

**University of Connecticut
Health Center
Strategic Plan for Diversity
2008-2011**

**Prepared by
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Once action plans are determined the following will be added

- a. accountabilities**
- a. timelines**
- b. measurement**

Strategic Plan for Building, Valuing and Managing Diversity at UCHC

In 2006 the Health Center Executive Vice President adopted a diversity vision that states “the University of Connecticut Health Center will be acknowledged as an institution where the best business practices of building, valuing and managing a diverse workforce and student body are fully implemented, operationally successful and continually improved. The Health Center will be a place where employees and students from all walks of life, backgrounds and experiences who represent different races, genders, ages, religions, sexual orientations, national origins, ancestries, abilities, marital status and veteran status will work and learn in an environment where they are valued for their unique combination of skills and talents. The Health Center will also be a place where understanding and appreciation of others characterizes the organizational culture. “

To realize this vision, the Health Center articulated a diversity mission”... to plan for, provide and implement policies, programs and processes that create and establish a workforce and student body that reflects the diversity of those we serve and sustains a working and learning environment where all members of the community can realize their full potential in an environment of equality, respect, appreciation and fairness.”

This document sets forth a plan to devise and implement strategies and associated action plans to achieve measurable successes in accomplishing the Health Center’s diversity mission and vision.

Strategic planning is a quality management step by step process designed to gather and analyze information which is used to define the goals and objectives for accomplishing the diversity mission and vision. The steps in this process are;

Strategic Planning Steps

1. Secure organizational leadership commitment
2. Adopt a diversity mission and vision statement that connects diversity to the organizational vision. (where we want to be)
3. Analyze the current state of organizational diversity against the stated diversity vision and mission (where we are now)
4. Using the results of the analysis in step # 3, identify strategic objectives used to guide action plans. (what are the gaps between where we are and where we want to be in 3-5 years?).
5. Identify action plans and accountabilities for objectives (how we are going to get there)
6. Provide a process for tracking and measuring success towards achieving objectives and goals (how we know that we are making progress).
- 7.

Because the Health Center's vision is ... 'to be acknowledged as an institution where the best business practices of building, valuing and managing a diverse workforce and student bodies are fully implemented, operationally successful and continually improved ', the strategic planning process for diversity will be divided into three components: building, valuing and managing diversity for employees and students. The definitions of these components can be found in the Health Center's stated diversity mission:

A. Building Diversity is to plan, provide and implement policies, programs and processes that create and establish a workforce and student body that reflects the diversity of those served by the Health Center.

B. Valuing Diversity is to plan, provide and implement policies, programs and processes that sustain a working and learning environment where all members of the Health Center community can realize their full potential in an environment of equality, respect, appreciation and fairness.

C. Managing Diversity contributes to valuing diversity by also planning, providing and implementing policies, programs and processes that provide for a non-discriminatory, inclusive and multicultural working and learning environment. With regards to differences of race, ethnicities and cultures, managing diversity means resolving associated conflicts and tensions such that communication barriers caused by distrust, stereotypes and prejudices are replaced with open and productive dialogue.

Status of Strategic Planning Steps

Step One: Engaging Leadership

The Health Center leadership has long recognized and acted to support the business case for diversity. To this end the Leadership Team for Diversity was established in February, 2006. The members of this team are : Mr. Sanford Cloud, UCHC Board Member, Dr. Peter Deckers, Executive VP for Health Affairs and Dean , School of Medicine; Ms. Susan Whetstone, Chief Administrative Officer; Mr. Brian Eaton, Associate VP, Human Resources; Mr. Daniel Upton, Chief Financial Officer; Dr. Monty MacNeil, Dean, School of Dental Medicine; Mr. James Thornton, Director, John Dempsey Hospital; Dr. Robert Trestman, Executive Director, Correctional Management Health Care, Dr. Lori Wilson, Professor and Surgeon, School of Medicine . Ms. Carolyn Lyle, Executive Director, Office of Diversity and Equity is also a team member.

The charge of this team is to adopt, support and promote the Health Center's Diversity Strategic Plan by providing input, direction and visibility to the Diversity Strategic Plan.

Leaders of the Health Center have actively supported various on-going efforts in support of building, valuing and managing diversity. Through consistent, structured and proactive affirmative action planning, user- friendly and informative UCHC departmental websites, active employee- based committees, periodic training classes and educational

forums we have begun to create an environment for realizing the Health Center's diversity vision and mission.

Step Two: Adopt a Diversity Vision and Mission Statement that Connects Diversity to the Overall Health Center Vision.

The Health Center's organizational vision statement includes this goal '... be the employer of ' first choice' in our region for people who want to be part of a caring, committed, talented and diverse workforce dedicated to advancing health and wellness for the people of Connecticut '. Also, the Health Center's vision states the following value '... promote the professionalism, compassion, diversity and social responsibility '.

Step Three: Analyze the current state of organizational diversity against the stated diversity vision and mission.

The Health Center diversity vision applies a broad and sweeping definition of diversity. The vision states that '...the Health Center will be a place where employees and students from all walks of life, background and experiences as well as representing different races, genders, ages, religions, sexual orientation, national origins , ancestries, abilities, marital status and veteran status will work and learn in an environment ..' This plan will focus on the area of diversity that involves race and ethnicity because 1) other than gender, racial and ethnic diversity is very broad and encompasses several other categories of differences 2) the majority of available data measures only race and ethnicity and 3) as a Health Care institution we must be concerned about eliminating health care disparities among racial and ethnic populations in Connecticut.

We collected data regarding the Health Center's racial and ethnic composition among the employee, student population and patient populations. Information was also collected and analyzed about how the employee and student populations perceived being treated, valued and respected and how they perceived the Health Center's demonstration of commitment to diversity, equality and non-discrimination.

This data was collected from Human Resources, Office of Diversity and Equity, School of Medicine, School of Dental Medicine, CT Board of Governors for Higher Education, AAMA and ADEA.

Building Diversity Indicators

Our mission is to have a workforce that reflects the populations we serve. As a state agency that provides employment, health care delivery and health care education, we serve three populations: a) the State of Connecticut labor pool b) students and c) patients. We have various and complimentary responsibilities relating to racial and ethnic diversity for each population. For the employment labor pool, we need to practice equal employment opportunity and reflect the labor pool when filing position vacancies using the tool of affirmative action. With regards to health care delivery, we must act to address and eliminate the health care disparities that exist among racial and ethnic

communities by using the National Standards for Culturally and Linguistically Appropriate Services in Health Care standard which advises ‘ building staff that adequately mirrors the diversity of the patient/customer population ‘. As educators, we need to provide an educational experience that equips students to care for a diverse population. Such an experience comes from a diverse student body.

We asked the following questions in order to identify the relevant building diversity data indicators:

- a. How does the racial composition of the UCHC workforce compare to the available labor pool?
- b. How does the racial composition of the UCHC workforce compare to the patient population?
- c. Is the racial composition of the UCHC workforce impacted by employee turnover?
- d. Is the racial composition of the UCHC workforce impacted by employees who resign, transfer or are dismissed?
- e. How does the racial composition of the UCHC workforce compare to the student population?
- f. How does the student population compare to national trends in medical and dental education?

Answers to these questions will help to identify improvement opportunities and action plans for creating and establishing an employee and student body that reflects the diversity of our service community. To get these answers the following datasets were collected:

Data Regarding UCHC Workforce:

- a. Percent of Part-Time Workforce by Race and EEO Category 2005-2007
- b. Percent of Full-Time Workforce by Race and EEO Category 2005-2007
- c. Percent of Total FT and PT Workforce by Race and EEO Category 2005-2007
- d. Percent of Total FT and PT Workforce that is Clinical by Race and EEO Category 2005-2007
- e. Annual FT turnover rate by race and EEO category FY 05-06 and 06-07
- f. Percent of FT dismissals by race and EEO category 2005-2007
- g. Percent of FT resignations by race and EEO category 2005-2007
- h. Percent of FT transfers out by race and EEO category 2005-2007

Benchmark data: What comparative data can be used to devise goals and objectives for building employee workforce diversity?

- a. CHRO Hiring Goal Achievement by EEO Category for 2006 and 2007
- b. Patient data by race as compared to clinical workforce for 2005 -2007

By comparing the patient data to the clinical workforce, we can determine how well we mirror the diversity of the patient/customer as recommended by the U.S. Department of Health and Human Services, Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services in Health Care. As in many businesses, the more we understand our customers, the better we can meet their needs. One way to do this, to the extent is it possible by the available labor market, is to employ 'service providers' that can gain the confidence and trust of the customer. It is for this reason that it is recommended as a best business practice that the health care delivery population reflect the patient demographics.

Dataset charts are in the Appendix under the 'Build- Employee' tab.

Dataset Definitions:

EEO Categories: categories of job groups (composed of UCHC job titles)

Hires: as defined by Affirmative Action Plan requirements are employment transactions that result in an increase in the EEO category such as hires, demotion, lateral transfer, promotions, PT to FT.

Race: White, Black, Other (Asian or Native American/ Alaskan Native)

Ethnicity: Hispanic

2005, 2006, and 2007: as of June 30 for each year

FY 05-06: June 30, 2005 to June 30, 2006

FY 06-07: June 30, 2006 to June 30, 2007

Data Regarding Student Body:

- a. Percent of under-represented minorities enrolled in SOM fall of 2003-2007
- b. Percent of under-represented minorities enrolled in SODM fall of 2003-2007
- c. Percent of under-represented minority graduates from SOM 2003-2007
- d. Percent of under-represented minority graduates from SODM 2003-2007

Benchmark data: What comparative data can be used to devise goals and objectives for building student body diversity?

- a. Percent of under-represented minorities enrolled in all US Medical schools as first year students for 2003-2007 according to AAMC.
- b. Percent of under-represented minorities enrolled in all US Dental schools as first year students for 2003- 2007 according the ADEA.
- c. Percent of under-represented minority graduates from all US medical schools for 2003- 2007 according to AAMC.
- d. Percent of under-represented minority graduates from all US Dental schools for 2003- 2007 according to ADEA.

Dataset charts are in the Appendix under the tab ‘Build- Students.’

Dataset Definitions:

‘An under-represented minority ‘refers to Black/ African American, Hispanic/Latino, Native American. The School of Medicine and the School of Dental Medicine do not include Asians as under-represented because this group is not ‘under-represented ‘according to their representation in the applicant pool as compared to their representation in the general population.

The Association of American Medical Colleges (AAMC) defines ‘underrepresented in medicine ‘as those ‘racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population ‘. The AAMC cautions that this definition is appropriate to gauge progress regarding access and diversity needs nationally or regionally but should not serve the purpose of individual medical school admissions policies. Instead the AAMC states that individual schools should customize their definition of underrepresented students based upon that particular school’s articulation of legitimate objectives to”... achieving the educational benefits of a diverse student body, including enhancing the cultural competency of all physicians it educates and improving access to care for under-served populations “. (*Roadmap to Diversity: Key Legal and Educational Policy Foundations for Medical Schools: AAMC, 2008*)

Valuing Diversity Indicators

Our diversity mission is to provide and sustain an inclusive working and learning environment where all members of the community can realize their full potential in an environment of equality, respect, appreciation and fairness. To employees and students from different races and ethnicities, this translates to non-discriminatory and equitable treatment by co-workers, colleagues, faculty and managers as well as being able to reach mutual appreciation and understanding through successful cross-cultural communication. In order to identify the relevant data for measuring the pulse of our employees and students regarding fair and respectful treatment we asked the following questions:

- a. What have we learned from employee surveys regarding employee perceptions of equitable, fair and respectful treatment in the workplace?
- b. What have we learned from student surveys regarding their perceptions of equitable, fair and respectful treatment in the learning environment?

Answers to these questions will provide valuable information for devising goals, objectives and action plans for improving the Health Center's working and learning environment.

The charts showing employee and student responses to surveys can be found in the appendix under the tab 'Valuing Diversity', 'Value-Employees' and 'Value- Students'.

Qualitative Information Regarding Employees

The Health Center has distributed several employee surveys over the past ten years and currently has in place a process for collecting qualitative information from employees who have decided to leave the Health Center. The following information was reviewed to gather qualitative information regarding employee attitudes:

- a. Summary results of Employee Relations and Satisfaction questionnaire administered by a consultant in 1995.
- b. Summary results of Workforce Climate Study (consultant) using employee focus groups in 1998.
- c. Summary results of Cultural Audit Survey (consultant) using employee focus groups in 2004.
- d. Summary results of Cultural Audit Survey (consultant) using mailer surveys in 2005.
- e. Summary results Employee Satisfaction Survey (C4 I Culture Group) using employee focus groups in 2006.
- f. Employee Exit Questionnaire Results 2005- 2008 (**charts exist for these results in the Appendix under 'Value- Employees'.**)

Benchmark information: There was no identifiable outside source of comparative survey information, however we can detect historical trends based on previous UCHC surveys.

Regarding Student Body:

Graduating medical and dental school students complete a graduation questionnaire that solicits their opinions about their medical or dental school experiences. Medical school students can comment about any general mistreatment as well as any unfair treatment due to gender, race and/or sexual orientation. They also have an opportunity to give their opinion about whether or not they were adequately trained about health care disparities and if they receive training in culturally appropriate care for diverse populations.

The School of Dental Medicine distributes a survey to seniors who can give their opinions about whether or not the school prepared them to a) accept and respect patients of different races, ethnicities and cultures and b) integrate knowledge regarding cultural differences into treatment planning and care delivery. Additionally, dental school seniors can comment about the cultural and social environment of the school in terms of promoting the acceptance and respect of the students and patients of different races, ethnicities and cultures.

Survey results of medical school graduates and dental school seniors can be compared to all US medical or dental school results for the years 2003-2007. The 'all schools' reports will help us to benchmark our own progress in valuing diversity in the learning environment. The Association of American Medical Colleges (AAMC) and the American Dental Education Association (ADEA) publish reports showing how students 'all schools' in the US responded to each question.

Therefore the following survey results were analyzed in this step of the diversity strategic plan:

- a. UHC Medical School Graduation Questionnaire Individual School Report for 2003- 2007
- b. AAMC Medical School Graduation Questionnaire All Schools Summary Report for 2003-2007.
- c. UHC Dental School Survey of Dental School Seniors Individual School Report for 2003-2007
- d. ADEA Survey of Dental School Seniors All Schools Summary Report for 2003-2007.

The charts showing School of Medicine student responses as compared to responses from 'all schools' as reported by the AAMC can be found in the appendix under the tab 'Valuing Diversity', 'Value – Students'.

Managing Diversity Indicators

If we are to realize our vision of a multicultural working and learning environment where differences are synergized and applied towards innovative contributions to health care delivery through education and research, then we must recognize and manage the natural associated tensions and misunderstandings that can result from building a diverse organization.

The discrimination complaint log is a source of data that can help identify particular tensions and misunderstandings associated with differences in race, ethnicity, gender, age, national origin, disability, sexual orientation, veteran status and marital status.

The ODE discrimination complaint log can reveal trends over time that can be used to develop goals and objectives towards better management of diversity.

Data charts of the complaint log can be found in the appendix under the tab ‘Managing Diversity’, ‘Manage- Employees’.

To determine if our students were aware of avenues they can use to address conflicts due to disrespect, mistreatment and/or discrimination we charted the medical student responses to the following questions:

1. How satisfied were you with the application of the school student mistreatment procedure?
2. Did you not report an incident of mistreatment due to fear of reprisal?
3. Did you not report an incident of mistreatment due to not knowing how to report?
4. Did you not report an incident of mistreatment due to it not being important?
5. Is there another reason you did not report an incident of mistreatment?

Data Analysis Results

EMPLOYEES

Building a Diverse Workforce:

The composition by race of the entire Health Center population shows that minorities have been under-represented as compared to our patient base:

Percent Minority (Black, Hispanic, Asian, Pacific Islander, Native American)

Year (as of 6/ 30)	***Workforce	**Patients	*First Time Student Enrollees
2005	19%	32%	25%
2006	20%	34%	21%
2007	20%	35%	15%

- ** CMHC patients not included * SOM and SODM (not include Asians)
- *** Workforce does not include special payroll, residents, graduate students, post-docs.

Because this table includes CMHC employees but does not include the CMHC patient population, we should review the comparison of minority CMHC employees to the CMHC minority patient base. The data for this comparison is:

Year (as of June 30)	CMHC Employees	CMHC Patients
2006	23%	unknown
2007	24%	unknown
2008	25%	55%

Additionally the medical and dental patient base has a greater representation of minorities than the Health Center’s clinical workforce:

Percent Minority

Year (as of June 30)	Patients Medical	Patients Dental	Clinical Workforce
2005	32%	44%	17%
2006	33%	52%	18%
2007	35%	57%	18%

We should also look at the diversity among the student body as compared to the faculty who instruct and mentor them. It can be argued that students learn best in a context where as customers they are understood and served according to their needs. The business case for diversity also applies here in that we will attract and retain a more diverse student base if we have a diverse faculty base that can best anticipate and meet their needs. An additional benefit is that we in turn can offer a multicultural educational context where future physicians gain cultural competency skills. Such skills then work to improve access and quality of care for under-served populations.

Because we define ‘under-represented students’ differently than we define minority employees in that Asians are not considered in the student definition but are included in the employee definition, we will show the faculty percentages with and without the Asian population:

Percent Under-Representation

Year (as of June 30)	SOM and SODM Students Enrollees	Faculty (FT & PT)
2005	25% (B,H,NA)	4% (B,H) 13 % (A,NA)
2006	21% (B,H NA)	5% (B,H) 14% (A,NA)
2007	15% (B,H,NA)	5% (B,H) 14 % (A,NA)

B: Black H: Hispanic NA: Native American A: Asian

This comparison demonstrates that there is a clear opportunity to increase the racial and ethnic diversity of our faculty. Even if we were to add the faculty Asian population, this group would still be less diverse than the student body, i.e. in 2007 15% of the student body is either Black, Hispanic or Native American while only 5% of the faculty is Black or Hispanic, or 19% are Black, Hispanic, Native American and Asian.

In order to devise strategic objectives for increasing clinical and faculty diversity we need to determine the extent to which the available labor pool can meet such objectives. Available labor pool statistics are used in our affirmative action program to guide our own workforce demographic objectives. Because faculty job titles belong to the faculty EEO category and clinical job titles are scattered among all EEO categories we collected data on how well we have met the affirmative action calculated goals or objectives in all EEO categories.

A close analysis of the data regarding goal achievement and workforce composition by race shows that the following EEO categories have not achieved any progress towards goal achievement for **both** or either 2006 or 2007 fiscal years (2005-06, 2006-07):

EEO Category	Race/Gender Group with 0% Goal Achievement
Executive	BM,BF,HM,HF,OM,OF
Faculty	WM,OF
Professional	BF,HM,OF
Clerical	BM,HM,OM,OF
Technical	BM,OM,OF
Skilled	WF,BM, HM,OM
Svc/Main	WF, BF, HF, OM, OF

Bold categories are those with 0% goal achievement for two years.

* Note: the racial designation ‘O’ includes Asians, Native Americans.

Goal Achievement - 2008

EEO Category	Race/ Gender Group 0% Goal Achievement Q3 2008
Executive	BF, HM,HF, OM,OF
Faculty	BF,HM,HF,OM,OF
Professional	HM
Clerical	HM
Technical	BM,HM
Skilled	WF,BM,HM,OM
Svc/Main	WM, OM, OF

Charts on goal achievement can be found in the appendix under the tab’ Build-Employees ‘.

We also looked at data that tells us how well we retain goal employees, as this is another aspect of building diversity. We can not build diversity and meet our affirmative action goals if we can not sustain the progress achieved. This data also shows that five of the six EEO Categories showing no goal achievement have fiscal year over year increases in exits of goal candidates:

Increase FY07 to FY08 by Racial Categories (excluding White)

EEO Category	Annual Turnover	Transfers	Dismissals	Resignations
Faculty	O,H,B	B		O
Professional	B,H	B	B,H	B
Clerical	O, B,H			H
Technical	O,H			B
Service Main.	B,H			B,H

Charts showing exits of employees by race and gender can be found in the appendix under tab ‘Build-Employees’.

Data Analysis Results

STUDENTS

The UCHC School of Dental Medicine and the School of Medicine track enrollment and graduation statistics for Black, Hispanic, Latino, Native American and Native Hawaiian students which are defined for data collection purposes as ‘under-represented’ students.

A review of the charts that appear in the appendix to this report, shows that the under-represented student (as defined above), enrollment in our medical schools is generally higher than the same population (also as defined above) enrollment benchmarked for ‘all schools’ by the Association of American Medical Colleges (AAMC) and the American Dental Education Association (ADEA).

Enrollment Averages over 5 years 2003-2007

	SOM	All Medical Schools		SODM	All Dental Schools
% under -rep. enrollment	21%	16%		16%	12%
% YTY increase	1%	0%		-5%	.4%

Note that the School of Medicine average under-represented enrollment is higher than the ‘all schools’ average as reported by the AAMC. In addition to this, the SOM average increase each year is also higher than the ‘all schools’ benchmark. Likewise, the SODM average % of under-represented student enrollment is higher than that reported by the ADEA for ‘all schools’ but the SODM is going in the wrong direction for year to year increase. This is due to the decrease of under-represented students into the dental school from 2006 when 18% were under-represented student enrollees to 2007 when only 3% were under-represented.

Another measurement of student body diversity is the extent to which the under-represented students stay and become graduates. To this end, we compared the composition of graduate classes from each school against the AAMC or the ADEA benchmarked data for under-represented students as defined by the SOM and SODM.

Average Percent Under-Represented Graduates over 5 years 2003-2007

	SOM	All Medical Schools		SODM	All Dental Schools
% under-rep. graduation class	15%	14%		8%	18%
% YTY increase	3%	0%		2%	0%

The average percent of under-represented students in the UCHC medical graduation classes school falls above the ‘all schools’ benchmarks. However the representation of under-represented students in the graduating classes for the dental school falls below the ‘all schools’ benchmark Both schools post a higher year by year average increase. We should be looking at strategies that retain under-represented students.

Detailed data charts for student

Data Analysis Results Continued

EMPLOYEES

Valuing a Diverse Workforce

Research has demonstrated that to attract and retain employees, they must be able to identify with how the work they do contributes to and benefits the organization’s mission. Additionally, motivated employees perceive that they are valued and respected. Employees from minority racial and ethnic groups must perceive that there is no discrimination and that policies, processes and procedures are applied objectively and equitably. When employees perceive that they are excluded by co-workers, are treated unfairly and /or in a discriminatory manner, the resulting working environment is characterized by discouragement and low morale which in turn, fails to attract and retain a diverse employee population.

The Health Center has endeavored to research and define employee attitudes and determine areas to improve employee engagement and motivation. Such surveys were issued in 1995, 1998, 2004, 2005 and 2006. These survey results were produced and interpreted for the Health Center as a whole. A summary of such results follows:

All survey qualitative results show both positive and negative indicators of employee attitudes about working at the Health Center. Each survey effort was charged with finding opportunities for improvement and suggested follow up recommendations. What follows is a summary of the overall conclusions as well as any conclusions regarding specific diversity measures.

The results of the Employee Relations and Satisfaction survey in 1995 which was delivered to all Health Center employees concluded the following:

- a. staff needed more direction in overcoming communication barriers and fostering teamwork
- b. management practices and leadership skills should be a focus going forward
- c. conflict resolution should be a future focus
- d. need for further understanding of interpersonal and personal relationships

In 1998, the Health Center held 44 focus group discussions over a period of three months in 10 departments (8 clinical, 1 research and 1 administrative). The focus groups met to discuss creating and maintaining a health and productive work environment. Three of the focus groups that were intentionally composed up of staff raised the following concerns:

- a. lack of proportional representation of ethnic minorities at all levels within the institution.
- b. problems between ethnic minority and majority staff are not handled in an equitable manner.
- c. ethnic minority concerns are addressed in a patronizing and/or denying manner
- d. staff of color are not promoted or retained in an equitable manner These focus groups reported concerns in the following areas:

The overall results of the 1998 survey identified the following concerns as barriers to creating and maintaining a healthy and productive work environment:

- a. lack of communication
- b. lack of leadership at various levels
- c. low morale
- d. lack of respect from upper echelon employees
- e. absence of teamwork/esprit de corps

On November 1, 2003 the Health Center entered into a three year grant agreement with the Connecticut Health Foundation. The title of this grant was Increasing Diversity by a Cultural Audit and Improving Cultural Competency. The cultural audit project began with 15 focus groups to discuss diversity recruitment, retention and the level of appreciation for diversity. The results of the 2004 Cultural Audit Focus Groups show the following:

- a. many managers/supervisors fail to behave consistently with existing policies of appreciating diversity, which states that everyone should be treated fairly and respectfully.
- b. managers/supervisors tend to give better assignments to employees from the dominant racial/ethnic groups.
- c. perception that 'foreigners' are taking jobs away from us.
- d. procedures for promotions are not well communicated to new employees and those from diverse backgrounds.

The cultural audit project also disseminated to all Health Center employees a written organizational survey in May, 2005. The results of this organizational survey 2005 Cultural Audit organizational survey showed the following:

- a. despite senior leadership commitment to diversity, managers and supervisors at lower levels are inconsistent in their support for diversity.
- b. many people from diverse backgrounds feel as if discrimination is still a problem
- c. most managers and supervisors are rated low in: teamwork, fairness, support and work/family balance.

The 2005 organizational survey data revealed that Black and Hispanic/Latino employees neither disagree or agree that 1) the organization does not tolerate discrimination and 2) values and respects differences. Native American employees somewhat disagree that #1 and #2 are true while White and Asian employees somewhat agree that diversity is accepted and practiced.

Also in 2005, the Human Resources department implemented a process to gather information about the organizational culture from employees who have decided to separate from the Health Center. Departing employees complete an exit questionnaire and are offered the opportunity to be interviewed. For the purposes of this Diversity Strategic Plan, data for 2005-2008 was requested and sorted by division regarding exiting employee's perceptions of fairness, respect and discrimination. Response data from the following exit survey questions was analyzed for each UCHC division:

- a. Reasons that influenced your decision to leave UCHC:
 1. Conflict with co-workers
 2. Conflict with supervisor
 3. Discrimination
 4. Work environment

- b. Describe your experience at UCHC re: treating employees fairly
 1. excellent
 2. good
 3. fair
 4. neutral
 5. poor

- c. Describe your experience at UCHC re: morale in your area
 1. excellent
 2. good
 3. fair
 4. neutral
 5. poor

- d. Did your manager treat you fairly?
 1. always
 2. usually
 3. seldom
 4. never

- e. Did you have knowledge of discrimination while at UCHC?
- f. Were you aware of avenues to address discrimination while at UCHC?
- g. Did you use avenues to address discrimination while at UCHC?

The raw data for the following summary charts can be found in the appendix under the tab ‘Value- Employees’.

A review of these responses by division shows the following:

Summary Tables

	Responses	Reasons That Influenced Decisions To Leave			
	<u>% of Total</u>	<u>co-worker conflict</u>	<u>supervisor conflict</u>	<u>discrimination</u>	<u>work environ.</u>
Admin	11%	0%	10%	8%	22%
CMHC	10%	12%	26%	16%	37%
JDH	17%	13%	15%	8%	41%
SODM	6%	0%	4%	0%	15%
SOM	51%	20%	7%	1%	13%
UMG	3%	0%	8%	0%	50%

	Experience at UCHC		
	<u>treat employees fairly (fair,neutral,poor)</u>	<u>morale (fair, neutral,poor)</u>	<u>mgr.treat fairly-(seldom, never)</u>
Admin	51%	59%	31%
CMHC	70%	84%	33%
JDH	60%	71%	28%
SODM	22%	33%	7%
SOM	38%	51%	21%
UMG	50%	75%	17%

	Respectful Workplace		
	<u>Knowledge of discrimination</u>	<u>aware avenues to address</u>	<u>used avenues</u>
Admin	4%	20%	6%
CMHC	16%	47%	12%
JDH	12%	41%	7%
SODM	4%	22%	7%
SOM	4%	30%	5%
UMG	17%	25%	17%

According to a review of the exit surveys, the work environment was the most prevalent reason that influenced employees in all divisions except, the School of Medicine, to leave the Health Center. On the Employee Exit Questionnaire, the choice of work environment ‘appears as’ working environment (i.e., work-related stress and/or work load issues). In the School of Medicine, the most prevalent reason for leaving was conflict with co-workers. In the divisions of Administration, CMHC, JDH and UMG over half of the responses about experience at UCHC rated their experiences as either fair, neutral or poor as it pertains to treating employees fairly and workplace morale. In the School of Medicine, half of the responses rated workplace morale as fair, neutral or poor. The

exception to this trend was persons who left the School of Dental Medicine where over 60% of the responses rated treating employees fairly and workplace morale as very good or good.

Note: The National Urban League compiled the results of an American Worker Survey regarding perceived impact of company-led diversity initiatives. When the American worker was asked if a problematic relationship with their supervisor would be a reason to seriously consider leaving, 20% gave an unfavorable response. In our exit responses, all divisions but SODM and UMG had over 20% negative response to the question regarding fair treatment from their managers. This would suggest a benchmark comparative.

With regards to respectful workplace, the highest percentages were reflected in persons knowing about avenues to address discrimination, but none of these were over 50%. In all divisions, there were persons who had knowledge of discrimination and/or used those avenues.

The exit questionnaire results reflect what the organizational survey results of 1995, 1998 and 2004 have been telling us that there is a great opportunity to improve the morale and engagement of all employees.

Data Analysis Results

STUDENTS

Valuing a Diverse Student Body

There are two aspects of the Health Center's vision to valuing diversity in the health delivery educational context. First we strive to provide and sustain an environment where the students are respected and valued for the unique perspectives they bring to the classroom and campus and secondly we must recognize our responsibility to contribute to the elimination of health care disparities by providing an educational experience that prepares our students for an increasingly diverse society.

The data used to measure how well our medical students felt respected, valued and treated fairly came from the following questions asked of graduating students on the Medical School Graduation Questionnaire for the years 2003-2207. This survey also asked our students about the school's commitment to eliminate health care disparities and prepare them to treat a diverse population.

1. Are you aware that your school has a mistreatment policy?
2. Have you personally been mistreated during medical school?
3. Indicate the frequency (never, once, occasionally, frequently) you experienced the following types of mistreatment:

Sexual Mistreatment

- a. been denied opportunities for training or rewards because of your gender?
- b. been asked to exchange sexual favors for grades or other awards?

- c. been subjected to unwanted sexual advances by school personnel?
- d. been subject to offensive sexist remarks/names directed at you personally?
- e. received lower evaluations or grades solely because of your gender rather than performance?

Racial Mistreatment

- a. been denied opportunities for training or rewards because of your race?
- b. been subject to racially or ethnically offensive remarks/names directed at you personally?
- c. received lower evaluations or grades solely because of your race or ethnicity rather than performance?

Sexual Orientation Mistreatment

- a. been denied opportunities for training or rewards because of your sexual Orientation?
- b. been subject to offensive remarks/names directed at you personally because of your sexual orientation?
- c. received lower evaluations or grades solely because of your sexual orientation rather than performance?

4. If you experienced mistreatment during medical school, please identify the source:
- a. preclinical faculty
 - b. clinical faculty (classroom)
 - c. clinical faculty (hospital)
 - d. residents/interns
 - e. nurses
 - f. administrators
 - g. students
 - h. patients

5. Did you report the incident to a designated faculty member or a member of the medical school administration empowered to handle such complaints?

Our medical student responses to these questions were benchmarked for each year with the ‘all schools ‘response provided by the Association of American Medical Colleges. The comparative results can be summarized as follows:

Student awareness of school mistreatment policy and personal experiences of mistreatment

Average % students reporting affirmative response 2003-2007

Question	UCHC SOM	AAMC -All Schools
Aware of mistreatment policy	84%	67%
Personally mistreated	13%	14%
Reported mistreatment	44%	32%
Source of mistreatment	Hospital faculty 64% Residents 48%	Hospital faculty 67% Residents 69%
Frequency of mistreatment		
Once	27%	27%

Occasion	33%	54%
Frequent	4%	6%

As compared to the national responses, our students report a greater awareness of our policy against mistreatment and are slightly more likely to report such mistreatment. As for having experienced mistreatment and identifying the source, our students respond similarly with the AAMC ‘all student’ national responses in terms of having experienced once instance of mistreatment. Our students report that they have experienced occasional mistreatment less than the all schools response. For the Medical School, the only year students (22%) reported that the experience of mistreatment was ‘frequent’ was in 2006. The remaining years did not show any report of ‘frequent’ experience.

2007 Survey Responses % Responding ‘occasion or frequent’	Gender		Race/Ethnicity		Sexual Orientation	
	SOM	AAMC All	SOM	AAMC All	SOM	AAMC All
Denied training/reward because of	17%	10%	0%	7.7%	0%	1.4%
Received lower grades because of	17%	8%	0%	7.5%	0%	1.5%
Offensive remarks because of	17%	14%	0% *	8.9%	0%	1.9%
Unwanted <u>sexual</u> advances (once, occasion and frequent)	30%	12%	NA	NA	NA	NA
Asked to exchange <u>sexual</u> favors	0%	2.3%	NA	NA	NA	NA

* Note that 16.7% of the SOM students responded ‘once’ when asked if they had received racially or ethnically offensive remarks directed to them personally. The corresponding AAMC ‘all schools’ response for ‘once’ is 6.5%.

This chart shows that with regards to mistreatment because of gender, our students report higher incidence of this situation than the benchmark responses. This indicates existing issues of gender bias and possible hostile working environment in the School of Medicine. Of particular concern are the medical student responses to the question about unwanted sexual advances where 30% of the students responded affirmatively.

Another aspect of valuing diversity in education is the extent to which the educational curriculum and overall experience equips our student with skills for caring for patients from diverse backgrounds. To determine if our educational environment adequately addresses the need to train future physician in culturally competent patient care and in turn provide care that helps to close the health care disparity gap among racial and ethnic groups we reviewed the 2007 responses to the survey questions of:

1. I was appropriately trained to care for individuals from racial and ethnic backgrounds different from my own.
2. My knowledge or opinion was influenced or changed by becoming more aware of the perspectives of individuals from racial and ethnic backgrounds different from my own.
3. Time devoted to culturally appropriate care for diverse populations was inadequate.
4. Time devoted to health and health care disparities was inadequate.

A summary of the most recent (2007) responses is as follows:

Survey Responses 2007 Satisfaction Factor	SOM	AAMC All Schools
Appropriately trained to care for difference background	satisfied	neutral
Changed by becoming more aware of differences	satisfied	satisfied
Time devoted to culturally appropriate care inadequate	19%	19%
Time devoted to health care disparities inadequate	15%	22%

Data charts can be found in the appendix under the tab ‘Valuing- Students’.

As compared to the AAMC benchmark of ‘all schools’ our students respond more favorably to the educational plan as being culturally relevant regarding care for diverse patient populations.

The American Dental Education Association Survey of Dental School Seniors results for the Health Center School of Dental Medicine as compared to all dental school responses reveals that the UCHC SODM has show consistent improvement beyond the benchmark of all dental schools responses in answers to the following questions:

- a. Amount of time devoted to your instruction in cultural competency
- b. Preparedness for providing oral health care to diverse groups.

Our students responded the same as the benchmarked all student responses in answering the following questions:

- c. Cultural and social environment promotes acceptance and respect of students and patients.
- d. Impact of extramural experience on ability to care for diverse groups

Data Analysis Results

EMPLOYEES -*Managing* a Diverse Workforce

Tracking and analyzing employee discrimination complaint trends reveals symptoms of problematic interpersonal working relationships caused by perceptions of discrimination

and inequality. A review of such complaints since 2006 shows that the most consistently prevalent basis of discrimination complaints is sexual harassment, followed by discrimination due to gender and race. CMHC is the division that, for each year, has the highest count of sexual harassment complaints. No doubt that this is in part due to the very strict regulatory process for such complaints in the form of Administrative Directive 2.2 which requires a written report and follow-up investigation of any possible violation of the Administrative Directive.

Second to sexual harassment complaints are complaints based on age, gender and race. Complaints based on disability are also among the highest for 2006; however the majority of these are evaluations for accommodation requests.

From year 2007 to current 2008 there is a marked increase in discrimination complaints based on race and national origin.

By far for each year, harassment is the percentage of adverse actions allegedly levied because of discriminatory treatment.

These trends confirm what we already know from both the exit questionnaires and the organizational culture surveys that there is a great need to improve interpersonal working relationships among co-workers and between managers and employees. However, when it comes to improving the working environment we need to turn around such perceptions of discrimination and resulting conflicts so to give way to mutual understanding, trust and respect. Objectives and action plans will focus on employees and manager skill development for communicating across differences.

Data Analysis Results

STUDENTS- *Managing* a Diverse Student Body

Conflicts among students and between students and school staff including faculty regarding issues of discrimination should be handled by the Health Center Office of Diversity and Equity. Dental and medical first year students receive information about the Health Center's equal employment and harassment-free policies as part of their overall several day long orientation. Faculty and other school administrative staff also receive this information at new employee orientation. Since the fall of 2007 faculty have been assigned to attend the training class on Harassment Free and Respectful Workplace which provides a more extensive explanation of the Health Center's non-discrimination policies and companion procedures. The extent to which our medical students believe that our policies are appropriately applied and the extent to which our medical students will not report instances of mistreatment can be captured in their responses to the following questions on the AAMC Survey for Medical School Graduates:

1. How satisfied are you with the application of the school’s mistreatment procedure?
2. Why did you not report an incident of mistreatment?
 - Not important
 - Did not know how to report it
 - Fear of reprisal
 - Other reason

Survey Responses 2007	SOM	AAMC All Schools
Satisfied with application procedure	satisfied	no opinion
Did not report – not important	68%	48%
Did not report- not know how to	0%	22%
Did not report- fear reprisal	32%	53%
Did not report-other	0%	20%

The good news is that our medical students know how to report an incident of mistreatment, including discriminatory conduct and that when they do report it, they are basically satisfied with the process for handling the complaint. However it is concerning that 68% of the responses did not report an incident because it did not seem important. This coupled with the data showing that our students report a higher than benchmarked average of frequency for mistreatment based on gender indicates that there may be a perceived acceptable level of behavior that is in fact not aligned with the mission of the health center for valuing diversity.

Step Four: Identify strategic objectives for progressing towards diversity vision and mission realization

Using the results of the data analysis which identified improvement opportunities, we will set objectives for progress towards realizing the mission of building, valuing and managing diversity.

1. Building Employee Diversity Strategic Objectives:

Since affirmative action is a method for diversifying the workforce and reflecting the available labor pool, building diversity strategies must include achieving affirmative action goals for under-represented racial and ethnic groups. Additionally building diversity strategies must include strategies to retain goals achieved and the existing diversity. The data on goal achievement, turnover and separations point to these priorities and strategic objectives:

- a. Executive EEO category should achieve progress in goal achievement in one or more of the non-white groups of Black, Hispanic, Asian, Native American.
- b. Determine and address the cause of exits in Faculty EEO Category in the goal categories of HM, BF and OM and establish retention initiatives.

- c. Faculty EEO category should achieve progress in goal achievement in Black Female, Hispanic Male and Asian/Native American Female. Focus on the Black and Hispanic goal achievement would address the gap between the student and faculty diversity.
- d. Determine and address the cause of exits in Professional EEO category goal categories of Black Males and Females.
- e. Professional EEO category should achieve progress in goal achievement in one or more of the non-white groups on Hispanic Male and Asian/Native American Female.
- f. Determine and address the cause of Clerical EEO exits of Hispanic Males and Females
- g. Clerical EEO category should achieve progress towards goal achievement of Black Male, Hispanic Male, Asian/ Native American.
- h. Review promotional goal achievement for opportunities to improve.

STUDENTS

2. Building a Diverse Student Body Strategic Objectives

- a. Review current SOM and SODM educational mission and vision statements regarding diversity strategies that connect diversity to educational benefits of enhancing the cultural competency of all future physicians and improving access to care for underserved populations. Revise as necessary for external publication and alignment with overall UCHC diversity mission and vision.

Note: Currently the School of Medicine addresses diversity in a 24 page publication called “*A Culture of Our Own*” which can be found on the website for both external and internal access. There are various statements about diversity in this brochure in sections:

Recruitment: ‘Through HCOP, the SOM operates an extensive recruitment and outreach program to ensure a diverse applicant pool. Visits to area colleges and historically Black colleges and universities, representation at recruitment programs...’

The Process- First-Year Admissions: ‘The SOM has a strong tradition of seeking a very diverse entering class, with diversity defined along a myriad of dimensions to include a representative sample of the highly capable applicant pool that can meet the health care needs of all segments of society.’

Health Career Opportunity Programs: ‘A top priority for the SOM has long been the recruitment and retention of students from diverse groups under-represented in American medicine.’

Society as the Patron: 'One of the most important imperatives guiding the SOM is the need to produce culturally competent physicians who are interested in providing care to under-served populations.'

Note: The School of Dental Medicine has an internal document entitled 'Predoctoral Admissions Committee Statement on Diversity and Applicant Selection'. According to this statement diversity is defined by the Committee to include but not limited to race, ethnicity, nationality, gender, socioeconomic status, educational and professional background and dental career aspiration. Additionally this statement commits the admissions committee to... 'admit students who contribute cultural and ethnic diversity to their class and upon graduation will enter the profession willing to and prepared to treat a diverse population in order to meet the future oral health needs of the citizens of the State of Connecticut and American society at large.'

- b. Review SOM and SODM goals and parallel processes for ensuring the recruitment of a diverse student body. Revise as necessary.
- c. Collect retention and graduation rates of under-represented students for development of relevant and successful strategies.

3. Valuing and Managing Employee Diversity Objectives

- a. The working environment must improve through the presence of leadership skills in management ranks, increased levels of positive employee morale, less conflict, less complaints of discrimination.
- b. The working environment must be a place where working relationships are built on trust, understanding and respect.
- c. Conflict is handled in a way that increases understanding and employee ability to communicate across differences in race, ethnicity and culture.
- d. Management will learn and model cross cultural communication skills.

4. Valuing and Managing **Student** Body Diversity Objectives

- a. The SOM and SODM leadership and faculty will communicate to all students their support and commitment to a respectful, non-discriminatory and harassment-free learning environment.
- b. All students will know the UHC policies and procedures on maintaining a respectful, non-discriminatory and harassment-free learning environment. Increase visibility and transparency of these policies and procedures.

- c. All residents and hospital staff will know the UCHC policies and procedures on maintaining a respectful, non-discriminatory and harassment-free learning environment.
- d. Determine the nature of the gender and sexual related mistreatment causing the higher survey responses as compared to the AAMC 'all schools' benchmark.
- e. Increase faculty cross cultural competency communication skills.
- f. Review curriculum for skills in cross cultural health care delivery.

Step Five: Identify action plans and accountabilities for objectives.

- 1. To accomplish the *Building Employee Diversity* objectives the following action plans are recommended to be implemented:
 - a. For all openings in the EEO categories showing 0% goal achievement a written detailed recruitment plan should be approved by HR and ODE that identify specific and targeted outreach sources for goal candidates. In the Executive, Faculty and Professional EEO categories this should include identification of face to face networking opportunities. Results of the recruitment plans should be tracked for focus on sources and methods that show a record of success.
 - b. Establish relationships with effective recruiting sources for minority faculty such as collaboration with AAMC and ADEA Centers of Diversity.
 - c. Require department managers to develop specific strategies with HR for outreach and networking sources.
 - d. Identify internal under-represented students for potential entry level faculty positions.
 - e. For all openings in the specified EEO categories, a written and detailed plan should be approved that outlines progressive steps to evaluate all qualified candidates that insures objective and consistent analysis of each candidate knowledge , skills and abilities.
 - f. For all openings in the specified EEO categories, the evaluation process should not commence unless there are qualified non-white goal candidates in the candidate pool.
 - g. For all openings in the specified EEO categories, no selection should be made unless the recruitment process and the evaluation process was approved by ODE and HR and determined to show good faith and/or appropriate goal candidate selection.
 - h. For all employees who leave the specified EEO categories, particular attention should be paid to exit surveys and exit interviews that indicate that unfair treatment and/or discrimination was an element in the employees' decision to separate employment. Any evidence of discriminatory treatment should be reported to ODE.

i. Review career paths for upward mobility in job groups showing little or no progress in goal achievement.

j. Establish a mentoring program to retain and develop minority talent.

k. Provide career development opportunities designed to increase minority diversity in higher level positions.

l. Form a team with human resources, management, union representatives and ODE to brainstorm ways to support and achieve AAP goals.

m. Review composition of Leadership Team for inclusion of union representation.

2. To accomplish the *Building Student Diversity* objectives the following action plans are recommended to be implemented:

a. Institutionalize building and valuing diversity in all aspects of public communication, public image and actions interfacing with the public.

b. Research ADEA grants such as: Academic Dental Career Program; Scholarships to Dental School Students in Pipeline; Minority Faculty Development Program.

c. Research AAMC grants and other collaborative efforts such as Health Professionals for Diversity.

d. Consider specific action plans to increase retention such as a Retention Coordination Council, monitor academic progress for under-represented students.

e. Establish effective mentoring programs designed to retain student under-represented diversity.

3. To accomplish *Valuing and Managing Employee Diversity* the following action plans are recommended:

a. Devise a communication campaign on the importance of valuing diversity to include follow-up discussions in departmental staff meetings, with demonstration of joint management- employee responsibility for morale in the workplace.

b. Develop a mediation program to resolve conflict due to perceived discriminatory treatment. This would include mediation training.

c. Design a 'diversity impact' analysis for use in reviewing and revising employee centered processes such as reward and recognition and reclassifications.

d. Demonstrate diversity appreciation in the form of celebrating different cultural events.

- e. Review and revamp EEO and Non-Discrimination Policies.
 - f. Provide an educational curriculum for developing intercultural sensitivity and cultural competency skills. Require all managers and faculty to complete this training.
 - g. Establish employee resource groups formed around an aspect of diversity.
 - h. Create a ‘Diversity Champion’ recognition for the leaders who hold themselves and others accountable for achieving objectives and demonstrate personal commitment to diversity.
 - i. Analyze discrimination complaint trends by department and work with management to devise proactive solutions to improve the working environment of their organization.
4. To accomplish *Valuing and Managing Student Diversity* the following action plans are recommended:
- a. Require SOM and SODM department chairs to devise a communication plan reaffirming personal commitment to valuing diversity as an imperative for a successful learning environment and support for current policies and processes regarding respectful and harassment – free behavior.
 - b. Infuse training on UHC non-discrimination, respectful and harassment-free policies and procedures in all student orientations.
 - c. Require training in such policies and procedures for all residents and hospital staff.
 - d. Update and SOM and SODM websites to reflect diversity vision and mission in health care education and research. Create similar supplemental public relations material to use in recruitment of students and faculty.
 - e. Devise educational curriculum for faculty development in cultural communication competency.
 - f. Institute a faculty to student and student to faculty evaluation criteria for cultural sensitivity and cross cultural communication skill. Review University of Wisconsin at Madison Doctoral Program in Counseling Psychology evaluation tool.
 - g. Collaborate with AAMC and ADEA Centers for Diversity on opportunities to improve curriculum for training in health care disparities.

Adopted action plans will have accountability assignments and timelines.

Step Six: Provide a process for tracking and measuring success towards achieving objectives and goals (how we know that we are making progress).

This process will be custom designed according to the action plans adopted.