inclusion to direct the Council on Diversity and to provide overall direction and leadership for School-wide diversity policies, programs and initiatives.
- Identify an individual to develop and direct the Office of Diversity and Inclusion.
- Develop a strategic plan for implementation of the Diversity Plan and identify funding sources.

## Responsibilities of the Office

- Implement, coordinate, evaluate and, as necessary, revise the SOM Diversity Plan.
- Establish timelines, accountability measures and benchmarks for implementation of the SOM Diversity Plan.
- Monitor progress toward achieving the SOM diversity goals and provide regular reports.
- Conduct a School-wide climate assessment with respect to diversity, inclusiveness, respect, and cross-cultural understanding; develop strategies, activities and programs to address areas of concern.
- Develop mechanisms to ensure that SOM diversity efforts are integrated with other key SOM programs, including strategic research development, recruitment, fundraising, professionalism and curriculum reform.
- Provide leadership and staff support to the SOM Diversity Council.
- Assist in developing programs to enhance academic support and career mentoring for URM students, residents and faculty.
- Assist curriculum leaders to identify experiential rotations in underserved communities for medical students.
- Assist education leaders to identify URM community physicians who are willing to serve as preceptors or small-group discussion facilitators for medical students.
- Identify grants and other funds to support the Office of Diversity and Inclusion and specific SOM diversity programs.
- Develop web site information and other communication vehicles to highlight topics related to diversity, cultural competence and health disparities.
- Conduct ongoing reviews of existing diversity programs at the University of Colorado and at other universities; identify current needs and suggest new policies, programs and goals to enhance the School's diversity programs.
- Communicate and collaborate with other campus and University diversity committees and task forces.
- Work with community partners, pre-baccalaureate education leaders, public health officials, political leaders and others to identify grants, gifts, scholarships and other funds to support diversity programs and strengthen connections between the SOM and the greater community.

**The SOM must still define the appropriate size, structure, budgetary needs and leadership and staffing requirements for this Office. But without such an office, it is unlikely that the SOM can achieve meaningful progress in achieving the diversity goals outlined in this document. The Council on Diversity believes that creation of this "lead office" is the most important step the SOM can take to give life to the School's Diversity Mission**

**Statement and bring about the changes and improvements called for in this report.**

Summary

The members of the SOM Diversity Council believe that, no matter how high we rank nationally in research funding or education, as a public institution we cannot be considered successful until such time as we are able to recruit and train a diverse health care workforce, able to meet the health care needs of the communities that surround us. Diversity and inclusion are central to the School's education, research, community service and health care missions. As pointed out recently in a report by the National Academy of Sciences,

*The health professions disciplines are grappling with the impact of major demographic changes in the United States population, including a rapid increase in the proportions of Americans who are nonwhite, who speak primary languages other than English, and who hold a diverse range of cultural values and beliefs regarding health and health care.*

Training a health care workforce that is optimally prepared to care for diverse populations is a core mission and fundamental obligation of the University of Colorado School of Medicine.

*Mitigating disparities in health and eradicating disparities in health care will bring us closer to the ideals at the foundation of our profession.<sup>1</sup>*

## **I. INTRODUCTION**

This document outlines a new diversity plan for the University of Colorado School of Medicine (SOM). The primary goal of this plan is to achieve a diverse and representative student body, housestaff, faculty and administrative staff. The plan also seeks to enhance cultural and diversity training throughout the medical school and residency curriculum, promote unexplored research agendas and, ultimately, improve access to quality health care for poor, minority and underserved populations. Diversity is central to the School's education, research, community service and health care missions. Indeed, diversity, academic excellence and effective health care are interdependent.

The Diversity Plan begins with a review of the 2002 LCME accreditation visit to the School of Medicine, which prompted the writing, discussion and approval of a Diversity Mission Statement (Section II). Section III ("Definitions") outlines the SOM's definitions of "diversity" and "under-represented in medicine" (URM). Section IV presents the rationale for a diversity plan, addressing the question, "Why do we want diversity in the School of Medicine?" The next sections provide background information and the rationale for increasing diversity in key areas: Medical student diversity (Section V); graduate medical education (VI); faculty (VII); and adding diversity and cultural competency training to the medical student curriculum (VIII). The final section (IX) includes five specific recommendations to be implemented over the next 12-18 months, including the creation of a Center for Health Disparities Research and a School of Medicine Office of Diversity and Inclusion.

This diversity plan is timely and necessary for two compelling reasons. The first reason is demographic. According to the state Census, there were 4.3 million residents of Colorado in the year 2000; of these, 17.1 percent were Hispanic, 3.8 percent were African-American and 1 percent were American Indian.<sup>2</sup> In Colorado and across the United States, Hispanics are the fastest growing sector of the population. By the year 2010, according to the Council on Graduate Medical Education, "Hispanic Americans, African-Americans and Alaska Natives will represent 28 percent of the U.S. population, and Asian Americans and Pacific Islanders will bring that proportion up to almost a third of the total U.S. population."<sup>3</sup> By 2050 there may be no majority population in the U.S.<sup>4</sup>

According to the National Academy of Sciences,

*The health professions disciplines are grappling with the impact of major demographic changes in the United States population, including a rapid increase in the proportions of Americans who are nonwhite, who speak primary languages other than English, and who hold a diverse range of cultural values and beliefs regarding health and health care.*<sup>5</sup>

The second compelling reason for developing this diversity plan is that in Colorado, and across the nation, there are increasing disparities in health and health care across racial and ethnic lines. Academic medicine is a public trust;<sup>6</sup> the “products” of our medical school --- education, research and clinical care --- must reach all of the public, including minority and underserved populations.<sup>7</sup> Indeed, when the University of Colorado School of Medicine was established in 1883, it was to serve a public purpose. The School was created because the Regents “believed that the lives and health of the people of Colorado are not second in importance to any other interest that can be subserved by [a] state university.”<sup>8</sup> Training a diverse health care workforce that is optimally prepared to care for a diverse population is a core mission and fundamental obligation of every school of medicine;<sup>9</sup> increasing diversity at the University of Colorado School of Medicine is a vital and achievable goal.

## **II. APPROVAL OF A NEW DIVERSITY MISSION STATEMENT**

The Liaison Committee on Medical Education (LCME), which reviews and accredits medical schools in the United States and Canada, requires that each school develop and implement a diversity plan. Standard MS-8 states that “*Each medical school should have policies and practices ensuring the gender, racial, cultural and economic diversity of its students.*”

During its accreditation visit to the University of Colorado School of Medicine in April, 2002, the LCME found that the School was in partial noncompliance with Standard MS-8. The LCME observed: “*Notwithstanding the school’s commitment to achieving appropriate diversity among both students and faculty, there is no written policy in this regard.*”

Indeed, at the time of the LCME visit, the *Rules of the School of Medicine* contained only a single sentence about diversity: “*In the case of a new appointment, the chairperson shall certify that an appropriate effort was made to identify and consider qualified women and minority candidates.*”<sup>10</sup> This rule was never enforced, nor was “appropriate effort” ever defined.

The 2004 Sullivan Commission report, *Missing Persons: Minorities in the Health Professions*, also emphasized the importance of unambiguous, written institutional commitments to diversity. The Commission declared,

*Diversity should be a core value in the health professions. Health professions schools should ensure that their mission statements reflect a social contract with the community and a commitment to diversity among their students, faculty, staff and administration.* <sup>11</sup>

In response to these mandates, the SOM Diversity Council prepared a Diversity Mission Statement in January, 2003. After discussion and revision, the Mission Statement was approved by the Faculty Senate (March 2003) and the Executive Faculty of the School of Medicine (July 2004). The Diversity Mission Statement is now included in the *Rules of the School of Medicine*, immediately following the "Preamble." The Diversity Mission Statement is also included in this document (Appendix A).

The Diversity Mission Statement asserts that diversity is a value that is central to the School's educational, research, service and health care missions. The Mission Statement commits the SOM to develop new policies to admit qualified students and appoint qualified residents, fellows, faculty, staff and administrators who represent diversity (See the definitions of diversity, below). The Mission Statement also states that the SOM shall develop programs to: 1) promote the academic success of minority students, residents and faculty; 2) enhance cultural, bilingual and diversity instruction throughout the curriculum; 3) develop educational programs that will help break down ethnic and racial stereotypes and promote cross-cultural understanding; 5) promote a culture of inclusiveness, respect and understanding; and 6) promote unexplored research agendas and new areas of scholarship related to cultural and racial disparities in health and health care.

### **III. DEFINITIONS**

As outlined in the Diversity Mission Statement (Appendix A), the School of Medicine adopts a definition of diversity that embraces race, ethnicity, gender, religion, socioeconomic status, sexual orientation and disability. The definition of diversity also includes life experiences, record of service and employment and other talents and attributes that can enhance the scholarly and learning environment.

The term "under-represented in medicine" (URM) is also used. As clarified recently by the Association of American Medical Colleges (AAMC), "under-represented in medicine" refers to "those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population." <sup>12</sup> The AAMC recommends that medical schools shift from a national perspective to a regional or local perspective to define under-representation.

Similarly, for research grants and other purposes, according to the U.S. Public Health Service, underrepresented minority is defined as "racial and ethnic populations who are underrepresented in the designated health profession discipline relative to the number of individuals who are members of the population involved." For most biomedical and behavioral research disciplines, "this definition would include Black or African American, American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, Hispanic or Latino, and any Asian other than [U.S. PHS emphasis] Chinese, Filipino, Japanese, Korean, Asian Indian or Thai."<sup>13</sup>

In accordance with these guidelines, the University of Colorado School of Medicine defines "URM" to include African Americans, Hispanic Americans and American Indians, along with citizens who were born and raised in rural locales.

#### **IV. RATIONALE: WHY THE SCHOOL OF MEDICINE SEEKS DIVERSITY**

In *Grutter v. Bollinger et al*, the University of Michigan affirmative action decision, the U.S. Supreme Court affirmed Justice Powell's earlier finding in *Bakke* that obtaining "the educational benefits that flow from a diverse student body" may be a compelling interest for an institution of higher education.<sup>14</sup> But the Court left it to each university to determine whether such diversity is essential to its particular educational mission. In response, the Association of American Medical Colleges (AAMC) warned,

*It is not enough to state that diversity is a compelling interest for [an] institution ... It is equally important to explore why racial and ethnic diversity in a medical school is important and to articulate these reasons, preferably in a written policy.*<sup>15</sup>

In this section we explain why under-representation of minorities in the medical school is a problem, and why the SOM is committed to recruiting and supporting a diverse student body, house officer corps, faculty and administrative staff. Diversity is a vital goal for three principal reasons: a) to enhance medical education; b) to help reduce health disparities in Colorado and across the nation; and c) to inform the School's research agenda.

##### **Enhancing Medical Education**

There is persuasive evidence that recruiting a diverse student body and faculty has a strong, positive effect on the quality of medical education that is provided to learners.<sup>9,16, 17</sup> The positive educational outcomes include:

- Helping students to break down stereotypes and racial biases, challenge assumptions and "broaden perspectives regarding racial, ethnic and cultural differences;"<sup>5, 18</sup>

- Broadening students' understanding of the effects of language and culture on medical care --- that is, achieving cultural competency;
- Teaching students how differences in race, ethnicity and other cultural experiences might affect adversely the interactions that occur between doctors and the patients and families who seek their help;<sup>19</sup>
- Increasing students' awareness of health and health care disparities in nearby populations; and
- Increasing students' interest in service to underserved communities and overall civic commitment.<sup>5</sup>

These “added educational values” strengthen medical education and better prepare graduates to deliver health care services to an increasingly diverse population. Importantly, these educational benefits accrue to both minority and non-minority students.

As pointed out by the Sullivan Commission, “By its very nature, diversity allows more people from different backgrounds to look at the same problem and to explore different approaches and different solutions.”<sup>11</sup> There must be a “critical mass” of students of varying races and ethnic backgrounds “in order for students to live and work and experience the diversity that is critical for developing the sensibilities that we call cultural competence.”<sup>17</sup>

In addition, increasing diversity among medical students will lead to greater representation of minorities, not only among practicing physicians, but also among medical educators, scientists, public health officials, health services researchers, health insurance executives and health care policy makers.<sup>9, 17</sup> It is also self-evident that the presence and perspectives of URM students and faculty are essential for the design, implementation and evaluation of cultural competency curricula.<sup>11</sup>

In a recent study from Harvard and the University of California, San Francisco medical schools, students confirmed that concrete benefits accrue from a diverse student body.<sup>20</sup> Students reported that contact with diverse peers led to a more balanced exchange of information in classroom discussions, more serious discussions of alternative viewpoints about disease and treatments, greater appreciation of inequities in the health care system, and more cultural sensitivity. The investigators concluded that “students regularly educate one another on important issues, such as differences among the cultures and how best to respond to those differences.” Further, according to the authors of the study, students “established close collegial and personal friendships with students of different races and ethnicities, and such ties contributed greatly to their understanding of medical practice and, ultimately, better trained them for service in a multicultural society.”

In *Grutter* the Supreme Court reached the same conclusion: “Classroom discussion is livelier, more spirited and simply more enlightened and interesting

when students have the greatest possible variety of backgrounds.”<sup>14</sup> It is also self-evident that the cultural competency that is so important to a well-trained physician workforce cannot be learned solely from textbooks or in the classroom; such competency can be acquired only if students are “immersed in a learning environment that reflects our diverse society.”<sup>9</sup>

### Reducing Health Disparities

*Health and health care are distributed unevenly in the United States, and under-represented minorities are likely to get less of both.*<sup>21</sup>

*Sadly, most physicians, medical students, health care organizations and members of the public are not even aware that disparities in health care exist.*<sup>1</sup>

Achieving a student body, housestaff and faculty that are representative of the diversity in society is indispensable for quality medical education.<sup>9</sup> But there are also other compelling rationales that underlie the School’s commitment to diversity. The most important is that in Colorado, and throughout the nation, there are growing disparities among racial, ethnic and sociodemographic groups in almost every measure of health status. The landmark Institute of Medicine Report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, provided 600 pages of overwhelming evidence that broad disparities in health care quality and health outcomes exist.<sup>22</sup>

The disparities encompass virtually every measure of health status. African Americans, Hispanics and American Indians have higher rates of suffering and premature death from heart disease, diabetes, asthma, obesity, hypertension, communicable diseases (including tuberculosis and HIV infection), cancer, stroke, injuries, violence and alcohol and substance use.<sup>3, 23 24 25 26 27 28</sup> Minority citizens are more likely to suffer from these chronic conditions, even while reporting that they are unable to afford to fill routine prescription medications.<sup>23, 29</sup> Minority populations have higher infant and childhood mortality rates, lower life expectancy, decreased quality of life, lost economic opportunity, decreased work productivity and increased health care costs. Hundreds of publications attest to these differences in health status. There are similar, striking disparities in health and health services in Colorado.<sup>30 31</sup>

One reason for the higher burden of illness and premature death is that ethnic and racial minorities are less likely to receive proven, needed medical and surgical services. Minorities receive fewer diagnostic tests for a variety of complaints. They receive fewer preventive services, such as immunizations, prenatal care, and cancer and cardiovascular screening tests. Physicians caring for minority patients spend less time discussing smoking cessation, diet and exercise.<sup>1</sup> Minorities are less likely to receive scores of other medical and

surgical interventions, ranging from pain management and mental health services to coronary revascularization and transplantation. They receive less care, and lower quality care, for AIDS, cancer, heart disease and virtually every other condition that has been studied.<sup>32</sup> They are even less likely to be offered enrollment in clinical research trials.

Even after adjusting for socioeconomic status and health insurance coverage, and even in Health Maintenance Organizations (HMOs), the Veterans Administration system and other settings where access is equal and quality is monitored, persons of color receive fewer health care services, and the services they receive are of a lower quality.<sup>21, 33, 34</sup>

There are multiple explanations for these disparities, which include patient-, provider- and system-level factors.<sup>21</sup> For example:

- Racial discrimination may be a contributing factor. Discrimination in the clinical encounter is defined by the Institute of Medicine as encompassing "personal bias, prejudice, stereotyping or miscommunication that undermines clinical decision-making."<sup>1, 21, 22, 35</sup>
- Patient-related factors include misinformation about disease and treatment options, medical mistrust and perceived discrimination.<sup>21</sup> Barriers related to culture, language and literacy also affect access to information, access to quality care and acceptance of health care services. Important lifestyle behaviors (for example, physical activity, diet, smoking, alcohol consumption and safety belt use) also vary according to race, ethnicity and socioeconomic characteristics, with profound effects on health status.
- On a societal level, contributing factors include our fragmented health care delivery and insurance systems and geographic variations in access to primary health care services.<sup>3, 21, 36</sup> Social and economic factors, such as poverty, lack of education, living in disadvantaged geographic areas, stress, unemployment and recent immigration also contribute to health and health care disparities.<sup>3, 23, 35</sup> Recent studies have also found that nutritious foods and beverages are not readily available in minority communities; instead, there is aggressive advertising and marketing of tobacco, alcohol and "junk foods."<sup>37 38</sup>

It should be emphasized that "adjusting for socioeconomic status almost always reduces, but seldom eliminates, the effects of race and ethnicity on the health care that patients receive ... Racial and ethnic minorities receive lower quality health care than whites, and have poorer outcomes, even when they have equal health insurance, socioeconomic status and ability to pay for care."<sup>22</sup> At the same time, the effect of socio-economic status on health access and health status may be even greater than the effect of race and ethnicity. As Isaacs and Schroeder stated recently, "there is a consistent, inverse, stepwise relationship

between class and premature death...[and while] a great deal of attention is being paid to racial and ethnic disparities in health care, we must not downplay the reality of class and socio-economic status and their impact on health.”<sup>35</sup>

The key point for this diversity plan is that achieving diversity of the health care workforce will have a direct, positive effect on the health care that is available to the people of Colorado. First, there is a direct link between the poorer health outcomes for minorities and the shortage of minority health care providers.<sup>11, 22</sup> And second, enhancing diversity among students, residents and faculty is likely to translate directly into improved delivery of health care services to underserved and minority populations. Since the time of Flexner, it has been documented that minority medical school graduates, and those from lower socioeconomic strata, are more likely to practice in underserved areas. They are also more likely to include in their practices higher proportions of patients with Medicaid or no insurance, low incomes, poor socioeconomic status and poor health.<sup>5</sup> There is strong and consistent evidence that under-represented minority physicians are more likely than other physicians to choose primary care careers, to practice in under-served locales and to treat under-served populations.<sup>39 40 41 42 43 44 45</sup> In Colorado, healthcare workers who grow up in rural areas choose to practice in rural areas at a rate five to seven times greater than their non-rural cohorts.<sup>46</sup>

These and other studies also demonstrate that a diverse physician workforce increases patient trust, satisfaction with care, adherence to recommended treatment, timeliness of follow-up visits and effective patient participation in health care decisions when caring for medically underserved populations.<sup>5, 47</sup> In one recent study, Latino patients with hypertension or diabetes had better health outcomes when their doctors also spoke Spanish.<sup>48</sup> In other studies, African American and Latino patients harbored various misperceptions about the pathogenesis of cancer or heart disease and the medical and surgical options available to manage these conditions. Full understanding of these illnesses and treatment options, and patient participation in decision-making, were enhanced if there was racial or ethnic "concordance" between patient and health care provider. In several recent studies, race-concordant visits to physicians lasted longer, contained slower speech and fewer interruptions, were more participatory and led to higher patient satisfaction and better health outcomes.<sup>21, 49 50 51</sup>

In summary, in addition to enhancing the curriculum and educational environment, the medical school's interest in building diversity is based on "the state's utilitarian interest in ensuring that medical professionals who graduate can do their job."<sup>16</sup> Thus, increasing the diversity of medical students, residents and faculty "must be considered an indispensable tool in efforts to improve access to health care for underserved populations."<sup>11</sup> There is a similar compelling rationale to increase the production of qualified minority physicians who can

become future leaders of medical schools, hospitals, health care organizations and health-related businesses.<sup>9</sup>

### Informing the Research Agenda

In addition to providing a more enlightened curriculum and educational environment, vital role models and better-trained physicians, increasing the diversity of the academic medical faculty can “inform and promote unexplored research agendas.”<sup>52</sup> As Dr. Jordan Cohen, Past-President of the AAMC, has argued:

Achieving diversity of the research workforce can accelerate advances in medical and public health research ... [It] is virtually certain to broaden the medical research agenda to engage, appropriately, many of the unsolved health problems plaguing all Americans. Progress on many of these problems, especially those rooted in social, cultural and behavioral determinants, is hampered by a dearth of concerned investigators... Investigators tend to research what they know, see and feel, and what investigators see as problems is significantly influenced by their own cultural and ethnic backgrounds and filters.<sup>9</sup>

The University of Colorado School of Medicine should seek to attract a diverse investigator faculty, including basic and clinician scientists, in order to accelerate the pace of medical, scientific, public health and health services discoveries that bear directly on health disparities and other health concerns of under-served populations. Much more research is needed to better explain the well-documented race-associated differences in health outcomes.<sup>53</sup> The Sullivan Commission recently recommended that public and private funding agencies increase funding for research not only about racial disparities in health status and health care, but also about culturally competent care, how to measure and eliminate racial bias and stereotyping and strategies for increasing positive health behaviors among racial and ethnic groups.<sup>11</sup>

### Summary: Why We Need Diversity

Originally, the rationale for diversity in medical education was based on fairness, equity and “an appeal to redress decades during which minority citizens were excluded from higher education in general and health professions education in particular.”<sup>54, 55</sup> But today, the arguments for diversity extend far beyond those that pertain to equity. Diversity programs seek to enhance the learning environment for students and residents, advance student, resident and faculty achievement, strengthen the School’s ties to nearby communities and contribute in measurable ways to improving the community's health.

The faculty and leadership of the SOM believe that, no matter how high we rank nationally in NIH funding, as a public institution we cannot be considered successful until such time as we are able to recruit and train a diverse health care workforce, able to meet the health care needs of the communities that surround us.

## **V. STUDENT DIVERSITY**

### National Perspective

During the past two decades, the number of under-represented minority (URM) students entering U.S. medical schools increased modestly. In 1980 African-Americans, Hispanics and Native-Americans comprised 11.3 percent of entering medical students. Twenty-five years later, this proportion has increased to 13.2 percent.<sup>56</sup> The nation's medical school classes that entered in the fall of 2004 included 16,648 new students across all 126 U.S. medical schools. Of these, just 1,175 (7.1%) were Hispanic, 1,086 (6.5%) were African American and 104 (0.6%) were American Indians.

According to most experts, the principal obstacle to increasing URM enrollment is poor academic preparation. The educational opportunities available to minorities, from pre-kindergarten through college, are substantially below the quality available to whites. Thus, "the 'supply' of URM students who are well-prepared for higher education [and, in particular, medical school] has suffered."<sup>5</sup> The academic qualifications of minority applicants, at least as measured by advanced course loads, grades and test scores, is lower for minorities.<sup>9</sup> Recent studies also have demonstrated that the predictors of interest in a medical education, and of successful matriculation, include reading proficiency in the earliest grades, parental education and family income. Disparities in these factors weigh heavily against minority applicants.<sup>3, 57</sup>

### University of Colorado School of Medicine: Current Data and Recent Trends

At the University of Colorado, the student population does not yet reflect the demographic characteristics of the state. The School of Medicine MD program has 144 students in the first-year class and 132 students in each of the second-, third-, and fourth-year classes. Underrepresented minority students constitute 13% of the Class of 2008 and 11% of the Class of 2009. By self-report, the Class of 2009 includes 16 URM students: 14 Hispanic, 1 American Indian, and 1 Vietnamese; there are no African American students in the class of 2009. In addition, four entering students self-identified as Muslim (2.8% of the entering class). Twenty-six students (18% of the entering class) attended rural high schools.

2004 and 2005 School of Medicine URM Admissions Data

<u>2004 and 2005 Applicant Pools and Matriculants</u>	
<u>2004 TOTALS</u>	<u>2005 TOTALS</u>
2,512 applications 327 URM	2,526 applications 385 URM
1,552 secondary applications 215 URM	1,663 secondary applications 160 URM
569 interviewed 70 URM	558 interviewed 51 URM
231 admitted 32 URM	244 admitted 26 URM
132 matriculants 17 URM*	144 matriculants 16 URM**

\*10 Latino, 1 African American, 2 Native American, 4 Vietnamese  
\*\*14 Latino, 1 Native American, 1 Vietnamese

Rationale for Diversity Efforts in Medical School Admissions

As pointed out by the AAMC's Dr. Jordon Cohen and others, and as highlighted in earlier sections of this document, medical schools cannot be solely in the business of awarding medical degrees to honor their applicants' past achievements and credentials. "It is the total class balance, not merely the virtuosity of the individuals who make up the class, that defines the very objective of the admission process."<sup>9</sup> While high school grades and admission test scores are strong predictors of similar academic success in medical school, they do not measure the full range of abilities that are needed to succeed in medical school or residency training or to become a skillful physician.<sup>3, 5</sup> In other words, test scores and similar credentials cannot be considered to be a "compelling distillation of academic merit."<sup>5</sup> Medical schools have a societal obligation to select and educate a balanced health care workforce for the future, one that is best equipped to serve all of our nation's and our state's communities. Indeed, it would be unfortunate if medical school admissions committees could not consider the needs of patients and communities.<sup>58</sup>

At the University of Colorado School of Medicine, the Admissions Office is "handcuffed" in its efforts to enroll larger numbers of URM students and students from lower socioeconomic backgrounds, primarily because of insufficient scholarship funds. There is intense competition for these applicants. According to the Associate Dean for Admissions, most top-ranked private medical schools, and many top public schools,

routinely offer scholarships to deserving medical students at the time that an offer of admission is made. The University of Colorado is unable to make early scholarship offers and is, therefore, hampered in its efforts to recruit a diverse student body.

### Admission Goals

The SOM Diversity Council endorses the following statement of principles:

- The SOM will seek to enroll a highly able and qualified student body, richly diverse across racial, ethnic, socio-demographic and geographic lines and reflecting a wide variety of experiences, personal interests and academic goals.
- Admission will remain highly competitive.
- Students will continue to be evaluated on the basis of academic and personal achievement, intellectual promise, industriousness, obstacles overcome, commitment to service, compassion, communication skills, potential for leadership and other personal characteristics.
- The School will consider all of these factors, along with Medical College Admission Test scores and grades, in an individualized, holistic evaluation of each applicant for admission. The School will evaluate each applicant in a flexible manner, "paying attention to who the applicant is, and what he or she may become."<sup>59</sup>
- Admission will be offered to those judged to have the most promise for success as medical professionals and leaders and who can contribute most to the learning environment of the School.<sup>i 5, 15</sup>

In August, 2004 the SOM Admissions Committee adopted a formal policy to guide the evaluation of medical school applicants and the selection of each incoming class. This policy is included as Appendix B. Several specific steps that should be undertaken to strengthen recruitment and academic support of URM medical students, including post-baccalaureate and pre-matriculation programs, are included in the final recommendations (Section IX).

---

<sup>i</sup> These "affirmative action" practices, which aim to enrich the educational environment at the School of Medicine, were recently upheld by the U.S. Supreme Court. Universities may use race, along with other attributes, as "plus factors" in admissions --- as long as there is an "individual evaluation of each applicant's ability to contribute to a diverse student body."<sup>15</sup> The Court's majority opinion defined a "compelling interest in obtaining the educational benefits that flow from a diverse student body."<sup>14</sup>

## VI. GRADUATE MEDICAL EDUCATION

### Current Status: University of Colorado School of Medicine

Graduate medical education (GME) programs are responsible for the training of interns, residents and fellows in primary care and in all the medical and surgical specialties and subspecialties. The 24 departments of the University of Colorado SOM oversee 99 residency and fellowship training programs. The numbers of trainees and the proportions who are under-represented minorities have remained fairly constant over the last 10 years

<u>Year</u>	<u>Residents (N)</u>	<u>URM (N)</u>	<u>URM (%)</u>
1994-95	803	43	5.3
1995-96	788	45	5.7
1996-97	798	45	5.6
1997-98	780	40	5.1
1998-99	773	36	4.7
1999-00	794	44	5.5
2000-01	798	36	4.6
2001-02	811	37	4.6
2002-03	820	48	5.8
2003-04	860	55	6.4
2004-05	864	51	5.9

The proportion of URM trainees in our GME programs is lower than the national benchmarks. According to the AAMC Report *Minorities in Medical Education: Facts and Figures 2005*, the national percentage of URM medical school graduates in 2004 was 6.5% African American, 6.4% Hispanic, and 0.6% American Indian.<sup>52, 60</sup>

In 1994 a minority house staff recruitment plan was implemented, in which the SOM and the University of Colorado Hospital each allocated \$50,000 to increase the School's presence at medical student recruitment fairs. In 1997 an alternative program was initiated, in which URM students were reimbursed for expenses incurred while serving sub-internships at the SOM. The percentage of under-represented minorities who selected, or were selected by, SOM residency programs did not increase with either program.

In 2004 the Dean's Office provided funding to develop and implement a more focused resident recruitment plan that included travel by minority faculty to national minority medical student meetings, targeted advertising in *The Journal for Minority Medical Students*, brochures, funding for selected minority resident candidates to travel to Denver and minority faculty personally contacting prospective minority candidates. This has begun to yield positive results; for example, the Department of Medicine successfully recruited seven minority

residents in the 2005 match). Not all departments involved in this pilot program have had the same success.

For these reasons, several of the recommendations in this Diversity Plan (See Section IX) focus directly on steps to increase recruitment of URM house officers from national and University of Colorado School of Medicine applicant pools. A strong partnership with the Office of Diversity and Inclusion, residency program directors, department chairs and administrators and a well-developed plan will be required in this effort.

## **VII. FACULTY DIVERSITY**

### **National Perspective**

In 1998, according to the AAMC Faculty Roster system, 5.9 percent of medical school faculty nationwide reported they were underrepresented minorities. By 2004 this percentage had increased to 7.2 percent. In 2004 there were approximately 114,087 medical school faculty. Of these, 8,237 were URM's: there were 3,552 African American faculty members (3.2%); 4,568 Hispanic Americans (4.0%); and 117 American Indian faculty members (0.1%).<sup>3, 60</sup> However, it must be recognized that 1,648 (20%) of these URM faculty were located at three historically Black or three historically Puerto Rican medical schools. When excluded, the proportion of URM faculty drops to 5.7%.<sup>5</sup>

Nationally, fewer than 7 percent of URM faculty members hold appointments in basic sciences departments; among all medical school faculty, the proportion holding positions in basic science departments is 16 percent.

URM faculty are rare in full professor, tenured and leadership positions. Research has shown that URM faculty are less likely to advance to associate or full professor, are less satisfied with their careers and are more likely to leave academic positions.<sup>61 62 63 64 65</sup> The scarcity of URM faculty in the higher ranks has been attributed to their low numbers in entry positions, inadequate mentoring and career support, professional and social isolation, absence of appropriate role models, lack of opportunities to teach students and residents of color and educational debt.<sup>52, 65</sup> Unfortunately, the trends are not favorable: In the past decade there has been a further decline in the number of URM medical students and residents who, upon graduation, want to become academic faculty physicians.<sup>52, 65</sup>

### **Current Status: University of Colorado School of Medicine**

As noted earlier, in April, 2002 the LCME found that the School of Medicine was in partial noncompliance with standards for increasing diversity.

The LCME noted that, “Faculty from under-represented minority groups are few in number and rare in administrative and leadership positions, undermining recruitment and retention efforts to achieve desired levels of student diversity.”

As of November, 2005 only 57 of 1,473 (3.9%) of SOM faculty members employed by the University of Colorado represented underrepresented minority groups. The remainder (96 percent) were non-Hispanic whites. The chart below shows the proportions of URM faculty according to rank, tenure status and appointment as department chair or dean/associate dean.

<b>University of Colorado School of Medicine Under-Represented Minority Faculty* (November, 2005)</b>					
	<b>Total Faculty (Instructor and above)  N=1,473</b>	<b>Full Professors  N=309</b>	<b>Tenured Faculty  N=241</b>	<b>Department Chairs  N=24</b>	<b>Deans/Associate Deans  N=17</b>
<b>Hispanic</b>	37 (2.51%)	8 (2.6%)	6 (2.49%)	0 (0%)	0 (0%)
<b>African-American</b>	11 (.75%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
<b>Native American</b>	9 (.61 %)	1 (.32%)	1 (.41%)	0 (0%)	0 (0%)
<b>Totals</b>	<b>57 (3.87%)</b>	<b>9 (2.91%)</b>	<b>7 (2.90%)</b>	<b>0 (0%)</b>	<b>0 (0%)</b>

\*These data are derived from the Health Sciences Center payroll system, and only faculty who are employed by the University of Colorado are included. Faculty at affiliate institutions (VAMC, DHHA and NJH) are excluded.

In recent years the SOM has made investments in faculty diversity. Still, the SOM has not reached its goals. There is considerable competition among medical schools for URM faculty candidates. The issue is compounded by the lack of a diverse student body, a relative lack of scholarship, recruitment and retention monies and a dwindling base of support from the state.

#### Faculty Diversity Goals

The SOM cannot materially improve its faculty recruitment outcomes through administrative fiat alone. A strong partnership with the School’s departments will be required. Indeed, faculty recruitment, mentorship and retention activities are, for the most part, decentralized processes that are initiated and carried out by the SOM’s 24 departments and 37 divisions. Therefore, one overriding objective of this Diversity Plan is to bring the diversity

goals of the SOM and the recruitment practices of the individual departments into closer alignment.

At the same time, considerable support and guidance from the SOM and campus administration will be required. Most of the recommendations and implementation steps for increasing faculty diversity (Section IX) will require collaboration among deans and other administrative officers, department chairs, faculty leaders, staff, students and residents. Coordination will also be required by the campus Office of Diversity, the Ethnic Minority Affairs Committee (EMAC), the SOM Office of Diversity and Inclusion and the SOM Diversity Council.

The implementation plan for faculty diversity will include at least the following key practices: (a) Communicating the diversity rationale to the faculty at-large, faculty governance bodies, department chairs, program and center directors, administrators and search committee members; (b) development of department-specific diversity plans, with periodic review; (c) universal, mandatory training of search committee members and improved monitoring of faculty search activities; d) development of programs for retention, mentoring and advancement of URM faculty members; and (e) strengthening institutional accountability for achieving greater diversity among faculty and administrative leadership within the SOM.

To meet the SOM's diversity goals, attention must be paid not only to recruitment, but also to retention. It is the SOM's responsibility to support and mentor minority faculty, especially early in their careers. Efforts must be made to guard against isolation of minority faculty within the institution. The SOM must ensure that resources are available to help URM faculty connect with helpful minority colleagues and with successful role models and mentors. Leadership training is also essential at intermediate stages of faculty development. Programs must be developed to ensure that URM faculty connect with their school, university and community. The SOM must also guard against over-committing minority faculty to task forces and committees that need "representation."

Retention of URM faculty members is also predicated on strengthening the School's diversity climate. An institution's "diversity climate" has been defined by the Institute of Medicine as the "perceptions, attitudes and values that define the institution, particularly as seen from the perspectives of individuals of different racial or ethnic backgrounds."<sup>5</sup> An institution's climate can exert a profound influence on diversity efforts. The "climate" includes more than just numbers and proportions of minority students and faculty (structural diversity); it also includes measures of how often and how well members of diverse groups talk, listen, interact, work together and exchange ideas (the diversity of interactions).<sup>5</sup> It is influenced by social and cultural awareness events, the range and quality of curricula, mentoring and role models, and the psychological

climate (for example, legacies of discrimination or bias and perceptions of racial tension).<sup>5</sup>

## **VIII. CURRICULUM REFORM**

Experts agree that medical school and residency curricula must be revised in order to include awareness of health care disparities and instruction in “cultural competency.”<sup>3</sup> However, there is little consensus on what, exactly, should be learned, or how learning should be measured. Certainly, medical students need a basic understanding of public health and health disparities. Students need to understand how ethnicity, race and culture affect the distribution and impact of illness and injury. They need to know how illness is perceived, how perceptions affect treatment and how these impact the outcome of care. Curricula will necessarily include discussions of bias and stereotyping and how to combat them in health care settings. In addition, the importance of language competency cannot be overestimated; all students will need to understand relevant translation skills, pitfalls in communication and how language skills promote culturally sensitive care and positive health outcomes.

Educators have recommended that these lessons be taught inside and outside of the lecture hall and that they be reinforced in the clinical years. New physicians will not become “truly culturally competent unless they experience first-hand the reality of the socioeconomic status of the disadvantaged individuals they will care for.”<sup>66</sup>

In September, 2005 a study published in *JAMA* found that about half of resident physicians in their last year of training had received little or no training to provide cross-cultural care. About one-fourth of the residents “felt unprepared to deal with patients whose health beliefs do not coincide with Western medicine.”<sup>51</sup>

In an interesting reflection, Allen Hixon warned that educators should not plan for, or expect, “mastery” of cultural competence, as enticing as it seems.<sup>67</sup> Quoting from a recent publication in the *Journal of Health Care for the Poor and Underserved*,<sup>68</sup> Hixon argued that a more useful concept is one of “cultural humility,” built on the concepts of self-reflection and self-critique. Hixon argues that communication skills should be built upon “the attitudes of openness, flexibility, self-reflection and ... humility, [that] will ultimately make individuals responsive and sensitive in the delivery of care to diverse populations.”<sup>67, 68</sup>

### **Current Status**

The School of Medicine understands the importance of teaching medical students and residents about diversity, cultural competency and health disparities throughout the medical school curriculum. But the School has not always done well in

this area. Each year, medical school graduates across the U.S. respond to a "Graduating Student Questionnaire." This questionnaire is aimed at collecting data from students regarding their perceptions of the effectiveness of their medical school education. In the area of diversity, there were some positives; for example, 44% of the 2003 CU medical school graduates and 37% of the 2004 graduates knew or had studied a second language, compared with only 24% of the graduates from all U.S. medical schools. However, combining data from the 2003 and 2004 graduate surveys, only 2% had attended a seminar on minority health, compared with 11% of all U.S. medical school graduates. Only 12% had participated in a workshop on cultural awareness (compared with 28% among all U.S. medical school graduates, and just 7% had worked on a project with a community-based minority group (versus 19% nationally). The graduates were also asked about time in the curriculum devoted to minority health issues. Thirty-eight percent of the 2003-2004 SOM graduates reported that the time spent on health issues for underserved populations was inadequate (versus 25% of the graduates from all medical schools). The same percentage (38%, compared with 20% nationally) said there was "inadequate time" devoted to understanding cultural differences in health-related behaviors and "inadequate time" for the study of culturally appropriate care for diverse populations. Clearly, there are gaps in the SOM's curriculum.

Aware of these and other educational needs, the SOM is undergoing a major curricular reform. "Cultural Competency and Diversity" and "Medicine and Society" have been introduced into the curriculum as integrated "threads." It is expected that, throughout the 4-year curriculum, the knowledge, skills and attitudes needed to practice culturally competent medicine will be fully integrated into the basic science and clinical curricula. In the longitudinal "Medicine and Society" thread, students will learn about health care and health disparities and study the role of economics, politics and social structures in the U.S. health care system.

The recommendations included in this Diversity Plan include modest steps to assist in strengthening the School's cultural competency curricula. For the most part, it is suggested that the Director of the Office of Diversity and Inclusion and the members of the Diversity Council work collaboratively with education leaders to ensure that cultural competency, cross-cultural understanding, public health, health care disparities and community service are learned in an integrated and experiential fashion throughout the four phases of the medical school curriculum.

## **IX. RECOMMENDATIONS**

In recent years, the SOM has made numerous investments in student, resident and faculty diversity, pipeline activities, curriculum reform, health disparities research and community engagement. A list of ongoing diversity efforts is included in this report (Appendix C). Still the SOM has not reached its goals. Therefore, the final section of the Diversity Plan focuses on specific

recommendations, which seek to strengthen existing programs and to achieve the goals outlined in the School's Diversity Mission Statement.

There are five broad recommendations, and each is accompanied by one or more specific implementation tasks. These recommendations were selected by members of the SOM Diversity Council from among more than sixty recommendations and actions steps originally considered. Council members selected these five key recommendations because they are important and feasible, even during a time of limited resources. The recommendations focus on action steps that can be taken over the next 12 - 18 months. They also suggest defined and measurable outcomes. Taken as a whole, Council members believe these recommendations, and the accompanying implementation tasks, will help the SOM demonstrate its commitment to diversity and successfully implement its new Diversity Mission Statement.

### **RECOMMENDATION #1**

**Enhance the visibility of the School of Medicine's diversity programs and strengthen ties to the community and community leaders.**

#### **Rationale**

The Institute of Medicine has recommended that medical schools seek public and private support for their diversity efforts. The University of Colorado School of Medicine must be proactive in seeking such support. Efforts should be made to strengthen dialogues with legislators, business leaders, philanthropists, alumni and other community stakeholders. Communication efforts should stress the importance of developing a diverse health care workforce that is optimally prepared to care for the people of the state.

In addition, over the past decade, several national organizations have recommended that medical and other health professions schools emphasize "community engagement" as an essential strategy to improve health professional education, achieve a more diverse workforce, increase access to health care and eliminate racial and ethnic disparities in health.<sup>69</sup> In February, 2005 the W.K. Kellogg Foundation and the Community-Campus Partnerships for Health released a new report, "Linking Scholarship and Communities." The report calls for medical schools to expand community-based teaching, research and service and develop more "authentic partnerships between health professional schools and communities." Medical schools, according to the report, should invest in the recruitment and retention of community-engaged faculty, advocate for increased extramural support for community-engaged scholarship and revise faculty review, promotion and tenure criteria to recognize community-based service and scholarship.<sup>70</sup>

Finally, we stress the importance of participation in community-based "pipeline" activities. Few medical schools across the country have succeeded in recruiting a diverse medical student body, house officer corps or faculty. According to the Sullivan Commission, the problem originates "at the very beginning of the pipeline, where primary and secondary schools are failing too many students."<sup>11</sup> On average, when compared with white students, "racial and ethnic minority students receive a K-12 education of measurably lower quality, score lower on standardized tests, are less likely to complete high school ... and are far less likely to graduate from a four-year college..."<sup>11</sup> According to the Council on Graduate Medical Education, "research indicates that the greatest barrier to URM admission to medical school is the low applicant pool of URM college graduates, resulting from high attrition rates in high school and low enrollments in college."<sup>3</sup>

At the same time, there is reason for optimism. A recent study by Cooper et al found that if URM students stay in the academic pipeline through college, the proportions of URM college graduates who apply to medical school are now similar to, or even higher than, the proportions of white college graduates applying to medical school.<sup>71</sup> Once graduation from a four-year college is assured, URM youth can succeed in medical training. Therefore, according to COGME, the AAMC and others, "To increase the pool of URM medical school applicants, the retention of URM students must be addressed, at both the high school and undergraduate levels."<sup>3</sup>

Still, it is clear that, even if an URM candidate graduates successfully from a 4-year college, there are other barriers, sometimes insurmountable, in the admission process. A major one is money. As the Sullivan Commission pointed out, "The burden of financing an education in the health professions has put the dream of becoming a [doctor] beyond the reach of far too many qualified underrepresented minority students."<sup>11</sup>

The faculty and administration of the SOM should participate in, and support, "pipeline activities;" these activities seek to identify and encourage promising URM students to consider a career in medicine or other health professions. Pipeline activities include K-12, pre-collegiate, collegiate and post-baccalaureate programs, "shadow" days, summer science programs, mentoring and outreach, and enrichment and recruitment activities aimed at increasing interest in, and preparation for, health sciences careers.<sup>3</sup>

Pipeline activities can be rewarding for faculty members. In addition, they are routinely career-defining for students. Examples include: a) assisting community organizations, public schools and business to provide students with classroom and other learning opportunities for academic enrichment in the sciences; b) participating in public awareness campaigns to encourage URM minorities to pursue careers in one of the health professions; c) participating or leading "bridging programs" that enable graduates of two- or four- year colleges

to succeed in the transition to medical school; d) participating in high school and college career days and job fairs; and e) providing support to socioeconomically disadvantaged college students who express an interest in medical education; such support can include mentoring, test-taking and interviewing skills and others.<sup>ii</sup>

Dr. Jordan Cohen, AAMC President, recently wrote:

*Some think that we could admit many more deserving minority applicants if we relied less on MCAT scores in making admission decisions ...but the facts should put that canard to rest. MCAT scores, far from posing an obstacle to the admission of minority students, are often discounted by admissions committees when they identify other qualities of mind and spirit that predict success as medical students and, more important, as caring physicians...The only sure pathway to more diversity in medicine, and to eliminating disparities in healthcare, is to repair gaping holes in the K-12 educational pipeline and provide every youngster with the educational foundation upon which success in college and medical school can be built. Medical schools can only do so much.<sup>72</sup>*

The SOM should take steps to recruit and reward community-engaged faculty and to develop new partnerships with communities. Further, the faculty and administration should participate in, and support, "pipeline" activities, which seek to identify and encourage promising URM students to consider a career in medicine.

### Implementation Tasks

- Reorganize the School of Medicine Diversity Council to include community, education, political, business and health agency leaders and other stakeholders.
  - Identify and invite other SOM and UCDHSC faculty, administrators, and staff who can assist in achieving SOM diversity goals, including education, clinical, and research leaders.
  - Identify and invite community and agency representatives who are willing to assist in fundraising and other diversity efforts.
  - Conduct a retreat of the reorganized committee to orient new and current members to the School's diversity plan and the role of the committee.
- Establish the Diversity Council as a standing committee of the Faculty Senate

---

<sup>ii</sup> For a review of recent literature on partnership and pipeline activities, including their promise and limitations in academic medical centers, see the recent monograph by the Robert Wood Johnson and W. K. Kellogg Foundations, *Learning from others: A literature review and how-to guide from the Health Professions Partnership Initiative*. Also, see *Minorities in Medicine*, a report by the Council on Graduate Medical Education, which includes a listing of model educational pipeline programs and collaborations.<sup>3</sup>

- Distribute and publicize the SOM Diversity Plan and related activities (for example through the SOM website, *Faculty Success Newsletter*, Faculty Senate and Executive Committee presentations, Dean's weekly e-mail, newspaper articles and other means).
- Compile a roster of faculty members who are willing to: a) serve as contacts for aspiring students who may be interested in pursuing a medical career; or b) participate in other ways in community pipeline activities. For example:
  - Identify faculty who are willing to mentor post-baccalaureate students.
  - Develop a list of faculty volunteers and their areas of interest/expertise.
  - Create a brochure with this information for dissemination at targeted schools and at recruitment events and add this information to the SOM web site.
  - Develop a process for coordinating contact between faculty members and prospective students and their schools and colleges.
- Assist SOM education leaders to identify URM community physicians who are willing to serve as preceptors or small-group discussion facilitators for medical students.
- Take steps to educate community stakeholders regarding the magnitude of health care disparities in Colorado, the importance of diversity at the SOM, the importance of a diverse physician workforce and the large gaps that remain in achieving the School's diversity objectives; and publicize the SOM's ongoing diversity initiatives.
- Develop formal working relationships with the Office of Health Disparities at the Colorado Department of Public Health and Environment, the Colorado Medical Society, Colorado Physicians of Color and other health-related community organizations.
- Identify other current and prospective inter-institutional and community partnerships.
  - Create a list of current community and agency partnerships and collaborations.
  - Determine optimal partnerships and how they should be formalized.
  - Add lists of partnerships and collaborations to the SOM web site.
- Invite speakers on diversity, cultural competency and health disparities to participate in the Dean's Distinguished Seminar series.
- Sponsor an annual Diversity Research Exchange, which should include invited speakers, abstracts and plenary presentations.
- Add language to faculty letters-of-offer that highlights the importance of diversity and professionalism in the SOM.
- Develop strategies to recognize and reward departments, centers and individual faculty for noteworthy diversity achievements (for example, recruitment activities, successful mentoring programs, cross-cultural initiatives, education innovations, research or service to diverse populations).
- Create annual diversity awards.

- Review and revise the SOM web site to highlight diversity and diversity efforts, partnerships, collaborations and opportunities (especially for minority and women faculty). The web site should include information and links designed to enhance minority recruitment and retention activities.

## **RECOMMENDATION # 2**

**Strengthen key recruitment and retention programs for minority students, house staff, faculty and administrative leadership, while monitoring the outcomes of these programs.**

### Rationale

As discussed in detail in Section IV, there is strong evidence that recruiting a diverse student body, house staff and faculty has a strong, positive effect on the learning environment and quality of medical education that is provided to learners. A diverse community of teachers and learners leads to a more enlightened curriculum and educational environment, vital role models and better-trained physicians. According to the Sullivan Commission, increasing the diversity of medical students, residents and faculty is also “an indispensable tool in efforts to improve access to health care for underserved populations.”<sup>11</sup> There is a similar, compelling rationale to increase the production of qualified minority physicians who will become future leaders of medical schools, hospitals, public health agencies, health care organizations and health-related businesses. Finally, increasing the diversity of the academic medical faculty will “inform and promote unexplored research agendas and accelerate the pace of scientific discoveries that bear directly on health disparities and other health concerns of under-served populations.”<sup>11</sup>

### Implementation Tasks

#### *General*

- Conduct a SOM climate assessment in order to identify areas of need with regard to the working and learning environment for minorities and women.

#### *Medical Students*

- Develop an orientation and training program to ensure that Student Admissions Committee members are prepared to implement the admission goals outlined in the Diversity Plan.
- Continue to support and strengthen, with appropriate outcome monitoring, key URM medical student recruitment, pipeline and academic preparation programs, including the current post-baccalaureate and pre-matriculation programs.

- Support the current Student Ambassador Program and develop other activities to encourage the matriculation of URM students who are offered admission to the School of Medicine.
- Develop a mentoring program for incoming URM medical students, with participation by minority and non-minority faculty and community physicians.
- Identify resources and funding to enhance academic support for URM students (for example, tutoring and preparation for residency applications and interviewing).
- Encourage and support participation and leadership activities by minority students in local, regional and national minority health and medical organizations, such as the National Hispanic Medical Association, National Medical Association, Association of American Indian Physicians and others.
- Annually, collect and distribute data about minority student recruitment, retention and diversity activities.
- Develop and fund programs to support URM and other students who demonstrate an interest in an academic medical career.<sup>iii</sup>

#### *Graduate Medical Education*

- Develop an orientation and training program to ensure that Residency Selection Committee members are prepared to implement the goals outlined in the Diversity Plan.
- Expand programs that seek to recruit new URM house officers (interns, residents and fellows) from national pools of applicants, through attendance at meetings, brochures, an enhanced web site, welcoming communications and other outreach efforts.
- Develop programs to increase recruitment of URM house staff from existing University of Colorado pools of URM medical students.
- Annually, collect and distribute data about resident and fellow diversity and diversity efforts.

#### *Faculty and Administration*

- Ensure that participation in pipeline activities, public service and community-engaged scholarship is recognized and rewarded --- for example, during annual performance reviews and at the time that promotion and tenure decisions are made.
- Distribute a quarterly “Tips for Successful Faculty Searches” to all departments, chairs and administrators (including, for example, advertising strategies, preparation of effective job descriptions, interviewing strategies and other topics).
- Ensure that a commitment to diversity is considered in the search processes for department chairs, division heads, assistant and associate deans and other leadership positions.

---

<sup>iii</sup> See, for example, a model program, the Fellowship Program in Academic Medicine (supported by Bristol-Myers Squibb), and other initiatives discussed in the COGME report, *Minorities in Medicine*.<sup>3</sup>

- Develop brochures, an enhanced web site and other outreach and information tools that will aid in recruitment of URM faculty.
- Conduct a needs assessment survey to assess the current academic climate for URM minority faculty, barriers to retention and academic success and mentoring needs;
- Conduct systematic exit interviews of departing faculty to identify barriers to academic and social success and retention of URM faculty; data should be shared with departments and administrators and used to improve the climate and support systems for URM and other faculty.
- Develop a collaborative mentoring program for URM and other new faculty, focusing on initial orientation to academic life, mentoring, teaching, research methods, mentored research opportunities, grant-writing, promotion and tenure information, methods to gain national exposure and other career-building skills.<sup>iv</sup>

### **RECOMMENDATION # 3**

#### **Establish systems of monitoring and accountability for school-wide and departmental diversity efforts**

##### Rationale

As discussed in the *Sullivan Commission Report*, the mandate to increase diversity and cultural competency will not be achieved unless institutions hold themselves accountable and are held accountable by others. The Commission also noted that diversity and cultural competence are measurable, and that collection of accurate data is a prerequisite to measurement and accountability. The Commission specifically recommended gathering data to assess institutional progress in achieving racial and ethnic diversity among students, faculty, administration and health services providers, as well as monitoring career patterns of graduates. The Sullivan Commission suggested that the “Department of Labor and the Department of Health and Human Services should ensure that the appropriate accrediting bodies hold medical residency and health professional training programs accountable for promulgating and implementing standards for diversity and cultural competence.”<sup>11</sup>

##### Implementation Tasks

- Improve the system for collecting faculty diversity statistics, and distribute these statistics to faculty, department chairs, deans, chancellors and the SOM Faculty Senate.

---

<sup>iv</sup> The Robert Wood Johnson Foundation supports the Minority Medical Faculty Development Program, a 4-year post-doctoral research fellowship for minority physicians. This program focuses on research training in order to "increase minority faculty who progress successfully through the ranks of academic medicine."<sup>3</sup>

- Regularly measure and report the representation of URM faculty in key leadership posts and on major institutional committees and governing boards.
- Ensure that all search committee members receive training and assistance in conducting searches that include efforts to increase the number of minorities and women in applicant pools.
- Ensure that departmental search committees adopt uniform procedures, and comply with all SOM and University policies, to facilitate effective faculty searches.
  - Monitor all faculty searches, in collaboration with UCDHSC Office of Diversity;
  - Monitor and, where appropriate, limit search waivers;
- Enhance the faculty and residency search committee databases to include race, ethnicity and gender of search committee members as well as new faculty applicants, finalists and hires.
- Require that each department submit an initial diversity plan, plus annual updates.
  - Develop a template for use by departments in completing diversity reports;
  - Plans should summarize the department's diversity programs, which may include: efforts to identify qualified minority candidates for residency, graduate student, faculty and leadership positions; participation in search committee training; development of mentoring programs; participation in SOM pre-matriculation and "pipeline activities;" efforts to infuse multicultural perspectives into educational or research activities; and providing service to diverse or underserved populations.
- Ensure that each department's diversity plan and record are considered in annual evaluations of the chair and during regular departmental reviews.
- Develop procedures for review and critique of departmental diversity plans by the Council on Diversity.

#### **RECOMMENDATION # 4**

##### **Establish a Center for Health Disparities Research.**

##### Rationale

*The urge to identify, understand and eliminate disparities in health and health care is strong, but the science is young and the field is currently most distinguished by its promise.<sup>21</sup>*

There are at least five compelling reasons to establish a Center for Health Disparities Research at the School of Medicine: a) to respond to the growing disparities in health and health care in Colorado and across the nation; b) to broaden and strengthen the research programs of the SOM; c) to help recruit and

train a diverse investigator faculty; d) to strengthen the connections between the academic programs of the SOM and community and public health stakeholders; and e) to advance our understanding of health disparities and develop new knowledge to “accelerate the pace of medical, scientific, public health and health services discoveries that bear directly on health disparities and other health concerns of underserved populations.”<sup>9</sup>

The Center for Health Disparities Research should strive to bridge theory and application and should emphasize collaborative and interdisciplinary programs. The Center should include investigations in the basic sciences, educational methods, the behavioral sciences, epidemiology, health services and health outcomes. The most successful research initiatives are likely to be action-oriented with a focus on collaborations with community organizations and local and state government agencies. As Carey et al argued recently, "Universities can and should be involved in three types of overall collaboration: with their communities; with state and local governments; and with other universities and partners ... and [with respect to community partnerships], in ideal circumstances, the community can function along side the university as both a research subject and a collaborator."<sup>73</sup> One exciting example of such community-based collaborative research is the academic partnership between universities and black churches. As Carey et al pointed out, "The Church has a particularly important role in the black community, with a widely recognized focus on health issues as an integral component of the pastoral mission." Carey et al further asserted,

*Health disparities research must undergo a "melding of disciplines [and of] scientists across disciplines who are interested in the problems of disparities in the financing, organization, delivery and outcomes of care ... A partial list of disciplines involved in collaborative health disparities research includes clinical medicine, epidemiology, health policy, health economics, health behavior and education, practical theology, sociology, medical anthropology, psychology and environmental science. Each constituent field brings a different but interrelated perspective to the study of health disparities. The melding of these various perspectives increases the likelihood of identifying transferable solutions to the multiple and complex challenges that contribute to health disparities. Of particular importance for health disparities research is translating research findings into action; researchers and society alike perceive a sense of urgency around these issues."*<sup>73</sup>

Promising areas of focus might include:

- Health care and health status in minority and under-served populations;
- Evaluation of public policies that may reduce health disparities, including those related to housing, education, transportation and the environment;

- Health care strategies to reduce health disparities, including those that focus on medical and surgical treatments, systems change, outreach and education;
- Methodologic issues that affect the measurement of disparities in health between groups in a population, and the ability to monitor trends in disparities.<sup>74</sup>
- Barriers to effective health care delivery in minority populations (at the patient, provider, health care organization and broad system levels);
- Innovative cultural competency curricula (and optimal methods to assess learning);
- Strategies for increasing positive health behaviors in various racial and ethnic groups;
- Effectiveness of various practices to increase student, faculty and staff diversity, including search strategies, pipeline activities and other initiatives recommended in this *Diversity Plan*;
- The effects of culture, language and literacy on health services utilization and treatment compliance;
- The effects of race and ethnicity on drug efficacy and surgical and medical interventions;
- Translation of scientific and evidence-based research into sustainable community change; and
- Barriers to academic advancement of URM medical school faculty, such as promotion and tenure criteria, resources, research support, availability of colleague networks and mentors, salaries or institutional climate.

The expected advantages of such a research initiative extend beyond grant acquisition and scholarly output. Other benefits are likely to accrue, including strengthening faculty and student recruitment, encouraging URM students and trainees to enter research careers, expanding faculty mentoring programs and enriching the medical curriculum.

### Implementation Tasks

- The Dean should appoint a committee to examine the feasibility of, and funding opportunities for, creation of a Health Disparities Research Center. The focus should be on collaborative, multidisciplinary and multicultural research programs that build on existing SOM programmatic strengths.
  - Identify and recruit partners and principal and co-investigators; consider program leaders from the Colorado Department of Public Health and Environment, the downtown campus (School of Education, Health and Behavioral Sciences Program, Ethnic Studies Department, Latino Research and Policy Center, Health Administration Program and Graduate School of Public Affairs) and the Boulder campus (Law School, Department of Sociology and others).

- Create mentored research opportunities for medical students, residents and fellows

**Establishing a strong, well-funded Center for Health Disparities Research is one of the most important recommendations in this Plan.**

### **RECOMMENDATION # 5**

**Create an Office of Diversity and Inclusion to oversee implementation of the School's Diversity Plan and to serve as the central point of responsibility for coordinating, developing and evaluating the School's diversity initiatives, and programs.**

#### **Rationale**

In 2004 the Sullivan Commission recommended that all medical schools “should have senior program managers who: a) oversee diversity policies and practices; b) assist in the design, implementation and evaluation of recruitment, admissions, retention and professional development programs and initiatives; c) assess the institutional environment for diversity; and d) assist in developing curricula for students, faculty and staff on key principles of diversity and cultural competence.”<sup>11</sup>

The members of the SOM Council on Diversity agree with the Sullivan Commission's recommendation. The Council recommends that the SOM establish an Office of Diversity and Inclusion and appoint a Director to oversee implementation of the SOM's diversity plan. This Office should serve as the central point of responsibility for coordinating, developing and evaluating all aspects of this plan.

#### **Implementation Tasks**

- Create a position for an Assistant or Associate Dean for Diversity and Inclusion to direct the Council on Diversity and provide leadership for diversity policies, programs and initiatives.
- Identify an individual to develop and direct the Office of Diversity and Inclusion.
- Develop a strategic plan and identify funding sources.

#### **Responsibilities of Office**

- Implement, coordinate, evaluate and, as necessary, revise the SOM Diversity Plan.

- Establish timelines, accountability measures and benchmarks for implementation of the SOM Diversity Plan.
- Monitor progress toward achieving the SOM diversity goals and provide regular reports.
- Conduct a School-wide climate assessment with respect to diversity, inclusiveness, respect and cross-cultural understanding; develop strategies, activities and programs to address areas of concern.
- Develop mechanisms to ensure that SOM diversity efforts are integrated with other key SOM programs, including strategic research development, recruitment, fundraising, professionalism initiatives and curriculum reform.
- Provide leadership and staff support to the SOM Diversity Council.
- Assist in developing programs to enhance academic support and career mentoring for URM students, residents and faculty.
- Assist curriculum leaders to identify experiential rotations in underserved communities for medical students.
- Assist education leaders to identify URM community physicians who are willing to serve as preceptors or small-group discussion facilitators for medical students.
- Identify grants and other funds to support the Office of Diversity and Inclusion and specific SOM diversity programs.
- Develop web site information and other communication vehicles to highlight topics related to diversity, cultural competence and health disparities.
- Conduct ongoing reviews of existing diversity programs at the University of Colorado and at other universities; identify current needs and suggest new policies, programs and goals to enhance the School's diversity programs.
- Communicate and collaborate with other campus and University diversity committees and task forces.
- Work with community partners, pre-baccalaureate education leaders, public health officials, political leaders and others to identify grants, gifts, scholarships and other funds to support diversity programs and strengthen connections between the SOM and the greater community.

**The SOM must still define the appropriate size, structure, budgetary needs and leadership and staffing requirements for this Office. But without such an office, it is unlikely that the SOM can achieve meaningful progress in achieving the diversity goals outlined in this document. The Council on Diversity believes that creation of this "lead office" is the most important step the SOM can take to give life to the School's Diversity Mission Statement and to bring about the changes and improvements called for in this report.**

## **SUMMARY**

The members of the SOM Diversity Council believe that, no matter how high we rank nationally in research funding or education, as a public institution we cannot be considered successful until such time as we are able to recruit and train a diverse health care workforce able to meet the health care needs of the communities that surround us. Diversity and inclusion are central to the School's education, research, community service and health care missions.

Training a health care workforce that is optimally prepared to care for a diverse population is a core mission and fundamental obligation of the University of Colorado School of Medicine. Furthermore, returning to the quotation that introduced this Diversity Plan,

*Mitigating disparities in health and eradicating disparities in health care will bring us closer to the ideals at the foundation of our profession.*<sup>1</sup>

## **APPENDIX A**

### **UNIVERSITY OF COLORADO SCHOOL OF MEDICINE**

#### **DIVERSITY MISSION STATEMENT**

The University of Colorado School of Medicine believes that diversity is a value that is central to its educational, research, service and health care missions. Therefore, the SOM is committed to recruiting and supporting a diverse student body, faculty and administrative staff. The SOM adopts a definition of diversity that embraces race, ethnicity, gender, religion, socioeconomic status, sexual orientation and disability. The definition of diversity also includes life experiences, record of service and employment and other talents and personal attributes that can enhance the scholarly and learning environment.

The SOM shall strive to admit qualified students and appoint qualified residents, fellows, faculty, staff and administrators who represent diversity. The SOM also shall develop programs that are designed to: Promote the academic advancement and success of minority students, house officers and faculty; enhance cultural and diversity instruction throughout the curriculum; break down racial and ethnic stereotypes and promote cross-cultural understanding; and promote unexplored research agendas and new areas of scholarship. The SOM's diversity programs also seek to enhance diversity and cultural competency in the health care workforce, improve access to health care for poor, minority and under-served populations and, ultimately, eliminate racial, ethnic and socioeconomic disparities in health and health services.

The SOM will work with all departments and programs within the SOM, and with other University of Colorado campuses and their leaders, to achieve the goals outlined above and to promote a culture of inclusiveness, respect, communication and understanding. The SOM will support the goals of the University's Vision 2010, that seek to develop a University culture in which diversity and academic excellence are seen as inter-dependent.

## **APPENDIX B**

### **UNIVERSITY OF COLORADO SCHOOL OF MEDICINE**

#### **MEDICAL STUDENT ADMISSIONS DIVERSITY POLICY**

The number of academically qualified applicants to the University of Colorado School of Medicine far exceeds the number of places in the first year class. Faced with the ongoing dilemma of choosing among a large number of qualified candidates, the Admissions Committee of the University of Colorado School of Medicine could use a single criterion, such as MCAT scores, to select an incoming class. However, the Committee, working on behalf of the University, has never used such an approach. The belief is that if scholarly excellence as measured by grades and test scores were the only criterion, the School of Medicine would lose a great deal of its vitality and intellectual stimulation and that the quality of the educational experience offered to all students would suffer. Consequently, while selecting those applicants whose intellectual potential and health care background seem excellent to the committee, the Committee seeks to matriculate a diverse incoming class to the School of Medicine to enhance the educational experience for the entire student body.

As we look at diversity within the incoming class, it is not solely ethnic diversity that is considered, but also diversity in educational and life experiences and diversity in socioeconomic background. It would be simple to matriculate a class at the School of Medicine, which is made up entirely of students who grew up in the Front Range of Colorado. This type of class would not be able to represent to each other the wide diversity of our population. In addition, it is unlikely that the alumni of the School of Medicine would then adequately serve the multiple needs of the state and of our country for outstanding clinicians, researchers, and medical school faculty.

The Admissions Committee has not set, nor does it intend to establish, quotas for any regional or ethnic group of students. These various numbers will of their own nature vary annually. However, it is the consensus of the committee that a single rural or Hispanic matriculant in a class of 140 or 150 students would hardly be able to represent the full range of rural or Hispanic experiences to his/her class. In the final analysis, each academically qualified applicant must be judged based on his/her unique characteristics. The further refinements sometimes required to admit a class help to illustrate the kind of significance attached to race, rural background, and socioeconomic diversity. The Admissions Committee, with only a few places left to fill in the class, might find itself forced to select between A, the child of a successful Hispanic physician who is him/herself a graduate of this school, and B, a rural Hispanic applicant who is the first college graduate in his/her family. If a good number of Hispanic students like A, but few like B had already been accepted, the Committee might prefer B; and vice versa. If C, a white student with outstanding musical talent, were also seeking one of the remaining places in the incoming class, his/her unique abilities might give him/her an edge over A and B. Thus the critical criteria are often individual qualities or experiences not dependent upon race or geography but sometimes associated with it.

## APPENDIX C

### UNIVERSITY OF COLORADO SCHOOL OF MEDICINE

### DIVERSITY AND INCLUSION ACTIVITIES & INITIATIVES

February 2006

#### ***Student/trainee access and recruitment***

- ❑ Colorado Rural Health Scholars Program
- ❑ Student Cancer Research Fellowship Program
- ❑ Association of American Indian Physicians pre-admissions workshop
- ❑ Medical Student Admissions Committee training
- ❑ Student Ambassador program
- ❑ Mentor Day dinner
- ❑ Post-Baccalaureate program
- ❑ School of Medicine Diversity Scholarships
- ❑ Rural Health track in the M.D. program
- ❑ Cultural Competency/Diversity curriculum thread
- ❑ CHAPA Rural Track
- ❑ CHAPA Diversity
- ❑ CHAPA Cultural Competency in the Curriculum
- ❑ Department of Pharmacology Minority Summer Undergraduate Research Fellowship program
- ❑ Graduate Medical Education Diversity Recruitment
- ❑ Residency Recruitment and Selection Committee Diversity training

### ***Student retention***

- ❑ Pre-Matriculation program
- ❑ Student National Medical Association

### ***Faculty and/or staff recruitment, retention and development***

- ❑ American Indian and Alaska Native programs
- ❑ School of Medicine search committee training
- ❑ Colorado Health Outcomes (COHO) Cultural Proficiency Learning Group

### ***Professional development [faculty]***

- ❑ Faculty development within Cultural Competency/Diversity curriculum
- ❑ Women in Medicine program
- ❑ Executive Leadership in Academic Medicine
- ❑ Association of American Medical Colleges Minority Faculty Development Seminar
- ❑ Colorado Health Outcomes (COHO) Cultural Proficiency Training for Researchers

### ***Education/Climate/Diversity Programming***

- ❑ Cultural Competency speaker: Melanie Tervalon, MD, MPH on Cultural Humility
- ❑ School of Medicine Diversity Plan
- ❑ School of Medicine Diversity Council
- ❑ Dean's co-sponsorship of reception for minority faculty, residents, fellows and students with EMAC

### ***Community Outreach/Service***

- ❑ Tribute to life and legacy of Dr. Charles Blackwood
- ❑ Center for Human Nutrition's America on the Move program

## REFERENCES

- <sup>1</sup> King TE, Wheeler MB. Inequality in health care: Unjust, inhumane and unattended. *Ann Intern Med.* 2004;141:815-817.
- <sup>2</sup> US Census Bureau. Census 2000 Data for the State of Colorado. <http://www.census.gov/census2000/states/co.html>.
- <sup>3</sup> U.S. Department of Health and Human Services. Health Resources and Services Administration. Council on Graduate Medical Education. Seventeenth Report. Minorities in Medicine: An ethnic and cultural challenge for physician training. April, 2005.
- <sup>4</sup> *US Census Bureau News, March 18, 2004*  
<http://www.census.gov/Press-Release/www/releases/archives/population/001720.html>  
(Retrieved 10/10/05)
- <sup>5</sup> National Academy of Sciences. In the nation's compelling interest: Ensuring diversity in the health care workforce. 2003. <http://books.nap.edu/catalog/10885.html>.
- <sup>6</sup> Schroeder SA, Jone JS, Showstack JA. Academic medicine as a public trust. *JAMA.* 1989;262:803-12.
- <sup>7</sup> Calleson DC, Seifer SD, Maurana C. Forces affecting community involvement of AHC's. *Acad Med* 2002; 77:72-81
- <sup>8</sup> Claman HN, Shikes RH. *The University of Colorado School of Medicine: A Millennial History.* A.B. Hirschfield Press, 2000.
- <sup>9</sup> Cohen JJ. The consequences of premature abandonment of affirmative action in medical school admissions. *JAMA.* 2003;289:1143-1149.
- <sup>10</sup> University of Colorado School of Medicine. *Rules of the School of Medicine* (Page 26). <http://www.uchsc.edu/sm/sm/SOM%20Rules%202004.pdf>.
- <sup>11</sup> Missing Persons: Minorities in the health professions. A report of the Sullivan Commission on Diversity in the healthcare workforce. The Sullivan Commission. Washington, D.C., 2004.
- <sup>12</sup> Association of American Medical Colleges. Underrepresented in medicine - definition. <http://aamc.org/meded/urm/start.htm>. Accessed on November 21, 2004.
- <sup>13</sup> PHS Act Section 799B. See <http://www.nigms.nih.gov/funding/table7.html>.
- <sup>14</sup> Grutter v. Bollinger et al. 123 S.Ct. 2325,2341 (2003).
- <sup>15</sup> Association of American Medical Colleges. Assessing medical school admission policies: Implications of the US Supreme Court's affirmative-action decisions. Washington, DC: 2003.
- <sup>16</sup> DeVille K. Defending diversity: Affirmative action and medical education. *Am J Public Health.* 1999;89:1256-1261.
- <sup>17</sup> Cohen JJ. Disparities in health care: An overview. *Acad Emerg Med.*2003;10:1155-1160.

- <sup>18</sup> Turner CSV. Diversifying the faculty. A guidebook for search committees. Washington, DC: Association of American Colleges and Universities, 2002.
- <sup>19</sup> Whitcomb ME. Achieving the educational value of diversity. *Acad Med.* 2003;78:429-430.
- <sup>20</sup> Whittle DK, Orfield G, Silen W et al. Educational benefits of diversity in medical school: A survey of students. *Acad Med.* 2003;78:460-466.
- <sup>21</sup> Long JA, Chang VW, Ibramim SA, Asch DA. Update on the health disparities literature. *Ann Intern Med.* 2004;141:805-812.
- <sup>22</sup> Institute of Medicine. Unequal treatment: Understanding racial and ethnic disparities in health care. Washington, DC: National Academy of Sciences, 2002.
- <sup>23</sup> Centers for Disease Control and Prevention. Health disparities experienced by Hispanics - United States. *MMWR.* 2004;53:935-945,
- <sup>24</sup> US Department of Health and Human Services. Data 2010: The healthy people 2010 database. Hyattsville, MD: US DHHS, CDC, National Center for Health Statistics, 2004.
- <sup>25</sup> Wong MD, Shapiro MF, Boscardin WJ, Ettner SL. Contribution of major diseases to disparities in mortality. *N Engl J Med.* 2002;347:1585-1592.
- <sup>26</sup> CDC. Health disparities experienced by Black or African Americans - United States. *MMWR.* 2005; 54:1-11.
- <sup>27</sup> CDC. Racial/ethnic and socioeconomic disparities in multiple risk factors for heart disease and stroke - United States. *MMWR.* 2004; 54:113-121.
- <sup>28</sup> CDC. Racial/Ethnic disparities in infant mortality - United States, 1995-2002. *MMWR.* 2005; 54:553.
- <sup>29</sup> US Department of Health and Human Services. Data 2010: The healthy people 2010 database. Hyattsville, MD: US DHHS, CDC, National Center for Health Statistics, 2004.
- <sup>30</sup> Hunsaker JA. Profile of health disparities among communities of color: Colorado, 2001. Colorado Department of Public Health and Environment, 2002.
- <sup>31</sup> Racial and ethnic health disparities in Colorado – 2005. Report of the Office of Health Disparities, Colorado Department of Public Health and Environment. 2005.
- <sup>32</sup> Liao Y, Tucker P, Okoro CA et al. REACH 2010 Surveillance for health status in minority communities – United States, 2001-2002. In: Surveillance Summaries, August 27, 2004. *MMWR* 2004;53(No. SS-6): 1-35.
- <sup>33</sup> Schneider EC, Zaslavsky AM, Epstein AM. Racial disparities in the quality of care for enrollees in Medicare managed care. *JAMA.* 2002;287:1288-1294.
- <sup>34</sup> Petersen LA, Wright SM, Petersen ED. Impact of race on cardiac care and outcomes in veterans with acute myocardial infarction. *Med Care.* 2002;40:186-196.
- <sup>35</sup> Isaacs SL, Schroeder SA. Class – The ignored determinant of the nation's health. *N Engl J Med.* 2004; 351:1137-1142.

- <sup>36</sup> Shi L, Macinko J, Starfield B et al. Primary care, social inequalities and all-cause heart disease and cancer mortality in US Counties, 1990. *Am J Public Health*. 2005; 95:674-680.
- <sup>37</sup> Lewis LB, Sloane DC, Miller L. African Americans' access to healthy food options in South Los Angeles restaurants. *Am J Public Health*. 2005;95:668-673.
- <sup>38</sup> Lavery SH, Smith ML, Esparza AA et al. The community action model: A community-driven model designed to address disparities in health. *Am J Public Health*. 2005;95:611-616.
- <sup>39</sup> Cohen JJ, Gabriel BA, Terrell C. The case for diversity in the health care workforce. *Health Aff (Milwood)*. 2002;21:90-102.
- <sup>40</sup> Komaromy M, Grumbach K, Drake M et al. The role of Black and Hispanic physicians in providing health care for underserved populations. *N Engl J Med*. 1996;334:1305-1310.
- <sup>41</sup> Cantor JC, Miles EL, Baker LC et al. Physician service to the uninsured: Implications for affirmative action in medical education. *Inquiry*. 1996;33:167-180.
- <sup>42</sup> Kington R, Tisnada D, Carlisle DM. Increasing racial and ethnic diversity among physicians: an intervention to address health disparities? In: Smedley BD, Colburn L, Evans CH, eds. *The right thing to do, the smart thing to do: Enhancing diversity in the health professions*. Washington, DC: National Academy Press; 2001;64:68.
- <sup>43</sup> Cohen JJ. Improving America's health status through a more diverse physician workforce. *Acad Med*. 1997;72:130.
- <sup>44</sup> Moy E, Bartman BA. Physician race and care of minority and medically indigent patients. *JAMA*. 1995;273:1515-1520.
- <sup>45</sup> Davidson RC, Montoya R. The distribution of services to the underserved: A comparison of minority and majority medical graduates in California. *Western J Med*. 1987;146:114-117.
- <sup>46</sup> Fryer GE Jr., Stine C, Vojir C, Miller M. Predictors and profiles of rural versus urban family practice. *Family Medicine*. 1997;29 (2)
- <sup>47</sup> Xu G, Fields SK, Laine C et al. The relationship between the race/ethnicity of generalist physicians and their care for underserved populations. *Am J Public Health*. 1997;87:817-822.
- <sup>48</sup> Perez-Stable EJ, Napoles-Springer A, Miramontes JM. The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. *Medical Care*. 1997;35:1212-1219.
- <sup>49</sup> Saha S, Abelaez JJ, Cooper LA. Patient-physician relationships and racial disparities in the quality of health care. *Am J Public Health*. 2003;93:1713-1719.
- <sup>50</sup> Cooper LA, Roter DL, Johnson RL et al. Patient-centered communication, ratings of care and concordance of patient and physician race. *Ann Intern Med*. 2003;139:907-915.
- <sup>51</sup> Weissman JS, Betancourt J, Campbell EG et al. Resident physicians' preparedness to provide cross-cultural care. *JAMA*. 2005; 294:1058-1067.
- <sup>52</sup> Lypson ML, Gruppen L, Stern DT. Careers in medicine – You've got to be careful if you don't know where you're going because you might not get there. Warning signs of declining faculty diversity. *Acad Med*. 2002;77:S10-S12.

- <sup>53</sup> Jones CP. Levels of racism: A theoretical framework and a gardener's tale. *Am J Public Health*. 2000;90:1212-115.
- <sup>54</sup> Cone DC, Richardson LD, Todd KH et al. Health care disparities in emergency medicine. *Acad Emerg Med*. 2003;10:1176-1183.
- <sup>55</sup> Bowen WG, Bok DC. *The shape of the river: Long-term consequences of considering race in college and university admissions*. Princeton, NJ: Princeton University Press, 1998.
- <sup>56</sup> Learning from others: A literature review and how-to guide from the Health Professions Partnership Initiative. Association of American Medical Colleges. Washington, D.C., 2004.
- <sup>57</sup> Cooper RA. Impact of trends in primary, secondary and postsecondary education on applications to medical school. II: Considerations of race, ethnicity and income. *Acad Med*. 2003;78:864-876.
- <sup>58</sup> Scotti MJ. Medical school admission criteria. The needs of patients matter. *JAMA*. 1997;278:1196-1197.
- <sup>59</sup> Lewis A. Diversity makes society stronger. Commentary, *Rocky Mountain News*, May 27, 1997 (Page 31A).
- <sup>60</sup> AAMC (Association of American Medical Colleges). 2004. *Minorities in Medical Education: Facts and Figures 2005*. Washington, DC: AAMC
- <sup>61</sup> Paepu A, Carr PL, Friedman RH et al. Minority faculty and academic rank in medicine. *JAMA*. 1998;280:767-771.
- <sup>62</sup> Palepu A, Carr PL, Friedman RH et al. Specialty choices, compensation and career satisfaction of underrepresented minority faculty in academic medicine. *Acad Med*. 2000;75:157-160.
- <sup>63</sup> Fang D, Moy E, Colburn L, Hurley J. Racial and ethnic disparities in faculty promotion in academic medicine. *JAMA*. 2000;284:1085-1092.
- <sup>64</sup> Marbella AM, Holloway RL, Sherwood R, Layde PM. Academic ranks and medical schools of underrepresented minority faculty in family medicine departments. *Acad Med*. 2002;77:173-176.
- <sup>65</sup> Carr P, Bickel J, Inui TS. *Taking root in a forest clearing: A resource guide for medical faculty*. Boston: Boston University School of Medicine, 2004.
- <sup>66</sup> Whitcomb ME. Preparing doctors for a multicultural world. *Acad Med*. 2003;78:547-548.
- <sup>67</sup> Hixon AL. Beyond cultural competence. *Acad Med*. 2003;78:634.
- <sup>68</sup> Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor and Underserved*. 1998;9:117-125.
- <sup>69</sup> W.K. Kellogg Foundation. National commission urges action to link scholarship and communities. Press Release (February 28, 2005).<http://depts.washington.edu/ccph/kellogg3.html>.

- <sup>70</sup> W.K. Kellogg Foundation. Linking scholarship and communities. February 28, 2005. <http://depts.washington.edu/ccph/kellogg3.html>.
- <sup>71</sup> Cooper RA. Impact of trends in primary, secondary and postsecondary education on applications to medical school. II: Considerations of race, ethnicity and income. *Acad Med.* 2003;78:864-76.
- <sup>72</sup> Cohen JJ. Meeting the diversity challenge. *AAMC Reporter.* December, 2004 (Page 2).
- <sup>73</sup> Carey TS, Howard DL, Goldmon M et al. Developing effective interuniversity partnerships and community-based research to address health disparities. *Acad Med.* 2005; 80:1039-1045.
- <sup>74</sup> Keppel , Pamu E, LynchJ et al. Methodological issues in measuring health disparities. National Center for Health Statistics. *Vital Health Stat 2(141).* 2005.
- 
- <sup>1</sup> King TE, Wheeler MB. Inequality in health care: Unjust, inhumane and unattended. *Ann Intern Med.* 2004;141:815-817.
- <sup>2</sup> US Census Bureau. Census 2000 Data for the State of Colorado. <http://www.census.gov/census2000/states/co.html>.
- <sup>3</sup> U.S. Department of Health and Human Services. Health Resources and Services Administration. Council on Graduate Medical Education. Seventeenth Report. Minorities in Medicine: An ethnic and cultural challenge for physician training. April, 2005. Also, data from the AAMC Report, *Minorities in Medical Education: Facts and Figures 2005.*
- <sup>4</sup> (*US Census Bureau News, March 18, 2004*). <http://www.census.gov/Press-release/www/releases/archives/population/001720.html>. (Retrieved 10/10/05)
- <sup>5</sup> National Academy of Sciences. In the nation's compelling interest: Ensuring diversity in the health care workforce. 2003. <http://books.nap.edu/catalog/10885.html>.
- <sup>6</sup> Schroeder SA, Jone JS, Showstack JA. Academic medicine as a public trust. *JAMA.* 1989;262:803-12.
- <sup>7</sup> Calleson DC, Seifer SD, Maurana C. Forces affecting community involvement of AHC's. *Acad Med.* 2002; 77:72-81
- <sup>8</sup> Claman HN, Shikes RH. *The University of Colorado School of Medicine: A Millennial History.* A.B. Hirschfield Press, 2000.
- <sup>9</sup> Cohen JJ. The consequences of premature abandonment of affirmative action in medical school admissions. *JAMA.* 2003;289:1143-1149.
- <sup>10</sup> University of Colorado School of Medicine. *Rules of the School of Medicine* (Page 26). <http://www.uchsc.edu/sm/sm/SOM%20Rules%202004.pdf>.
- <sup>11</sup> Missing Persons: Minorities in the health professions. A report of the Sullivan Commission on Diversity in the healthcare workforce. The Sullivan Commission. Washington, D.C., 2004.
- <sup>12</sup> Association of American Medical Colleges. Underrepresented in medicine - definition. <http://aamc.org/meded/urm/start.htm>. Accessed on November 21, 2004.
- <sup>13</sup> PHS Act Section 799B. See <http://www.nigms.nih.gov/funding/table7.html>.

- 
- <sup>14</sup> Grutter v. Bollinger et al. 123 S.Ct. 2325,2341 (2003).
- <sup>15</sup> Association of American Medical Colleges. Assessing medical school admission policies: Implications of the US Supreme Court's affirmative-action decisions. Washington, DC: 2003.
- <sup>16</sup> DeVille K. Defending diversity: Affirmative action and medical education. *Am J Public Health*. 1999;89:1256-1261.
- <sup>17</sup> Cohen JJ. Disparities in health care: An overview. *Acad Emerg Med*.2003;10:1155-1160.
- <sup>18</sup> Turner CSV. Diversifying the faculty. A guidebook for search committees. Washington, DC: Association of American Colleges and Universities, 2002.
- <sup>19</sup>Whitcomb ME. Achieving the educational value of diversity. *Acad Med*. 2003;78:429-430.
- <sup>20</sup> Whitla DK, Orfield G, Silen W et al. Educational benefits of diversity in medical school: A survey of students. *Acad Med*. 2003;78:460-466.
- <sup>21</sup> Long JA, Chang VW, Ibramim SA, Asch DA. Update on the health disparities literature. *Ann Intern Med*. 2004;141:805-812.
- <sup>22</sup> Institute of Medicine. Unequal treatment: Understanding racial and ethnic disparities in health care. Washington, DC: National Academy of Sciences, 2002.
- <sup>23</sup> Centers for Disease Control and Prevention. Health disparities experienced by Hispanics - United States. *MMWR*. 2004;53:935-945,
- <sup>24</sup> US Department of Health and Human Services. Data 2010: The healthy people 2010 database. Hyattsville, MD: US DHHS, CDC, National Center for Health Statistics, 2004.
- <sup>25</sup> Wong MD, Shapiro MF, Boscardin WJ, Ettner SL. Contribution of major diseases to disparities in mortality. *N Engl J Med*. 2002;347:1585-1592.
- <sup>26</sup> CDC. Health disparities experienced by Black or African Americans - United States. *MMWR*. 2005; 54:1-11.
- <sup>27</sup> CDC. Racial/ethnic and socioeconomic disparities in multiple risk factors for heart disease and stroke - United States. *MMWR*. 2004; 54:113-121.
- <sup>28</sup> CDC. Racial/Ethnic disparities in infant mortality - United States, 1995-2002. *MMWR*. 2005; 54:553.
- <sup>29</sup> US Department of Health and Human Services. Data 2010: The healthy people 2010 database. Hyattsville, MD: US DHHS, CDC, National Center for Health Statistics, 2004.
- <sup>30</sup> Hunsaker JA. Profile of health disparities among communities of color: Colorado, 2001. Colorado Department of Public Health and Environment, 2002.
- <sup>31</sup> Racial and ethnic health disparities in Colorado – 2005. Report of the Office of Health Disparities, Colorado Department of Public Health and Environment. 2005.
- <sup>32</sup> Liao Y, Tucker P, Okoro CA et al. REACH 2010 Surveillance for health status in minority communities – United States, 2001-2002. In: Surveillance Summaries, August 27, 2004. *MMWR* 2004;53(No. SS-6): 1-35.

- 
- <sup>33</sup> Schneider EC, Zaslavsky AM, Epstein AM. Racial disparities in the quality of care for enrollees in Medicare managed care. *JAMA*. 2002;287:1288-1294.
- <sup>34</sup> Petersen LA, Wright SM, Petersen ED. Impact of race on cardiac care and outcomes in veterans with acute myocardial infarction. *Med Care*. 2002;40:186-196.
- <sup>35</sup> Isaacs SL, Schroeder SA. Class – The ignored determinant of the nation's health. *N Engl J Med*. 2004; 351:1137-1142.
- <sup>36</sup> Shi L, Macinko J, Starfield B et al. Primary care, social inequalities and all-cause heart disease and cancer mortality in US Counties, 1990. *Am J Public Health*. 2005; 95:674-680.
- <sup>37</sup> Lewis LB, Sloane DC, Miller L. African Americans' access to healthy food options in South Los Angeles restaurants. *Am J Public Health*. 2005;95:668-673.
- <sup>38</sup> Lavery SH, Smith ML, Esparza AA et al. The community action model: A community-driven model designed to address disparities in health. *Am J Public Health*. 2005;95:611-616.
- <sup>39</sup> Cohen JJ, Gabriel BA, Terrell C. The case for diversity in the health care workforce. *Health Aff (Milwood)*. 2002;21:90-102.
- <sup>40</sup> Komaromy M, Grumbach K, Drake M et al. The role of Black and Hispanic physicians in providing health care for underserved populations. *N Engl J Med*. 1996;334:1305-1310.
- <sup>41</sup> Cantor JC, Miles EL, Baker LC et al. Physician service to the uninsured: Implications for affirmative action in medical education. *Inquiry*. 1996;33:167-180.
- <sup>42</sup> Kington R, Tisnada D, Carlisle DM. Increasing racial and ethnic diversity among physicians: an intervention to address health disparities? In: Smedley BD, Colburn L, Evans CH, eds. *The right thing to do, the smart thing to do: Enhancing diversity in the health professions*. Washington, DC: National Academy Press; 2001;64:68.
- <sup>43</sup> Cohen JJ. Improving America's health status through a more diverse physician workforce. *Acad Med*. 1997;72:130.
- <sup>44</sup> Moy E, Bartman BA. Physician race and care of minority and medically indigent patients. *JAMA*. 1995;273:1515-1520.
- <sup>45</sup> Davidson RC, Montoya R. The distribution of services to the underserved: A comparison of minority and majority medical graduates in California. *Western J Med*. 1987;146:114-117.
- <sup>46</sup> Fryer GE Jr., Stine C, Vojir C, Miller M. Predictors and profiles of rural versus urban family practice. *Family Medicine*. 1997;29 (2)
- <sup>47</sup> Xu G, Fields SK, Laine C et al. The relationship between the race/ethnicity of generalist physicians and their care for underserved populations. *Am J Public Health*. 1997;87:817-822.
- <sup>48</sup> Perez-Stable EJ, Napoles-Springer A, Miramontes JM. The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. *Medical Care*. 1997;35:1212-1219.
- <sup>49</sup> Saha S, Abelaez JJ, Cooper LA. Patient-physician relationships and racial disparities in the quality of health care. *Am J Public Health*. 2003;93:1713-1719.
- <sup>50</sup> Cooper LA, Roter DL, Johnson RL et al. Patient-centered communication, ratings of care and concordance of patient and physician race. *Ann Intern Med*. 2003;139:907-915.

- 
- <sup>51</sup> Weissman JS, Betancourt J, Campbell EG et al. Resident physicians' preparedness to provide cross-cultural care. *JAMA*. 2005; 294:1058-1067.
- <sup>52</sup> Lypson ML, Gruppen L, Stern DT. Careers in medicine – You've got to be careful if you don't know where you're going because you might not get there. Warning signs of declining faculty diversity. *Acad Med*. 2002;77:S10-S12.
- <sup>53</sup> Jones CP. Levels of racism: A theoretical framework and a gardener's tale. *Am J Public Health*. 2000;90:1212-115.
- <sup>54</sup> Cone DC, Richardson LD, Todd KH et al. Health care disparities in emergency medicine. *Acad Emerg Med*. 2003;10:1176-1183.
- <sup>55</sup> Bowen WG, Bok DC. *The shape of the river: Long-term consequences of considering race in college and university admissions*. Princeton, NJ: Princeton University Press, 1998.
- <sup>56</sup> Learning from others: A literature review and how-to guide from the Health Professions Partnership Initiative. Association of American Medical Colleges. Washington, D.C., 2004. Additional data from *Minorities in Medical Education: Facts and Figures 2005*.
- <sup>57</sup> Cooper RA. Impact of trends in primary, secondary and postsecondary education on applications to medical school. II: Considerations of race, ethnicity and income. *Acad Med*. 2003;78:864-876.
- <sup>58</sup> Scotti MJ. Medical school admission criteria. The needs of patients matter. *JAMA*. 1997;278:1196-1197.
- <sup>59</sup> Lewis A. Diversity makes society stronger. Commentary, *Rocky Mountain News*, May 27, 1997 (Page 31A).
- <sup>60</sup> *AAMC Minorities in Medical Education: Facts and Figures 2005 (chart, page 30)* : AAMC, 2002 chart; also see faculty roster system, AAMC;
- <sup>61</sup> Paepu A, Carr PL, Friedman RH et al. Minority faculty and academic rank in medicine. *JAMA*. 1998;280:767-771.
- <sup>62</sup> Palepu A, Carr PL, Friedman RH et al. Specialty choices, compensation and career satisfaction of underrepresented minority faculty in academic medicine. *Acad Med*. 2000;75:157-160.
- <sup>63</sup> Fang D, Moy E, Colburn L, Hurley J. Racial and ethnic disparities in faculty promotion in academic medicine. *JAMA*. 2000;284:1085-1092.
- <sup>64</sup> Marbella AM, Holloway RL, Sherwood R, Layde PM. Academic ranks and medical schools of underrepresented minority faculty in family medicine departments. *Acad Med*. 2002;77:173-176.
- <sup>65</sup> Carr P, Bickel J, Inui TS. *Taking root in a forest clearing: A resource guide for medical faculty*. Boston: Boston University School of Medicine, 2004.
- <sup>66</sup> Whitcomb ME. Preparing doctors for a multicultural world. *Acad Med*. 2003;78:547-548.
- <sup>67</sup> Hixon AL. Beyond cultural competence. *Acad Med*. 2003;78:634.

---

<sup>68</sup> Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor and Underserved*. 1998;9:117-125.

<sup>69</sup> W.K. Kellogg Foundation. National commission urges action to link scholarship and communities. Press Release (February 28, 2005).<http://depts.washington.edu/ccph/kellogg3.html>.

<sup>70</sup> W.K. Kellogg Foundation. Linking scholarship and communities. February 28, 2005. <http://depts.washington.edu/ccph/kellogg3.html>.

<sup>71</sup> Cooper RA. Impact of trends in primary, secondary and postsecondary education on applications to medical school. II: Considerations of race, ethnicity and income. *Acad Med*. 2003;78:864-76.

<sup>72</sup> Cohen JJ. Meeting the diversity challenge. *AAMC Reporter*. December, 2004 (Page 2).

<sup>73</sup> Carey TS, Howard DL, Goldmon M et al. Developing effective interuniversity partnerships and community-based research to address health disparities. *Acad Med*. 2005; 80:1039-1045.

<sup>74</sup> Keppel , Pamu E, LynchJ et al. Methodological issues in measuring health disparities. National Center for Health Statistics. *Vital Health Stat* 2(141). 2005.