HEALTH PROFESSIONS ACCREDITATION AND DIVERSITY:
A Collaborative Approach to Enhance Current Standards

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Commissioned by The W.K. Kellogg Foundation and The California Endowment
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I. OVERVIEW

Accreditation organizations play a central role in ensuring optimal quality among America’s higher education institutions. The accreditation process is complex; issues of comparative quality are balanced with academic freedom and consistency with institutional mission, and national interests balanced with regional and state level dynamics.

In an era when outcomes and accountability have become watchwords in higher education, accrediting bodies have increasingly been called on by policy makers and the public to emphasize a regulatory or policing function, making it easy to lose sight of the important role that the peer review process of accreditation contributes to quality improvement. Resolution of these issues requires in depth and ongoing dialogue between accreditors as well as administrative and faculty leaders in higher education; and such discussions would be strengthened by more frequently involving public policymakers and the general public.

Among higher education institutions, professional schools have a special responsibility to align their educational process with evolving societal needs and priorities. This responsibility is perhaps most clear among health professions education institutions, which are charged with providing their students with the insights and competencies that will enable them to serve our increasingly diverse communities.

Increasing diversity in the health professions has been identified as a societal imperative, most notably by two blue ribbon panels commissioned by the W.K. Kellogg Foundation in 2003 to conduct a comprehensive review of research and practices. The panels released extensive reports of findings and recommendations, both of which indicated that the process of accreditation for health professions education institutions (HPEIs) can serve as an important lever to catalyze more serious attention and action to diversity issues.

This brief builds on findings from a national study published in the May 2007 report “Health Professions Accreditation and Diversity: A Review of Current Standards and Processes,” and outlines a set of consensus recommendations for ongoing dialogue and collaboration between health professions accreditors and HPEI administrative and faculty leaders. The recommendations discussed here are themselves the product of ongoing collaborative discussions among educational leaders and accreditors in selected health professions.
A. Project Intent and Process

Building on the foundation established in the May 2007 report, this project’s aim is to advance the potential of accreditation as a tool for ensuring sufficient diversity in the health professions to address the evolving health needs of culturally and demographically distinct populations. We recognize that the extent to which such potential will be actualized depends on some factors which are beyond the scope of this brief, such as the commitment of the various professions to address health issues relating to diversity, external pressures on those professions and their associated educational and accreditation organizations, and the willingness of accreditors and educational institutions to establish ambitious but achievable goals and policies for creating and sustaining a diverse learning environment.

A key message conveyed by health professions accreditors in the 2007 study was that meaningful change in standards is driven by leaders in the field. With this in mind, the co-authors of the May 2007 report secured a grant from the W.K. Kellogg Foundation to convene national leaders and develop consensus recommendations that will facilitate definitive progress in the field. Additional funding was secured from The California Endowment through a partnership with California’s Connecting the Dots Initiative, a comprehensive statewide strategy to increase health professions workforce diversity.

Project Co-Investigators selected four disciplines from which to recruit academic leaders, specifically dentistry, allopathic medicine, clinical psychology, and public health. While each of the four health professions disciplines represents a distinct area of education and training, experience in the 2007 study suggested that shared examination of the accreditation processes and diversity-related issues across disciplines could yield significant insights. These four disciplines were selected from the broader pool of health professions education institutions because they share many common issues and challenges in the areas of focus for this project (see below). That having been said, many of the recommendations outlined in this brief are certainly relevant and applicable to other health professions disciplines.

With assistance from accreditors for each of the four disciplines, the project co-investigators identified and engaged 5-6 academic leaders from each discipline. In most cases, individuals were nominated because of their demonstrated interest in the issue of diversity and/or involvement on accreditation committees charged with related responsibilities. Selected leaders included administrators (e.g., Deans, Associate Deans), faculty with significant experience and expertise in the area, and practitioners in the field who serve on accreditation committees. A list of the leaders who participated in the project is included as Section VII.

There were four stages in the project:

- **Convene discipline-specific conference calls** to introduce topics and establish common understandings, solicit initial input on content areas of focus, share recent developments in relevant areas, and identify unique and common issues to examine.

- **Convene leaders and accreditors for a half-day meeting** across disciplines to flesh out topic areas, solicit detailed input, and discuss issues, challenges, and emerging opportunities.

- **Develop and refine draft recommendations** based upon follow-up feedback from project participants.

- **Convene a joint conference call** to solicit input on the final draft report and related recommendations

Based on the initial conversations, four specific areas of focus were identified as a framework for
further discussion and the development of consensus recommendations:

- **Institutional commitment and leadership** – The development of formal strategies and the role of leadership in fostering and sustaining an institution-wide commitment to diversity.

- **Admissions** – Strategies to strengthen and clarify the role of diversity in the admissions process, addressing both attendant structures and processes. Examples of relevant issues include, but are not limited to the composition of the admissions committee, roles and responsibilities, criteria and process for applicant review and decision-making, as well as setting admission goals and objectives and review of progress against these goals and objectives.

- **Institutional climate** – Strategies to move beyond structural, or compositional diversity, which may be an easily measurable factor, but can often reinforce a divisive, zero-sum interpretation of the scope and meaning of diversity. A more holistic approach gives attention to the establishment of an institutional climate that fosters the accrual of the benefits of diversity through shared learning, both in the formal and informal curriculum. The informal curriculum ranges from general social interactions among students, to faculty and alumni mentoring, community service learning, supported dialogue among different student interest groups, and the deliberate integration of important, yet subtle lessons learned through experiential clinical and field training experiences.

- **Social contract** – The acceptance of a social contract for health professions education institutions. Key elements of such a commitment include examining roles and responsibilities for regional investment in expanding the pool of future applicants from under-represented backgrounds, and engaging communities to address major societal imperatives such as eliminating health disparities and increasing access to quality health care.

### B. Our Definition and Framework for Diversity

For the purposes of this project and based on lessons from the field, we have defined diversity in broad terms. Race and ethnicity represent important dimensions, given historical and political dynamics, demographic trends and projections (i.e., growing racial and ethnic diversity), racial and ethnic-based health disparities, and substantial under-representation of expanding demographic groups in the health professions. Increasing diversity in the health professions, however, also requires recognition of many other dimensions, including, but not limited to gender, sexual orientation, cultural background, socio-economic status, language, cognitive style, nationality, and age.

Our conceptual framework for diversity is drawn from what has been described previously by leading researchers on higher education and diversity, with three interacting dimensions; a) compositional, or structural diversity, b) formal curricular diversity, referring to classroom and practical training interactions, and c) institutional climate, referring to an environment that supports diversity as a core value and provides opportunities for active and ongoing exchange of ideas among students, faculty, and staff from diverse backgrounds. (see Figure 1). Compositional diversity is essential, as articulated by Supreme Court Justice Sandra Day O’Connor in the Grutter v. Bollinger case in 2003, since a “critical mass” of diversity is needed to produce ongoing exposure of students and faculty to the broadest spectrum of ideas and experiences. At the same time, however, thoughtful and deliberate integration of relevant content and pedagogical approaches in the classroom and practicum settings are needed to facilitate a dynamic
exchange of ideas. These formal interactions then set the stage for continued interactions in informal settings in the campus environment, which are supported by campus leaders and coordinated through multiple student, faculty, and administrative mechanisms.

We also recognize the need to examine the issue of diversity from a contextual perspective. Programs and institutions in different geographic regions and with distinct educational missions may have different areas of emphasis, as well as practical concerns that impede efforts to address diversity in specific dimensions. This is not to say that responsibility is deferred; rather, that an assessment of performance and strategies to advance diversity should take these issues into consideration.

Finally, we note that while achieving or enhancing diversity in its broadest sense may be a desirable goal, it is just as important to understand that for the health professions diversity also provides a tool for more effectively addressing specific inequities in health care (notably health disparities, culturally sensitive care, and health needs for underserved populations). Thus, greater diversity is not simply an end in itself but a means for improving the health of the public.

Figure 1: Three Dimensions of Diversity
II. BACKGROUND / IMPETUS

A. IOM Committee and Sullivan Commission accreditation recommendations

In recent years, the notion of a role for accreditation standards and processes to help advance diversity efforts in health professional schools was first noted in two blue ribbon panels, commissioned by the W. K. Kellogg Foundation to advance diversity goals in the health professions and published in 2004. The Institute of Medicine (In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce) included six recommendations in a section of its report entitled: “Accreditation as a Key to Increase Diversity in Health Professions.”

In parallel fashion, the Sullivan Commission issued four recommendations in its report (Missing Persons: Minorities in the Health Professions. A Report of the Sullivan Commission on Diversity in the Healthcare Workforce) explicitly noting that accrediting bodies of health professions schools have an important contributing role in fostering ‘accountability’ for the actions of those schools and their leadership in addressing diversity issues. Together, these two panels called for additional efforts by professional organizations (including accrediting bodies) to promulgate guidelines, set standards and regulations, and develop other mechanisms for promoting cultural competency and diversity within the health professions.

B. Brief overview of 2007 study and selected findings

Given the enthusiasm of these two respected national panels for using health professional school accreditation standards and related mechanisms for advancing diversity, the W.K. Kellogg Foundation provided additional support to a subset of panel members to do a more detailed exploration of the topic. That support led to a series of activities culminating in the publication of the May 2007 report entitled: Health Professions Accreditation and Diversity: A Review of Current Standards and Processes.

The aim of the activities connected to this 2007 study was to capture the current state of accreditation standards and related processes across the health professions of medicine (allopathic and osteopathic), dentistry, nursing and doctoral level training in clinical psychology. The authors of that report thought it useful to expand the scope to include graduate training in public health as well as baccalaureate and graduate training in social work. The 2007 report also provided some details about the conflict between the U.S. Department of Education and the American Bar Association’s efforts to strengthen diversity standards in legal education, as an illustration of the kinds of obstacles that accreditation bodies can encounter in addressing diversity issues.
In presenting the findings about approaches to diversity among the various health professions accreditation organizations, the authors thought it useful to summarize each accrediting body’s current standards and processes as they related (or not) to the full breadth of the dimensions of diversity. In addition to narrative descriptions, the May 2007 report contained a summary table noting whether the reach of each particular accrediting body’s standards and/or guidelines touched on the issues of compositional diversity, formal classroom diversity and informal institutional climate — the various dimensions of diversity noted above. We found that there was a fair amount of variability in the scope and content of the diversity-related standards across the various health professional accrediting bodies.

C. Diversity standard review/enhancement by accreditors since 2007

The Liaison Committee on Medical Education (LCME) adopted two new diversity-related accreditation standards in 2008, facilitated by the discussions surrounding the May 2007 report as well as by the leadership of LCME members and professional staff, the Association of American Medical Colleges, and several medical schools.\(^{10}\)

The first new standard places greater emphasis on the need for medical schools to increase the pool of diverse applicants who may want to enter allopathic medicine, through efforts of the schools themselves as well as through partnerships with other organizations. The annotated guidance accompanying the standard notes that schools can accomplish that aim through a variety of approaches, including but not limited to the development and institutionalization of pipeline programs, collaborations with institutions that serve students from disadvantaged backgrounds, community service activities that heighten awareness of and interest in the profession, or academic enrichment programs for applicants who may not have taken traditional pre-medical coursework.

The other new standard focuses on compositional diversity for all of a medical school’s constituencies, and is grounded in the notions that the environment in which medical schools operate should be one that is inclusive and supportive of diversity, and that future physicians should be trained in:

- Basic principles of culturally competent health care
- Recognition of health care disparities and the development of solutions to such burdens

One observation, based upon consistent input from accreditors, was that meaningful change in standards is driven by leaders in the field.

In addition, the report included twelve ‘Key Observations’ that highlighted various themes that we noted in reviewing the accreditation standards and related processes of these health professions accrediting bodies. One observation, based upon consistent input from accreditors, was that meaningful change in standards is driven by leaders in the field. That specific observation became a cornerstone for our final chapter of the May 2007 report, and is the focus of the current effort to develop a set of consensus recommendations for ongoing dialogue and collaboration between health professions accrediting bodies and HPEI administrative and faculty leaders. The other 11 observations were used to inform our discussions during the current phase of research to better define a path for making concrete progress in the diversity arena.
The importance of meeting the health care needs of medically underserved populations

The development of core professional attributes, such as altruism and social accountability, needed to provide effective care in a multi-dimensional diverse society.

Each school is expected to articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. Whether or not medical schools will limit their focus of diversity efforts to the compositional dimension, or expand their focus to address other aspects of diversity in responding to this new standard remains an open question at this juncture. It is likely, however, that the new standards will increase awareness and focus on diversity-related issues, and will produce a wealth of lessons from different approaches taken by schools of medicine across the country.

In November 2009 the accrediting body for clinical psychology also made an effort to clarify the language in its diversity-related accreditation standards (Domain D) through the development of new implementing regulations. The revised regulations emphasize the need for programs to make multiple year efforts and plans to attract and retain diverse students and faculty. Importantly, they also attempt to broaden the focus of program efforts to not only include considerations of compositional diversity — but also emphasize the need to place attention on the diversity curriculum that is provided through both didactic and experiential training. Programs are also encouraged to detail their efforts by describing the specific activities, approaches, and initiatives it has taken to integrate issues of diversity. Currently, these regulations are out for public comment to the clinical psychology educator field.

D. Ongoing education/engagement/research efforts by health professions educational organizations to advance diversity

While the LCME was the only accrediting organization of the four involved in this project to formally adopt new standards during this time period, the other health professional groups have been addressing diversity issues through other approaches. Frequently led by their school administrators and faculty members, these professions have been engaged in serious discussions of the issue and have promulgated a variety of statements and documents tied to the topic.

For example, in graduate public health education, the Association for Schools of Public Health (ASPH) created a diversity committee whose aim is to help schools of public health to learn about health disparities/diversity research and educational activities that could help to advance important goals in this area. In 2008, guided by that committee, ASPH published a report entitled: Schools of Public Health Goals Towards Eliminating Racial and Ethnic Health Disparities which grew out of a 2005 conference on the subject. The report includes a set of goals that public health schools can adopt in order to advance diversity goals. In total, there are 22 goal statements organized in categories of: research; curriculum, faculty, tenure and promotion, students, community outreach and authentic partnerships, and policy and advocacy.

In dental education, the American Dental Education Association (ADEA) has updated a number of different policy statements that touch upon the diversity issue. Its 2008 revision of policy statements aimed at advancing the efforts of dental schools tied to:

- improving recruitment, retention and access to best practices;
- advancing cultural and linguistic competence in curricula;
increasing gender and minority representation of faculty.\textsuperscript{16}

partnering with other organizations to advance diversity.\textsuperscript{17}

In addition, ADEA developed a statement on professionalism that includes encouragement to dental school students, faculty, researchers and administrators to be sensitive to diversity in patients’ cultures, and notes some examples of how this is accomplished.\textsuperscript{18} In light of impending health care reform, ADEA also promulgated language addressing the need for a more diverse oral health workforce.\textsuperscript{19}

Finally allopathic medicine has continued to explore how best to encourage and support medical schools in their efforts to advance diversity goals. In 2008, the Association of American Medical Colleges (AAMC) published a guide: \textit{Roadmap to Diversity: Key Legal and Educational Policy Foundations for Medical Schools}. The stated purpose for this guide is to: “help medical schools align admissions to mission, and establish and implement institution-specific, diversity-related policies that will advance their core educational goals with minimal legal risk.”\textsuperscript{20} AAMC plans to publish two other guides related to diversity issues in the upcoming years.
A. Evolution and role of health professions accreditation

As noted in the introduction, the accreditation process in higher education represents a very precise, and sometimes precarious, balancing act. It is fundamentally a voluntary process based on peer evaluation and the general acceptance, by the institutions or programs that are accredited, of the standards and criteria by which they will be judged. Because accreditation is voluntary, ensuring compliance with accreditation standards can be challenging. Successful promulgation of new standards or criteria is possible only if there is a recognition and acceptance among the community of accredited entities (programs and/or institutions) and the profession that the proposed standards meet a recognized need, contribute to educational quality, and can be applied in a consistent way by the peers in any given profession and carry out the assessment of compliance with accreditation standards.

For health professions accrediting bodies, the need to focus on the issue of whether accreditation standards or criteria adequately address diversity grows from the evolving discussion and literature suggesting that diversity can have significant impacts on health care delivery and health outcomes. However, educators and accreditors, concerned with both educational quality and educational outcomes, are also challenged by the fact that the literature on diversity effects is sometimes equivocal as to the measurable effects of ethnographic diversity on education and health. They are also affected by the current political and sociological climate, which can often be so volatile around diversity issues (as indicated, for example, by the controversy within the U.S. Department of Education in its last review of the accreditation activities of the American Bar Association and the ABA’s strengthened standards on diversity; that controversy is described in detail in the May 2007 report). Successful development of more rigorous approaches to diversity among health professions accreditors must therefore establish reasonably clear definitions of diversity and its effects on educational quality and outcomes in order to garner broad acceptance of diversity as a marker of educational quality and not a vehicle for social change.

B. Institutional and programmatic diversity

While educational programs must meet accreditation expectations, their sponsoring institutions are responsible for creating a climate and providing the resources necessary to meet accreditation requirements. This dynamic can sometimes limit the ability of programmatic accrediting agencies to garner or stimulate institutional commitment to achieve diversity-related goals and objectives. That does
not mean that programmatic accreditors are powerless, especially for professional programs that are considered prestigious within institutions of higher education. It does mean, however, that the development of more rigorous programmatic approaches to diversity must be sensitive to the resource requirements that may result, and mindful of the importance of broad institutional support for a more comprehensive approach to diversity issues within any given health professions field.

C. Alternative approaches to standards development / application

The focus of this project is to stimulate discussion and actions which are based on a recognition that exposure to the experiences and perspectives of people from diverse backgrounds is an important factor in the assessment of quality in higher education, and therefore merits explicit attention in the framework of accreditation standards and processes of health professional education programs. We recognize that the time frames in which different accrediting bodies evolve their approaches will vary, given the general challenges that they face, as well as the need to anchor diversity standards in research findings which demonstrate the connections between advancing diversity and educational outcomes.

Nevertheless, the ultimate goal that we seek, as indicated in the recommendations that follow, is for the accrediting bodies to develop standards or criteria that address the three dimensions of diversity and the four areas of focus that have framed our discussions. While there is a growing evidentiary base to support such evolutionary change as it relates to the three dimensions of diversity, some of the participating disciplines are presently further along than others in addressing selected dimensions and areas of focus in standards. Thus, we are not advocating a single or common strategy for any particular accrediting agency or the discipline it represents. Where standards currently do not exist, it is important for accreditors to engage their communities (programs, schools, or both) in the dialog necessary to achieve a consensus upon which standards can be created. Such a dialog may well require additional efforts on behalf of both the accrediting bodies and the entities they accredit, including further research on the educational impact of diversity, dissemination of the outcomes of program diversity initiatives, and the development of appropriate tools for the measurement of diversity and its effects.

While the development of relevant accreditation standards is a desired outcome for the authors of this study, there are other ways in which accrediting bodies can contribute to a more visible recognition of the contributions of diversity to educational quality. One obvious strategy is to incorporate diversity considerations in the appointment of the members of decision-making bodies for accreditation, and in the formation of peer evaluation teams that carry out the educational program assessment process on behalf of the accrediting bodies. Another approach is to examine existing accreditation standards to determine if they are in any way antithetical to a more comprehensive approach to diversity.

D. Collaboration and leadership – opportunities and challenges

While this project has looked to the accreditation community as a critical venue for strengthening the role of diversity in health professions education, it is abundantly clear that accreditors will require the collaboration and support of the institutions and programs they accredit, and of the professional organizations which represent those institutions and programs. The professional organizations representing the various disciplines serve a key role, as they can bring
together often disparate institutions and programs (research-intensive, community-based, free-standing, etc.) and help to define the framework and strategies to address diversity issues, and facilitate or support further studies on the measurement and outcomes of diversity.

Another area for potential collaboration is the accreditation community itself. While there are some formal and informal opportunities for accreditors of different disciplines to engage in dialog with each other, those opportunities are limited in scope and generally focus more on operational issues and practices. It may be timely for the accrediting bodies of key health professions to engage in ongoing discussions and mutual learning about successes and challenges they have encountered in addressing diversity issues.

The current economic and sociopolitical climate represents an obvious barrier to efforts to strengthen approaches to diversity both within and outside of the accreditation framework. A multi-faceted approach to diversity, whether required by accreditors or not, entails a commitment of financial and human resources that have become increasingly scarce in the present economic downturn. Similarly, a political climate that is increasingly leery of diversity-related public policies (such as immigration and affirmative action) makes it more difficult for health professions institutions and programs to develop and implement diversity initiatives that may be construed as having a social or political agenda. These economic and sociopolitical challenges are substantial, but they emphasize the importance of collaboration and leadership for ensuring that the education of future leaders in health and health care delivery meets the needs of an increasingly diverse society.
IV. RECOMMENDATIONS

In advancing these recommendations, we understand that there are unique characteristics among the four disciplines engaged in this project that call for different approaches to the development and implementation of specific diversity-related standards.

We believe, however, that the identification of the full spectrum of issues and strategies will inform the dialogue between accreditors and the leadership of the institutions and programs they accredit in determining which elements can and should be addressed in the accreditation process. Similarly, we believe that leaders of educational institutions and programs can strengthen the effectiveness of their educational efforts by assessing the level and manner in which these issues are addressed within their organizations, and take appropriate actions whether or not their accrediting bodies call upon them to do so.

We strongly encourage accreditors of health professions educational programs and institutions to work with their associated membership organizations, and with individual constituents within those organizations to (1) formally recognize diversity as a core element of educational quality that must be addressed systematically as part of the education and training of future health care professionals; and (2) collaborate in the development of policies, practices, standards, and assessment criteria that will allow educational institutions to articulate clearly stated diversity goals and identify strategies to achieve them that are consistent with existing legal strictures.

The four general areas for potential standards development described below, and the associated components listed for each domain, emerged from our discussions with leaders of the various health professions involved in this project. As expressions of the thinking of those leaders, the recommendations that follow should provide a sound framework for collaborative dialog between accrediting agencies and their constituents about what should be included in a comprehensive approach to increase diversity and foster the accrual of the benefits of diversity for all in health professions education.

A. Challenges Requiring Attention

In the course of the project and associated discussions, leaders identified a number of specific challenges that need to be addressed within the four areas of focus. Each of these challenges is summarized in this section.
1. Institutional Commitment and Leadership

Current accreditation standards do not explicitly address the roles and expectations of administrative leadership and faculty in ensuring diversity among faculty, staff, and students or creating an environment that fosters the accrual of the benefits of diversity for faculty, staff, and students from all backgrounds. The lack of attention to this important issue contributes to significant variation in the degree and manner in which leadership is provided to enhance academic processes in this regard.

On a related issue, a number of leaders noted that the accreditation site visit and self-study process engage ‘central’ administrative leadership, but somewhat less attention is given to responsibilities, strategies, and specific objectives among faculty departmental leadership. To date, there are relatively few examples where institutional or programmatic incentives have been established to broadly engage faculty members in the development of a diverse learning environment.

Leaders noted that the increasingly short tenure of deans and department heads makes it difficult to sustain diversity efforts in the absence of a stated institutional commitment, concrete goals or objectives, and documentation of related activities. In such an environment, deans and department heads have limited ability to garner the support and engagement of tenured faculty to actively support diversity efforts. When leadership changes are made in schools and programs, more explicit guidelines are needed to ensure that successor leaders are informed about their roles, responsibilities, and strategies to ensure continued progress towards achievement of diversity goals and objectives.

Leaders also cited a generalized tendency among academic decision making bodies charged with faculty recruitment and retention to view diversity as an ancillary concern that is generally unrelated to research or clinical productivity and academic quality. Diverse candidates may present additional strengths in non-traditional research (e.g., collaborative and/or participatory action research), service learning, and mentorship that enhance academic quality but may not be included in a job description or recruitment criteria. When faculty recruitment and retention are focused narrowly on specific contributions to institutional or departmental productivity goals, the net effect is to reduce efforts to increase diversity to ad hoc, incidental or incremental criteria that are unlikely to produce a diverse academic community.

2. Admissions

One of the overriding issues cited by leaders in regards to the HPEI admissions process is a lack of clarity and consistency in the application of Holistic Review23 as a tool for incorporating diversity considerations in the evaluation of candidates for admission. While a growing number of health professions education institutions claim to have implemented some form of Holistic Review in their admissions process, there is significant variability in how the reviews are conducted (e.g., use and weighting of criteria, sequencing and application), which leads to questions about the reliability of the approach.

In some institutions, use of Holistic Review may be limited to a sub-cohort of the larger applicant pool who meet specific criteria (e.g., test scores and GPA within a particular range). This approach undermines an important goal of Holistic Review, which is to consider an entering class as an interactive whole; in essence, selection is informed by attention to ensuring the optimal breadth of backgrounds, skills, and experiences. In summary, there has been substantial experimentation in efforts to implement holistic review of applicants, but a lack of clarity, consistency, and transparency can produce results inconsistent with intended goals, and impede efforts to assess the relative effectiveness of alternative approaches.
Leaders also expressed concern about subtle or unintended dominance of admissions committee deliberations by faculty members who may be narrowly focused on academic achievement or standardized test scores and may not empathize with, or aspire to fully understand, the impact of diversity on education. In some cases, there is miscommunication and/or variation in orientation and action on diversity issues, between deans or other senior leaders and the members of admissions committees. Some administrative leaders may be less inclined to clearly outline issues and priorities as a part of the admissions committee orientation, resulting in differential understanding and interpretation of the information used to make admissions decisions.

Last, but not least, HPEI leaders noted that in some states, such as California, Michigan and Washington, recent laws or court decisions have created new barriers to the use of race and ethnicity in determining who is offered admission into HPEI programs. This has had variable impact, with some HPEIs in these states demonstrating a high level of innovation in building approaches to diversity in a manner that does not violate the legal statutes, even though many others have been reluctant to do so. Greater understanding and dissemination of innovative approaches is likely needed in order to overcome some of the concerns of those programs, and to provide them with strategies that respect current laws while concomitantly working to advance diversity goals.

3. Institutional Climate

In general, leaders indicated a need to focus on how diversity helps institutions to achieve their goals and fulfill their mission, rather than pursuing compositional diversity as a goal in and of itself.

Leaders cited a lack of understanding and a need for a more complete definition of institutional climate that includes recognition of the need for shared learning across groups comprising a health professional education institution. There are numerous examples where campus level special interest groups have been created, but most are student driven, and often lack substantive support from schools and programs and their attendant leaders. All too frequently there is little attention to cross-fertilization across groups at the general campus level.

Leaders also noted a lack of attention to strategies for integrating the diverse experiences of students entering and returning from field training into the formal curriculum. Direct engagement of faculty is needed to examine, design, implement, and evaluate the impact of relevant curricular strategies related to diversity. One leader pointed out that students in clinical placements may provide services to uninsured people, but often don’t understand the broader cultural and socio-economic factors that impact the care delivery process.

An important challenge in building broader support is the ability to articulate how diversity in the academic environment helps to better serve societal interests. Leaders identified a need for more of a focus on the specific competencies acquired by students tied to this broader educational context beyond the classroom or patient care suite (e.g., what they learn about populations, culture, and place). What specifically does the school/program do to “cultivate” the competencies associated with learning in a diverse environment? One leader spoke of the need to get beyond a “checklist” approach where actions are being taken without understanding of the broader educational intent.

4. Social Contract

A generalized concern cited in discussions with a broad array of leaders is the lack of attention and focus on the
social contract obligations of higher education. Support for higher education, whether in the form of direct budgetary allocations for public-supported institutions, or in the indirect form of tax exemption, comes with an implicit expectation of social returns on that investment. Fulfillment of expectations, particularly in professional higher education, can and should occur on multiple levels which include but are not limited to a) ensuring optimal alignment of educational content with current and emerging needs in the communities where such education takes place, b) outreach, engagement, and support for inclusion of students from diverse backgrounds, and c) conducting research that both advances the field and addresses important societal challenges.

One of the most significant challenges cited by leaders is a disconnect between higher education institutions and residents of communities in their region. While most HPEIs pursue prospective students from diverse backgrounds, their efforts are often limited to a pool of under-represented candidates who meet traditional academic criteria. Only a small (but growing) group of HPEIs focus on the support of youth at the K-12 level within their region, directly addressing their social contract obligation to at least play a supporting role in efforts to build a health workforce that is drawn from and effectively serves their state or local population.

Leaders indicated that in many HPEIs, students tend to lead community outreach and engagement efforts, with lesser or less visible participation by or support from faculty members and institutional leaders. This appears to be particularly the case in dentistry, medicine, and psychology (again, with important exceptions), and less so in public health. Even at public health schools and programs, however, there is often little explicit encouragement and/or incentives for faculty engagement in community service. While many higher education institutions include “community service” as an element in the consideration of advancement for faculty members, institutional incentives for advancement tend to work against substantial engagement in this area. In fact, junior faculty are often discouraged from such work and are told that spending time on community service is inconsistent with advancing scholarship (i.e., publication in peer review journals).

One of the most significant challenges cited by leaders is a disconnect between higher education institutions and residents of communities in their region. In low income communities in particular, there may be little perceived connection to the stated community mission of HPEIs in the region, nor is there common understanding that these institutions’ exemption from public obligations such as municipal property tax comes with an obligation to engage and/or serve populations within the region. While there is no explicit legal obligation, there is growing recognition among communities that some level of engagement and support is appropriate.
B. Recommendations

1. Institutional Commitment and Leadership

To strengthen the recognition of the educational and health care impact of diversity, accreditors are encouraged to collaborate with their professional societies and leaders of institutions and programs to consider criteria or standards and supporting documentation addressing the following steps for strengthening diversity:

- Develop a mission statement that articulates institutional goals and expectations for diversity across component communities (faculty members, students, staff, etc.) in order to create a learning environment that fosters understanding of diversity as a health issue.

- Identify a single institutional leader (e.g., Associate Dean of Diversity) responsible for leadership, coordination, and monitoring progress towards identified diversity goals and objectives.

- Define roles and responsibilities of administrative leaders (deans, department chairs, section chiefs, etc.) to achieve and sustain goals and objectives for diversity.

- Document steps taken to create and maintain a supportive environment that facilitates shared learning about diversity issues from an appropriate variety of perspectives.

- Establish metrics and/or concrete actions that establish accountability for achievement of diversity-related goals and objectives.

- Develop, as needed, appropriate incentives to enhance broad engagement in and commitment to the achievement of goals and objectives related to diversity.

- Identify diversity-related activities that help to achieve specified objectives.

- Identify tangible contributions that all academic departments and programs should make to achieve goals and objectives for diversity.

- Exemplify institutional commitment to diversity through the relative diversity of senior administrators in both health professions education institutions and professional training programs.

- Engage recognized external diversity consultants and experts to conduct audits to assess progress as part of a quality improvement process.
2. Admissions

As further evidence of a commitment to diversity, educational institutions can establish, and accreditors can encourage, formal acknowledgment of diversity in the structure and functioning of admissions committees and their related procedures. Our discussions with HPEI leaders and accreditors indicated the following aspects of the admissions process as elements to be considered in a re-examination of the impact of diversity in this area.

- Develop a formal mission statement and/or purpose for the admissions committee that recognizes the institutional and educational benefits of admitting and matriculating a diverse student body.

- Implement admission strategies, such as Holistic or Whole File Review that facilitate the due consideration of individual characteristics and attributes (including the various dimensions of diversity) in addition to the academic performance or potential of applicants.

- Establish breadth of diversity as one of the criteria for membership on admissions committees.

- Provide ongoing and/or periodic activities to educate members of admissions committees about diversity-related issues relevant to their responsibilities for student selection.

- Focus attention and needed resources to address the financial barriers that often confront students from financially disadvantaged backgrounds.

3. Institutional Climate

Advancement of diversity standards in the health professions academic arena requires attention to all three dimensions of diversity, including compositional or structural diversity, classroom diversity, and institutional climate or informal interactional diversity. For a variety of reasons, the primary focus to date in accreditation and institutional practice has been on compositional diversity; i.e., the number of students from under-represented backgrounds, and classroom diversity; i.e., the integration of diversity related content into the formal curriculum. Much more effort is needed to create an institutional climate that facilitates shared learning among students from diverse backgrounds; both in the classroom and through a variety of mechanisms in extra-curricular settings that establish an institutional climate that is supportive of diversity.

We recommend that accrediting bodies engage the leaders of health professions educational
institutions and programs in a joint effort to create and sustain a supportive environment for diversity that facilitates formal and informal shared learning by students and faculty members from diverse backgrounds. In such an environment, it is important to recognize the key influence and contributions provided by faculty and staff members, and to provide appropriate incentives to encourage their direct involvement and action. Elements that can be addressed in standards or criteria relating to the institutional climate include:

- Establish accountable leadership and centralized coordination of activities to strengthen compositional and classroom diversity as well as the overall institutional climate tied to diversity.
- Integrate student learning from field or clinical experiences into the classroom setting as well as in the design of the overall educational experience.
- Encourage direct participation of faculty members with expertise and experience in field or clinical service activities that provide more varied forms of student learning.
- Integrate diversity-related health and health care issues across the curriculum.
- Provide institutional support for student interest groups, and for the facilitation of productive interactions across such groups.

In addition to the recommendations outlined above, the institutional or programmatic self-study conducted for accreditation should explicitly encourage programs and institutions to discuss and support further research into strategies to create and maintain a supportive environment for diversity. Key questions to be addressed include:

- What constitutes a critical mass for achieving diversity goals, and how can it be measured?
- What competencies are gained or enhanced by having students and faculty members from suitably diverse backgrounds?
- What changes in behavior are expected when learning takes place in a diverse environment?
- What sort of specific barriers inhibit the creation or maintenance of a supportive environment for diversity?
- What sort of metrics should accompany the creation or maintenance of a supportive environment for diversity?
4. Social Contract between Health Professions Institutions and the Communities They Serve

If the health professions accept the premise that diversity plays a significant role in health care, accrediting bodies can justify holding educational institutions or programs accountable for identifying concrete steps taken to incorporate diversity-related health issues, as well as societal issues of relevant concern, into (a) the curriculum in general; (b) field or clinical learning experiences; and (c) extracurricular and/or service learning activities. The particular elements of an institution’s social contract should be clearly articulated at the local, regional, national, and international levels as appropriate.

Educational institutions should be able to document specific steps taken within their area of influence to conduct outreach programs, and to admit, support, mentor and graduate students from disadvantaged backgrounds. They should also be able to document efforts to develop a diverse faculty community able to address relevant societal and health issues in their research and service activities as well as in their educational roles. Among the issues relating to social contract that can be addressed by accrediting bodies and by the educational institutions or programs they accredit are the following:

- Clarify the roles and responsibilities of an institution or program in addressing local or regional health and/or health care disparities.
- Provide leadership for the development and implementation of diversity strategies.
- Develop mechanisms to ensure ongoing engagement with local stakeholders, especially in communities with disproportionate unmet health-related needs.
- Adjust curricular content to meet emerging needs at the local, regional, national, and international levels.
- Expand the pool of qualified applicants from under-represented backgrounds who may be interested in pursuing a career in the health professions through targeted investment in the development of a regional or local pipeline.
- Consider appropriate professional attitudes or behaviors, such as a commitment to social justice or dedication to community service, as important criteria in the admissions process for students and the recruitment process for faculty members and staff.
V. AREAS FOR FURTHER INQUIRY

While the case has been made for increasing diversity in higher education in general\textsuperscript{27} and for the health professions in particular,\textsuperscript{28,29} further research is needed to support and build upon efforts to date.

Research on the impact of diversity in specific areas will help to clarify and illuminate issues, challenges, and opportunities, provide further evidence of the educational and societal benefits, and provide insights into the relative efficacy of alternative strategies.

In the most practical sense, further research will provide the necessary validation and understanding that contributes to a broader understanding and support for the benefits in public health and health care delivery that would accrue from increased diversity in the health professions.

These recommendations were initially developed for a joint discussion of Advisory Board and Kellogg Research Council in Atlanta, Georgia on September 10 and 11, 2009. Areas for further inquiry parallel the four concerns addressed in this brief, but also include two additional and related issues, faculty development and the curriculum.

1. **Institutional Commitment and Leadership**

Further research is needed to examine the impact of alternative institutional strategies to increase diversity among faculty, staff, and students, with attention to different combinations and application of the following components:

- Institutional mission statement
- Development of strategic plan
- Administrative leadership designation
- Economic incentives for programs
- Promotion and tenure incentives for faculty
- Student Promotions and related institutional support systems
- Pedagogical approaches

One specific area of near term research could be a comparative analysis of health professions education institutions, with attention to a) the current diversity of faculty, students, and staff, b) the integration of diversity-related content in the curriculum, and c) the institutional climate for diversity. A parallel analysis could also focus on the degree and manner in which institutions may effectively fulfill their stated mission in the absence of an emphasis upon diversity.
2. Admissions

Further research is needed to build on inquiries conducted by AAMC and others to date regarding the concept and application of Holistic Review, with particular attention to the following dimensions:

- Admissions Criteria
- Differential weighting of variables
- Application review sequence
- Committee composition
- Role of administrative leaders
- Institutional infrastructure (e.g., mission, goals, strategic plan, accountability)

Another line of research could focus on factors that influence decisions by under-represented students to select particular health professions education institutions (i.e., beyond financial incentives), as well as factors that contribute to academic attrition of students from under-represented populations.

3. Institutional Climate

Creating Opportunities for Shared Learning

Further research is needed to build upon evidence at the pre-professional level[^30] and in HPEIs[^34,35] to further illuminate the benefits of learning in a diverse academic environment. In the process, it will be important to identify and analyze specific mechanisms employed to foster shared learning outside of classroom settings. Examples of possible mechanisms include, but are not limited to the following:

- Curricular and extracurricular educational series with external leaders (academic and community)
- Structured presentations/roundtables to share lessons from field experience
- Formal facilitation of inter-interest group dialogues

Research into the benefits of diversity could focus on a comparative analysis of different mechanisms to foster shared learning among students from diverse backgrounds and associated academic and professional practice outcomes. These inquiries will provide invaluable insights and stimulate innovation among institutions seeking to advance practices.

On a parallel basis, research should also examine current knowledge and attitudes among students and faculty on diversity-related issues such as the causes and consequences of health disparities, and attitudes towards underserved populations. Findings in these kinds of inquiries will provide both a baseline assessment of work to be done and inform the design of institutional and programmatic interventions.

**Faculty Development**

Further research is needed into the issues and challenges associated with faculty in efforts to increase diversity in health professions education institutions, with particular attention to the following:

- Environmental issues in faculty recruitment and retention (e.g., critical mass of under-represented faculty, character of academic community, “town-gown” issues around diversity, employment opportunities for spouses).
- Influence and prioritization of institutional priorities (e.g., research, service-orientation), self-identity, and aspirations (e.g., views on what is needed to become a “tier 1” institution).
- Disproportionate burdens carried by under-represented faculty (such as commitment of time and energy on
student recruitment or support) and their impact upon promotion, tenure, and research pathways.

- Impact of the diversification of faculty upon scope/content of research within institutions and external assessments of quality.

Comparative analysis of alternative criteria used for promotion and tenure, with particular attention to incentives for community-based research and forms of community service.

**Diversity and the Curriculum**

Further research is also needed into alternative approaches to the integration of diversity-related issues into the formal curriculum, with attention to pedagogical methods, breadth and depth of issues addressed, timing, and form of integration (e.g., concentration within specific courses, dispersal of relevant content across the curriculum). In recent years, researchers have challenged categorical approaches that define cultural boundaries and norms as having the potential to reinforce biases and contribute to stereotyping and call for a focus on building a critical consciousness that reflects a deeper knowledge of self and others in the context of society.

A key challenge going forward is how to effectively document the impact of alternative approaches to education and training on measures of cultural competency, critical thinking capacity, and professional practice behaviors. A comprehensive review of literature in 2005 documented considerable shortcomings in the methodological rigor of studies assessing the impact of cultural competency education and training programs. One recent study offers a set of guidelines to measure the impact of cultural competency training for practicing physicians on health outcomes, addressing previously documented shortcomings in the methodological rigor of training programs. A similar framework and follow up studies are needed to assess educational outcomes in HPEIs.

**4. Social Contract**

Further research is needed into the impact and implications of health professions educational institution investment in expanding the regional pipeline of students from under-represented backgrounds, with focus on long-term investment at the K-12 level. Attention should be given to outcomes that reflect a net expansion of the pool (e.g., for HS graduates).

Further research is also needed into the general role of health professions education in addressing societal imperatives such as increasing academic, social and economic achievement opportunities for diverse populations.

A recent study of medical schools offers a set of criteria for assessing the “social mission” of institutions, focusing on the percentage of graduates who a) practice primary care, c) work in health professional shortage areas, and c) are from under-represented groups. Many schools typically considered to be among the “elite” in terms of educational quality were ranked poorly by these criteria. While one may question whether these criteria adequately reflect the commitment of medical schools to fulfill their social contract obligations, the findings highlight the need for more attention to the degree and manner in which our HPEIs are helping to address relevant practical challenges in our communities.

In general, there is a need to challenge current calls to defer definitive action by HPEIs until all relevant empirical questions have been answered. Greater effort is needed to integrate research questions, metrics, and monitoring strategies into strategies undertaken at the outset of the process. While considerable evidence has been compiled to date, more is needed to both clarify and refine educational strategies and to document the benefits of diversity for all students, as well as the patients and communities they will serve in the future.
VI. NEXT STEPS

A. Continuing Engagement in the Field

The experience in working with academic leaders in this project and in the initial 2007 study suggests that there is considerable value associated with inter-disciplinary dialogue and examination of common issues. Distinctions in the way that related issues manifest themselves and are addressed in different disciplines provide insights into how current strategies may be revised and refined. As such, further insights may be gained through establishment of a more formal, ongoing inter-disciplinary committee that brings together academic, accreditation and practitioner leaders from a variety of health professions disciplines.

On a parallel path, one leader suggested the potential engagement of departmental chairs across institutions in periodic meetings to share perspectives and innovations, and address obstacles to progress.

Discipline-specific education associations such as AAMC, ADEA, APA, and ASPH have played important roles to date in providing leadership on this issue. We strongly encourage their continued leadership in convening leaders, conducting research, and communicating with stakeholders in the field.

Continued leadership is also needed from foundations that have provided critical support in education, research, and advocacy, including, but not limited to the WK Kellogg Foundation, The California Endowment, the Robert Wood Johnson Foundation, the Josiah Macy Foundation, and the California Wellness Foundation. Particular attention should be given to investment in research and institutional capacity building, to both validate accomplishments and facilitate systemwide reform.

B. Issues in Implementation

In the course of this study, a number of leaders noted that the level of knowledge, engagement, and commitment to diversity varies significantly among HPEIs. As such, it presents a significant challenge in the translation of the recommendations outlined in this report into standards that can be broadly applied in the field. While it is understood that there is an evolutionary process in enforcement of new standards that provides the flexibility to encourage experimentation and learning, some HPEIs are early in the learning curve, and may be faced with significant internal resistance. Among these institutions, while a systemic, comprehensive framework is essential to ensure ultimate success, it may be prudent to take incremental steps in strategic areas in order to build momentum.

An important first step for HPEIs that are in the early stages of capacity building is to authorize and fund an institutional assessment, with attention to all relevant structures and functions and all three dimensions of diversity. The assessment findings should point
to specific areas where there is sufficient support from faculty, staff, or students to take near term actions that can begin to raise awareness and broaden support.

One strategy outlined by one of the leaders engaged in this study is for faculty, staff, and students with a commitment to diversity in the training of health professionals to create a formal group, charged by HPEI administrators to develop a mission statement that fully articulates a commitment to diversity training of health professionals. A key aspect in such a mission statement is language that reflects an understanding of the integral links between the education/training process and practice in the field. The overarching goal is to build greater understanding of diversity and related issues throughout the school/program.

Attention to the full range of backgrounds and experiences among students and faculty in the recruitment process reflects a commitment to inclusion in all its forms.

This same group may also consider initiating a range of processes that both operationalize the commitment outlined in the mission statement and facilitate the broader engagement of others in the academic and practice community. Actions can include but are not limited to periodic retreats to identify and address emerging issues, the development of a monthly reading group, colloquial series, and the integration of diversity-related content across the curriculum. Outreach should extend beyond the parameters of the academic institution to engage professionals and associations at the local, state, and national level.

These initial engagements include the development of scholarly activities that are tied to the evaluation of outcomes associated with a broader implementation process, including, but not limited to measurement of acquired knowledge and expertise, engagement and understanding, institutional attachment, and career trajectory.

A number of leaders cited the importance of reaching out to engage community-based organizations, health professions employers, and other external stakeholders as a strategy to build increased understanding and interest in diversity-related issues. These kinds of partnerships expose students and faculty to the practical issues and challenges faced in both urban and rural low income communities with diverse populations in a way that can enrich academic content and dialogue. Of equal importance, they can create opportunities to mentor, support, recruit, admit, matriculate, and graduate youth from diverse backgrounds. There are a growing number of these kinds of partnerships being documented and supported by groups such as Community-Campus Partnerships for Health. An excellent example of this kind of partnership recently documented at a medical school has yielded multiple benefits, including substantial federal funding to establish an institute for translational medical research.

While acknowledging the need for attention to race and ethnicity, some leaders noted that an important strategy to build broader support for diversity in the academic setting is to operationalize the broader definition of diversity outlined at the beginning of this report. While the emphasis may shift in different regions of the U.S., attention to the full range of backgrounds and experiences among students and faculty in the recruitment process reflects a commitment to inclusion in all its forms.
Finally, a few leaders noted that advancing diversity at HPEIs is not likely to be accomplished by making a few uncoordinated gestures; rather, more systematic efforts by HPEIs are essential in order to achieve meaningful results. One study notes that despite efforts during the past decades, the proportion of African American physicians to African Americans in the U.S. population is currently lower than it was in 1910.46 While systemic problems at the societal level (e.g., K-12 reform) must also be addressed, it is clear that HPEIs can also play an important role by making efforts to reform the ‘way they do business.’

Accreditation can serve as an invaluable tool to bring together HPEIs and take coordinated action to further enhance the educational quality of their progress and at the same time yielding tangible progress in efforts to increase health professions workforce diversity. It is our hope that these recommendations and associated findings will help inform and support dialogue and action in the coming months and years.
VII. ACADEMIC AND ACCREDITATION LEADER PARTICIPANTS

The co-authors would like to extend our appreciation to the academic and accreditation leaders from various health professions education disciplines who set aside considerable time from their busy schedules to participate in this study.

Their participation in multiple conference calls over the course of the last two years reflects the seriousness of their commitment to both inform and advance efforts to increase health professions workforce diversity.

The findings and recommendations contained in this report represent our best efforts to capture the key points raised in discussions with the leaders, who are listed below. While we have tried to faithfully capture the thinking of the participants in this project, we acknowledge that there are likely to be differences of opinion among them regarding any specific finding or recommendation. Nevertheless, the findings and recommendations as a whole represent the collective thinking of the participants, and as such constitute a tacit endorsement of the general framework and content, but not necessarily any particular finding or recommendation, of the report.

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VIII. About the Authors

Kevin Barnett, DrPH, MCP

Dr. Barnett is a senior investigator at the Public Health Institute. His research over the last 15 years has focused primarily on the charitable obligations of nonprofit hospitals, with an emphasis on institutional alignment and strategic investment in collaborative approaches to community health improvement. Between 2002 and 2006, he led a multi-state demonstration project to develop and implement a set of uniform community benefit standards. He is currently leading a national project funded by the WK Kellogg Foundation to document and facilitate the implementation of practices and policies aligned with these standards.

A significant focus of Dr. Barnett’s work in recent years is increasing diversity in the health professions. Dr. Barnett served on the Institute of Medicine committee that produced the 2004 report In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce, and co-authored a commissioned paper with Dr. Paul Hattis on the role of teaching hospitals, which was included in the 2004 Sullivan Commission report entitled Missing Persons: Minorities in the Health Professions. He co-directed a statewide initiative in California, funded by The California Endowment, that focuses on strategies to increase health professions workforce diversity. He currently serves as the co-director of the California Health Workforce Alliance, a statewide public-private partnership focusing on health workforce development and diversity in California.

Paul A. Hattis, MD, JD, MPH

In his career as a physician-attorney, Dr. Hattis has worked in a wide variety of roles in the fields of health administration, law, and policy, as well as in the field of preventive medicine. Since 2002, he has been a faculty member in the Department of Public Health and Community Medicine at Tufts University Medical School, where he also serves as the Senior Associate Director of the MPH Program.

In addition to this project, Dr. Hattis assisted Dr. Kevin Barnett with components of a statewide initiative in California that Dr. Barnett has led with colleagues at the University of California at Berkeley that focused on the issue of how university- and hospital-based health professional training programs can effectively advance
workforce diversity and health disparity goals. Dr. Hattis also joined with Dr Barnett on a paper that was incorporated as part of the 2004 report of the Sullivan Commission on diversity in the healthcare workplace. Along with Thomas Perez and Dr. Barnett, Dr. Hattis currently serves as a member of the Sullivan Alliance.

Dr. Hattis comes to this work on diversity in the health care professions from having focused for about 20 years on the issue of hospital community benefit responsibilities. In that regard, Dr. Hattis helped to develop a novel set of Community Benefit Standards for Hospitals and worked with 49 demonstration hospitals from across the country to test the efficacy of the standards.

Dr. Hattis received his medical and law degrees from the University of Illinois, where he was part of the Medical Scholars Program. He also received a master’s of public health from UCLA and a bachelor of science from the University of Michigan. Dr. Hattis is board certified in public health and preventive medicine and is a Fellow of the American College of Preventive Medicine.

Robert H. Eaglen, Ph.D.

Dr. Robert H. Eaglen joined the faculty and staff of the Northeastern Ohio Universities Colleges of Medicine and Pharmacy (NEOUCOM) in 2008 as scholar in residence. In the summer of 2009 he was appointed to his current position, where he is responsible for the management of the Office of Faculty Affairs, and for the development of a new Office of Collaborative Research in Health Professions Education. In his liaison role, he works with NEOUCOM’s partner universities to develop and refine the baccalaureate/MD and other collaborative educational programs. He is also an associate professor in the Department of Behavioral and Community Health Sciences.

Prior to accepting his current position, Dr. Eaglen was an associate vice president at the Association of American Medical Colleges (AAMC) in Washington, DC. His principal responsibility with that organization was to serve as its assistant secretary for the Liaison Committee on Medical Education (LCME), the national accrediting body for M.D.-granting medical education programs in the United States and Canada. He also functioned as interim secretary of the LCME in the year preceding his appointment at NEOUCOM.

Before joining the AAMC in 1996, Dr. Eaglen was a faculty member in the Department of Anatomy at the University of Puerto Rico School of Medicine. During his tenure at the University of Puerto Rico, he was the first student ombudsman for the medical science campus of the university, and served a term as interim chair of the Department of Anatomy. He received his doctorate in biological anthropology from Duke University in 1980.
IX. References


3. The 2007 study included two general meetings that brought together accreditation representatives from seven health professions disciplines; one at the beginning of the process to share project goals and objectives, and one at the end of the data/information collection process to share and seek input on preliminary findings.


7. Institute of Medicine, In the Nation’s Compelling Interest, PP. 140-141

8. See Chapter 6 of Missing Persons and recommendations 6.3, 6.4, 6.9 and 6.10.


10. Revised standard MS-8: Each medical school must develop programs or partnerships aimed at broadening diversity among qualified applicants for medical school admission

New Standard IS-16: Each medical school must have policies and practices to achieve appropriate diversity among its students, faculty, staff, and other members of its academic community, and must engage in ongoing, systematic, and focused efforts to attract and retain students, faculty, staff, and others from demographically diverse backgrounds.

11. C-22. Diversity Recruitment and Retention (Commission on Accreditation, November 2009)

“An accredited doctoral program should demonstrate that it has developed a multiple year plan, implemented and sustained over time, in its efforts to attract and retain students and faculty from a range of diverse backgrounds. An accredited internship or postdoctoral program should demonstrate that it has developed a multiple year plan, implemented and sustained over time, in its efforts to attract and retain trainees, staff, and supervisors from a range of diverse backgrounds.

An accredited program is expected to describe in its self-study the specific activities, approaches and initiatives it implements to increase diversity among its students, trainees, faculty, staff, and supervisors. A program may include institutional-level initiatives geared towards achieving diversity, but should also be able to demonstrate concrete actions taken by the training program to achieve diversity. Activities, approaches, and initiatives to attract and retain diversity should be broadly integrated across key aspects of the program. A program is encouraged to discuss the areas of diversity in which it excels, as well as the areas of diversity in which it is working to improve. The program is encouraged to discuss its initiatives and success for aspects of diversity beyond those requested in the tables for the self-study and annual report. The program should examine the effectiveness of its efforts to attract and retain diverse trainees, staff, faculty, students, and supervisors; and should revise/ enhance efforts as needed.”

C-23. Diversity Education and Training (Commission on Accreditation, November 2009)

"...An accredited program is expected to articulate and implement a specific plan of learning that is integrated throughout its didactic and experiential training, consistent with the program’s goals and objectives. A program should describe the specific activities, approaches, and initiatives it has taken to integrate issues of diversity, and an appreciation of individual and cultural differences, into the science and practice of psychology. This must be accomplished in a manner that is sequential, cumulative,
needs of various populations including the indigent, minorities, disease prevention and health promotion techniques to meet the graduates to work with community-based programs to expand retention, and promotion plan.

17. Dental education institutions and programs should prepare graduates to work with community-based programs to expand disease prevention and health promotion techniques to meet the needs of various populations including the indigent, minorities, the elderly, and other underserved groups.

18. Respect: honoring the worth of others. (From ADEA statement on Professionalism)

Expanded Definition: Encompasses acknowledgment of the autonomy and worth of the individual human being and his/her belief and value system; sensitivity and responsiveness to diversity in patients’ culture, age, gender, race, religion, disabilities, and sexual orientation; personal commitment to honor the rights and choices of patients regarding themselves and their oral health care, including obtaining informed consent for care and maintaining patient confidentiality and privacy (derives from our fiduciary relationship with patients); and according the same to colleagues in oral health care and other health professions, students and other learners, institutions, systems, and processes. Includes valuing the contributions of others, inter-professional respect (other health care providers), and intra-professional respect (allied health care providers); acknowledging the different ways students learn and appreciating developmental levels and differences among learners; includes temperance (maintaining vigilance about protecting persons from inappropriate over- or under-treatment, abandonment, or both) and tolerance.

Alignment with:

ADA Principles of Ethics: autonomy, beneficence and non-malfeasance
ADHA Code for Dental Hygienists: individual autonomy and respect for human beings, beneficence and non-malfeasance
ASDA Student Code of Ethics: patient autonomy and non-malfeasance and beneficence

1. For students: Develop a nuanced understanding of the rights and values of patients; protect patients from harm; support patient autonomy; be mindful of patients’ time and ensure timeliness in the continuity of patient care. Keep confidences; accept and embrace cultural diversity; learn cross-cultural communication skills; accept and embrace differences. Acknowledge and support the contributions of peers and faculty.

2. For faculty: Model valuing others and their rights, particularly those of patients; protect patients from harm; support patient autonomy. Accept and embrace diversity and difference; model effective cross-cultural communication skills. Acknowledge and support the work and contribution of colleagues; accept, understand, and address the developmental needs of learners. Maintain confidentiality of student records; maintain confidentiality of feedback to students, especially in the presence of patients and peers.

3. For researchers: Protect human research subjects from harm; protect patient autonomy. Accept and understand, and address the developmental needs of learners. Acknowledge and support the work and contributions of colleagues.

4. For administrators and institutions: Recognize and support the rights and values of all members of the institution; acknowledge the value of all members of the institution; accept and embrace cultural diversity and individual difference; model effective cross-cultural communication skills. Support patient autonomy, protect
patients from harm, and safeguard privacy; protect vulnerable populations. Create and sustain healthy learning environments; ensure fair institutional processes.

19. A diverse and culturally competent workforce is necessary to meet the general and oral health needs of our demographically changing nation. Racial and ethnic diversity of health professionals contributes to improved access to care, greater patient choice and satisfaction, and enriched educational experiences for students.[19] Proposals to reform the U.S. health care system should include adequate funding for programs that are designed to increase the number of underrepresented minorities in the health professions. This would ensure a workforce that is prepared to meet the needs of a diverse population that continues to expand. Academic dental institutions, which educate and train oral health care professionals, have a distinct responsibility to educate dental and allied dental health professionals who are competent to care for the changing needs of society. This responsibility includes preparing oral health care providers to care for a racially and ethnically diverse population, an aging population, and individuals with special needs.


19. Public sector budget shortfalls and precipitous declines in investment portfolios have resulted in the scaling back of discretionary spending, which disproportionately impacts recently established programs and initiatives that may not be viewed as core functions needed to preserve the integrity of the institution.

22. In addition to California, Michigan, and Washington, a number of states have launched anti-affirmative action campaigns to prevent the use of race and ethnicity as a consideration in the recruitment and admissions of students into higher education institutions.

23. Holistic, or Whole File Review in the context of the health professions education admissions process involves the use of multiple criteria in the assessment of applicant qualifications, including, but not limited to traditional criteria such as standardized test scores and grade point average, as well as linguistic and/or cultural experience, demonstrated commitment to community service, specific areas of career interest (e.g., plans to practice in underserved communities), and distanced traveled (i.e., personal, familial, and other experiential challenges overcome).

24. Cited by numerous leaders who participated in the Institute of Medicine’s and the Sullivan Commission’s panels on increasing diversity in the health professions, as well as key informant interviews conducted with academic leaders and health professions employers as part of the California Connecting the Dots Initiative.

25. Studies by Hurtado (1999), Gurin (2002), Whitla (2003), and Antonio (2004) provide substantial evidence of the benefits of learning in a more diverse environment in higher education, but more research is needed to further validate and expand upon findings to date.

26. It should be noted that there is considerable variability among health professions accreditors in terms of relative attention, clarity, and effectiveness to date in current standards within these two dimensions. This issue is addressed in more detail in the initial report published as part of this study.


28. In The Nation’s Compelling Interest; Ensuring Diversity in the Health Professions, Institute of Medicine, 2004.


38. Boutin-Foster, C., Foster J.C., Konopasek, L., Physician, Know Thyself: the Professional Culture of Medicine as a Framework for
38.


44. Community Campus Partnerships for Health is described on their website (www.ccph.info/) as “a nonprofit organization that promotes health (broadly defined) through partnerships between communities and higher educational institutions. Founded in 1996, we are a growing network of over 2,000 communities and campuses across North America and increasingly the world that are collaborating to promote health through service-learning, community-based participatory research, broad-based coalitions and other partnership strategies.”

