

Building Diversity in a Complex Academic Health Center

Jeannette E. South-Paul, MD, Loren Roth, MD, MPH, Paula K. Davis, MA, Terence Chen, Anna Roman, PhD, Audrey Murrell, PhD, Chenits Pettigrew, EdD, Candi Castleberry-Singleton, MBA, and Joel Schuman, MD

Abstract

For 30 years, the many diversity-related health sciences programs targeting the University of Pittsburgh undergraduate campus, school of medicine, schools of the health sciences, clinical practice plan, and medical center were run independently and remained separate within the academic health center (AHC). This lack of coordination hampered their overall effectiveness in promoting diversity and inclusion. In 2007, a group of faculty and administrators from the university and the medical center recognized the need to improve institutional diversity and to better

address local health disparities. In this article, the authors describe the process of linking the efforts of these institutions in a way that would be successful locally and applicable to other academic environments. First, they engaged an independent consultant to conduct a study of the AHC's diversity climate, interviewing current and former faculty and trainees to define the problem and identify areas for improvement. Next, they created the Physician Inclusion Council to address the findings of this study and to coordinate future efforts with institutional leaders. Finally, they

formed four working committees to address (1) communications and outreach, (2) cultural competency, (3) recruitment, and (4) mentoring and retention. These committees oversaw the strategic development and implementation of all diversity and inclusion efforts. Together these steps led to structural changes within the AHC and the improved allocation of resources that have positioned the University of Pittsburgh to achieve not only diversity but also inclusion and to continue to address the health disparities in the Pittsburgh community.

The Surgeon General's 2001 report on mental health and the subsequent Institute of Medicine report in 2002 entitled *Unequal Treatment* analyzed behavioral and physical health disparities in the United States and noted the factors that contribute to these inequities, including less access to and lower-quality medical and psychiatric services for diverse populations.^{1,2} Also contributing to these health disparities are patient, provider, and social factors. For instance, graduating U.S. medical students associate their preparedness to care for diverse patients and their intent to practice in underserved areas with having a greater percentage of underrepresented minority (URM) medical school classmates.³ Thus, we must continue to educate health care professionals and promote integrated,

diverse leadership teams and programs to address the health disparities in our country.

The University of Pittsburgh has been the major health science research and education institution in western Pennsylvania for some time, and it was selected by the Association of American Medical Colleges in 2003 as one of four medical schools in the country to launch the Aspiring Docs program because of its success recruiting minority premedical students. Yet the diversity of its faculty and other trainees has not reflected the diversity of the region or the nation. The population surrounding the university consists predominantly of minorities, largely African Americans, who have particularly poor health when compared with their non-Hispanic white counterparts. For example, the death rates for African Americans in this population for HIV/AIDS, cardiovascular diseases, and cancer are four times higher than for non-Hispanic whites.⁴ These disparities have remained relatively unchanged for more than a decade.

were African American compared with the national average of 3.7%, and between 2.4% and 2.9% were Hispanic compared with the national average of 2.8%.⁵ As minority clinicians are more likely to practice in culturally concordant communities, the lack of diversity in the physician workforce has limited physician-led initiatives to address the health disparities in local populations.⁶

A diverse group of faculty and administrators from the University of Pittsburgh (Pitt) and the University of Pittsburgh Medical Center (UPMC) recognized the need to improve institutional diversity and to better address local health disparities. They used the computer paradigm for evaluating diversity efforts introduced by Mark Nivet of the Association of American Medical Colleges to identify that they had achieved the diversity operating system (DOS) 2.0 level of diversity. As such, their efforts increased awareness of how diversity benefits everyone. However, these efforts focused minimal attention on the interconnectedness and consistency of excellence and diversity, which is essential for reaching the DOS 3.0 level.⁷

Please see the end of this article for information about the authors.

Correspondence should be addressed to Dr. South-Paul, Department of Family Medicine, University of Pittsburgh School of Medicine, 3518 Fifth Ave., Pittsburgh, PA 15261; telephone: (412) 383-2378; e-mail: soutjx@upmc.edu.

Acad Med. 2013;88:1259-1264.
First published online July 24, 2013
doi: 10.1097/ACM.0b013e31829e57b0

Supplemental digital content for this article is available at <http://links.lww.com/ACADMED/A139>.

A review of the demographics of the University of Pittsburgh School of Medicine (UPSoM) faculty from 2006 to 2010 revealed that only 2.4%

For 30 years, the many diversity-related health sciences programs targeting the undergraduate university (Pitt), school of medicine (UPSoM), schools of the health sciences, clinical practice plan (Physician Services Division [PSD]), and medical center (UPMC) were run independently and remained separate within the academic health center (AHC). This lack of coordination hampered their overall effectiveness and progress toward achieving diversity, specifically the goals of DOS 3.0. In this article, we describe the process of linking the efforts of these institutions and groups in a way that would be successful locally and applicable to other academic environments.

Identifying the Tipping Point

Our first step was to determine what combination of programs and/or behaviors was necessary to spread the concepts of diversity and inclusion within these interrelated organizations—in other words, to “tip” the institutional culture in favor of enhancing diversity and inclusion. Malcolm Gladwell⁸ described this tipping point as a seemingly small change that precipitates large shifts in the status quo.

Conducting an external study of the diversity climate

In 2007, the Leadership Team was created to bring a variety of talents together to set a vision for and organize an institutional approach to diversity. It included leaders from the school of medicine (two department chairs and assistant dean, student and minority programs), the schools of the health sciences (associate senior vice chancellor, health sciences, and assistant vice chancellor, health sciences diversity), the health system (chief diversity officer, senior vice president for administration, associate vice president for continuing education), and a representative from the local minority medical society. The two original team leaders (authors L.R. and A.R.) engaged an independent consultant to assess the factors influencing the URM medical students, housestaff, and faculty at the AHC. This consultant compared those professionals who remained at the AHC and those who left. To better understand the experiences and decision-making processes of these URM professionals, independent external interviewers, including the CEO of

Campos, Inc., who is of Hispanic origin, and the president of the local African American medical society, conducted interviews with a representative sample of African American and Hispanic alumni of the AHC between August 2008 and January 2009. These physicians had finished a portion of their education or training and/or been faculty at either UPSoM or UPMC between 1999 and 2007. Of 49 eligible physicians, 38 were located and agreed to be interviewed. In addition to these alumni physicians, 6 of the 20 department chairs who were seeking new faculty at the time also were interviewed to further define new strategies for building a truly diverse culture within the AHC.

Alumni reported experiencing little overt discrimination or active exclusion. They valued the quality of their academic and clinical experiences but did not perceive a career ladder for themselves at the AHC. They also reported a noticeable lack of diversity in both the university and the health system among staff, peers, faculty, administrators, and academic leaders. They identified this perception as negatively affecting the retention of URM faculty and preventing any true sense of inclusion. In addition, they identified effective mentorship, inclusion, and networking opportunities as keys to the future success of all professionals, especially minorities. URM students noted a need to (1) create an environment where trainees are invited to participate and be mentored, and (2) create inclusion opportunities, such as hosting URM residents and faculty in the homes of AHC leaders. In effect, they were asking for a culture not only of diversity but also of inclusion.⁹

Identifying leaders to promote diversity

Created in 2009, the Physician Inclusion Council used the results of this study to develop and implement a strategic approach to diversity and inclusion at the AHC. The council included minority and majority students, faculty, staff, administrators, and health professional representatives from the community, including a Gateway Medical Society representative; the associate senior vice chancellor, health sciences; the assistant vice chancellor, health sciences diversity; a PSD representative; the assistant dean, minority student affairs, UPSoM; the director, Center for Health Equity,

Graduate School of Public Health; the vice president, graduate medical education, UPMC; and the chief diversity officer, UPMC. The Physician Inclusion Council was co-chaired by two of the authors (J.S.P., J.S.S.), each of whom is also the chair of an academic clinical department at UPSoM and UPMC. They were selected with attention to diversity of race, gender, discipline, and leadership styles. The council embraced involvement from community leaders to promote shaping regional medical education and the AHC. Such close community relationships aid both the recruitment and the retention of diverse professionals.¹⁰ The council's comprehensive approach also is consistent with the role that AHCs should play in expanding the cross-cultural workforces in their communities.¹¹

Recognizing the need for dedicated resources, the Leadership Team worked with the dean of UPSoM, the CEO of UPMC, and the president of PSD to pool their funding and resources for all diversity and inclusion initiatives. Over a period of three months from January to March 2009, the Leadership Team met to design a program for which they could measure the progress. They catalogued the current diversity initiatives and available resources across the AHC and organized the list according to the academic calendar. They identified gaps according to discipline or educational level of the target audience. Next, they drafted a combined program budget and presented it to the dean of UPSoM, the CEO of UPMC, and the president of PSD. These three individuals subsequently agreed to jointly fund the resulting diversity and inclusion program and to allow the Physician Inclusion Council to jointly manage the individual initiatives.

Strategizing and implementing the diversity and inclusion program

To implement the diversity and inclusion program, the Physician Inclusion Council first formed four working committees in 2009 to address (1) communications and outreach, (2) cultural competency, (3) recruitment, and (4) mentoring and retention. Each committee contributed equally to creating a welcoming milieu, providing professional support, and promoting career progression to strengthen diversity at the AHC. URM and female faculty

were the initial targets of these efforts. The council chose co-chairs (one clinician and one administrator) for each committee to ensure that both the clinical and training needs as well as the administrative challenges were addressed. Housestaff participated in and were active leaders of the communications and recruitment committees.

The communications and outreach committee focused on creating a visible alumni council, community outreach, and a communication plan for students, housestaff, and faculty. Their strategies included developing social media campaigns, a listserv, and a quarterly newsletter. They also aimed to strengthen the AHC's support for the local minority medical society (the Gateway Medical Society, a local National Medical Association branch), which, through its social, medical, and mentoring functions, increased communication among URM students and Pitt and UPMC faculty, thus promoting community cultural competency for all participants.

The chief inclusion and diversity officer (CDO), with support from the Physician Inclusion Council, developed clinical programs within UPMC under the umbrella of the Center for Inclusion, which was established in 2008. The CDO implemented the UPMC 4C Inclusion Strategy, which focused on four areas—customer, community, culture, and company. They assigned an “Inclusion” theme to each year—Imagine in year 1, Experience in year 2, and Champion in year 3. Next, the CDO launched a Dignity and Respect Initiative to promote a culture of inclusion through behavioral and organizational change. Across a three-year period, starting in January 2009, she and her team expanded the Dignity and Respect Initiative to a UPMC competency on which employees are evaluated during annual performance reviews, then to a national campaign with tools and a Dignity and Respect index to measure employee feedback, which other health care organizations now use to create and measure their culture of inclusion.

The Center for Inclusion expanded efforts to focus on the overall AHC environment as well as the creation of a network in the community to offer feedback and best practices. The CDO and her team

encouraged division directors to nurture diversity and inclusion throughout the AHC to enhance clinical effectiveness, inform research, and effectively manage cross-cultural situations. Finally, during the third year of the Dignity and Respect Initiative, the CDO developed a cultural competency model to increase employee awareness and engage UPMC in regional health literacy efforts and added a cultural competence tool to the electronic medical record to provide clinicians with immediately available and relevant background information regarding more than 20 cultures, faiths, and diverse communities. Today, each of the direct reports to the CEO of UPMC has a 4C Inclusion Strategy, and division leaders report quarterly to the UPMC board of trustee's inclusion and diversity committee. These efforts were guided by the CDO's principle that diversity for its own sake does not ensure inclusion. Inclusion, however, can lead to diversity.

Since its creation in 1978, the UPSoM Office of Diversity Programs has implemented and evaluated pipeline programs. Ten undergraduate institutions partner with UPSoM to support faculty and student engagement in science programming and research. Annual visits by faculty and staff to each institution support relationships with the premed advisors at those institutions. In addition, undergraduate students have the opportunity to complete summer or postbaccalaureate UPSoM experiences that provide a valuable foundation for future academic health science careers. Indirectly, each of these interactions also helps students to develop professional ties in Pittsburgh. See Figure 1 for a description of UPSoM's and UPMC's outreach efforts targeting students and trainees at multiple levels.

In 2008, the increasing success of such diversity programs prompted the dean of UPSoM to promote the assistant dean for diversity in the school of medicine to assistant vice chancellor for diversity responsible for all six schools of the health sciences and to expand the team responsible for these programs.

Gathering and disseminating actual numbers of URM students and faculty is an essential step in defining the problem and crafting solutions. The Office of Diversity Programs had successfully

leveraged diversity programs to increase the numbers of URM students matriculating in UPSoM, but those numbers were substantially lower in the other schools of the health sciences, in residency programs, and among the faculty. In 2010, the Leadership Team compared the numbers of students, housestaff, and faculty to describe the potential pipeline for diversifying the AHC and to identify points for improving the retention of diverse professionals (see Supplemental Digital Table 1 at <http://links.lww.com/ACADMED/A139>). The data revealed that diversity efforts were more successful in retaining Hispanic than African American students, trainees, and physicians.

In early 2012, the Physician Inclusion Council decided to organize a health disparities conference to be held in October of that year to highlight the poor health status of minorities in the communities surrounding the AHC as well as to promote the AHC to scientists and clinicians who were interested in these problems, with the goal of encouraging the AHC to recruit these individuals as housestaff and faculty. More than 60 attendees gathered for the conference, which included national keynote speakers, peer-reviewed poster and oral presentations by students, residents, and junior faculty, and networking receptions and dinners.

Data from the 2007 alumni interviews (referred to here as the Campos Report) suggested the importance of a mentoring initiative to enrich the experience of junior faculty, especially URM junior faculty—a concept described by Bickel and Brown¹² and Bickel and Rosenthal¹³ within the context of both diversity and generational trends. In 2011, the Promoting Academic Talent in the Health Sciences (PATHS) program was launched as a direct response to the Campos Report.¹⁴ The PATHS program includes the formal training of both mentors and mentees, using national experts (including author A.M.). Mentors and mentees sign contracts committing to regular, structured engagement. Fifteen mentor–mentee teams from three academic departments piloted the PATHS program in the first year. Their activities included self-reflection, conflict resolution, review of performance evaluation processes, and work–life balance. In addition, at the end of the first year, a

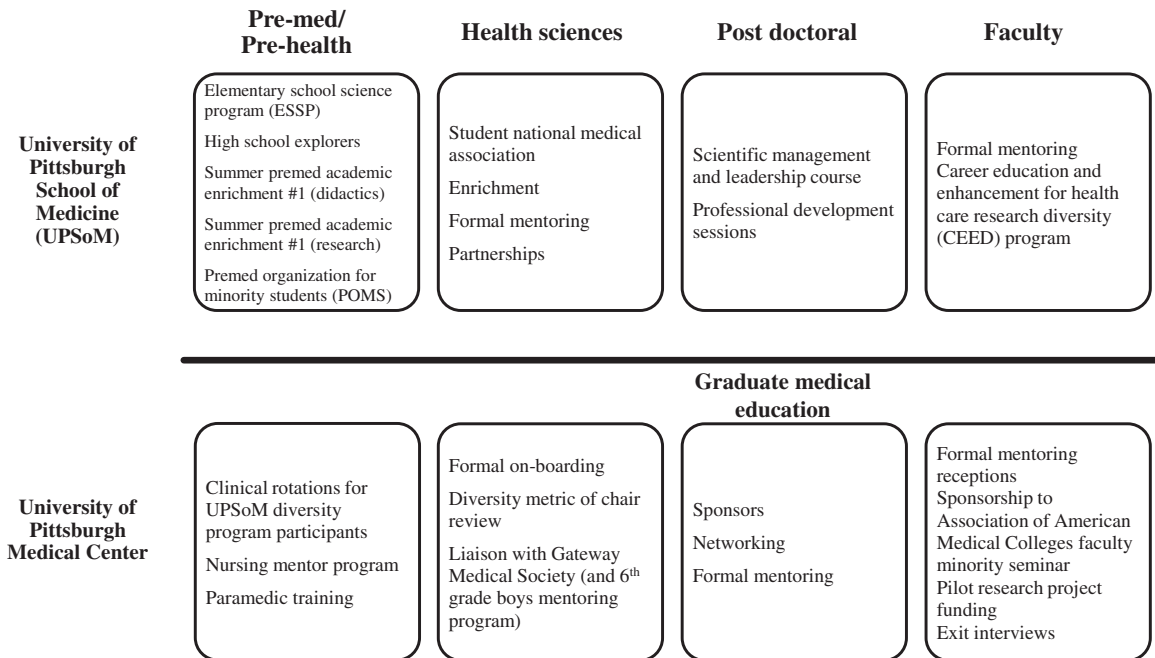


Figure 1 List of the diversity and inclusion outreach efforts by the University of Pittsburgh School of Medicine and the University of Pittsburgh Medical Center targeting students and trainees at multiple levels.

competitive pilot program was launched to provide seed grants to mentees to launch or augment their research.

The first PATHS program mentee cohort reported satisfaction with the program (see Supplemental Digital Table 2 at <http://links.lww.com/ACADMED/A139>). Mentors noted that they wanted to be able to devote more time to their mentees. This positive feedback led the Physician Inclusion Council to recruit 30 mentor-mentee pairs for the second cohort, which started the program in October 2012.

In keeping with the recognized best practices to secure the most skilled workforce in the business community, the Physician Inclusion Council combined the PSD’s on-boarding program with a structured mentoring program. The on-boarding program, which is geared toward faculty, residents, and fellows, introduces them to the new academic and clinical environment as well as to the surrounding community. Partnering with the Graduate School of Business, the senior vice president of PSD opened additional positions for diverse faculty in a “mini-MBA” leadership program, which was developed for early- and midcareer clinical faculty members. It provided them with a foundation in business and management principles. They later developed a similar program for residents, fellows, and practice managers.

Barriers and Solutions—Lessons Learned

Our efforts to create a successful diversity and inclusion program illustrate the slow pace at which such initiatives move until a tipping point is reached (see Figure 2). We reached that tipping point with the release of the Campos Report and the AHC leadership’s acceptance of its findings. Only then did they commit resources to these efforts in a more concisely defined process.

Recruiting URM faculty who already have demonstrated success and academic prominence at the AHC—the known superstars—is tempting. However, if this approach is the primary or sole focus of the initiative, it instead may act as a barrier to change and inhibit the rapid growth necessary for the diversity program to succeed. Alternatively, recruiting only young faculty who may become overwhelmed by service commitments also hinders the success of such programs. A commitment to developing the potential of early-career faculty, then, is critical to building a robust and visible pipeline that supports a diverse faculty.

In addition to recruiting promising and talented diverse professionals, the institution also must provide skill development and coaching beyond the traditional scope of faculty development to target and support modifiable resilience

characteristics, as Cora-Bramble and colleagues¹⁵ conclude in their recent analysis of URM faculty members’ academic productivity. The authors suggest that such resilience-centered intervention strategies may positively affect the advancement of URM faculty in academic medicine. In our diversity and inclusion efforts, the PATHS program mirrors this resilience intervention as it focuses on academic enrichment. The Career Education and Enhancement for Health Care Research Diversity (CEED) program, which focuses on research skills, also provides faculty with a strong foundation in resilience training. Hosted by the Institute for Clinical Research Education at UPSOM and the Clinical Translational Science Institute, CEED seeks to provide URM faculty researchers with the training needed for successful research careers by helping them develop leadership, management, and grant writing skills. The program’s primary goal is to ensure a supply of well-qualified investigators to carry out basic science, clinical, and translational research in the health sciences.

The tipping point for achieving diversity and inclusion at UPSOM and UPMC was the convergence of (1) the direction provided by the findings of the Campos Report, (2) the seniority and experience of the Leadership Team, including the buy-in of high-level AHC officials, (3) the joint

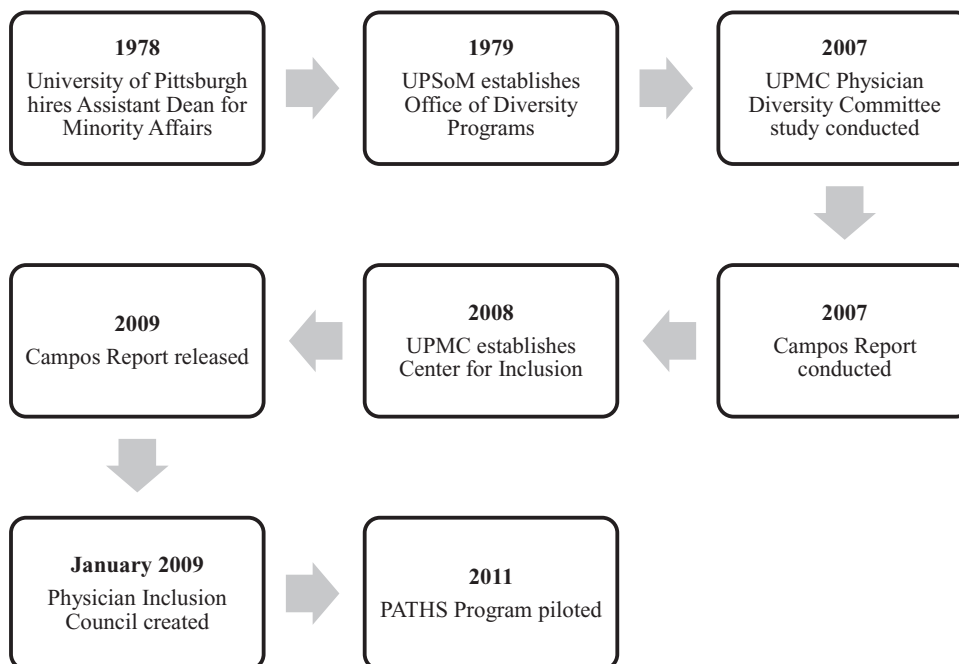


Figure 2 Timeline of the diversity and inclusion efforts at the University of Pittsburgh School of Medicine (UPSoM) and the University of Pittsburgh Medical Center (UPMC), 1978–2011. PATHS indicates Promoting Academic Talent in the Health Sciences.

effort of the four active, engaged, and diverse committees, and (4) the commitment of sustained resources by the three major leaders (dean of UPSoM, CEO of UPMC, and president of PSD) at the AHC to fund the program. Through a process that incorporated diversity and inclusion into the core workings of the AHC, Pitt and UPMC demonstrated that a vibrant partnership can lead to a DOS 3.0 paradigm that effectively meets the educational and service needs of the institution.

To assess further the impact of these changes, ongoing outcomes measurements are needed. These include

1. Repetition of the Campos Report, including independent qualitative studies of URM students and faculty.
2. Presentation of updated statistics regarding URM medical students, housestaff, and faculty to the larger university and community for additional input on diversity initiatives.
3. Further expansion of consolidated AHC diversity and inclusion efforts to the community, such as the increased mentoring of younger URM students from precollege through college to encourage them to pursue health sciences careers.
4. Retention of URM junior faculty and their progression towards more

senior AHC positions as well as the promotion of their academic and clinical productivity.

While the health disparities in the Pittsburgh population persist, the AHC is making a substantial institutional, cultural, and training commitment to cultivate a diverse and skilled health care workforce, with the goal of continuing to address these disparities. The framework we described here for using the experiences of diverse alumni to shape current and future strategies has positioned the AHC for success in achieving inclusion, not just diversity, and overall academic success. With the support of the UPMC board of trustees, these efforts will continue to strengthen the culture of the AHC.

Funding/Support: None.

Other disclosures: None.

Ethical approval: Not applicable.

Dr. South-Paul is Andrew W. Mathieson Professor and Chair, Department of Family Medicine, University of Pittsburgh School of Medicine and University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania.

Dr. Roth is associate senior vice chancellor for clinical policy and planning, Health Sciences, University of Pittsburgh, Pittsburgh, Pennsylvania.

Ms. Davis is assistant vice chancellor for diversity, Schools of the Health Sciences, University of Pittsburgh, Pittsburgh, Pennsylvania.

Mr. Chen is pursuing a master's degree in public health with a focus in health policy and management, University of Pittsburgh, Pittsburgh, Pennsylvania.

Dr. Roman is senior vice president for administration, University of Pittsburgh Physicians and University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania.

Dr. Murrell is associate professor of business administration, psychology, and public and international affairs, and director, David Berg Center for Ethics and Leadership, University of Pittsburgh, Pittsburgh, Pennsylvania.

Dr. Pettigrew is assistant dean for student affairs and director of diversity programs, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.

Ms. Castleberry-Singleton is chief inclusion and diversity officer, University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania.

Dr. Schuman is the Eye and Ear Foundation Professor and chairman, Department of Ophthalmology, University of Pittsburgh and Eye and Ear Institute, Pittsburgh, Pennsylvania.

References

- 1 Department of Health and Human Services. U.S. Public Health Service. Mental Health: A Report of the Surgeon General. 1999. www.surgeongeneral.gov/library/mentalhealth/cre. Accessed May 20, 2013.
- 2 National Research Council. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academies Press; 2003.
- 3 Saha S, Guiton G, Wimmers PF, Wilkerson L. Student body racial and ethnic composition and diversity-related outcomes in US medical schools. *JAMA*. 2008;300:1135–1145.

- 4 Urban League of Greater Pittsburgh, Allegheny County Health Department, and the University of Pittsburgh University Center for Social and Urban Research. Allegheny County Health in Black and White. Pittsburgh, Pa: Urban League of Greater Pittsburgh; April 2011.
- 5 Association of American Medical Colleges. Diversity in the Physician Workforce: Facts & Figures 2010. <https://members.aamc.org/eweb/upload/Diversity%20in%20the%20Physician%20Workforce%20Facts%20and%20Figures%202010.pdf>. Accessed May 20, 2013.
- 6 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.
- 7 Nivet MA. Commentary: Diversity 3.0: A necessary systems upgrade. *Acad Med*. 2011;86:1487–1489.
- 8 Gladwell M. *The Tipping Point: How Little Things Can Make a Big Difference*. Boston, Mass: Little, Brown; 2000.
- 9 Diversity Committee, Physician Services Division, University of Pittsburgh Medical Center. Qualitative Improvement Study Report by Campos Inc. Pittsburgh, Pa: University of Pittsburgh Medical Center; July 2009.
- 10 Garcia-Shelton L, South-Paul JE, Davis A, Arevalo J. Family medicine training programs successful in recruiting minorities. *Ann Behav Sci Med Educ*. 2000;7:23–28.
- 11 Betancourt JR, Maina AW. The Institute of Medicine report “Unequal Treatment”: Implications for academic health centers. *Mt Sinai J Med*. 2004;71:314–321.
- 12 Bickel J, Brown AJ. Generation X: Implications for faculty recruitment and development in academic health centers. *Acad Med*. 2005;80:205–210.
- 13 Bickel J, Rosenthal SL. Difficult issues in mentoring: Recommendations on making the “undiscussable” discussable. *Acad Med*. 2011;86:1229–1234.
- 14 PATHS—Promoting Academic Talent in the Health Sciences. <http://www.healthdiversity.pitt.edu/programs/PromotingAcademicTalentintheHealthSciences.php>. Accessed May 20, 2013.
- 15 Cora-Bramble D, Zhang K, Castillo-Page L. Minority faculty members’ resilience and academic productivity: Are they related? *Acad Med*. 2010;85:1492–1498.