UNC
GILLINGS SCHOOL OF
GLOBAL PUBLIC HEALTH

In our hands...

13 Recommendations on Diversity and Inclusion to the UNC Gillings School of Global Public Health Community

September 2011

Inside This Report

Diversity and inclusion mean we welcome, value and learn from individual differences and perspectives.

More than just a definition, diversity and inclusion are tools to help us accomplish our mission and vision.

A letter from the Dean

Dear Readers,

I have a dream (with acknowledgement to Martin Luther King, Jr.). It is a School in which everyone who walks through our doors is valued, respected and accepted, and feels so—no exceptions. We are diverse and inclusive. That means Blacks, Whites, Asians, Hispanics, Native Hawaiians, American Indians, multi-race and multi-ethnic people, LGBTQ individuals, those with disabilities, people of differing politics, values and socioeconomic backgrounds, Muslims, Jews, Buddhists, Christians, Catholics, other religions and agnostics, people born here and those born outside the USA, people of all sizes and shapes, and backgrounds, including individuals not represented above. This is the School that many of us said we wanted to be in the year 2020, as part of our School's SPH2020 strategic planning effort. It is not just my dream; it is our dream.

In public health, we aim to solve some of the biggest problems facing the planet. We cannot do that effectively without understanding the world's people. If we are going to live up to our global name and heritage, we must reflect global diversity, in all forms, within our walls. We are evidence-based. Evidence shows that diverse groups make better decisions. Diversity can make us stronger, smarter and more sensitive.

A significantly more diverse and inclusive School is an achievable dream, but it is not yet reality. Over the six years since I have been dean, we have taken many steps to increase diversity. Based on feedback given through focus groups early during my first term, we made diversity a performance criterion for chairs and other senior academic leaders. We changed the mission of the School, altered the text in our job ads, re-engaged diverse alumni in supporting the School, increased the number of diverse scholarship recipients, received Provost's support for several faculty recruitments, appointed Dr. Jessie Satia special assistant to the dean for diversity, refined and assessed diversity metrics, and a lot more. I have talked about and written about diversity regularly (including in my blog), and it is often a topic for our School's Dean's Council, Chairs' Committee and various advisory groups. Some departments created diversity committees and began to change how they operated. We have done many more things that are beyond what is mentioned here.

Still, feedback from climate surveys and the demographic makeup of our community indicated little had changed by 2010. Many of us were not satisfied with the status quo. In summer 2010, we formed the Diversity and Inclusion Task Force (DITF). The DITF is a tangible commitment to creating effective and lasting change by me, the School's leadership, task force co-chairs and its members. The DITF has two remarkable leaders, Rumay Alexander, RN, EdD, Clinical Professor of Nursing and Director of Multicultural Affairs, and Bryan Weiner, PhD, Professor Health Policy and Management. We said that the DITF should attempt to understand what was getting in the way of us becoming a notably diverse and inclusive school, suggest specific, concrete steps that would help to overcome those barriers and then begin to take us on a transformational journey. I cautioned the group that, with the economy in recession, and the School having suffered significant budget cuts, we would not be able to increase funding for diversity and inclusivity

dramatically. We would do what we could through strategic investments. Over time, as the economy improves, investing in diversity and inclusivity should accelerate.

It was thrilling that over 60 people volunteered to serve on the DITF, and 22 agreed to serve on a Change Team that did significant work towards developing a report. I have been gratified by Bryan and Rumay's leadership and by the efforts of so many people to make this School more diverse and inclusive.

Our School's Dean's Council will review the report and prioritize recommendations for immediate action and then monitor results. Our chairs and assistant/associate deans will be involved at a more granular level.

Even with this excellent report and recommendations, change will not happen without all of us staying committed. Diversity and inclusion are outcomes of many smaller steps: the frames we bring to discussions about applicants to the School as we evaluate them for admission, how we greet and interact with our fellow staff, faculty, students, alumni and visitors, mentoring we give our junior faculty, award nomination processes, problems we study, policies that govern us, content we cover in courses, characteristics of senior hires and members of internal and external leadership committees and whether we are willing to keep looking at ourselves and asking hard questions about whether we are doing enough, whether we are doing the right things, and how we could do better.

The DITF report is a cause for celebration, because the process that we undertook and completion of the report are change agents in and of themselves. It is not the end of a journey. It is the beginning of a new phase, one which we will begin with new insight, commitment and collective intelligence. We are not turning back. Thanks to the DITF for getting us to this point. We could not have done it without you!

With warm appreciation,

Barbara K. Rimer, DrPH
Dean and Alumni Distinguished Professor

A Note from the Co-Chair:

Each and every day, I read the following quote to myself.

"If you touch a spider's web anywhere, you set the whole thing trembling. As we move through and around this world, and as we act with kindness, or indifference, or even hostility toward the people we meet, we too, are setting the great spider web a-tremble. The life I touch will touch another life, and that, in turn another, until who knows where the trembling stops or in what far place and time my touch will be felt. You can't find a better way to quantify or qualify someone's legacy. Just think of the web you have set a-tremble".

Frederick Buechner

I do so because it keeps ever before me the immense responsibility and understanding of what it means truly means to live a life and be about meaningful work where curiosity is maximized and certainty is minimized for the purpose of realizing creative potential in every encounter. I think that Buechner has also captured the noble endeavor over the past 15 months The Gillings School of Global Public Health has undertaken.

By design and with integrity the DITF worked to know about the lived experiences and the impact of those experiences on students, faculty and staff. Creating the web of experiences was the GPS for this endeavor. The courageous dialogue brought collective wisdom together and thus the recommendations provided in this report. It is the culmination of thinking out loud by the SPH community. The recommendations, shaped and molded by current SPH members and alumni when implemented can create a culture of accountability…meaning a culture where by thought and deed there is demonstrable commitment congruent with the expectations of its constituency. My thanks to each of you for your cooperation and the honor to join you in this work. Indeed, a web has been set a-tremble!

G. Rumay Alexander

G. Rumay Alexander, EdD, RN
Clinical Professor and Co-Chair, SPH Diversity and Inclusion Task Force

A Note from the Co-Chair:

When Dean Barbara Rimer asked me to serve as Co-Chair of the Gillings School of Global Public Health's Diversity and Inclusion Task Force (DITF), I did not hesitate to say yes. I knew that Dean Rimer was fully committed to increasing diversity, and but I did not know until we met a few weeks later that we shared a similar perspective on organizational performance and change. Simply put, if we keep doing the things we have been doing, we will keep getting the results that we have been getting. If we want different results, we have to change the way we do business. More importantly, we have to change the mindset that informs the way we do business.

When we issued the call for volunteers to serve on the DITF, more than sixty faculty members, staff members, and students signed up. Twenty of these volunteers also agreed to serve on the DITF Change Team, which met monthly to delve more deeply into the issues identified by the DITF. After a six-month period of assessment, the DITF formed smaller teams to develop recommendations in three areas: organizational climate, recruitment and retention, and curriculum. The teams sought to make recommendations that were specific enough to be actionable, powerful enough to create meaningful change, and feasible enough to be implemented within a difficult budgetary context. I believe they succeeded on all three fronts.

Throughout this process, I have been repeatedly struck by the energy, enthusiasm and creativity that so many people brought to the work of the DITF. Although task force members participated in different ways at different times, the recommendations included in this report reflect the will of the DITF as a whole. Their signatures are offered as endorsement of this collective work.

I wish to thank all of those who contributed, in large ways and small, to the work of the DITF. I found myself inspired many times by the passion and commitment of DITF members and others in the School for increasing diversity. Although the road ahead may be difficult, I believe that implementing the recommendations included in this report will change the way we do business and, further, that the process of implementing them will change the mindset that informs the way we do business.

Bryan J. Weiner

Bryan J. Weiner, Ph.D.
Professor and Co-Chair, SPH Diversity and Inclusion Task Force

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GLOBAL PUBLIC HEALTH

GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH,

SEPTEMBER 8, 2011.

AN ENDORSEMENT

BY THE MEMBERS OF THE

DIVERSITY AND INCLUSION TASK FORCE, IN ASSEMBLY.

AT UNC

The case for diversity and inclusion

At the UNC Gillings School of Global Health, diversity and inclusion mean we welcome, value and learn from individual differences and perspectives. The case for diversity and inclusion comes from our core – our mission – "*to improve public health, promote individual well-being, and eliminate health disparities across North Carolina and around the world*." Also, diversity and inclusion are important pillars of SPH2020, the School's strategic planning effort. To accomplish our ambitions and make an impact in public health, many hands, minds, and perspectives are required.

Making the School more diverse and welcoming could give us a competitive advantage; all top schools of public health have diversity commitments, offices, initiatives, awards or other programs. Diversity and inclusion are expectations – of prospective students, prospective faculty and staff, the public whose health we want to improve and the workforce our graduates will join. If we don't educate, employ and deploy people who reflect the diversity of experiences in the practice of public health, we will not be as effective in solving public health problems as we could be.

DITF discussions and recommendations cite the added value of diversity in the classroom, on research teams and in public health practice. The presence of different experiences and points of view makes case discussions richer, new ideas more likely, debates and decisions more informed and learning deeper. The whip of necessity demands responsible stewardship of all resources and intentional deployment of strategies which address the cognitive costs and the residue of depleting cognitive resources. For selected literature on this topic---different approaches, recommendations, evidence of effectiveness and "business" vs. social drivers of change--- see Appendix J. No single approach is a "best practice," but common themes in successful diversity and inclusion programs include strong endorsement from top management, acknowledgment that different organizations require different approaches, the importance of changing the culture, and the value of goals, metrics and accountability.

Executive Summary

In April 2010, Dean Barbara K. Rimer created the Diversity and Inclusion Task Force (DITF) to "identify barriers and facilitators to increasing diversity in the Gillings School of Global Public Health and recommend changes that would take the School to a new level of diversity among faculty, students and staff." More than 60 faculty, staff, and students volunteered to serve. Co-chaired by Drs. Bryan Weiner and Rumay Alexander, the DITF surveyed the SPH community about organizational climate issues, conducted a dozen focus groups with constituencies in the School, consulted with department chairs and program leaders, and reviewed the history of the School's efforts to increase diversity. In April 2011, the DITF shifted its focus from assessment to recommendation. The DITF decided to make recommendations in three areas: organizational climate, recruitment and retention, and curriculum. Briefly, the DITF recommends,

To strengthen the organizational climate for diversity and inclusion (D&I):

- Issue a strong statement from Dean's Council in support of D&I.
- Develop a model and process for spreading D&I principles and practices in SPH.
- Appoint a school-level champion to oversee D&I efforts.
- Strengthen links with campus and community resources to foster D&I.
- Support an Ombuds dedicated to addressing D&I issues.

To increase recruitment and retention of a diverse body of students, faculty, and staff:

- Take greater recruiting advantage of the Annual Minority Health conference and William T. Small, Jr., Keynote Lecture.
- Engage diverse and minoritized alumni in recruitment, training and placement.
- Promote cross-departmental sharing of recommended practices.
- Encourage admission and support students with exceptional potential but not traditional admissions profiles.
- Require greater specificity in departments' D&I goals, plans and reports.

To promote diversity and inclusion through the SPH curricula:

- Increase course content to address the health issues of diverse populations.
- Increase cultural competence and opportunities to discuss D&I topics productively.
- Coordinate D&I in SPH content and approaches in core courses.

In its report, the DITF describes each recommendation in more detail and discusses its potential impact, implementation, timeline, resource requirements, anticipated results and metrics for measure those results. It also proposes a champion for each recommendation. Although each recommendation is actionable, the recommendations collectively are mutually reinforcing.

The DITF's work is now complete. The School's work continues. In 2012, the Dean's Council will discuss the DITF report and adopt specific recommendations based on strength of evidence. To assure implementation, the School will incorporate adopted recommendations into its strategic plan (SPH2020), engage internal and external stakeholders, monitor progress and maintain accountability for results.

13 recommendations to enhance diversity and inclusion

5 recommendations to strengthen the organizational climate:

Recommendation 1.		The Dean's Council should establish, endorse, and disseminate a strong statement of commitment to diversity & inclusion (D&I).
1.1	**Potential Impact**	A strong statement will demonstrate SPH leadership's firm commitment to and acceptance of responsibility for D&I.
1.2	**Implementation Plan**	1. Dean's Council endorses a strong statement that builds on the report of the Diversity and Inclusion Task Force (DITF) 2. Dean's Council distributes the statement to faculty, staff, students, and alumni for comment 3. Dean's Council revises statement and disseminates it broadly.
1.3	**Timeline**	Fall 2011: Dean's Council polishes a statement, distributes for comment Winter 2012: Dean's Council disseminates statement Bi-annually: Dean's Council discusses and revises statement
1.4	**Resource Requirements**	Dean's Council members' time and staff members' time to create, discuss, distribute, revise and disseminate statement.
1.5	**Measurable Results**	• Dean's Council members become more engaged in providing transformational leadership to increase diversity and inclusion • Dean's Council members discuss D&I issues, set goals, and expect results • More SPH community members believe the Dean's Council is committed to D&I as an organizational priority
1.6	**Metrics to Assess Results**	• Measure* of Dean's Council members' level of engagement in D&I • Measure of Dean's Council members' degree of commitment with D&I issues • Measure of SPH community's level of awareness of statement • SPH community's perception of Dean's Council's commitment to enhancing D&I
1.7	**Proposed Champion**	Dean and Dean's Council
1.8	**Assumptions**	The Dean's Council will engage fully in the process of establishing, endorsing and disseminating a statement and the SPH community will perceive the statement as a meaningful commitment on part of Dean's Council.

*Measure of can be a number, percentage or other quantitative or qualitative form of evaluating outcomes.

Recommendation 2.		SPH creates a model and process for spreading diversity and inclusion principles and practices throughout the School.
2.1	**Potential Impact**	A SPH model incorporating recommended practices for D&I would create greater consistency in departmental/program policies, guidelines and procedures. A School-wide process for developing and spreading the SPH model would promote community engagement, cross-fertilization and mutual accountability.
2.2	**Implementation Plan**	1. Dean appoints DITFI (Diversity and Inclusion Task Force - Implementation Committee that includes faculty, staff and students from all departments and programs) 2. Committee identifies D&I recommended practices in SPH, UNC and other universities and develops SPH model 3. Dean charges Dean's Council members with responsibility for implementing SPH model, tailored to department/program(s) 4. Faculty, staff and students evaluate SPH model implementation and outcomes annually
2.3	**Timeline**	Fall/Winter 2011: Dean appoints DITFI Committee Winter/Spring 2012: Committee develops model July 2012: SPH model implementation begins Annually: SPH model implementation/outcomes evaluated
2.4	**Resource Requirements**	• Faculty, staff, student volunteers' time for DITFI Committee • Department/program leaders' time for implementation • Department/program faculty and staff's time for implementation
2.5	**Measurable Results**	• Recommended practices spread across departments and programs/units in (1) cultural competence, (2) dialogue on diversity and inclusion, (3) curriculum and classroom and (4) recruitment and retention • Greater consistency/coordination across departments/programs/units
2.6	**Metrics to Assess Results**	• Assessment of deployment and use of recommnded practices to enhance organization climate for diversity and inclusion • Academic program/course evaluation for coverage of D&I • Measure of increased engagement and participation at department/program/unit level
2.7	**Proposed Champion**	Dean and Dean's Council, DITFI Committee members
2.8	**Assumptions**	Faculty, staff and students from each department/program will commit time and effort to DITFI Committee. The resulting model is responsive to legitimate differences in departmental/program/unit cultures, and department chairs, other School leaders can be held accountable for implementing SPH model.

Recommendation 3.		The Dean should appoint a designated champion for Diversity and Inclusion to oversee, support, and assess SPH efforts to enhance D&I.*
3.1	**Potential Impact**	Assurance of a continued school-wide focus on D&I, championed by a new School leader who will provide ongoing monitoring and accountability..
3.2	**Implementation Plan**	1. Dean, with input from DITFI Committee, defines roles/responsibilities of Designated Champion for Diversity and Inclusion (D&I Champion) 2. Dean charges DITFI Committee to study whether a new office is needed (e.g., Office of Multicultural Affairs) 3. Dean appoints (D&I Champion) 4. Dean creates new office, if recommended 5. D&I Champion works with Committee and Dean's Council to support/assess SPH model implementation, liaise with other campus units such as UNC Diversity and Multicultural Affairs and counterparts in other Health Affairs schools and direct other activities (e.g., reporting)
3.3	**Timeline**	In short-term, Dean could ask a current Assistant/Associate Dean to assume this role as *Interim* D&I Champion and/or collaborate with UNC School of Nursing's Office of Multicultural Affairs. Within 3 years, Dean appoints new D&I Champion and creates new office (if recommended or needed at the time).
3.4	**Resource Requirements**	• Salary and benefits for new position (if recommended) • Office space for new office (if recommended) • Administrative support staff for new position/office (if recommended)
3.5	**Measurable Results**	• Consistent, visible, point-of-contact D&I leadership from School • Accelerated SPH model implementation resulting from administrative support and assessment/accountability • Improved tracking/awareness of D&I activities in SPH • Stronger collaboration and coordination with other D&I activities at UNC
3.6	**Metrics to Assess Results**	• Performance evaluation of D&I Champion, with input from DITFI Committee, Dean's Council (measure of student, staff, faculty and alumni appreciation of the champion) • Assessment of SPH model implementation against timeline • Timeliness, accuracy, and completeness of reporting of D&I activities • Measure of inquiries/consultations/disclosures to D&I Champion
3.7	**Proposed Champion**	Dean
3.8	**Assumptions**	Financial resources can be allocated for this recommendation, one person/office could keep track of SPH D&I activities, and department chairs/program leaders will accept the leadership provided by this new position (and office, if recommended).

*The recommendation team did not reach consensus on this recommendation. Not all agreed a separate and centralized individual needs to be appointed. The duties could be managed by DITFI committee or another alternative solution.

Recommendation 4.		Faculty, staff and students create or enhance links between the School and UNC-Chapel Hill campus resources and other community groups to foster a more diverse and inclusive environment and increase support.
4.1	**Potential Impact**	Closer coordination of strategy between the School, the rest of campus and the community improves cohesiveness for student affairs, increases resources for faculty and staff, provides greater transparency and encourages interdisciplinary collaborations, thereby making UNC's overall climate more diverse and inclusive.
4.2	**Implementation Plan**	1. Infrastructure involving collaboration of University Ombudsman's Office, Human Resources, vice chancellor of student affairs, Graduate School, SPH degree directors, the associate deans of student and academic affairs, and the School's D&I Champion (if appointed) is formed to ensure communication and collaboration 2. Faculty and Staff engage in diversity-building activities 3. The School's D&I Champion, or other appointee catalogs links and collaborators; leads effort to engage these contacts, perpetuates continued collaboration via social networking and listservs; collects and reports feedback; assertively publicizes communications/website efforts.
4.3	**Timeline**	In spring 2012, current resources/policies could be shared with faculty, staff and students as part of orientation. By fall 2012, annual meeting could be hosted by D&I Champion (if appointed) and DITFI committee. Within 3-6 years, reporting and evaluation implemented regarding links and partnerships.
4.4	**Resource Requirements**	• Dedicated time for new D&I Champion and School community • Database development and evaluation resources • Budget for materials/refreshments for annual meeting
4.5	**Measurable Results**	• Development of data collection system and reporting structure • Evidence-based prioritization of goals • Existence of annual meeting • Documentation of planned activities • Collaboration & recognition of achievements
4.6	**Metrics to Assess Results**	• Measure of activities planned and implemented • Measure of faculty, staff and students engaged in these activities • Assessment of awareness by faculty, staff and students of these activities
4.7	**Proposed Champion**	New D&I Champion; DITFI; Dean's Council
4.8	**Assumptions**	Linkages/resources are accessible; activities help prevent exclusionary behavior; participation in diversity activities is supported and encouraged from departments; action is taken to address feelings of exclusion; environment is created for expression of viewpoints; School is positioned to initially lead efforts (in absence of Associate Provost for Diversity) for linkages (see appendix for listing of various campus, community and other university groups); linkages should be established and enhanced; DITFI committee helps to provide oversight.

Recommendation 5.		SPH identifies and supports an Ombuds* dedicated to D&I.
5.1	**Potential Impact**	Establishing a dedicated School Ombuds provides an additional layer of protection, safety and confidential availability for members of our School community independent of the School's structure, and creates a feedback loop for diversity and climate improvement.
5.2	**Implementation Plan**	1. Dean's Council/D&I Champion and DITFI committee hires, or appoints in a volunteer capacity, a resource to serve in the role 2. Ombuds, Office of Student Affairs and new D&I Champion establish roles and responsibilities (see full recommendation section 5.9 for further considerations about the role of this Ombuds). Please note the relationship between the Ombuds and D&I Champion will need to be delineated.
5.3	**Timeline**	Ombuds is hired/appointed 6 months after new D&I Champion is hired and begins annual term (performance review cycle, if hired). In the meantime, the School community is encouraged to use UNC Ombuds office.
5.4	**Resource Requirements**	• Salary and benefits (if person is hired rather than appointed in volunteer capacity) • Publicity and reporting resources
5.5	**Measurable Results**	• Appointment of an Ombuds • Articulation of his/her roles and responsibilities • Establishment of activities and goals for having an impact
5.6	**Metrics to Assess Results**	• New position established (yes/no) • Performance evaluation of policies and procedures (TBD) • Measure of community awareness of, utilization of and satisfaction with the Ombuds
5.7	**Proposed Champion**	Dean's Council champions the hire/appointment but ultimately the Ombuds sustains the vision for a healthy organizational climate.
5.8	**Assumptions**	Ombuds is experienced, mature, facilitative, encouraging, gentle and is empowered and resourced to carry out his/her purposes. He/she fosters alignment between community and leaders, demonstrates characteristics akin to the integrity required of this role, has independence and autonomy in the School so as not seen as somebody who reports to an authority figure and is appointed with support from all units in the School so that all interests are represented. He or she is seen as champion of a healthy organization climate rather than a purveyor of complaints.

*An Ombud is a person trained to assist members of a community or organization through safe, confidential and anonymous means, and provide dispute resolution and an educated response.

5 recommendations to increase student, faculty and staff recruitment and retention:

Recommendation 1.		Expand the partnership with the Minority Student Caucus (MSC)* and MSC alumni** to cultivate more prospective students and faculty by taking greater advantage of opportunities afforded by the Annual Minority Health Conference (MHC) and William T. Small, Jr., Keynote Lecture broadcast.
1.1	**Potential Impact**	Increase the School's national visibility among students and organizations interested in diversity and health disparities, build more partnerships inside and outside UNC and advertise public health career opportunities to student's unaware of them.
1.2	**Implementation Plan**	1. Hold discussions with former leaders and organizers of these groups 2. Identify ways to facilitate the work of the Caucus and MHC Planning Committee (e.g. making links to on-campus groups such as ECHO and student government, secondary schools, community colleges, minority-serving institutions, HBCUs, tribal colleges and national organizations.) 3. Secure funds for MSC/MHC leaders to attend APHA 4. Expand outreach and increase awareness of events; follow-up with contacts 5. Encourage these groups to promote the events more proactively 6. Consider creating a credit course related to these events 7. Document and publicize the MSC's and the School's history in promoting health equity and combating marginalization
1.3	**Timeline**	3 years
1.4	**Resource Requirements**	• Staff support/GRA (to assist MSC/MHC) • Travel funds
1.5	**Measurable Results**	• More partner conferences for the MHC and WTS Jr. Keynote broadcast • Greater publicity for Conference and Keynote broadcast to relevant audiences • More awareness of the events among UNC students and alumni from all schools • Increased alumni participation and promotion of the events • Increased applications and enrollment by minoritized students
1.6	**Metrics to Assess Results**	• Measure of partner conferences for the WTS Jr. Keynote broadcast • Extent of publicity for the Conference and broadcast to APHA members • Measure of alumni who participate or promote Conference or broadcast • Measure of applicants & enrolled students who attended Conference or viewed the Keynote broadcast
1.7	**Proposed Champion**	SPH Faculty Member as appropriate (e.g. Dr. Victor Schoenbach)
1.8	**Assumptions**	Greater impact can be achieved by a coordinated effort; mutually-beneficial partnerships can be built between the MSC and other student organizations; the MSC will continue to attract student leaders who can devote time and energy to the Caucus and Conference; many MSC alumni are concerned and committed and can therefore be mobilized to promote these activities; faculty, staff, and administrators will continue to actively support the Caucus' activities; other campus units and the General Alumni Association can be stimulated to collaborate; and the story of the MSC will continue to inspire students and alumni.

*Minority Student Caucus (MSC) advocates for issues of concern to students of color in the School and promotes research and programs aimed at addressing public health issues that affect people of color.
**MSC Alumni have a listserv called Minority Student Caucus Alumni Network, or "MSCalumnet."

Recommendation 2.		Continue to develop targeted opportunities for minoritized alumni to participate at all levels through local and regional events.
2.1	**Potential Impact**	Greater visibility, stronger and more expansive network, potential to increase support through scholarships and professorships.
2.2	**Implementation Plan**	1. Continue to add on to existing cultivation activities at the School level (e.g. Minority Health Conference opening reception in 2012) 2. Add on to cultivation activities at the regional level (e.g. events in Atlanta or Washington D.C.) 3. Utilize connections with Alumni Committee on Diversity and Inclusion members and PHF Board leadership.
2.3	**Timeline**	3-5 years in conjunction with 75th Anniversary planning
2.4	**Resource Requirements**	Acknowledge that additional staff support will be needed to maximize opportunities, but may not be available in the short term.
2.5	**Measurable Results**	• More persons to whom marketing materials are distributed • More placement opportunities (e.g. internships, GRAs, practicum, etc.) • More alumni visits to the School • Increase in giving (change in percentage of minoritized alumni giving) • Increase in successful outreach efforts
2.6	**Metrics to Assess Results**	• Measure of persons to whom marketing materials are distributed • Measure of placement opportunities (e.g. internships, GRAs, practicum, etc.) • Measure of alumni visits to the School • Change in percentage of minoritized alumni giving • Measure of documented cases of successful outreach efforts
2.7	**Proposed Champion**	Office of External Affairs (e.g. Stephen Couch)
2.8	**Assumptions**	The implementation as listed has been in practice for FY 2010 and 2011 with results comparable to those listed in 2.5. We expect to maintain this momentum and build on demonstrated success.

Recommendation 3.		Improve the sharing of recommended practices and information across departments and programs regarding the recruitment and financial resources for students, faculty, and staff from minoritized backgrounds.
3.1	**Potential Impact**	Enhanced competitiveness in recruiting based on the ability to employ effective strategies and offer available financial resources in a timely fashion.
3.2	**Implementation Plan**	1. Incorporate an agenda item regarding the recruitment and retention of diverse students, faculty, and staff for the Student Services Council meetings and the Human Resource Representatives meetings 2. Identify a diversity champion in each department who can help facilitate the sharing of recommended practices across departments 3. Departments and programs elicit feedback from minority student graduates on their experience as a student to inform future enhancements 4. Department representatives from these meetings report back to respective chair 5. Identify other Schools at UNC that have diversity recruitment and financial resource efforts in place and invite a representative to share their recommended practices 6. The Dean's office designates a "diversity recruitment officer" who will be conversant with the current availability of recruitment funds and the process of negotiating their use to assist departments and programs in the process of identifying and recruiting minoritized candidates.
3.3	**Timeline**	1-3 years
3.4	**Resource Requirements**	None, aside from resources for recruitment.
3.5	**Measurable Results**	Written reports on recommended practices shared between departments.
3.6	**Metrics to Assess Results**	• Assessment of deployment and use of recommended practices shared across departments (see Organizational Climate 2.6) • Measure of faculty satisfaction regarding having access to information, resources and procedures when recruiting candidates from minoritized groups • Measure of increased engagement and participation at department/program/unit level regarding recruitment and retention of diverse students, staff and faculty • Increase in number/percentage of diverse and minoritized students, staff and faculty at SPH
3.7	**Proposed Champion**	DITFI
3.8	**Assumptions**	Improvements in the sharing of recommended practices and information across departments and programs will increase recruitment and expand opportunities to access financial resources for students, faculty, and staff from minoritized backgrounds.

Recommendation 4.		Expand the criteria for acceptance of students with exceptional potential for contributions to public health that may not meet traditional criteria for admission and develop preparation and support systems contingent with admission.
4.1	**Potential Impact**	Identify more promising diverse applicants and assist them in achieving their potential
4.2	**Implementation Plan**	1. Encourage departments/programs to use holistic approaches in evaluating student admissions through identification and consideration of current state-of-the-science predictors of success 2. Identify course that may be required prior to degree coursework in public health 3. Consider the development of pre-curriculum workshops possibly using the model of the UNC Kenan-Flagler School's "Pre-Curriculum: Analytic Skills Workshops" 4. Alert assigned faculty advisors to contact the admitted student early to put any support systems necessary in place 5. Provide feedback to applicants who did not get accepted into a department the first time and encourage them to pursue additional coursework or preparation that will strengthen their future application 6. Department designee will contact top rated diverse applicants who declined admission to the School and inquire what influenced their decision to go elsewhere.
4.3	**Timeline**	7-10 years (sufficient time to establish graduation rates to relevant student sub-groups and measure periodically).
4.4	**Resource Requirements**	Workshops expenses
4.5	**Measurable Results**	• Increased admission/matriculation rates • Retention and graduation rates among students enrolled under this recommendation commensurate with school-wide rates
4.6	**Metrics to Assess Results**	• Increase in number of "high-potential" admissions/matriculations/graduation rates
4.7	**Proposed Champion**	The interim and new D&I Champion would be well suited to take on the tasks. An orientation team from this group of the Task Force could quickly get them up to speed.
4.8	**Assumptions**	Expansion of the criteria for acceptance of students with exceptional potential for contributions to public health will increase the number of persons from minoritized backgrounds who will be admitted, enroll and graduate. The implementation of this recommendation might look different between departments.

Recommendation 5.		Make departmental diversity goals, plans and annual reports more specific by adding additional content requirements to departments and programs' annual progress reports.
5.1	**Potential Impact**	Increase engagement of department chairs and program leaders in diversity as related to recruitment and retention of faculty, staff and students, thereby increasing overall diversity in departments and programs.
5.2	**Implementation Plan**	1. Require each department chair/program leader to include diversity goals for recruitment/retention of faculty, staff, and students and to report on progress toward these goals within various annual reporting mechanisms 2. A new item in the yearly progress report to the Dean would indicate a department's specific goals for diversity and targeted timeline for reaching those goals 3. Identify faculty/staff who will champion these goals 4. Designate faculty member(s) to lead recruiting efforts that take place outside of formal searches and report on their progress 5. Implement alternative student recruitment strategies like targeting pre-med students, undergraduates from Minority-Serving Institutions, HBCU's and Tribal Colleges and students in the MURAP/Summer Bridge and report on the progress of these efforts.
5.3	**Timeline**	1-3 years (One year for first two metrics; three years for third metric).
5.4	**Resource Requirements**	None for increased engagement. Targeted hires may require resources.
5.5	**Measurable Results**	• New diversity content added to chairs/leaders yearly progress reports • Responses of chairs/leaders to those items
5.6	**Metrics to Assess Results**	• Document and assess how (spoken or written), how often and to whom department chairs and program leaders communicate diversity goals to others in their departments/programs • Measure of department/program/unit diversity goals accomplished on annual basis
5.7	**Proposed Champion**	The interim and new D&I Champion would be well suited to take on the tasks. An orientation team from this group of the Task Force could quickly get them up to speed.
5.8	**Assumptions**	Increased engagement of department chairs and program leaders in diversity will result from making departmental diversity goals, plans and annual reports more specific.

3 recommendations to promote diversity and inclusion through the SPH curricula:

Recommendation 1.		Increase course content that addresses diversity and health issues related to people from minoritized groups.
1.1	**Potential Impact**	Improve cultural competency (a core CEPH, ASPH *and* UNC-SPH goal) for students and instructors, reduce feelings of isolation among students and contribute to promoting a more supportive School climate for people of all backgrounds.
1.2	**Implementation Plan**	1. Conduct syllabus review of required courses from all departments to create an inventory of D&I content 2. Prepare brief action plans to increase/improve D&I content (with goal of changing at least 2.5% of content, if measurable) 3. Report action plans and progress in departments' annual reports 4. Have new faculty seek advice when designing curricula [e.g., consult with Center for Faculty Excellence] 5. Add evaluation items to capture D&I effectiveness 6. Offer stand-alone elective course on topics such as Lesbian-Gay-Bisexual-Transgender (LGBTQ) health issues, American Indian health issues, etc. 7. Facilitate D&I workshop series with expectation that all faculty participate at least once every three years; staff participation to follow.
1.3	**Timeline**	AY2011-12: Review syllabi and prepare action plans Spring 2012: Report action plans and progress in departments' annual reports AY2011-12: Implement consultation AY 2011-12: Add course evaluation items to capture D&I effectiveness Spring 2012: Offer aforementioned stand-alone elective courses [every other year] Fall 2012: SPH begins faculty workshops
1.4	**Resource Requirements**	Faculty and TA time in required courses for each degree program, likely consultant fees, workshop time for all faculty and perhaps staff (every three years), staff time and other expenses for course evaluation revisions/workshop management.
1.5	**Measurable Results**	• Increased D&I content across programs • Trends in D&I instruction (i.e., course evaluation results) • Increased faculty/TA comfort with new material • LGBTQ course, American Indian course offered regularly • Attendance at workshops
1.6	**Metrics to Assess Results**	• Measure of value and effectiveness of content from course evaluations, • Measure of value and effectiveness of content from annual department/program/unit reports • Measure of workshop attendance rates and attendees' evaluations
1.7	**Proposed Champion**	Department chairs, Associate Dean for Academic Affairs, D&I Champion
1.8	**Assumptions**	Students want/need more/better opportunities to discuss challenging issues around D&I. Offering more/better D&I content in courses is an efficient mechanism for improving D&I climate, cultural competency and changing social norms around D&I issues. Modest adjustments in a number of courses could add up to major improvements in curricula and students' experiences.

Recommendation 2.		Increase opportunities for students and faculty to discuss D&I topics, while improving quality of such discussion(s)
2.1	**Potential Impact**	Improve cultural competency (a core CEPH, ASPH *and* UNC-SPH goal) for students and instructors, reduce feelings of isolation among students and contribute to promoting a more supportive School climate for people of all backgrounds.
2.2	**Implementation Plan**	1. Review syllabi from each department's required courses to assess <u>how</u> D&I issues are handled 2. Prepare brief action plans for increasing/improving D&I content by at least 2.5% 3. Report action plans and progress in departments' annual reports 4. Have new faculty seek advice when designing curricula [e.g., consult with Center for Faculty Excellence] 5. Capture D&I effectiveness through course evaluations 6. Offer stand-alone elective course on topics such as Lesbian-Gay-Bisexual-Transgender (LGBTQ) health issues, American Indian health issues, etc. 7. Facilitate D&I workshop series with expectation that all faculty participate at least once every three years; staff participation to follow.
2.3	**Timeline**	AY2011-12: Review syllabi and prepare action plans Spring 2012: Report action plans and progress in departments' annual reports AY2011-12: Implement consultation AY 2011-12: Add course evaluations to capture D&I effectiveness Spring 2012: Offer aforementioned stand-alone elective courses [every other year] Fall 2012: SPH begins faculty D & I workshops
2.4	**Resource Requirements**	Faculty and TA time in required courses for each degree program; possible consultancy fees; workshop time for all faculty and perhaps staff (every three years); staff time and other expenses attached to course evaluation revisions and management of workshops
2.5	**Measurable Results**	• Increased D&I content across programs • Trends in D&I instruction (i.e., course evaluation results) • Increased faculty/TA comfort with new material • LGBTQ course, American Indian course offered regularly • Attendance at workshops
2.6	**Metrics to Assess Results**	• Measure of value and effectiveness of content from course evaluations • Measure of value and effectiveness of content from annual department/program/unit reports • Measure of opportunities for students and faculty to discuss D&I issues
2.7	**Proposed Champion**	Department chairs, Associate Dean for Academic Affairs, D&I Champion
2.8	**Assumptions**	Students want/need more/better opportunities to discuss challenging issues around D&I. Offering more/better D&I content in courses is an efficient mechanism for improving D&I climate, cultural competency, and changing social norms around D&I issues. Modest adjustments in a number of courses could add up to major improvements in curricula and students' experiences.

Recommendation 3.		Develop a unified approach to addressing diversity, inclusion and cultural competencies in Core Courses.
3.1	**Potential Impact**	Improve cultural competency (a core CEPH, ASPH *and* UNC-SPH goal) for students and instructors, reduce feelings of isolation among students and contribute to promoting a more supportive School climate for people of all backgrounds.
3.2	**Implementation Plan**	1. Conduct syllabus review of all core courses 2. Conduct review of how core courses were globalized as potential model 3. Change at least 2.5% of each course by (a) increasing D&I content and/or discussion, or (b) designing an activity that threads through all five core courses 4. Revise course evaluations to capture effectiveness of changes 5. Train TAs in recommended practices for teaching D&I topics.
3.3	**Timeline**	Align syllabus review and content changes with SPH review of core courses AY2011-12: revise course evaluations AY2012-13: train TAs in recommended practices for teaching D&I topics.
3.4	**Resource Requirements**	Faculty and TA time; staff time attached to course evaluations.
3.5	**Measurable Results**	• Increased D&I content across SPH core courses • Mechanism created for monitoring trends in D&I instruction (i.e., course evaluation results) • Increased faculty/TA comfort with new material
3.6	**Metrics to Assess Results**	• Measure of value and effectiveness of content from course evaluations • Measure of satisfaction from students, faculty and TAs
3.7	**Proposed Champion**	Dean and associate dean for academic affairs, D&I Champion
3.8	**Assumptions**	Students want/need more/better opportunities to discuss challenging issues around D&I. Offering more/better D&I content in courses is an efficient mechanism for improving D&I climate, cultural competency, and changing social norms around D&I issues. Modest adjustments in a number of courses could add up to major improvements in curricula and students' experiences.

Glossary of Terms and Acronyms

APC	Academic Programs Committee
ASPH	Association of Schools of Public Health
CEPH	Council on Education for Public Health
CFE	Center for Faculty Excellence
CRS	Curriculum Recommendations Subcommittee
D&I	Diversity and Inclusion
DITF	Diversity and Inclusion Task Force Committee
DITF-I	Diversity and Inclusion Task Force - Implementation Committee
Diversity	Means difference
GRA	Graduate Research Assistant
HBHE	Health Behavior and Health Education
HPM	Health Policy and Management
Inclusion	Refers to climate
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Questioning
Minoritized	"Minoritized" is used instead of "minority" throughout this document to signify the social construction of underrepresentation and subordination in U.S. social institutions, including colleges and universities. (Harper, S. R., & Griffin, K. A, http://works.bepress.com/sharper/37/)
MCH	Maternal and Child Health
MHC	Minority Health Conference
MSC	Minority Student Caucus
OC	Organizational Climate
Ombuds(Ombudsman)	A person trained to assist staff, faculty, and administrators as a confidential, impartial, informal, and independent resource. (http://www.ombuds.unc.edu/)
SES	Socioeconomic Status
SPH	School of Public Health
TA	Teaching Assistant
Minority	Used when referring to a numerically underrepresented population

Appendices

Appendix A: Summary of DITF Process and Procedures

The recommendations in this report are informed by a comprehensive set of information gathering strategies that took place between spring 2010 and summer 2011. The strategies were used to assess the current climate regarding diversity and inclusion at the UNC Gillings School of Global Public Health and to identify a plan of action to enhance diversity and inclusion among faculty, staff and students. Briefly, the strategies included;

Hiring a consultant and forming the Diversity and Inclusion Task Force (DITF)
In spring 2010, Dr. Rumay Alexander, Director of the Multicultural Affairs Office at UNC's School of Nursing, was hired by Dean Rimer as a consultant to help lead the charge in improving diversity and inclusion at the SPH. Following the hiring of Dr. Alexander, the DITF was formed with more than 60 volunteers from SPH faculty, staff and students. Soon thereafter, Dr. Bryan Weiner, a professor in the Department of Health Policy and Management, joined Dr. Alexander as co-chair of the DITF. Lastly, a DITF Planning Team and Change Team were created in the summer of 2010 to help operationalize the Task Force's objectives.

Literature search
In the beginning of the assessment process, a literature search of background documents and relevant diversity and inclusion articles was done in an attempt to gather recommended practice from the higher education literature. This search helped the DITF focus on specific diversity and inclusion issues and provided a starting point for data gathering and assessment.

Environmental scan
An environmental scan of six peer Schools of Public Health (Johns Hopkins, Harvard, U. of MI., U. of WA., Columbia and Emory) was conducted in June of 2010. The scan was an effort to learn more about the organizational structure and strategies that our competing institutions are planning and implementing and the types of internships, awards, trainings and funding opportunities they offer to improve diversity and inclusion among their faculty, staff and students. In addition, diversity and inclusion initiatives and recommended practices from institutions of higher learning, private businesses and other organizations were scanned.

Wordle
In the fall of 2010, Dr. Alexander asked the DITF to engage in a brainstorming exercise about all the words that represented diversity and inclusion to them. Following this exercise, a Wordle was created for the definition of diversity. The Wordle is a tool that generates "word clouds" from the text provided and gives greater prominence to the words more frequently used.. The purpose of using the Wordle was to visually display the words most frequently associated with diversity and inclusion and begin the process of developing a definition of diversity and inclusion that is specific to the School.

SPH diversity and inclusion climate survey
In September 2010, the DITF surveyed SPH students, faculty and staff members to obtain both qualitative and quantitative insight about their personal experiences with respect to diversity and inclusion. Nearly 450 members of the SPH community volunteered to share their perspectives and experiences through a brief, anonymous, online survey. Forty-nine percent of respondents were students, 17 percent were faculty members, 12 percent were staff members and 22 percent did not indicate their role. This survey produced a report that offered a glimpse into the current climate of the School.

Index cards
Index cards were filled out by DITF members and collected at several Change Team and Full DITF meetings in 2010. The cards were used as a way to anonymously collect feedback from DITF members on the main topics areas that the Task Force should focus their efforts, the possible processes to undertake in exploring these topic areas, the type of information needed, and general feelings on the definition of diversity and inclusion.

Individual interviews with the SPH Department Chairs and Program Leaders
In January 2011, Dr. Bryan Weiner met individually with the department chairs and program leaders for informal interviews designed to gain a better understanding about the needs, wants and concerns that chairs and leaders had as they specifically pertained to improving diversity and inclusion within the School.

Historical overview of diversity and inclusion efforts at the School
The January 25, 2011 DITF Change Team meeting included presentations from representatives of different constituencies at the School. Speakers were Danny Bell, Dr. Bill Jenkins, Kat Turner and Elizabeth French (based upon an interview with Dr. Jo Anne Earp). The speakers provided an overview of past efforts by UNC-Chapel Hill and the SPH to address equity issues involving ethnic/racial minorities (African-Americans and American Indians), sexual orientation (LGBTQ) and gender (women). The intention was for the DITF to identify and examine possible lessons learned from these past efforts in order to guide the current effort.

Focus groups
Twelve focus groups were scheduled with various constituencies in the School between February and March of 2011. The focus groups were intended to explore issues around diversity and inclusion in more in-depth and personal way. A total of 65 participants attended 9 of the focus groups. 30 participants were staff, 23 were students and 12 were faculty. Concurrently, a virtual focus group was conducted where 22 surveys were taken with 7 surveys completed. In total, we heard from 72 individuals.

Definitions team
A group of DITF members formed a definitions team in the spring of 2011. The goal of this group was to synthesize the DITF Wordle and diversity and inclusion definitions that had been voted on by the larger group in previous meetings. The definitions team met on several occasions to reflect on and discuss the meaning of diversity and inclusion and the elements that should apply to the SPH definition. As a result of these meetings, 2-3 definitions were presented back to the larger group who were tasked with making a final decision.

Appendix B: DITF Wordle

Appendix C: SPH Diversity and Inclusion Climate Survey Executive Summary

In September 2010, the DITF surveyed current students, faculty and staff about their personal experience in the School and their perceptions of the School's climate of inclusion.

Respondents
About 450 SPH community members responded to the brief, anonymous, online survey. Forty-nine percent of respondents were students, 17 percent were faculty, 12 percent were staff and 22 percent did not indicate their role. Fifty-five percent were women, 22 percent were men and 22 percent did not indicate their gender. In terms of race/ethnicity, 55 percent self-identified as Caucasian, non-Hispanic, 8 percent self-identified as African American or Black, 5 percent self-identified as Hispanic/Latino, 4 percent self-identified as some other race or two or more races and 25 percent did not indicate their race/ethnicity. In some analyses, survey respondents were grouped into "majority" (i.e., Caucasian, non-Hispanic) and "non-majority" categories (i.e., all other racial/ethnic identities).

Results
Twenty-two percent of respondents indicated that they had been treated differently (positively or negatively) because of who they were or what they believed. Staff indicated more frequently (33%) than faculty (27%) or students (17%) that they had been treated differently. Men and women indicated with about the same frequency (~22%) that they had been treated differently. Non-majority respondents indicated more frequently (31%) than majority respondents (18%) that they had been treated differently. The inclusion of the phrase "positively or negatively" in the survey question makes these findings somewhat difficult to interpret. However, many of the open-ended responses accompanying this question described instances of being treated differently in negative terms.

Nearly half (47%) of respondents indicated that they felt "different" than their peers in SPH. Students indicated more frequently (56%) than faculty members (28%) or staff members (41%) that they felt "different" than their peers. Men and women indicated with about the same frequency (~47%) that they felt "different" than their peers. Non-majority respondents indicated more frequently (73%) than majority respondents (38%) that they felt "different" than their peers. Among those who indicated that they felt "different," the most common sources of difference were age (19%), race (10%) and ethnicity (10%). Students mentioned race and ethnicity as reasons for feeling "different" more frequently than faculty or staff members did (10% versus 9.7% and 2.3% respectively for race; 14% versus 6.5% and 2.3% respectively for ethnicity). So did non-majority respondents compared to majority respondents (21% versus 1.3% for race; 21% versus 2% for ethnicity). Majority respondents mentioned age more frequently than non-majority respondents (25% versus 14%). So did men compared to women (23% versus 13%). As with the previous survey question, these findings are somewhat challenging to interpret because feeling "different" is not always a negative experience. However, many of the open-ended responses accompanying this question described instances of feeling "different" in negative terms.

Most respondents indicated that they had never been treated in an insensitive or unfair manner by another SPH student, faculty member, or staff member because of their gender (80% said "never"), race/ethnicity (83% said "never"), sexual orientation (95% said "never"), gender identity (96% said "never"), disability (97% said "never"), language and/or accent (91% said "never"), religious beliefs (87% said "never"), political views (86% said "never"), age (80% said "never"), weight (93% said "never") or specific attire or tattoos (94% said "never"). Among respondents who indicated that they had been treated in an insensitive or unfair manner "occasionally" or "often" because of some personal characteristic, the most frequently attributed reasons were age (10%), gender (6%), race/ethnicity (6%), and political views (6%). Overall these findings are encouraging. However, some specific findings are difficult to interpret without a relevant denominator. For example, the finding that 97% of respondents have "never" been treated insensitively or unfairly due to disability could understate the frequency with which differently-abled SPH community members have been treated insensitively or unfairly for this reason.

Overall, respondents rated the social environment (or climate) in SPH favorably. On a 5-point ordinal scale with "1" as the most favorable rating, respondents overall indicated the SPH environment was friendly (mean = 1.53), respectful (mean = 1.52), collegial (mean = 1.71), collaborative (mean = 2.08), cooperative (mean = 2.11), supportive (mean = 1.88), diverse (mean = 2.53), non-racist (mean = 1.55), non-sexist (mean = 1.52), non-homophobic (mean = 1.48), and non-transphobic (mean = 1.5). Staff members perceived the SPH environment somewhat less favorably than students or faculty members with respect to three dimensions: collaboration, cooperativeness, and supportiveness. Non-majority respondents also perceived the SPH environment somewhat less favorably than majority respondents with respect to these three dimensions. Men and women rated the SPH environment with about the same degree of favorability. None of the ratings of the SPH environment exceeded 2.9 on the 5-point scale. Despite some differences across groups, ratings were generally favorable. The dimension rated least favorably was diversity. The mean ranged from 2.34 to 2.84 across subgroups of respondents.

Conclusion

The 2010 SPH Diversity and Inclusion Survey offers a glimpse into the climate of the School as experienced by SPH faculty members, staff members, and students. Although many survey respondents reported having positive experiences in the School and perceived the School's climate to be inclusive, some survey respondents reported having experienced insensitive or unfair treatment or perceived the School's climate to be unwelcoming because of who they were or what they believed. The DITF was pleased that nearly 450 members of the SPH community volunteered to share their perspectives and experiences. However, the DITF cautions that the survey results should not be interpreted or portrayed as a representative sample of the SPH community.

Appendix D: Themes from Interviews with Department Chairs & Program Leaders

1. Some department chairs and program leaders seemed more passionate and engaged than others with regard to increasing diversity and inclusion. This passion/engagement seems to come through (or not) in the way that they talked about the issue (e.g., it's important, we need to do more, we need to do better) and the level of activity that they described to address diversity and inclusion issues.
2. In the current budgetary climate, departments and programs cannot hire more faculty and staff as a means to increase diversity. Several departments have used Provost Office money to recruit minority faculty. One person mentioned using adjunct faculty as a means for increasing the diversity of educators that the students encounter in the classroom. Another person mentioned that, in the absence of funding for faculty and staff hiring, attention should shift from recruitment to retention.
3. Several people mentioned student pipeline issues. For some departments, "pipeline" refers to the number of minoritized applicants (e.g., departments that draw from physical sciences and mathematics). In others, "pipeline" refers to the preparation of minoritized applicants (e.g., GRE scores). Departments seem to vary in their willingness to "take risks" by admitting students who might not have desired test scores, but have other promising features in their application (e.g., strong letters, distinctive work experience, prior coursework). Interestingly, some chairs said that they don't have a pipeline problem; they have a recruitment problem. They get plenty of great applicants, but have trouble competing with other schools in terms of scholarships.
4. Pipeline issues are even worse at the faculty level. Competition among universities for minority faculty can be fierce. UNC has had some success in recruiting minority faculty. One person mentioned that the use of these funds can involve a complicated process with the faculty recruit, the Provost Office, and the department.
5. Only one chair mentioned any inclusion issues occurring in his/her department. The others said that they were not aware of any inclusion issues. Two departments have an organized process/activity for getting feedback from students about whether inclusion issues are occurring. The others have no such process/activity. That might or might not be true.
6. Department chairs and program leaders indicated that they do not feel that further exhortation to do more or do better is constructive. What they want are concrete, actionable recommendations. A few said that increasing funding to recruit minoritized students is the single most important thing that the School could do. Other suggestions included:
    - School-level assistance with minority faculty recruitment
    - A School-level or departmental ombuds that people could talk with to discuss inclusion (and other) issues
    - More LGBTQ and disability topics in the curriculum
    - More effort to build a student pipeline. One chair suggested the development of an undergraduate course titled, "Introduction to Public Health," as a way to raise awareness of the field among UNC undergraduates.
    - Clarify whether applicants who self-identify as "other" or self-identify as Caucasian and another category are eligible for minority scholarships.

Appendix E:[Anecdotal] Overview of Diversity and Inclusion Efforts at UNC Gillings School of Global Public Health: Welcoming all races, ethnicities, genders and sexual orientations

by Brenda McAdams Motsinger

The author provided the context, but much of the information below is not her original writing. It has been extracted from presentations to the Diversity and Inclusion Task Force (DITF) Change Team by Danny Bell, Dr. Bill Jenkins, Kat Turner and Elizabeth French (based upon an interview with Dr. JoAnne Earp) and information from various documents. It should not be taken as authoritative until confirmed by others. (See sources at the end of this paper.) I would very much like to acknowledge Dr. Vic Schoenbach and thank him for his guidance and for sharing his work, An Evolving History of Minority-Related Activities at the UNC Gillings School of Global Public Health. Many thanks also to Linda Kastleman and Elizabeth French for their comments and edits.

This overview provides some general information on diversity but focuses primarily on the dimensions of race/ethnicity (i.e., African-Americans and American Indians), gender (i.e., women) and sexual orientation (LGBTQ).

With the aim of identifying possible lessons learned, the School's Diversity and Inclusion Task Force (DITF) examined past efforts by UNC and the public health school to address equity issues involving gender (women) and ethnic/racial minorities (African-Americans and American Indians).

Before and during the Civil Rights era, when the public health school was still in its early days, the value of diversity and inclusion did not appear to be the driving force. The expressed concerns were health disparities and equal rights; yet addressing these domains in the curriculum and in outreach efforts did foster increased diversity and inclusion in educational settings. Awareness of sexual orientation and LGBTQ issues did not surface until much later.

In 1939, the Division of Public Health separated from the UNC School of Medicine and became the UNC School of Public Health, with Dr. Milton Rosenau as dean. Dr. Lucy Morgan was appointed in 1943 as the first chair of what is now the School's Department of Health Behavior and Health Education (HBHE). While there were very few women in academic leadership positions at that time, Dr. Morgan, with support from the dean, was determined to tackle divisive racial issues by working with African- Americans. She began a collaborative public health education program in 1945 with the N.C. College for Negroes (now N.C. Central University) and, in her own home, taught Blacks and Whites together in what may have been the first, if unsanctioned, integrated "classroom" at UNC.

Over a decade later, public health faculty became increasingly concerned that American Indians' health needs were not being addressed. Many Indians suffered from illnesses, including diarrheal diseases, which long had been under control in other populations. With the health education department's Dr. Vaughn Smith as project director, the School contracted with the U.S. Public Health Services in 1959 to create a health education training program for American Indians in N.C.

Except for limited areas of study, including nursing, UNC-Chapel Hill students were primarily male until 1963, when UNC Trustees approved the admission of women without regard to residence or major. In an interesting confluence of events, the civil rights sit-ins to protest racial segregation began in Chapel Hill that same year. At UNC, women would benefit from the Civil Rights Act of 1964 as much as African-Americans. The provisions of this civil rights act also forbade discrimination on the basis of sex and race in hiring, promoting and firing. Even so, the word "sex" was added to the Act at the last moment.

While women had pioneered some of the early efforts to address racial and ethnic health disparities at Carolina and political will finally had been mustered to address equal rights, women at UNC's School of Public Health were finding it hard to have equal footing. There appears to have been a more concerted effort to recruit and support African-Americans than women during this era. One woman in the mid- 1970s, who thought she had been hired as a tenure-track assistant professor at the School describes how, many months later, she discovered that she actually been appointed as a research associate. Only six months after earning her own PhD, she was asked to mentor a black student working on his dissertation. He was soon afterward appointed to the faculty while she struggled to get her designation changed. In that particular department and (it seems) throughout the School, there were no "written down" policies; department chairs made many decision by fiat. If department chairs had the political will to hire African-Americans to rectify imbalances, they would do so, as was the case in at least one department. However, the same "affirmative action" was not available on behalf of women.

The School's long tradition of involvement in minority health and research has focused heavily on African-Americans. For many, the word "minority" became almost synonymous with "black." By enrolling students from developing countries in the mid-1960s, the School began changing its complexion. The first chair of the Department of Epidemiology (EPID), Dr. Sidney Kark, had emigrated from South Africa and its apartheid policies. He recruited Dr. John Cassel, another anti-apartheid South African émigré. Another South African anti-apartheid "refugee," Dr. Guy Steuart, became chair of the health education department. In the early '70s, students mobilized to form the Minority Student Caucus, and a full-time minority recruiter was appointed. The number of minority students, primarily African-American, increased from 20 to 49.

The preponderance of attention on minority health and minority recruitment remained focused on African-Americans in these days. When UNC-Chapel Hill integrated, several black students enrolled at the public health school. Dr. Bobby Brayboy, a Lumbee Indian, was one of the few non-black minority students to enroll. Co-sponsored by the Carolina Indian Circle and the UNC Division of Health Affairs in 1979 and 1980, the School contributed to and participated in two conferences that focused on developing opportunities for American Indian in higher education. (See the "Documents" folder in DITF Blackboard.) There was one major initiative to recruit American Indians. During the mid-1980s, with strong support from Dean Bernard Greenberg,

minority recruiter/associate dean Bill Small submitted a proposal to the Indian Health Service and obtained a grant to create the American Indian Recruiting Program. Ronald Oxendine, a Lumbee Indian, was the first director for the program and was one of the first Native American doctoral students enrolled in the Department of Health Administration during this time. Later, David McCoy, a Lumbee Indian who had matriculated as a master's student in HEED during this period, was hired to direct the program. (McCoy later became the N.C. state government's fifth Controller.) After McCoy left the School, the activity became one of many for which Bill Small was responsible, and American Indian enrollment was not sustained.

In terms of women's equity at the School, Dr. Jo Anne Earp, chair of HBHE, reported that at some point in the 1970s, her students pushed her to lead an effort to overturn what they perceived as sexist, patriarchal dynamics within the School. As an untenured assistant professor, Dr. Earp had to respond with discretion. She needed to remain collegial with colleagues throughout the School, she told students, if she were to be promoted and tenured and remain in the School. However, their activism did push her to create the first course at UNC focused on women's health (which Dr. Earp and several departmental women taught for 15+ years). Having academic offerings such as thee helped legitimize (and eventually normalize) areas of study that had previously been trivialized or ignored. In terms of School structure, women at that time had a presence on the health education faculty. But it appeared that men progressed through the ranks more rapidly and were more likely to hold prestigious appointments, and were paid higher salaries at the same ranks. Data suggests that women still have a tendency to "sit" at the associate professor level for a longer time than their male colleagues.

LGBTQ advocates have struggled to bring their health issues to the forefront. One lesbian student from the 1980s reported that she had been astounded to learn that Dr. Earp's women's health course at that time did not include sexual orientation policy issues. Although the alumna reported that Dr. Earp initially had been doubtful about including such information in her course, she was open to suggestions, and later did include such material. Unfortunately, that course is no longer taught and, indeed, there is almost no place in the entire School curriculum where LGBTQ issues are addressed, despite their importance to public health. Alumnus Joseph Lee, for example, reported in the journal Tobacco Control (August 2009) that men and women who are gay or lesbian are more likely than their heterosexual counterparts to smoke (37 percent of lesbian women, compared to 18 percent heterosexual; 33 percent of gay men, compared to 24 percent of straight men).

In spring 2008, the Department of Maternal and Child Health, along with the School of Social Work, sponsored a course in LGBTQ health (MHCH 740/SOWO 709). Unfortunately, there appear to be no plans as of now to repeat this course. One course required for the Interdisciplinary Certificate in Health Disparities (EPID/MHCH 892) has featured a lecture dedicated to LGBTQ health. Additionally, the Minority Health Conference, which the School significantly supports, invited its first speaker to present research on LGBTQ health in 2009. This invitation was proffered again last year, and it appears this might be a regular component of the conference. During the School's first Summer Health Fellowship Program, an explicit effort was made to ensure that students were exposed to an introduction of LGBTQ health. The School now includes LGBTQ issues in its optional Diversity Orientation offered to new students at the start of the fall semester. (See the "Documents" folder in DITF's Blackboard.)

Sources:

1. History of the School, UNC Gillings School of Global Public Health Web Page.
2. An Evolving History of Minority-Related Activities at the UNC Gillings School of Global Public Health.
3. History in the Making, Carolina Public Health Magazine, Winter 2006.
4. "Lesbian, Gay, Bisexual, and Transgender (LGBTQ) Health is Public Health: Looking towards the future for the University of North Carolina Gillings School of Global Health." By SPH students within the Health Sciences LGBTQ Alliance. (DITF Blackboard)
5. "Dreaming of a Time: the School of Public Health, the University of North Carolina at Chapel Hill," 1939-1989. Robert Rodgers Korstad. 1990.
6. "Breaking the Barriers, Making History: Timeline of Women's Education at UNC." Prepared by the Southern Oral History Program by Jenner Donnally and Jessie Wilkerson. (DITF Blackboard)
7. Communications with Carolina Indian Circle. (DITF Blackboard)
8. "UNC researchers: Smoking rates significantly higher among homosexual men, women". UNC Gillings School of Global Public Health, News and Events, July 27, 2009.
9. Recordings and Presentation Notes from speakers Danny Bell, Bill Jenkins, Kat Turner and Elizabeth French at the January 25, 2011 meeting of the DITF Change Team.

Appendix F.i: DITF Focus Group Executive Summary

A total of 12 focus groups were scheduled with various constituencies in the School between February and early March of 2011. A total of 65 participants attended 9 of the focus groups. 30 participants were staff, 23 were students and 12 were faculty. Concurrently, a virtual focus group was conducted where 22 surveys were taken with 7 surveys completed. A combined summary of both sets of focus group data are below.

Participants shared a number of variations defining diversity and inclusion, with the two concepts seldom treated as mutually exclusive. Separation of concepts seemed to occur most distinctly around admissions applications where inclusionary categories are given less attention and in coursework where different points of view are missing.

The overwhelming majority of focus group participants feel there is a strong need for a plan to achieve enhanced diversity and inclusion at the School. Participants discussed a number of reasons that supported the need to have a diverse and inclusive School. It exposes all of us to different ideas and perspectives; promotes more informed classroom discussion; changes cohort dynamics; helps with problem solving; prepares students for the workforce—particularly given the practitioner-oriented nature of public health; bolsters credibility having a trained workforce that looks like the populations we work with; aligns with one of the key focuses of Healthy People 2020; and reflects the growing diverse population in our state and around the country.

While the general sentiment is one of appreciation, respect and support for such a plan, most express that it is time to stop talking and start doing. Up to this point, the consensus was that School leadership, while supportive of diversity and inclusion, has demonstrated little explicit effort in developing and implementing programs or practices to initiate necessary changes. There is a strong implication that in order to achieve a more diverse and inclusive School, a multi-pronged approach will be needed that is comprehensive, pervasive and modeled from the top-down.

There was widespread agreement among participants that there are not overt or deliberate attempts to offend or exclude individuals at the School, but that in most cases people just are not aware of how their comments or actions might be offense to a particular group. Modest, incremental attempts at raising awareness and cultural competence will go far in creating a more tolerant and inclusive environment. Perhaps, instead of focusing on the default being how we create more inclusion among groups, we should focus on preventing random exclusionary occurrences.

Moving forward with a plan to develop a more diverse and inclusive School, participants consistently identified several barriers they felt need to be addressed pertaining to the School's organizational climate. They include the insular nature of departments within the School and lack of cross-departmental communication and collaboration that results from this detachment; the hierarchical academic environment and the contentious level of degree-consciousness that tends to create a disconnect among faculty, staff and students; the absence of an approved and safe outlet for individuals to discuss their diversity and inclusion experiences, report complaints,

access information and organize support; the absence of groups/coalitions/organizations for certain constituencies that could interpersonally benefit from meeting as a group and help increase diversity and inclusion interest outside the School; and finding ways to reduce "feeling out of place" and the level of loneliness that accompanies being the minority or minoritized group.

There was participant concordance in the idea that in order to attract more diversity and inclusion to the School, a necessary step is to recruit and retain a more diverse cohort of students, faculty and staff. The primary challenges identified by participants around the issue of recruitment of students include;

- inability to compete with other Schools of Public Health who offer far better funding opportunities over multiple years for minority students
- lack of a diverse pool of applicants to choose from
- lack of information sharing across departments about approaches used to achieve greater diversity including, recommended practices, lessons learned, etc.
- need for finding ways to say "yes" to medium and high risk applicants and ensuring that these borderline students have strong mentorship in place
- inability to currently recruit students when there is no standard way to identify who these applicants are (low SES, LGBTQ, and first generation college students)
- confusion around student applicants refusing to check the race/ethnicity box on applications or choosing more than one box and, thus, becoming ineligible for consideration as a under-represented minority based on the School definition.

In terms of student retention, some participants expressed disappointment at deciding, at least in part, to attend the School because they were told this was a very diverse place, but their initial expectations did not match the reality of the situation once they arrived at School.

There was general agreement across student groups that faculty support of students is lacking and that faculty generally does not take the time to get to know students. Faculty need to do a better job relating their research interests with the student's education instead of their own professional development. These feelings were usually set in the broader context of being in a Health Affairs School where intense pressure is placed on faculty to produce research results in the form of papers, presentations and proposals. This kind of academic environment, which does not place top priority on teaching, makes it difficult for faculty to engage students in a meaningful way.

Under-represented minority and LGBTQ student participants felt coursework can be and should be modified to create a more diverse and inclusive curriculum for the School. Participants largely feel their point of view is often not part of the current conversation in the classroom, and that the classroom discussion is tailored more to the mainstream perspective.

This summary is based on a larger report of the findings that emerged from the focus groups and can be available upon request

Appendix F.ii: DITF Focus Group Full Report

A total of 12 focus groups were scheduled with various constituencies in the School between February and March of 2011. A total of 65 participants attended 9 of the focus groups. 30 participants were staff, 23 were students, and 12 were faculty. Concurrently, a virtual focus group was conducted where 22 surveys were taken and 7 surveys were completed. A combined summary of both sets of focus group data are below.

I. General Findings

1. Definitions/thoughts from focus group participants on *diversity*:

- *My take on diversity is that an active effort needs to be made to make sure people aren't being overlooked because of some other characteristic totally unrelated to their ability. I don't go for diversity like a butterfly collection where you have to have one of those and one of those and one of those….the way I see diversity is trying to even the playing field and ensuring people aren't being overlooked.*

- *I like the idea of naming groups explicitly when defining diversity. It wipes away any ambiguity, shows the groups being named they are taken seriously and helps clarify policy.*

- *When people hear diversity it immediately equates with skin color. Diversity is a lot more than having different colored faces, it's about how you approach the world, how you react to things and how your POV is different.*

- *Diversity needs to be a word and idea that can be shared and discussed openly. It should not be something we have to tip-toe around, always being careful what you say. This will have everyone walking around on eggshells—that is not diversity. That creates more resentment.*

- *Without diversity I sometimes feel very lonely. Sometimes I'd like to talk to just one other person with the same ethnicity in my program.*

2. Definitions/thoughts from focus group participants on *inclusion:*

- *General consensus from departmental admission directors is very little is done with inclusion issues. Diversity is where the focus lies now.*

- *Inclusion to me means my marriage to my partner is recognized. Now, when I cross the state line I have become single again—this state and UNC-CH, as a representative of the state, does not currently recognize my reality.*

- *Inclusion is not having to make a concerted effort to always be recognized or respected. Alleviating some of the burden of being the voice of given group—e.g.—"It would be nice to have LGBTQ issues already out there, so I'm not tasked with always bringing it up."*

• Want to recognize the efforts the school is making with the DITF and this Focus Group and the ally buttons, BUT it's important to point out that it is no longer sufficient. The absence of overt

homophobia does not mean it's an inclusive and welcoming environment. Just like the absence of disease does not mean it's a healthy environment. So, while this is all a necessary and important step, it's no longer sufficient.

3. Participants have mentioned a number of reasons why diversity and inclusion in the School is important.

- Promotes more in-depth, more informed classroom discussion
- Changes cohort dynamics
- Provides better problem solving opportunities
- Helps to prepare students for the workforce; particularly given the practitioner-oriented nature of public health.
- Exposing people to different ideas and perspectives
    - "Important for American students who sometimes have no idea about the world and they can be exposed to folks from other countries."
- The populations that need us are often from disadvantaged and underserved communities. There is real credibility that comes from having a workforce that looks like the populations we're working with.
- It's a focus of Healthy People 2020
- Having a critical mass of diverse students and scholars makes sense reflecting the growing diverse population

4. The majority of participants mentioned that a modicum of raised awareness or cultural competence will go far in creating a more inclusive environment. The overwhelming feeling is that individuals do not deliberately try to offend or exclude other people, they just are not aware of how their comments/actions might be offense to a particular group.

- *"It's about modest changes in behavior…it's nothing big."*
- *"Sometimes you just want your name remembered. Don't act like I wasn't in your class last semester."*

5. There was a shared sentiment from participants that the focus groups acted in a therapeutic way for them. Not only did participants express how good it felt to talk about these issues with other people, but there seemed to be an excitement and an eagerness to organize and DO after coming together. Providing a forum to talk about issues that folks might have spent time thinking about but had not necessarily had a chance to express, discuss, and hear like-minded sentiments from others was welcomed. This kind of information sharing motivates people to want to go out and "be the change they want to see in others."

II. Organizational Climate

1. Departments in the SPH are very silo-ed and insular and powerful in their own way. Students, staff and faculty alike, can easily get "trapped" in their own little world. This lack of cross- departmental collaboration is perceived as a barrier to creating a more diverse and inclusive environment. For example, a few departments were consistently recognized for the practices they have implemented to improve diversity and inclusion. But the lack of communication or consistency across departments has prevented uniformity or the spreading of these good ideas.

- *"It has to be a department Chair-down climate that says go for it, it's okay to spend time on these issues."*

- *"It feels like each Chair is very autonomous, so the Dean can say something but not necessarily be heeded by Chairs."*

2. The School works under a very "degree-conscious climate". It is hierarchical and often comes across as intimidating, aloof and disrespectful.

- *"The school's ranking and rating makes it proud, [there is] nothing wrong about that. But it is wrong if you pick and choose who you decide to highlight to represent the SPH."*

- *"[School] leadership will say how do you know what you are saying. There's a climate that evidence must be shown to convince people that what you say is correct. Not necessarily the frame of reference for staff."*

- *"There's disconnect that plays out in the work environment and it becomes uncomfortable sharing thoughts and feelings with one another because staff and faculty speak a different language."*

- *"There is a lack of thoughtfulness about people, how we phrase things, how we structure meetings, infringement on family time; there needs to be a shift to being more thoughtful of people's whole lives, not just their work lives."*

3. Student and staff focus group participants echoed that interpersonally they feel welcomed in the School, but in terms of the School's culture, not so much. There's NOT a strong feeling of effort being expended by the SPH leadership to improve the climate. Having said that, it was repeatedly mentioned during the focus groups that there is admiration and respect for the School and the Dean for trying to tackle these issues through the work that the DITF is doing.

- *"I feel like the opportunities I've had at the School can be contributed to wonderful individuals, not structural aspects of the school. The structure as a whole is not conducive."*
- *"There's a weird recognition on the School's part that there are things that can be done, but the onus is on the group's part. We do need to take part in the change, but at the same time, I am a student, I need to write my dissertation. It's unreasonable that other students don't have to*

spend as much time letting the school know these are faucets in my environment that need to be addressed. And I need to continue to remind you. It seems a little backwards."

- *"We need to encourage all of us to convey respectfulness—this is lacking in „corners" of the School. If people don't feel their opinions aren't respected, then they don't feel welcomed."*
- *"There is a need for more action. I feel like we have talked enough. We went over these same issues last year at the Town Hall discussion."*
- *"If it is equally dispensed and valued by leaders -- administrators, faculty, and students -- then it can create a very welcoming environment for all."*

4. The perception exists that there are no approved or safe outlets within the School to currently talk about issues around diversity and inclusion. The Office of Student Affairs seems to be the default place to send individuals if they bring up an issue regarding diversity and inclusion, but the office is not in a position to do much about these issues.

- *"I like idea of going to the Dean's office that they are open and approachable to these issues — they just need to advertise more that they are open to the School."*

- *"Where do I go when I have a grievance to air regarding diversity and inclusion?"*

5. Viewed within the context of the other Health Affairs Schools at UNC-CH, it is worth noting that in terms of diversity and inclusion, the School seems to fall somewhere in the middle of the continuum. The School Of Dentistry being perceived as a very unwelcoming environment and the School of Social Work (though not officially a Health Affairs School) as being very welcoming.

- *"Have less focus on 'diversity' and more of a focus on enhancing everyone's ability to succeed. If the School could develop a culture of excellence and acceptance, regardless of identity, that would be ideal and help provide a model for other Schools on campus."*

6. Staff participants shared a feeling of "old school versus new school" mentality among staff members where elements of education levels, regionalism and to a certain degree territorialism, come together to produce resentment among one another. In general, there is little diversity among administrative staff. In addition, there is no stand-alone group for EPA Non-faculty, so it is hard to say where colleagues are, who colleagues are, or what policies and practices are in place for advancement. As a result, EPA Non-faculty can sometimes feel out of place since they are not in academia and they are not necessarily engaged directly in health related activities.

7. When describing what it is like to be minority group at the School, there was a repetitive theme of feeling lonely and isolated.

- *"I've built my village of people I can count on in the School. This village ranges from the housekeeper of the school to staff in my department…I've had to create that village of people."*

8. There is the sentiment that this is a "food fixated" environment and folks are judged on how physically fit they are and whether they appear as "good representatives of the School."

- *"We are SPH so while we are working to address problems of obesity/overweight on a population basis, we need to recognize that discrimination, name-calling and lack of sensitivity (including outright discrimination) are not acceptable intervention strategies. This is a tough balancing act but we could set the right tone for how to do this well and still make the public health impact we are striving for."*

III. Recruitment/retention

1. Departments express one of two major challenges in achieving a diverse cohort of students.

・ *Funding/Recruiting***.** A major barrier in achieving a diverse graduate student body is the fact that other universities are able to offer far better funding opportunities than UNC; i.e., they offer more funding over multiple years. The Graduate School does offer one year minority presence scholarships through a competitive process, but this is not nearly sufficient.

・ *Pipeline*. The overall undergraduate pool has already been balanced for diversity at the University level, but SPH departments have very little flexibility when applications to BSPH programs do not rise to a sufficiently competitive level. Admissions directors and staff also cited challenges with the pipeline at the graduate level.

- *"We felt helpless. We could have admitted more."*

2. There is very little consistency across departments regarding student admissions.
Diversity is one of the criteria that all participants said their departments weigh during admissions process. But departments have different practices in place:

・ One department has a "three tier" effort in place to "flag" certain applicants: 1) minoritized students, 2) Male students and 3) Asian women.

・ Another department handles admissions in a similar way, with the addition that they also flag international applicants.

・ A third department indicated that they had recently initiated a "second look" policy as well "to see if [there was] something [in the packet] that would overcome the initial rejection."

・ A fourth department does a whole portfolio review; committee members tend to give the applicant the benefit of the doubt when low GRE scores are counter-balanced by good grades and strong letters of recommendation.

・ A fifth department does not have a formal way of flagging minoritized students, but has achieved pretty good diversity nonetheless. This program is unique in that it allows nontraditional students an opportunity to find out whether a graduate program in public health is a good fit for them

・ A sixth department places primary emphasis on matching faculty research interests with student interest when considering applicants for admission.

3. Saying "Yes" to Medium and High Risk Applicants. Participants tried to identify some "do's and don'ts" when deciding whether to admit borderline students. Admissions directors and staff seemed to agree, if the applicant did not reach a certain threshold (i.e., grades or GRE could not be below mediocre), it would be bad for both the department *and* the applicant if she or he were admitted and enrolled in the program.

- *"The exceptions we've made have worked out pretty well, but it's hard to figure out [what criteria to use in making those exceptions]."*

- *"The struggle is with the student who has some public health experience and you think they might make a good practitioner, but you are not sure if they can make it in the environment—this is where data and evidence on what we can trust as indicators of success would be helpful."*

4. Inclusion is admittedly less of a priority for department admissions directors. It is difficult to recruit and retain other types of students when you are not made aware who they are: low socioeconomic status (SES), LGBTQ, and first-generation college students are groups mentioned in this context.

- *"Sometimes we try to earmark economically deprived students for awards or scholarships, but it's hard to assess whether they fit this category unless they write about it in their essay."*

6. **There has been a noticeable spike in the past two or three years with student applicants refusing to respond to questions on the application regarding their race or ethnicity**. The box on the application is being left unchecked, which makes it difficult to know who applicants are. In addition, student admissions personnel are seeing more and more applicants self-identify using more than one option on race/ethnicity checkbox (e.g.—checking black and white) and therefore, being discounted as a minoritized student. According to SPH's definition of a minority applicant and the way data are kept, multi-ethnicities do not count. This has resulted in a drop, on paper at least, in a more diverse student cohort. This presents a new challenge in trying to increase student diversity and inclusion.

- *"Now, you can admit a student and find out after they've been admitted that they are an URM (Underrepresented minority) and it's a shame because they could be given a merit award."*

- *"The challenge is this group [admissions managers] live in a world of reports so when it comes to counting diversity, how do you count 'two or mores'?"*

6. Some student participants expressed disappointment at their initial expectations of deciding to attend a School with great diversity and inclusion, but having this expectation not match the reality of the situation. There is the feeling that a lot of effort was expended in some situations at attracting potential students to the School, either through pairing them up

during their recruitment visits with other students and faculty of color, or giving the impression that this is a diverse and inclusive place in other ways. But once students arrived at the School, there seemed to be a false representation of itself.

- *"I had high expectations when I entered School here, being told I would have a diverse cohort. But those expectations have been lower. I was expecting better."*

- *"I felt like the School romanced me here."*

7. When trying to recruit and retain international students, it is important to remember that some of the biggest obstacles for them tend to include;

- Language and accent
- Understanding how processes work in the US (e.g. credit history, Social Security card, etc.)
- Understanding the academic system
- Understanding academic expectations
- Potential stress of spousal/family separation for extended periods of time

8. Regarding recruitment of minoritized students, a question that emerged was where are the Hispanics in the SPH? With Hispanic and Latino issues being very prevalent in public health and given the surge in the past 5-10 years in the Hispanic or Latino population in this state, why isn't there proper representation of Hispanics or Latinos in the student body? The consensus is there are pockets of interest across departments, however it is scattered. A more organized movement needs to occur with a push for 1) more relevant course content that covers Hispanic public health issues and 2) the development of Hispanic or Latino organizations or coalitions within the School that can help with networking into University-level channels and beyond to increase recruitment efforts.

- *"It feels like a bit of island when it comes to Hispanics and community in the School."*

IV. Curriculum

1. There was general agreement across student groups that faculty support is lacking and faculty do not take the time to get to know students. Faculty need to do a better job relating their research interest with the student's education instead of their own professional development. These feelings were usually set in the broader context of this being a Health Affairs School and the intense pressure that is placed on faculty to produce research results in the form of papers, presentations and proposals. This kind of academic environment, which does not place top priority on teaching, makes it difficult for faculty to engage students in a meaningful way.

- *"…it takes a lot of self-motivation to continue with school. This School is interested in the final product but not in helping students get there."*

- *"Part of the challenge in being a Health Affairs School is the pressure placed on the faculty. You have to make your own way. 25-30 years ago faculty collaborated much more, hung out much more. Now, the impetus is so much more, nose to the grind."*

- *"The expectation put on faculty to be part of the 'rat race' is an obstacle to making students a priority. Is there a way to reward faculty based on the time they spend engaging students?"*

- *"I realize it is very hard to alter this academic mindset, but we might be able to at least make people more contemplative and conscious if we raise the level of conversation around it."*

- *"…I personally never felt the need to be mentored by someone who looked like me. I would rather have someone mentor me who represented what I wanted to accomplish with my career."*

2. This School is currently not the place to come for individuals who are interested in doing LGBTQ research. There are stronger schools that are working on LGBTQ-related research. SPH leadership should be made aware that they will be "eclipsed" on this area of public health research if they don't act.

- *"The fact that you can graduate from our Master's program and go out into the real world and work in LGBTQ communities having never been exposed to LGBTQ health-related issues doesn't make any sense."*

3. Minoritized and LGBTQ student participants largely feel their point of view is often not part of the conversation in the classroom, and that the classroom discussion is tailored more to the mainstream perspective.

- *"If we are truly of a School of Global Public Health, people should understand that different cultures have different ways to appreciate, acknowledge and interact with people."*

- *"Many of my classes here don't even acknowledge that students come from a different background."*

- *"I think the focus should be on open communication and increasing self-awareness. If we are all self-aware, we will own our perceptions and recognize that our values may not be the same as others. This in turn, will hopefully help us enable others to succeed on their own terms."*

Appendix G: Diversity and inclusion priority topics

As a result of the Diversity and Inclusion Task Force meetings, surveys, focus groups and other activities, three topics have emerged as priorities for taking action to enhance diversity and inclusion within the School. Below is a list of each of the three priority topics, as well as examples of feedback and perceptions that inspire the need to make formal recommendations for change. Please consider these as a starting point for the mission of preparing recommendations that transform the School into a place where one would want to be and where diversity and inclusion are woven into the fabric.

Three Topics

I. Organizational Climate
II. Recruitment and Retention –Faculty, Staff and Students
III. Curriculum

Organizational Climate Challenges

(Relating to Administrative Structure)

- Need for strong leadership statement in support of diversity
- Need for established, unified or standard policies for all departments across the school.
- Need for diversity in faculty, students and staff at all administrative levels
- Need modest, incremental attempts to raise awareness and cultural competence
- Need for designated Ombuds person within School
- Need for panels or committees that would create guidelines, recommendations for safe dialogue about both the meaning and benefits of diversity and inclusion and challenges and hesitations in diversifying the School
- Need for orientation, counseling, training and programs to educate faculty, staff and students about cultural competencies and sensitive language
- Need for infrastructure to sustain implementation of recommendations and hold the School accountable
- Need for approved and safe outlet for individuals to discuss their diversity and inclusion experiences, report complaints, access information and organize support
- Need to prevent and reduce exclusionary behavior

(Relating to Environment of Inclusion, Diversity)

- Need to increase feelings of inclusion
- Need for diversity and inclusion to be better visualized in the School through posters, photos, etc.
- Need for multi-cultural day/celebration of diversity to promote awareness
- Need for minoritized students from different departments to gather together

- Feeling of loneliness that affects minoritized groups
- Insular composition of Departments within the School creates detachment and prevents notion of School-wide approach
- Hierarchical structure based on degree creates a disconnect between faculty, staff and students
- Need for Department Chairs to endorse and model diversity and inclusion
- Need to link to support from campus environment or resources
- Need for bond between School and surrounding communities regarding diversity and inclusion

Recruitment and Retention Challenges

(Relating to Students)

- Challenges with admissions process including confusion about race/ethnicity box, or indication of other minority status for applicants (such as low SES, LGBTQ, first generation college students, etc.)
- Need for increased ability to compete with peer Schools who offer better funding opportunities for minoritized students
- Need for diverse applicant pool and/or knowledge about minority status for those that do apply
- Need for information sharing across departments about approaches that work, recommended practices, lessons learned and ways to admit and ensure support for medium and high-risk students
- Need for organized or structured approach for minoritized students who want to connect with other departments, University resources and support systems or become acclimated to academia
- Disappointment exists sometimes after applicant chooses to come here and then feels they were misled regarding level of diversity within the School
- Need for search committees for recruitment of minority faculty and staff

(Relating to Faculty and Staff)

- Need for funding to support development of minority faculty
- Need for organized or structured approach for career development of minority faculty and staff
- Need for more competitive salaries to retain minority faculty
- Need for identifying equity issues related to salary and gender

(Relating to Broad School Community)

- More outreach needed
- Need for efforts to increase pipeline
- Need for mentorship programs for minoritized faculty, staff and students

Curriculum Challenges

- Current curriculum under-addresses diversity and under-represents minority health issues
- Need for unified approach to addressing diversity, inclusion & cultural competency in Core Courses
- Need for seminars taught by faculty and staff that specifically focus on diversity, inclusion, minority health issues and cultural competency
- Need for promotion within curriculum to engage in learning activities about inclusion and diversity
- Impression that faculty focus more on their own research rather than student education
- Need for recognition or acknowledgement of teachers who promote diversity and inclusion in the classroom, and need for formal requirements for all teachers
- Need for teaching evaluations to include review of diversity and inclusion topics
- Feeling among minoritized students that their point of view is not included in the classroom
- Need for resource list or handbook for diversity and inclusion
- Need for policies within the School, University and University-System

Appendix H.i: Organizational Climate: Executive Summary

The Charge

The Diversity and Inclusion Task Force (DITF) **Organizational Climate Recommendation Group (OC Group)** was charged with developing a set of recommendations to help transform the climate of the UNC Gillings School of Global Public Health (SPH or School) into *"a place where you want to be and where diversity and inclusion are woven into the (organizational) fabric."* Improving the climate of the School was one of the three priority topics that emerged as a result of diversity and inclusion surveys, an environmental scan, focus groups and other information-gathering activities conducted by DITF members school-wide between October 2010 and March 2011.

Definitions

The OC Group's discussions led to recommendations that touched on key features of organizational climate and/or culture as defined and used in related research. (*The Handbook on Organizational Culture and Climate* (2011), Edited by Ashkanasy, Wilderom and Peterson).

- "…[T]he policies, practices and procedures, and the behaviors that get rewarded, supported, and expected in a work setting and the meaning those imply for the settings' members" (p. 39)
- "…both what employees observe happening to them and around them and the meaning in the form of the climate or climates that what they experience connotes." (p.39)

Specific Climate Challenges

The starting point for the OC Group was a set of "needs" related to organizational climate "challenges" that were summarized from data gathered by the DITF. These "challenges" were further organized by the DITF into two groups related to the School's administrative structures and other aspects of the environment for inclusion and diversity.

Summary of Recommendations

The **first recommendation** calls for the School's Dean's Council to proclaim their support for diversity and inclusion throughout the School by creating and disseminating an endorsement statement. The Dean's Council is comprised of school-level deans and directors, department chairs and representatives from two student groups and is the only regular forum in which these leaders gather on a regular basis. The result should be a complete vision for diversity and inclusion in the School.

The **second recommendation** proposes the development of a school-wide model that would form the underpinnings of constructive policies that would promote the School's new vision for diversity and inclusion. A volunteer committee of faculty, staff and students across the School would transform existing models and recommended practices into policies, procedures and activities optimal for the School's multiple environments.

The **third recommendation** argues for the provision dedicated personnel and other resources at the school-level. A dean of diversity and inclusion, with supporting staff, would provide leadership and inspiration for diversity and inclusion goals and efforts. In addition, to help hold the School's community accountable for diversity and inclusion, this leader would oversee organizational climate evaluation and reporting efforts throughout the School.

The **fourth recommendation** seeks to expand climate development and maintenance to include the UNC community and beyond. The external communities would both support the School through services and resources and help hold the School's community accountable for meeting the climate goals and vision.

Finally, the **fifth recommendation** adds to the School's community a person dedicated to assisting members of the School's community by providing a safe and confidential space to discuss diversity and inclusion issues and to assist with the adjudication of relate conflict. This Ombud would have the autonomy to help people successfully navigate challenging these issues.

Additional Overarching Themes

- Rather than prioritizing one recommendation over another, the OC Group highlights (in yellow) realistic, short-term, low-resource actions within each recommendation to permit them to move forward in concert, creating the necessary synergy and momentum required to generate positive and lasting change in the School's climate.
- The OC Group recognizes that the School's community is large and its structure largely decentralized. It may be necessary for school-level recommendations to provide consistent underpinnings and values and allow for department, program or unit specific implementations. A good portion of our faculty, staff and students' identities in the School are driven by departmental, program or unit values, policies and procedures. We strive for unity across units without negating the value of unit or individual differences.
- The literature on organizational climate and our discussions note the importance of consistent messages on diversity and inclusion and the importance of incorporating diversity and inclusion goals into human resource practices (e.g., hiring, performance appraisal, incentives and promotions). This applies to the equivalent ways that we evaluate students.
- The OC Group recognizes that curriculum, recruitment and retention are components of the School's environment. Consequently, some of the recommendations make note of specific actions related to those components.
- The OC Group assumes that the School encompasses all faculty, staff and students. Any omission of all three groups is inadvertent. And, as appropriate, we also include alumni, employers, our community partners, the UNC community and others.
- While the recommendations focus on accountability across the School via the Dean's Council, the OC Group also recognizes that all faculty, staff and students influence the School's climate and should also be held responsible for their roles and actions.

Recommendation 1: Dean's Council Endorsement Statement

1.	Recommendation :	**The School's Dean's Council would create and disseminate a strong statement in support of diversity and inclusion. The statement would have an abridged version for easier dissemination in some venues.**
1.1	**Potential Impact**	This outcome is imperative because it would: 1.1.1 Demonstrate an unquestionable, unified commitment and acceptance of responsibility for diversity and inclusion throughout the School. 1.1.2 Heighten the importance, visibility and awareness of diversity and inclusion. 1.1.3 Eliminate questions concerning commitment to diversity and inclusion across the School. 1.1.4 Promote cohesiveness across department, programs and other units. 1.1.5 Inspire people who are more likely to accept and adopt ideas from someone who inspires them or whom they trust (e.g., their department chair or unit leader). (Transformational Leadership Theory) 1.1.6 Require collaboration among departments and other units, another avenue through which the statement will showcase the importance of and commitment to addressing diversity and inclusion. 1.1.7 Promote the development of a diverse staff, faculty, and student body who feel fully welcome. 1.1.8 Help promote caring about each other as human beings and the value of benefiting from everyone's talents.
1.2	**Implementation Plan**	The Dean's Council would: 1.2.1 Start with the definition of diversity and inclusion developed by the DITF as the basis for their statement of commitment. 1.2.2 Consider feedback from faculty, staff and students. Engagement might involve focus groups, interviews, surveys, and/or whiteboard discussions. 1.2.3 Using the qualitative and quantitative research collected, draft a statement of two-three paragraphs and a shortened form of one-two sentences. The Dean will appoint or solicit one-three members of the Dean's Council, with the support of the School's communications director, to craft the first draft. 1.2.4 Distribute draft statements to Dean's Council members at a Dean's Council meeting. A lively discussion is *expected*. A passionate member of the Dean's Council should be selected in advance to lead the discussion. 1.2.5 Based on the discussion, revise and distribute draft statements to faculty, staff, students and alumni in a variety of ways (e.g., email, whiteboard, website, social media) with time allotted and a venue created for the collection of feedback. The original draft group should continue to take the lead on creating subsequent drafts. 1.2.6 Based on additional feedback, revise the statements and present them again to the Dean's Council. 1.2.7 Continue the iterative process until all members of the Dean's Council believe they can support and be a champion of the full statement and the abridged version. The number of faculty, staff and students engaged in providing feedback in the first year could be limited to help ensure that a statement is completed. This assumes that the community would have opportunities to share their input each and that the statement would be revised periodically (as noted below). 1.2.8 A formal copy of the statement would be signed by all members of the Dean's Council, framed and placed in the main hallway of the first floor of Rosenau Hall. 1.2.9 The statement would be posted on the School's website and announced to the School via the weekly news email, LCD slides and posters/bulletin boards, social media, etc. Departments, the School's Offices of Student Affairs and External Affairs, NCIPH, student organizations and other units would also distribute the statement to their stakeholder lists.

		1.2.10 Every degree and certificate program's Student Handbook or Program Guide would include this statement, as well as any other unit specific policy handbooks or guides. 1.2.11 The statement would be reviewed annually by the Dean's Council, with school community engagement, and refreshed as appropriate. 1.2.12 The Dean would add two permanent positions for one faculty and one staff representative who are not in a leadership role, as another way to demonstrate commitment to inclusion and commitment.
1.3	**Timeline**	• June and July 2011: Notify the Dean's Council of this recommendation and plan. Collect qualitative and quantitative data with staff, faculty and students who are available. • September: Collect additional qualitative and quantitative data with students, faculty and staff. • October: Complete the first draft and present it to the Dean's Council. Make revisions and send to the School's stakeholders. • November: Complete the second draft and email it to Dean's Council members. • December: Complete iterations and the final statements. • January 2012: Disseminate statement as described above. • Ongoing: The statement would run periodically as space permits on the LCD slides with a goal of a minimum of two non-concurrent weeks per semester. The statement would stay on bulletin boards for at least a month and on the website permanently. • Annually in August/September: The statement would be disseminated via the methods described above. • Bi-annually in the spring: The statement would be discussed and revised after additional feedback is collected. • Annually in the spring: Awareness and support for the diversity and inclusion statement and the Dean's Council's endorsement would be assessed. The number of faculty, staff and students engaged in providing feedback in the first year could be limited to help ensure that a statement is completed. This assumes that the community would have opportunities to share their input each and that the statement would be revised periodically.
1.4	**Resource Requirements**	The primary resources would be the time of the one-three Dean's Council statement team and any staff charged with collecting feedback/data, writing and revising the statements and disseminating the results.
1.5	**Measurable Results**	1.5.1 A statement and a shorter version are created and disseminated according to the recommended implementation process and timeline. 1.5.2 Dean's Council members become more engaged in transformational leadership regarding diversity and inclusion. 1.5.3 Dean's Council members become more comfortable talking about diversity and inclusion and have a better understanding of definitions and expectations. 1.5.4 School community members become aware of the diversity and inclusion statement and the Dean's Council support statement. 1.5.5 More School community members believe that the School's leadership is committed to diversity and inclusion as an organizational priority. 1.5.6 More School community members value the diversity and inclusion statement.
1.6	**Metrics to Assess Results**	1.6.1 Statement creation and dissemination (1.5.1). Via interviews, focus group and/or surveys: 1.6.2 Dean's Council members and other faculty, staff and students rate the Dean's Council's level of engagement (1.5.2) and level of comfort (1.5.3). 1.6.3 The School's community rate their level of awareness of the statements (1.5.3), whether or not they believe School leadership's commitment (1.5.5) and how much they value the statements (1.5.6). The first annual survey would set a baseline from which goals can be set for the following year. (E.g., if the baseline survey shows 50% awareness (1.5.4), 30% belief (1.5.5) and 75% value

		(1.5.6), the following year's goals might be 60%, 40% and 85%, respectively.
1.7	**Proposed Champion**	1.7.1 The Dean and Dean's Council would be the primary champions. Supportively: 1.7.2 HPM- Health Policy and Management would serve as a process example, with Peggy Leatt and Peggye Dilworth-Anderson providing inspiration and motivation. 1.7.3 The one-three member statement drafting team would help ensure completion of the initial process. 1.7.4 Students on Dean's Council and TRIAD within the Minority Student Caucus (and any other volunteers) would advocate for this activity and lobby for its progress and completion. 1.7.5 The communications, external affairs and student affairs and NCIPH units would champion School-wide dissemination and department chairs would champion departmental dissemination.
1.8	**Assumptions**	1.8.1 The Dean's Council will engage in the process to implement the recommendation. 1.8.2 The Dean's Council will solicit feedback and use an iterative process to achieve consensus on the statement. 1.8.3 Post-dissemination surveys will show that item 1.5.4 will have a higher result rate than 1.5.5, and that 1.5.5 will have a higher result rate than 1.5.6. 1.8.4 It is expected that the rates of awareness, belief and value will increase annually. 1.8.5 The statement will cause reflection in members of the School community and modify behavior in the long term. 1.8.6 The statement will inspire faculty, staff and students throughout the School, individually or as smaller units, to also endorse this statement.

Recommendation 2: A School-Wide Model for Diversity and Inclusion

2.	Recommendation :	**An acceptable school-wide diversity and inclusion model would be created to support the diversity and inclusion principles set forth by the DITF and the School's leadership. A volunteer committee comprised of faculty, staff, students and alumni would be created to provide feedback and creativity in addressing diversity and inclusion strengths and weaknesses within the School.**
2.1	**Potential Impact**	These outcomes are imperative because they would: 2.1.1 Demonstrate an unquestionable, unified commitment and acceptance of responsibility for diversity and inclusion throughout the School. 2.1.2 Heighten the importance, visibility and awareness of diversity and inclusion. 2.1.3 Require collaboration among departments and other units, another avenue through which the statement will showcase the importance of and commitment to addressing diversity and inclusion. 2.1.4 Provide a standardized set of principles for guiding and framing diversity and inclusion-related issues. 2.1.5 Create a working process for increasing diversity and inclusion that each department or unit could adopt. 2.1.6 Help ensure that each department or unit participates in inclusion and acceptance of a variety of differences, including cultural. 2.1.7 Create a feedback mechanism for guiding principles and processes that can be used to alter global guidelines of the School and large units within the School. 2.1.8 Help improve the morale of faculty, staff and students who may be negatively affected by a perceived lack of diversity and inclusion. 2.1.9 Facilitate the incorporation of values that address diversity and cultural competence into the programs' curriculum, including health equity, social, economic, leadership, and global education perspectives.
2.2	**Implementation Plan**	2.2.1 The Dean would appoint a leader to create and manage a diversity and inclusion integration committee that includes faculty, staff and students and with representation from all departments and school-level units. 2.2.2 The committee would be charged with developing a school-wide diversity and inclusion model and recommending related guidelines, policies and procedures based on recommended practices from literature and other organizations or units (e.g., HPM model) and including the following required elements: • Diversity and inclusion training for faculty, staff and students (once a year). • Diversity and inclusion dialogue on an ongoing basis (quarterly). • Diversity and inclusion activities and communication through games or social functions (faculty, staff, students, and alumni). • Diversity and inclusion faculty, staff and student team building exercises (quarterly, for each department and unit and in different combinations among units or groups). • Diversity and inclusion information showcased on the School's website, emphasizing ongoing activities. • Diversity and inclusion goals and values considered high priorities when recruiting and evaluating faculty, staff, and students. • Diversity and inclusion emphasized in curriculum and classroom environments. 2.2.3 The Dean would hold each member of the Dean's Council responsible for the implementation of guidelines, policies and procedures based on the model and recommendations. 2.2.4 Faculty, staff and students would evaluate the committee and diversity and inclusion policies, procedures, climate and other outcomes (annually). Before the development of an acceptable model and its application, departments and other units can implement at least three of the specific activities and exercises under 2.2.2. The results can also be evaluated.

2.3	**Timeline**	2.3.1 September 2011: Appointment of the committee and its leadership. 2.3.2 June 2012: Implementation and evaluation of the highlighted activities. 2.3.3 June 2012: Development of the model and recommendations for the application of the model to policies and procedures and evaluation of outcomes. 2.3.4 June 2013: The application of the model to remaining policies and procedures. 2.3.5 Annually: Evaluation of processes, the model and resulting outcomes.
2.4	**Resource Requirements**	2.4.1 Leadership from HPM departmental diversity and inclusion committee 2.4.2 Volunteers from each department and school-level unit. 2.4.3 Time dedicated to increasing diversity and inclusion of the School (give opportunity).
2.5	**Measurable Results**	2.5.1 The appointment of a leader for the diversity and inclusion integration committee. 2.5.2 The formation of the diversity and inclusion integration committee, with noted representation. 2.5.3 The development of a school-wide model, with guidelines. 2.5.4 The adaptation and implementation of the model by all departments, school-level units, and student organizations 2.5.5 The Dean's evaluation of each Dean's Council member's contribution to the implementation of this recommendation as part of each individual's annual performance review. 2.5.6 Department chair and unit leaders' evaluation of faculty, staff and students' contributions to the implementation of this recommendation and as part of each individual's annual performance review.
2.6	**Metrics to Assess Results**	2.6.1 Whether or not the following actions meet the recommended timetables: • The appointment of the committee's leader (2.5.1). • The formation of the committee (2.5.2). • The committee's development of a model and guidelines for policies and guidelines (2.5.3). • The adaptation and implementation of the policies, guidelines and evaluation metrics (2.5.4, 2.5.5 and 2.5.6). • Performance review evaluations (2.5.5 and 2.5.6). 2.6.2 The composition of the committee compared against the requirement of faculty, staff and student participation representing all departments and school-level units. 2.6.3 Positive changes in or high levels (more than 50%)of faculty, staff and students': • Awareness of this recommendation and the results. • Satisfaction with the committee, processes and the resulting policies and guidelines, including those related to academics. • Morale. • Assessments of overall climate, morale, diversity and inclusion. • Engagement in and contributions to diversity and inclusion efforts.
2.7	**Proposed Champion**	2.7.1 All members of the Dean's Council 2.7.2 Volunteers 2.7.3 HPM diversity and inclusion faculty leaders
2.8	**Assumptions**	4.8.1 These efforts will diminish the insular composition or nature of departments and units that creates detachment and prevents the notion of a school-wide approach. 2.8.1 A model similar to one used by HPM is scalable for a school–wide model. 2.8.2 Faculty, staff, and students will be motivated to volunteer. 2.8.3 Recommendation is achievable and the results are measurable. 2.8.4 HPM diversity and inclusion faculty leaders will agree to be actively involved in setting-up the committee and providing expertise and experience 2.8.5 There are enough faculty and staff representatives who are familiar with diversity from a departmental or unit perspective to complete the committee as instructed. 2.8.6 Creation of a volunteer committee with mandatory departmental representation would ensure that each department participated in inclusion. 2.8.7 The resulting model is responsive to legitimate differences in departmental and other units' cultures.

Recommendation 3: Leadership and Accountability for Diversity and Inclusion

3.	Recommendation :	**The Dean would appoint a school-level director or dean who would lead or oversee ongoing diversity and inclusion efforts, including assessing outcomes, helping to ensure accountability, securing resources and providing inspiration and support.**
3.1	**Potential Impact**	This outcome is imperative because: 3.1.1 Regular assessments that support ongoing accountability would help ensure ongoing efforts and growth around diversity and inclusion. 3.1.2 The decentralized nature and size of the School requires a dedicated leader to help ensure continued focus on diversity and inclusion and comprehensive and consistent assessments. 3.1.3 Prospective faculty, staff and students and other stakeholders often look for designated positions or offices as a signal about the importance of diversity and inclusion. 3.1.4 A dedicated and central resource could develop knowledge about the SPH experience and recommended practices that would help facilitate cohesiveness and equity across the school. It is critical that this recommendation not be seen as taking away the Dean's Council or all faculty, staff and students' responsibility for the school's climate.
3.2	**Implementation Plan**	3.2.1 The Dean would appoint an Assistant/Associate Dean for Diversity and Inclusion. As a short-term step, the Dean would ask a faculty or assistant/associate dean to initiate this role on a part-time basis. 3.2.2 The diversity and integration committee would advise the Dean on the necessity for a school-wide Office of Diversity and Inclusion, similar to the UNC School of Nursing's Office of Multicultural Affairs and led by this new position. See notes in section 3.9.1 and 3.9.2. 3.2.3 If recommended by the committee, the Dean would create the new office. 3.2.4 The diversity and inclusion integration committee would recommend the responsibilities for this position and office (if needed) to include: • Regular assessments of diversity and inclusion policies and their implementation, including and not limited to: ○ Surveys ○ Focus groups ○ One-on-one interviews • Regular reports on diversity and inclusion in SPH. • The securing of grants and other resources to support diversity and inclusion. • Collaboration with faculty, staff and students throughout the school. • General support of departmental and other units' efforts. • An appropriate link to the Ombuds position. 3.2.5 The Dean would appoint an advisory group for this position/office. The diversity and inclusion integration committee would also advise the Dean on the responsibilities and composition of this group. 3.2.6 The Dean's Council would publicly recognize faculty, staff students and departments/units with excellent diversity and inclusion efforts and/or outcomes. 3.2.7 The advisory group and/or the Dean's Council would collect and report evaluations of this position/office.
3.3	**Timeline**	3.3.1 Within six months of the DITF's final report: Appointment of a part-time leader. Within 12-18 months of the DITF' final report Appointment of this new dean. 3.3.2 Within the fiscal year following the diversity and inclusion integration committee's recommendation: Creation of a new office (if recommended). 3.3.3 Within six months of the creation of a new office: Creation of an advisory group. 3.3.4 Spring 2012: Dean's Council recognition of diversity and inclusion efforts and outcomes.

3.4	**Resource Requirements**	3.4.1 3.4.2 3.4.3 3.4.4	Salary and benefits for a new dean. Administrative support staff for this dean and an office (if recommended). Funding for assessments and support of the advisory group. Resources for data collection (e.g., focus groups, surveys, interviews).
3.5	**Measurable Results**	3.5.1 3.5.2 3.5.3 3.5.4 3.5.5 3.5.6	The appointment of a new Assistant/Associate Dean for Diversity and Inclusion. The creation of an Office for Diversity and Inclusion (if recommended). The articulation of the purpose, responsibilities and expectations for this new position/office and how they would be evaluated by the community. The activities of this new position/office. The announcement of public recognition of SPH community achievements on diversity and inclusion. The creation of an advisory group.
3.6	**Metrics to Assess Results**	3.6.1 3.6.2	Whether or not the creation of the new position, advisory group or office (if recommended), and Dean's Council recognition meets the timetables. The new dean would be evaluated using appropriate performance review policies and procedures (based on the nature of the appointment), including feedback from the community.
3.7	**Proposed Champion**	The Diversity and Inclusion Task Force	
3.8	**Assumptions**	3.8.1 3.8.2 3.8.3 3.8.4 3.8.5	This new dean would: • Report directly to the Dean. • Collaborate with all SPH units. • Support (and depending on timing) lead the diversity and inclusion integration committee. The Dean, departments/academic programs and other major units would provide financial support for this position/office. One leader can help the School and its units stay on track with the range and volume of diversity and inclusion initiatives throughout the School. The Committee's recommendation for or against a new office would consider the School's overall structure and resources. As much as possible, the evaluation of diversity and inclusion efforts would rely on existing evaluation mechanisms (e.g. course evaluations or program exit interviews).
3.9	**Notes and Other Recommendations**	3.9.1 3.9.2 3.9.3	Part of the OC Groups sees the pending change in leadership for the Office of Student Affairs (fall 2011) as an opportune time to consolidate student diversity responsibilities into an office of diversity and inclusion. This recommendation needs careful consideration. Student services staff, degree program directors, other faculty and students throughout the school (dozens of people each year) engage in activities with a diversity and inclusion component related to students. They talk to prospective students, admit students, advise students, etc. And, some of those efforts need to vary based on legitimate department-specific challenges. It would be difficult for one office or position in this School to take responsibility for all of those efforts. As proposed in this section, a dean in this area would provide leadership and collaborate with the multitude of people throughout the School who would be responsible for diversity and inclusion efforts specifically aimed at students. UNC School of Nursing's Office of Multicultural Affairs ○ The vision is: *To create a welcoming, accepting, and supportive environment for students, staff, and faculty to live, learn, grow, and pursue dreams.* ○ The mission is: *To develop and support the UNC-Chapel Hill SON agenda that addresses and impacts the most salient multicultural issues shaping the lives of people in a global society* ○ The rules of engagement are: *Achievement, acceptance, fairness, and merit are pursued aggressively; Zero tolerance for assaults on another's self-esteem; All encounters are filled with candor, truth, intentionality, sensitivity, and humor; Data are used to address excellence, equity, effort, efficiency, and effectiveness; We encourage story-telling, from which comes true understanding; A bias towards action; We will follow the facts where they lead us* The recommendation for the creation of a diversity and inclusion office is not

unanimously supported by the OC Group. The current financial environment is causing the school to rethink the role of separate offices for major initiatives. While diversity and inclusion should be held as a priority on par with global health or research, the diversity and inclusion integration committee may be in a better position to recommend a support structure for the proposed new dean that fits with the school's organizational evolution.

3.9.4 Recommended specific assessment content (for recruitment, diversity and curriculum):

- Are issues being addressed?
- Are department chair and other leaders seen as the locus for affecting change?
- Is there a tangible difference seen by faculty, staff and students?
- Are faculty, staff and students more likely to entertain new thoughts presented by leadership or peers?
- Other diversity and inclusion measures:
    - Annual percent distribution of SPH student applicants, accepted, matriculated, and graduated by race, ethnicity, first generation, and with a disability.
    - Annual percent distribution of SPH tenure-track and fixed-term faculty applicants, interviewed, offered a position, and hired by race, ethnicity, and with a disability.
    - Annual percent distribution of SPH tenure-track and fixed-term faculty reviewed for a promotion, promoted, denied promotion, and resigned by race, ethnicity, and with a disability.
    - Annual percent distribution of SPH staff applicants, interviewed, offered a position, and hired by race, ethnicity, and with a disability.
    - Annual percent distribution of SPH staff reviewed for a promotion, promoted, denied promotion, and resigned by race, ethnicity, and with a disability.
    - Annual number of certificate programs, cross-listed course offerings, and seminar series that include a health equity component, SPH faculty as lead instructor, co-instructor, or guest lecturer.
    - Annual number of scholarships, endowed professorships, grants, and awards embarked for and received by students, faculty, and staff by race, ethnicity, and with a disability.

Recommendation 4: Links with External Groups

4.	Recommendation :	Faculty, staff and students would create or enhance links between the School and UNC-Chapel Hill campus resources and other community groups to foster a more diverse and inclusive environment and increase support.
4.1	**Potential Impact**	The potential impact of these linkages would be: 4.1.1 Closer coordination of diversity and inclusion strategies, resources, and efforts between the School and the rest of the UNC-Chapel Hill campus for: Student recruitment, enrollment, retention, and timely completion of degree requirements; Faculty recruitment, appointment, retention, and timely promotion; Staff identification, hiring, and retention 4.1.2 Increased resources or support for the School's faculty, staff and students. 4.1.3 Greater transparency of the School's and the rest of the UNC-Chapel Hill campus' diversity and inclusion policies, procedures for assuring accountability, and guidelines for assessing services and other resources. 4.1.4 Increased multidisciplinary diversity and inclusion-related collaborations among UNC-Chapel Hill's 14 schools (including ours) and the College of Arts and Sciences, including adding a health equity component to certificate programs across campus, more cross-listing of related courses, and engagement via seminars.
4.2	**Implementation Plan**	Related to resolving issues related to diversity and inclusion: 4.2.1 Faculty and staff would be encouraged to utilize the University's Ombudsman Office. 4.2.2 HR staff across the School would be charged with annually communicating this Information to faculty and staff, including at new hire orientations. 4.2.3 Students would be directed to the appropriate office of the Vice Chancellor of Student Affairs or the Graduate School. 4.2.4 Degree program directors and the School's dean of student affairs would be charged with communicating this information to students via program guides/handbooks, online/social media and orientations. Related to other types of collaborations: 4.2.5 Faculty, staff and students across the School would engage in diversity and inclusion building activities with units and organizations external to the School. The new assistant/associate dean for diversity and inclusion [See Recommendation 3.] would: 4.2.6 Develop a mechanism for collecting information on external links and collaborations. 4.2.7 Complete bi-annual reports on existing links and collaborations. 4.2.8 Lead an effort to prioritize existing and proposed links and approaches based on how they support diversity and inclusion goals, especially related to climate. 4.2.9 Host an annual meeting of faculty, staff and students engaged in these links, including partners outside of the School. 4.2.10 Collect feedback to evaluate efforts.
4.3	**Timeline**	4.3.1 Fall 2011: Faculty, staff and students would be informed or reminded of campus resource as part of orientations and the updating of policies/guides (4.2.1 – 4.2.4). 4.3.2 Within a year of appointing a new dean, that position would host this annual meeting (4.2.9) 4.3.3 Ongoing: Faculty, staff and students would continue to support current links (4.2.5). 4.3.4 Starting in the second term of the new dean: Develop information mechanisms and reports and collaborate with internal and external stakeholders to prioritize linkages and evaluate them (4.2.6 – 4.2.8, 4.2.10).

4.4	**Resource Requirements**	4.4.1 Faculty, staff and student time 4.4.2 UNC campus offices staff time 4.4.3 Dean for diversity and inclusion (and support staff) time and possibly database development/evaluation resources 4.4.4 Refreshments and materials for an annual meeting
4.5	**Measurable Results**	The development of the following: 4.5.1 A data collection mechanism (where possible tied to other data collection efforts) 4.5.2 Bi-annual reports and other communications on current activities. (e.g., via the website, social media, regular news emails). 4.5.3 The creation of priorities based on diversity and inclusion goals. 4.5.4 The existence of an annual meeting of engaged faculty, staff and students. 4.5.5 Actual activities/collaborations, including recognition of achievements.
4.6	**Metrics to Assess Results**	1.8.1 Whether or not the following is created on the proposed timeline : • The data collection and evaluation mechanisms • Reports and communications • Priorities • Annual meetings • Actual activities, including recognition 4.6.2 The level (e.g., number of people or proportion of groups or units) of faculty, staff and students engagements in these recommendations, including use of campus resources to resolve issues. 4.6.3 Faculty, staff and student awareness and assessments of (e.g., satisfaction, changes in behaviors) of these links and collaborations.
4.7	**Proposed Champion**	4.7.1 The Dean's Council 4.7.2 The new dean for diversity and inclusion (long term)
4.8	**Assumptions**	These linkages will: 4.8.2 Be accessible and safe for faculty, staff, and students. 4.8.3 Help prevent exclusionary behavior and increase feelings of inclusion within the School 4.8.4 Increase opportunities for diverse students from different departments to gather together. 4.8.5 Address and decrease feelings of loneliness that may accompany diversity, and create space for expressing diverse points of view. 4.8.6 While UNC-Chapel Hill is engaged in the search for an Associate Provost for Diversity and Multicultural Affairs, <u>now,</u> the School is uniquely positioned to take the initiative of (1) addressing the current void in campus-wide coordination of programs and resources to address diversity issues, and (2) calling attention to the *body politic* of public health benefits from diversity and inclusion. A sample listing of existing programs and resources with which SPH could establish or enhance linkages are: <u>Campus Groups</u>: American Indian Studies; Carolina Women's Center; Carolina Latina/o Collaborative; Institute of African-American Research; NC Health Careers Access Program (NC-HCAP); Sonja Haynes tone Center for Black Culture and History; Upward Bound; Gay, Lesbian, Bisexual, Transgender, and Straight Alliance; Office of Student Academic Counseling; Office of Disability Services; Pre-Orientation; Summer Bridge; Black Student Movement; Carolina Indian Circle; Carolina Hispanic Student Association; Sangam; Asian Student Association; Advisory Alumni Association; UNC Health Careers Opportunity Programs (UNC HCOP); The Graduate School's diversity person; Health Affairs Pipeline Initiatives (HAPI); UNC Division of Student Affairs, Campus Y, Carolina Union, Carolina Center for Public Service, ACRED- UNC Alumni Committee on Race and Ethnic Diversity

			Community Groups: Visions, Inc.; Peoples' Institute for Survival and Beyond; Racial Equity Institute; NC Alliance for Diversity in Health Professions; Indian Health Board; NC Commission of Indian Affairs; NC Alliance of Disability Advocates; Center for Creative Leadership; CHICLE Other Colleges and Universities: North Carolina Central University, Campbell, Shaw, St. Augustine, Bennett College, UNC Pembroke, UNC Wilmington, Western Carolina University
		4.8.7	Linkages should be made by faculty, staff and students throughout the School, not just a new dean.
		4.8.8	The diversity and inclusion integration committee would also make recommendations for how this effort should be integrated into the other initiatives.
		4.8.9	Faculty, staff and students would also be encouraged to start with departmental and School support services and personnel.
		4.8.10	An office of diversity and inclusion could also provide some support initially shifted to external offices.
		4.8.11	Departmental and unit initiatives would eventually reduce the need for external support to resolve diversity and inclusion issues.

Recommendation 5: An Ombuds for Diversity and Inclusion

5.	Recommendation :	**The School would identify and support an ombuds dedicated to diversity and inclusion.** **An Ombuds is a person trained to assist members of a community or organization through safe, confidential and anonymous means and provide dispute resolution and an educated response.**
5.1	**Potential Impact**	This outcome is important because it would: 5.1.1 Help establish new and enhance existing links with similar efforts on campus. 5.1.2 Keep the School on the cutting edge of diversity training and climate improvement. 5.1.3 Decrease the number of disagreements and amount of pent-up anger. 5.1.4 "Give voice" to people who ordinarily are too reticent to speak up. 5.1.5 Provide a feedback loop between anonymous informants and other committees within the School. 5.1.6 Provide a sanctuary or safe house for people who are less powerful. 5.1.7 Based on experiences with students, staff, and faculty issues, be a key informant on the expressed and demonstrated needs related to diversity and inclusion efforts.
5.2	**Vision Similarity and Implementation Plan**	Although Recommendation 3 establishes a school-level leader for diversity and inclusion issues, this recommendation sets a broader standard by highlighting the importance of having this specific role and having the position dedicated to the School and focusing on faculty, students and staff. The importance of this role in modeling and promoting a safe and inclusive climate in the School merits an independent recommendation and consideration for a separate resource allocation. 5.2.1 The Dean's Council would hire a resource to serve in this role. 5.2.2 The new dean of diversity and inclusion would work with the UNC Ombuds and Office of Student affairs to define the position's roles and responsibilities and ask them to take the lead on any evaluations of the role.
5.3	**Timeline**	5.3.1 Six months after the hiring of the dean for diversity and inclusion: Hire an Ombud for the School. 5.3.2 Annually: Conduct performance reviews based on relevant HR practices and including feedback from the community. 5.3.3 Until the School resource is in place: Encourage the community to use the UNC Office.
5.4	**Resource Requirements**	5.4.1 Salary and benefits 5.4.2 Publicity and reporting resources.
5.5	**Measurable Results**	5.5.1 The appointment of an ombuds. 5.5.2 The articulation of the purpose, responsibilities and expectations for this new position/office and how they would be evaluated by the community. 5.5.3 The activities of this new position/office.
5.6	**Metrics to Assess Results**	5.6.1 Whether or not the creation of the new position the timetable. 5.6.2 This position would be evaluated using appropriate performance review policies and procedures (based on the nature of the appointment), including feedback from the community.
5.7	**Proposed Champion/ Metaphor**	The goal of the School's ombuds should be In keeping with public health's paradoxical vision which includes both protecting the health of vulnerable populations and maximizing the efforts towards and results in population and community health. The Ombuds can risk being viewed solely as a complaint taker/spreader/resolver while missing out on the unique opportunity they have by virtue of their role to also serve as educator and standard bearer of a unified vision made up of and utilizing all the diverse parts. The goal would be an ever improving unity amid an ever growing diversity. The Ombuds should maintain pathways for diverse individuals to maintain their individuality while becoming part of the holistic school effort that should include all departments and units, faculty, staff and students acting to improve community health. A metaphor

		for this is a school of public health "public health sauce." A good sauce has a certain essential base, which consists of the collaboratively established and collectively accepted values, principles, mission, and vision of public health and the school. Examples include community as client, epidemiology as science, social justice as philosophy, socio-ecological model of health as theory, and primary prevention, protecting vulnerable populations, and achieving excellence as key values. Added to this common base are the "ingredients" of the values, identity, and lived experience of each individual. When mixed into the sauce, these ingredients do not change the fundamental character of the base, but rather enhance its character. They are not subsumed or lost in the sauce, but instead synergistically augment the taste of the whole, while at the same time are able to still be tasted/recognized as a part of the sauce by a discriminating taster. The master taster is the Ombuds while the Master Chef and Champion is the multi-headed Dean's Council which adds and mixes the various ingredients of the School. The master taster is a sage individual whose experience and modeling of what is quality is respected and emulated by all in the community and sets the high standard for behavior. This independent yet highly visible Ombuds, should possess great emotional intelligence and skill and provide a great deal of service to and support of diversity efforts. Their goal would be to "work their way out of a job," teaching each of us to be unifying ombudspersons, by being part of a world/school that respects and values each other. The Ombuds would likely need to be hired towards the end of the process to make sure they are hired to be consistent with the School's models, policies and practices, so that the hiring person cannot say, "If I'd known they would need to do this in the Ombuds job, I wouldn't have hired this person."
5.8	**Assumptions**	The Ombuds would: 5.8.1 Have the authority, resources and sponsorship needed to succeed. 5.8.2 Be an experienced, skilled facilitator. 5.8.3 Ideally be an independent position, not answering to anyone in the School There may be a transition phase in which other units of UNC that have resources who could partially serve in this role are utilized. They might be a boundary spanner, serving in the Ombuds position for several organizational units of the same school or across departments or schools 2.4.1 Be hired by representatives of all units of the School to help ensure acceptance of the hire and no saying, "He/She wasn't my choice; I didn't choose that person!" 2.4.2 Eventually require a full FTE.
5.9	**Questions for further consideration**	5.9.1 Where should this person come from? Outside, inside, close, far away? 5.9.2 Do we have enough resources to keep this position without giving them other duties? 5.9.3 How do we keep this person both independent and perceived as such? 5.9.4 Can the person truly be independent and still have sufficient understanding of the School's varied environments and units? 5.9.5 How can this person not be viewed as a complaint depository/bearer of bad news? 5.9.6 How should the success of the recommendation be measured? 5.9.7 Should this role have an advisory group? Separate or the same as existing or proposed groups? 5.9.8 Who would this person report to? The advisory group? A UNC office?

Appendix H.ii: Recommendations for: Recruitment and Retention

1.	Recommendation :	Partner with the Minority Student Caucus to cultivate more prospective students and faculty by taking greater advantage of the Annual Minority Health Conference and William T. Small, Jr., Keynote Lecture broadcast.
1.1	**Potential Impact**	Increase the School's national visibility, build additional external partnerships and tie more closely the recruitment activities to public health that will lead to enrollment of a more diverse student body and faculty.
1.2	**Implementation Plan**	Step 1: Hold a discussion of past MSC/MHC leaders. Step 2: Identify ways to facilitate the work of the Caucus officers and MHC Planning Committee so they can accomplish more with less time and effort, such as making links to secondary schools and community colleges statewide. Step 3: Preserve and disseminate the MSC's and the School's history in promoting health equity and combating underrepresentation to highlight the School's commitment to diversity and reinforce recruitment for underrepresented students and faculty.
1.3	**Timeline**	1-3 years
1.4	**Resource Requirements**	Staff support/GRA
1.5	**Measurable Results**	Result 1: Number of partner conferences Result 2: Number of faculty members of interest presenting at the Conference Result 3: Number of prospective students attending the Conference Result 4: Number of conference attendees who apply for admission to SPH.
1.6	**Metrics to Assess Results**	Metric 1: Metric 2:
1.7	**Proposed Champion**	Dr. Victor Schoenbach (Which people or groups should ensure implementation, results and sustainability?)
1.8	**Assumptions**	Your beliefs about what is true in regard to this recommendation [descriptive]

2.	Recommendation :	Continue to develop targeted opportunities for underrepresented minority alumni to participate at all levels through local and regional events
2.1	**Potential Impact**	Greater visibility, stronger and more expansive network, potential to increase support for scholarships and professorships.
2.2	**Implementation Plan**	Step 1: Continue to add on to existing cultivation activities at the School level, e.g. Minority Health Conference opening reception in 2012; Step 2: Add on to cultivation activities at the regional level, e.g. events in Atlanta or Washington D.C. Step 3: Utilize connections with Alumni Committee on Diversity and Inclusion members and PHF Board leadership.
2.3	**Timeline**	3-5 years in conjunction with 75th Anniversary planning
2.4	**Resource Requirements**	Acknowledge that additional staff support will be needed to maximize opportunities.
2.5	**Measurable Results**	Result 1: Number of persons to whom marketing materials are distributed Result 2: Number of placements Result 3: Number of alumni visits to the School Result 4: Amount of giving increase (change in percentage of minoritized alumni giving) Result 5: Documented cases of successful outreach efforts
2.6	**Metrics to Assess Results**	Metric 1: Metric 2:
2.7	**Proposed Champion**	Mr. Steve Couch
2.8	**Assumptions**	

3.	Recommendation :	Improve the sharing of recommended practices across departments and programs regarding the recruitment and financial resources for students, faculty, and staff from underrepresented backgrounds.
3.1	**Potential Impact**	Increased recruitment and financial resources identified for all departments and programs based on efforts that have been successful in previous years.
3.2	**Implementation Plan**	Step 1: Incorporate an agenda item regarding the recruitment and retention of diverse students, faculty, and staff to the Student Services Council meetings and the Human Resource Representatives meetings. Step 2: Additionally, identify a diversity champion in each department who can help facilitate the sharing of recommended practices across departments. Step 3: Concurrently, departments and programs would elicit feedback from minority student graduates on their experience as a student to inform the development of enhanced recruitment/retention efforts. Step 4: Department representatives to these meetings would report on the diversity agenda items to their respective department Chairs. Step 5: Concurrently, identify other Schools at UNC that have minority recruitment and financial resource efforts in place and what invite a representative to share their recommended practices.
3.3	**Timeline**	1-3 years
3.4	**Resource Requirements**	none
3.5	**Measurable Results**	Result 1: Written reports on recommended practices shared between departments.
3.6	**Metrics to Assess Results**	Metric 1: Metric 2:
3.7	**Proposed Champion**	
3.8	**Assumptions**	

4.	Recommendation :	**Expand the criteria for acceptance of students with exceptional potential for contributions to public health who may not meet traditional criteria for admission and develop preparation and support systems contingent with admission.**
4.1	**Potential Impact**	Increase diversity among student body, graduates, and alumni
4.2	**Implementation Plan**	Step 1: Encourage departments/programs to use holistic approaches in evaluating student admissions through identification and consideration of current state-of-science on predictors of success. Step 2: Identify course that may be required prior to degree coursework in public health. Step 3: Consider the development of pre-curriculum workshops possibly using the model of the UNC Kenan-Flagler School's "Pre-Curriculum: Analytic Skills Workshops" Step 4: Alert assigned faculty advisors to contact the admitted student early to put any support systems necessary in place. Step 5: Provide feedback to minoritized applicants who did not get accepted into a department the first time and encourage them to pursue additional coursework or preparation that will strengthen their future applications. Steps 6; Concurrently, Department designee will contact top rated minoritized applicants who declined admission to the School and inquire what influenced their decision to go elsewhere.
4.3	**Timeline**	3-5 years (sufficient time to establish graduation rates to relevant student sub-groups).
4.4	**Resource Requirements**	Development of workshops would incur expense
4.5	**Measurable Results**	Result 1: Admission/matriculation rates Result 2: Retention and graduation of students enrolled under this recommendation
4.6	**Metrics to Assess Results**	Metric 1: Metric 2:
4.7	**Proposed Champion**	
4.8	**Assumptions**	

5.	Recommendation :	Aim to make departmental diversity goals, plans and annual reports more specific by adding additional content requirements, to departments and programs' annual progress reports to the School.
5.1	**Potential Impact**	Increase engagement of department Chairs and program leaders in diversity as related to recruitment and retention of faculty, staff, and students, thereby increasing overall diversity in departments and programs.
5.2	**Implementation Plan**	Step 1: Require each department Chair/program leader to include diversity goals for R/R of faculty, staff, and students and to report on progress toward these goals annually. Step 2: A new item in the yearly progress report to the Dean would indicate a department's specific goals for diversity and targeted timeline for reaching those goals. Step 3: Identify faculty/staff who will champion these goals Step 4: Concurrently, designate a faculty member(s) to lead recruiting efforts that take place outside of formal searches and report on their progress. Step 5: Explore alternative student recruitment strategies like targeting pre-med students not pursuing a medical degree of developing partnerships with HBCUs in NC to help develop public health interest among undergraduates. Step 6: Develop links with agencies/organizations outside the University like the Society of Professional Hispanics headquartered in Raleigh.
5.3	**Timeline**	1-3 years (1 year for first two metrics; 3 years for third metric).
5.4	**Resource Requirements**	Targeted hires may require resources.
5.5	**Measurable Results**	Result 1: New diversity content added to Chairs/leaders yearly progress reports. Result 2: Responses of Chairs/leaders to those items. Result 3: Attainment of diversity goals stated in reports.
5.6	**Metrics to Assess Results**	Metric 1: Document how (spoken or written), how often, and to whom department Chairs and program leaders communicate diversity goals to others in their departments/programs.
5.7	**Proposed Champion**	???
5.8	**Assumptions**	

Appendix H.iii: Curriculum

DITF Curriculum Recommendation Subcommittee
Draft 1: Recommendations

Background: In March 2011, the DITF shared seven possible recommendations with the DITF Curriculum Recommendation Subcommittee (CRS). To determine which of the recommendations to pursue, the CRS conducted a brief survey asking all 17 subcommittee members to rank the seven possible recommendations (a) in order of importance based on respondents' weighing of the evidence in the DITF Briefing Book and other supporting materials; and (b) according to their own interest in working on each topic.

Ten completed surveys were returned. Three possible recommendations emerged as clear choices for full development by the CRS:

(1) Increase course content and/or courses that address diversity and health issue related to underrepresented minorities;
(2) Develop a unified approach to addressing diversity, inclusion and cultural competencies in Core Courses; and
(3) Include diversity/inclusion topics in all end-of-course evaluations.

During the April 29, 2011 meeting of the CRS, committee members quickly agreed to support Item 2 (*unified approach in SPH Core Courses*) and Item 3 (*including diversity/inclusion topics in end-of-course evaluations*). Upon review of the DITF briefing book and other ancillary materials, however, committee members felt that the data supporting "*increased course content/courses addressing diversity*" seemed less definitive than the data for the other two recommendations. The problem (as suggested by a number of survey responses) may be less that such topics are not addressed in the curriculum than that they are handled in awkward, insensitive ways to the point where minoritized feel shut out of the conversation and, perhaps, feel their perspectives are not valued when such issues arise. Alternatively, course instructors may "sanitize" their way of examining and addressing health disparities; this approach can result in students poorly equipped to understand or respond to the various "isms" (racism, classism, homophobia, ethnocentrism, etc.) encoded in our institutions and culture that are tied to poorer health outcomes in non-majority populations. In short, we may be doing our students a disservice if we do not help facilitate a deeper understanding of how these "isms" play out in people's lives in subtle and not-so-subtle ways. From the survey data, it also seems that students would appreciate more opportunities to discuss challenging issues around diversity/inclusion in more nuanced ways. It may be that instructors could both create more opportunities for such discussions in their classes *and* develop further skill with facilitating such discussions.

For these reasons, the CRS modified its recommendations while continuing to address the aims encoded within the original three recommendations. Modified recommendations are:

1. *Increase course content and/or courses that address diversity and health issues related to underrepresented minorities as needed across programs*;
2. *Increase opportunities for students and faculty to discuss such topics, while focusing attention and resources on encouraging depth and critical thinking in these discussions;*
3. *Develop a unified approach to addressing diversity, inclusion and cultural competencies in Core Courses.*

Efforts toward these overarching goals, as outlined below, should result in improved cultural competency (a core CEPH, ASPH *and* UNC-SPH goal) for instructors and students alike, even as they help reduce feelings of isolation among non-majority students and contribute to a more supportive climate in the School for people of all backgrounds.

Recommendation 1: Increase course content (and one course, as specified below) that address diversity and health issues related to underrepresented minorities.

Recommendation 2: Increase opportunities for students and faculty to discuss such topics, while improving the quality of the discussion(s) arising from D&I content;[1]

Implementation Plan.

Step 1: In AY 2011-12, curriculum committees (or program heads) in each department should facilitate syllabus reviews of required courses for each degree program to determine what D&I content is being covered (and what the gaps are), how it is covered, and whether content/teaching approaches could be improved. Student representatives should participate in the review. Domains to address in the syllabus review should include race, ethnicity, culture, LGBTQ issues, disabilities, religion, political beliefs, and others. Note: departments may wish to pattern their curriculum reviews off the upcoming review to be conducted in the Department of Health Policy and Management. HPM PhD candidate Dio Kavalieratos, in collaboration with HPM Associate Dean Dr. Laurel Files, will conduct this review in AY 2011-2012. Alternatively, program heads could oversee a process in which course instructors could do their own syllabus reviews. This approach would allow instructors to identify D&I content that may not appear in syllabi.

Conducting an assessment will help quantify the extent to which departments address D&I in their curricula and *how* they address such issues. These data should be shared with course instructors, the department chair, and finally to the Dean with the aim of increasing D&I in the curriculum as needed.

The assessment should also illustrate *how* D&I issues are handled in classes. Are there opportunities for students to hold meaningful discussions of/engagement with D&I issues? If not, could those opportunities be created? Do instructors feel confident in designing discussion questions/exercises (and then facilitating those discussions) so that they yield meaningful dialogue among students? If not, would instructors be open to working with someone from the Center for Faculty Excellence to help design at least one or two high quality exercises focused on D&I? Knowing what D&I content is taught and how it is addressed will serve as a starting point for increasing/strengthening D&I content and instructional approach.

Overall goals for the syllabus review are to: increase D&I content, where appropriate; improve articulation across courses; and identify opportunities for discussion, activities, or assignments that would help students explore D&I topics.

Step 2: In AY 2011-12, departments should draw up brief action plans for increasing D&I content, as appropriate, filling in gaps in the curriculum and selectively strengthening D&I teaching approaches based on the curriculum review. Action plans should be designed with the goal of changing at least 2.5% of a department's courses (i.e., the equivalent of about one hour total per 3-credit course), either by (a) *increasing* the D&I content, (b) increasing opportunities for in-class activities/discussion, or by (c) redesigning/improving a current activity/assignment or discussion. Developing an action plan and including measures of change helps ensure that

[1] Note, these two recommendations are interdependent and so are presented together.

departments act on the data they have gathered through their syllabus review. Where possible, curriculum improvements should be adopted immediately. Larger order changes could be implemented in AY 2012-13. **Note: modest adjustments in a number of SPH courses could add up to major improvements in the overall curriculum and in students' experience.**

Step 3: Beginning in Spring 2012, action plans (and steps taken) should be shared with the Dean in departments' Annual Report. These action plans (and departments' steps towards implementing these plans) should be reviewed annually by the Dean during end-of-year reviews over at least the next three years to ensure that departments are making headway in increasing/improving D&I content and instruction.

Step 4: Beginning in AY 2011-12, department chairs should direct all newly hired faculty, together with those teaching a course for the first time, to consult with someone from the *Center for Faculty Excellence* (formerly the *Center for Teaching and Learning*) when they are creating a syllabus and course plan. One general purpose of the directive is to create efficiencies for faculty by helping them craft high quality learning opportunities at a course's inception (rather than asking faculty to "fix" courses later, after they have been teaching a class for several or many years). A more specific purpose of this directive is to have faculty consult with CFE staff in the design of high quality D&I activities, discussion opportunities, and/or assignments.

Step 5: In AY 2011-12, all course evaluations should include questions designed to evaluate (a) instructors' selection and handling of D&I topics and (b) their creation of an inclusive environment (i.e., whether students felt included/respected). The School should select at least four evaluation questions (two closed-ended and two open ended) to be used across all courses in the School to address these two areas. Guidance on this matter can be accessed from the Department of Health Policy and Management, which has already incorporate two D&I-related items on all student course evaluation surveys. Formatted on 5-point Likert-type scales (1 = strongly disagree…5 = strongly agree), the questions are as follows: "The course integrated the perspectives of people with diverse backgrounds and life experiences." and "The instructor established a respectful and welcoming classroom environment for all students, where I felt comfortable expressing my opinions." It's likely that the data bank for UNC's new online course evaluation system has other items that would address both issues. Departments may also choose to add additional D&I course evaluation questions.

End-of-course evaluations often help instructors address problem areas in their courses. At the department and School levels, these data will provide important baseline information about how well SPH courses address D&I topics and discussions. It will also provide further information on how to improve as departments and as a School. Over time, the Associate Dean for Academic Affairs or her designee should compare D&I course evaluation items across years to identify trends, areas for improvement, etc. After three years, a small, ad-hoc committee of faculty, students and staff could be convened to evaluate the effectiveness of the changes and offer suggestions for continued improvements and/or adjustments. The final report from this group would go the Dean and department chairs for consideration.

Step 6: By Spring 2012, the School should offer a stand-alone elective course focused on LGBTQ issues, with the long-term aim of teaching it once every-other year. In Fall 2010, public health students in the Health Sciences LGBTQ Alliance submitted a white paper to the DITF ("Lesbian, Gay, Bisexual, and Transgender Health Is Public Health: Looking towards the future for the UNC Gillings School of Global Public Health") offering strong evidence that the SPH needs to address LGBTQ issues in the curriculum. Since then, SPH advanced doctoral students Derrick Matthews

(HBHE) and Dio Kavalieratos (HPM) have created a draft syllabus for such a course, including readings, assignments, activities, and potential guest lecturers. The proposed course is trans-disciplinary and should be open to students from across the School. Drs. Noel Brewer and Bryan Weiner have offered to serve as "instructors of record;" although advanced doctoral students from HBHE and HPM will expend the majority of instructional effort. Adding such a course in Spring 2012 would indicate a high level of responsiveness to the excellent work of SPH students in having created such resources. It also represents "low hanging fruit" in that we already have instructors and high quality course materials that are ready to go and a great deal of good will and support among a well-organized constituency. In the longer term, it would be advisable to identify a member of the faculty willing to teach the course as an elective every-other year.

Step 7: By Fall 2012 (and preferably by Spring 2012), the School should initiate a workshop series (at least two workshops per year, held early in each semester), in partnership with the *Center for Faculty Excellence*, focused on designing assignments, activities or class discussions on D&I topics. Alternatively, some workshops could be developed in partnership with *Dismantling Racism* (www.dismantlingracism.org), a community-based organization in North Carolina designed to help organizations that are working to understand and address racism, within their organizations and in the communities where they work. Departments should set a goal of having all faculty participate in one workshop at least once every three years. This opportunity should also be extended to staff when the topics are relevant to their work or lives. Responsibility for organizing and hosting workshops could be assigned to a small, departmentally diverse committee with rotating membership. Committee members would identify topics and design workshops/discussions in tandem with representatives from the Center for Faculty Excellence. The CFE could then facilitate the workshops. Having such workshops will create opportunities for faculty to come together across departments, both to strengthen their teaching of D&I topics, and to strengthen their cultural competency. Hosting regularly scheduled workshops in the School provides faculty with needed instructional resources, even as it may generate open dialogue about difficult D&I topics.

Recommendation 3: Develop a unified approach to addressing diversity, inclusion and cultural competencies in Core Courses.

Background: To maintain the School's CEPH accreditation, all MPH students are required to pass an introductory course in each of the core public health disciplines: biostatistics, health policy and management, environmental science, epidemiology, and health behavior and health education. Currently, each of these core courses is administered by the home department associated with the disciplinary area in question. Faculty that teach core courses do meet on a semi-annual basis to discuss issues common across courses [or have in the past]. However, course content has generally been left to instructors, given that all courses need to meet the many CEPH requirements of their respective disciplines, and given that the courses meet the needs of many constituencies (e.g., residential, degree-seeking students; continuing education students; distance education students; undergraduates, etc.).

As a way of addressing the uneven quality of the public health core courses, the Dean's Office has recently made a call to: (a) centralize the teaching of the courses and (b) thoroughly update (and possibly integrate) the courses into a one-year (or two year?) sequence. In the event that such a comprehensive review and updating of core courses **does** take place, it would be strategic and efficient to use this opportunity to develop a unified approach to addressing diversity, inclusion and cultural competencies in core courses. Such a unified approach could

manifest in any number of ways. For example, instructors could design one or more diversity case studies that thread through the five courses, allowing students and instructors to approach a set of D&I topics through the five different disciplinary lenses. Possibly a debate or discussion could be scheduled once per semester in which students are placed in small groups that include class members from each of the 5 core courses, so that each of the five lenses could be represented in a discussion. Many other ways of developing a unified approach to addressing D&I topics (and cultural competencies) may emerge from the core course review. In other words, the approach to implementing this recommendation should be left to the discretion/creativity of lead instructors. If they need support in this effort, however, we recommend working with staff at the Center for Faculty Excellence as they have a strong reputation for helping faculty design high quality courses, class sessions and assignments. Developing a unified approach to addressing D&I topics in core courses helps ensure that all MPH students gain at least some competence in working with such topics across public health disciplines. It also promotes dialogue across departments for how to approach teaching of these topics.

Note: The implementation plan for *Recommendation 3* mirrors, in many ways, the implementation plan for Recommendations 1 and 2.

Implementation Plan

Step 1: At the time when SPH core course instructors are asked to redesign/integrate their courses, the leader of this effort (Dr. Anna Maria Siega-Riz) should also ask instructors to conduct a syllabus review to determine what D&I content is being covered (and what the gaps are), how it is covered, and whether content/teaching approaches could be improved. Again, domains to address in the syllabus review should include race, ethnicity, culture, LGBTQ issues, disabilities, religion, political beliefs, and others. Student representatives should participate in the review.

Conducting a syllabus review will help quantify the extent to which each core course addresses D&I and *how* it addresses such issues in the classroom. Are there opportunities for students to hold meaningful discussions of/engagement with D&I issues? If not, could those opportunities be created? Do core course instructors feel confident in designing discussion questions/exercises (and then facilitating those discussions) so that they yield meaningful dialogue among students? If not, would instructors be open to working with someone from the Center for Faculty Excellence to help design at least one or two high quality exercises focused on D&I? Having conducted the syllabus review, do instructors spot opportunities for synchronizing their approach to D&I topics with other core courses? The overall goals of the syllabus review are to: increase D&I content, where appropriate; identify opportunities for discussion/activities that would help students explore D&I topics; and improve articulation across courses.

Step 2: In tandem with the overall course updates, core course instructors should aim to change at least 2.5% of their course (i.e., at least one hour of class time per 3-credit course), either by *increasing* the D&I content, increasing opportunities for in-class activities/discussion, by redesigning/improving a current activity, assignment, or discussion, and/or by designing an activity/topic that threads through all 5 courses. Including such modest measures of change helps ensure that instructors will act on the recommendation without overburdening them with a recommendation of wholesale change. The leader of this effort (Dr. Siega-Riz), and perhaps the School's APC committee, should oversee the process in order to ensure that course changes get adopted. *Again, modest adjustments in SPH core courses could add up to major improvements*

in the overall curriculum, in students' experience, and in instructors' confidence and competency in handling such challenging topics.

Step 3: In AY 2011-12, all SPH core course evaluations should include several questions designed to evaluate instructors' (a) selection and handling of D&I topics and (b) creation of a more inclusive environment than presently exists. Once the core course redesigning has taken place, end-of-course evaluations should also include (c) a question addressing whether core courses are taking a unified approach to D&I topics and whether they are successful in that effort. End-of-course evaluations often help instructors address problem areas in their courses. At the School level, having these data will give us important baseline information about the degree to which the courses offer a thoughtful, unified approach to engaging with this material. Over time, the Associate Dean for Academic Affairs should compare the evaluations across years to identify trends, areas for improvement, etc.

Step 4: TAs facilitate much of the discussion that happens in core courses. Given that many TAs are new to the instructor role, they may benefit significantly from receiving some professional development in this domain. To that end, beginning in AY 2012-13, the Associate Dean for Academic Affairs or her designee should be responsible for designing a workshop in partnership with the *Center for Faculty Excellence* focused on leading discussions on D&I topics. All TAs for required core courses should be required to attend. The workshop should be participatory and interactive, not simply didactic.

Timeline, Recommendations 1 and 2

1. Increase course content (and add one course, as specified) that addresses diversity and health issues related to underrepresented minorities
2. Increase opportunities for students and faculty to discuss such topics, while improving the quality of discussions arising from D&I content.

Action Steps	Fall 2011	Spring 2012	Summer 2012	Fall 2012	Spring 2013	Summer 2013	Fall 2012	Spring 2013	Summer 2013	Fall 2013	Spring 2014
Step 1: Syllabus Review											
Step 2: Action Plan for increasing/strengthening D&I content by 2.5%											
Step 3: Submit action plan as part of department Annual Reports											
Step 4-A: Include D&I measures in course evaluations for all core courses in SPH degree programs											
Step 4-B: Compile, analyze and share data on course evaluations re. D&I measures											
Step 4-C: Evaluate effectiveness of changes; recommend adjustments											
Step 5: New faculty advised to consult with Center for Faculty Excellence											

Action Steps	Fall 2011	Spring 2012	Summer 2012	Fall 2012	Spring 2013	Summer 2013	Fall 2012	Spring 2013	Summer 2013	Fall 2013	Spring 2014
Step 6-A: Initiate course on LGBTQ											
Step 6-B: Institutionalize course on LGBTQ											
Step 7-A: Initiate D&I workshop/seminar series (earlier, if possible)											
Step 7-B: 100% of faculty participate in at least one D&I workshop/seminar											

Timeline, Recommendation 3

Develop a unified approach to addressing diversity, inclusion and cultural competencies in SPH core courses

Action Steps	Fall 2011	Spring 2012	Summer 2012	Fall 2012	Spring 2013	Summer 2013	Fall 2013	Spring 2014	Summer 2014
Step 1: Syllabus Review*									
Step 2: Instructors develop strategies for increasing/strengthening D&I content by 2.5%*									
Step 3-A: Include D&I measures in course evaluations for all core courses in SPH degree programs									
Step 3-B: Compile, analyze and share data on course evaluations re. D&I measures									
Step 3-C: Evaluate effectiveness of changes; recommend adjustments									
Step 4: TAs participate in D&I class facilitation workshops									

*Note, these steps should be timed/adjusted to coincide with the upcoming review of SPH core courses, to be led by Associate Dean Anna Maria Siega-Riz.

Appendix 1: DITF Definition Team Summary

The way we define both diversity and inclusion is extremely important as we move forward. Throughout the year, members of the DITF expressed impassioned interest concerning the School's choice of definition. The DITF as a whole struggled to adequately summarize the collective thoughts and feelings on this matter. To address this, twelve (12) members of the DITF formed the "DITF Definition Team" in April of 2011. The Definition Team met face-to-face on multiple occasions and corresponded via email to review, discuss and formulate a definition of diversity and inclusion for the SPH. The activities are summarized briefly below.

Diversity versus inclusion: One definition or two?
In May 2011, the group met to: A) reflect on diversity and inclusion as autonomous concepts that are interrelated and connected, B) review suggested definitions to date, C) review definitions used by other institutions and D) decide if the School needed a definition in addition to the DITF Wordle. This discussion led to the following conclusions:

- The School needs a definition in addition to the Wordle.
- The definition should encompass both diversity and inclusion, keeping in mind that diversity is the overarching word and inclusion refers to the climate in which we diversely live.

Writing a definition
Based on these conclusions, Definition Team members submitted possible definitions to be reviewed by the group. Submitted definitions were either aspirational or descriptive and varied in length. In June 2011, after review and discussion, the group decided the definition should be:

- Short (10 words or less)
- Aspirational in nature
- Actionable (something we do, rather than something we are)

Next, the group identified key words to be included and those to be avoided.

The final definition
Recognizing that no one definition will be perfect for everyone, the group worked to find one that made everyone feel substantially comfortable. Nine definitions were created using the agreed-upon components. The group ranked their preferences until there were two top choices. The final definition was written by merging the top two choices together. The Planning team made the decision to add a clarifying statement about how we use diversity and inclusion to achieve our School's mission and vision.

In summary,
Diversity and inclusion means we welcome, value, and learn from individual differences and perspectives.

More than just a definition, diversity and inclusion are tools to help us accomplish our mission and vision.

J. The Case for Diversity and Inclusion: Selected References

Challenges To Using A Business Case For Addressing Health Disparities

For health care organizations, the social case for reducing health disparities should be just as important as the business case.

Nicole Lurie, Stephen A. Somers, Allen Fremont, January Angeles, Erin K. Murphy and Allison Hamblin

Abstract

The authors consider the challenges to quantifying both the business case and the social case for addressing disparities, which is central to achieving equity in the U.S. health care system. They describe the practical and methodological challenges faced by health plans exploring the business and social cases for undertaking disparity-reducing interventions. Despite these challenges, sound business and quality improvement principles can guide health care organizations seeking to reduce disparities. Place-based interventions may help focus resources and engage health care and community partners who can share in the costs of—and gains from—such efforts.

Dolores Acevedo-Garcia and colleagues write powerfully about the root causes of racial and ethnic disparities in health, indicating the need to go beyond conventional public health and health care interventions to "increase the opportunities for healthy living in disadvantaged neighborhoods."[1] We also need to understand the role of the health care system in the context of disparities by looking at the quality of care minorities are receiving and understanding the role of plans and providers in doing what they can to improve minority health and making sure the quality of care is equitable. Here we explore issues surrounding making a business case for addressing health and health care disparities in health care organizations.

Setting the Context

The Institute of Medicine's (IOM's) seminal report, *Crossing the Quality Chasm,* articulated six quality aims for the U.S. health care system: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.[2] Essential to achieving the equity aim are efforts to reduce racial/ethnic or socioeconomic disparities in health care and health outcomes.

A key component of the equity aim is to increase accountability by monitoring and improving the quality of clinical care for individual patients and populations. Health care organizations contemplating interventions to address disparities on their own often assess whether there is a

"business case" for doing so. Specifically, these entities may want to know whether the investment in a given intervention will produce the desired outcome, which may range from improving the ability of the organization to optimally provide services in the future, to saving money in future health care costs, or increasing market share. Indeed, some medical or quality directors working within health care organizations seeking to address disparities need to project a positive return on investment (ROI), to gain institutional support for their efforts.

Common challenges faced by those considering the ROI implications of interventions are twofold: first, returns (whether financial or otherwise) might not be realized for many years after the investment is made—particularly those related to chronic diseases other than asthma or congestive heart failure, for which some utilization-based savings can be more rapid.[3] Second, any returns might not go to the investors but instead might be realized years later by other parties who might not have been involved in the intervention at all. Part of this is the result of narrowly held ideas about what constitutes an intervention (for example, expanding language access is not usually considered an intervention but may improve quality and safety), or because patients frequently change health plans or practices. Part is also because, as we discuss later, returns may accrue well beyond the health care system.

Another major challenge, more specific to disparities, arises when one is assessing the ROI for interventions. Until recently, the lack of data on race/ethnicity in the health system has precluded routine detection of disparities in quality of care and accountability for reducing them. In our view, this has seriously impeded the development of interventions, and related infrastructure, to address disparities.[4] In this context, persuading decisionmakers to invest in obtaining data on race and ethnicity—a prerequisite to considering the business case—can be challenging because many still assume that no significant disparities in care exist within their systems. This is the case not only for the gold standard of self-reported data on race, ethnicity, and language but also for indirect, or estimated, methods for obtaining the information.[5] The Catch-22 is that these decisionmakers have no real way to find out about disparities or optimal ways to address them until such data have been obtained and analyzed and different strategies tested. This conundrum can, unfortunately, focus the discussion on the business case for obtaining data, thereby disconnecting it from the broader goals of achieving equity and addressing disparities. Understandably, many health care organizations will question the value proposition for obtaining data alone, particularly when obtaining self-reported data for large proportions of a population can take years and may require changes to an already complex information technology infrastructure.[6]

Despite such challenges, a growing number of health plans and hospitals have begun collecting race/ethnicity data and have detected disparities among commercially insured and Medicaid populations.[7] For example, health plans participating in the National Health Plan Collaborative (NHPC), a group of eleven large insurers working together to address disparities, have obtained race/ethnicity data from either self-reported or estimated methods and have used those data to identify important disparities within their care systems. Some of these plans have also been exploring the value propositions involved.[8] These include not only identifying activities for which there is a business case (that is, there is a positive short-term ROI), but also clarifying the social case—that is, whether the activities or interventions provide a "benefit to the individual (patient) or to society of improved health status and productivity regardless of cost."[9]

Challenges to Assessing ROI

On the surface, it would seem that the ROI for a given intervention should be relatively straightforward to assess. However, in addition to the common challenges described above, health plans struggle to measure disparities over time and to account for the benefits (and costs) of either the data collection or the intervention, as well as how to attribute changes in market share to a given intervention. To begin with, capturing the input costs in order to measure ROI may be complex. Attributing changes in market share to these efforts is also difficult, as is valuing the increase in reputation or brand equity that may result from such efforts. Further, information about what works is slow to diffuse, and it is still not clear which interventions produce which results.[10] Therefore, even once the disparities in quality are documented, we lack the tools to reliably estimate what it takes to reduce them. Finally, no convincing evidence exists that improving quality, regardless of disparities considerations, actually generates a positive ROI. Although a recent meta-analysis found evidence of a positive ROI for interventions to improve quality for some diseases, such as congestive heart failure, the evidence for a positive ROI for improving the quality of care for many other conditions is mixed.[11]

Quantifying the social case related to reducing disparities is even more challenging. The social case may be measured, for example, in terms of increased wages or productivity from better health and reductions in absenteeism, or averted costs for disability payments or to the end-stage renal disease (ESRD) program from reductions in diabetes-related complications. A 2002 study conducted for the American Diabetes Association found that diabetes care in the United States accounted for $132 billion in direct and indirect costs.[12] Minority populations, who disproportionately suffer from diabetes and related conditions, tend to have worse outcomes and to generate a significant portion of these costs even when insured. Although Sandeep Vijan and colleagues estimated a per person, per year cost of nearly $3,200 in lost productivity as a result of diabetes, robust methodologies for estimating racial/ethnic or socioeconomic disparities in lost productivity are not well developed.[13] And as previously mentioned, with regard to health care interventions, it is not clear how to quantify the level of societal investments that must be made, in either the short or the long run, to eliminate or even reduce these disparities and realize the social benefits.

Several NHPC plans have explored aspects of the business and social cases associated with interventions to improve quality and reduce disparities. Their experiences corroborate the challenges outlined above.[14] Some found that these efforts require substantial access to financial data, including the program costs required to develop, implement, and operate initiatives, and to health care claims to assess changes in utilization patterns over time—data that are often challenging to obtain. Further, they report that such analyses are mainly suited to interventions and outcomes that are measurable in a reasonably short time frame, since the business case becomes less meaningful to any given organization over time, because of membership churning, near-term financial priories and pressures, and ability to accurately forecast impacts. They note that the business case would be easier to assess if interventions were implemented with strong evaluation designs that could isolate intervention effects associated with the business case. But such studies are complex and resource-intensive. In the absence of valid design and comparison groups, though, it will be difficult to isolate true financial savings from artifacts caused by factors such as selection and regression to the mean.

A final complication is that one health care entity's short-term ROI may be another one's loss. For example, if a health plan can save money by reducing emergency department (ED) and inpatient care for congestive heart failure, the local hospital may well suffer a loss of revenue. Such financing misalignments may serve as disincentives for addressing disparities. Stakeholders need to understand the financial implications for the multiple organizations involved (purchaser, plan, hospital, and physician) and may need to realign financing so that there can be cost sharing—and gain sharing—of any savings. However, methods for efficiently doing the necessary financial analysis or the actual risk sharing have not yet been fully developed.

Steps Can Be Taken To Reduce Disparities

Despite these challenges, a combination of business and quality improvement principles may still be able to guide health care organizations seeking to reduce disparities. For example, using Pareto charts and the 80-20 rule—that 80 percent of the problem, be it costs or disparities, arises from 20 percent of patients—they can begin to focus their efforts and, ideally, target scarce resources more effectively. Even absent gold-standard data on patients' race/ethnicity, they can focus on health care settings, whether a hospital or a provider's office, that simultaneously serve large numbers of minority patients and provide poorer-than-average quality of care. Support for this approach can be found in work by Peter Bach and colleagues, which found that approximately 80 percent of African Americans were cared for by 20 percent of physicians, often in under-resourced settings in which providing high-quality care was challenging.[15] Targeting intervention opportunities can also be improved by using geographic information system (GIS) tools to map and highlight concentrated areas of poor quality as small as the census-tract level. For instance, several NHPC plans are using these approaches to highlight local "hot spots" and salient characteristics of those areas to help develop and target interventions.[16]

In their paper, Acevedo-Garcia and colleagues argue that such pockets of poor care for minority populations have their roots in racial segregation, whose impacts are felt broadly, including in low-opportunity neighborhoods that also likely generate many of the nonmedical determinants of health.[17] In these and other respects, instead of going it alone in these neighborhoods, a health care organization may reap greater efficiencies—and results—by partnering with other community stakeholders (such as employers, community groups, public health agencies, and others) on broader initiatives to improve quality and reduce disparities, both for its own ROI and for the broader social good. Policymakers increasingly accept that interventions within the personal health care delivery system, while important, may do little to address the root causes of those disparities, and to be effective, these efforts must be combined with broader community and policy efforts.[18] Partnerships among multiple health care organizations, with significant market share in low-opportunity neighborhoods, could lower the intervention costs for any one health care organization. Additional partnering with other community stakeholders can also increase the likelihood of effectiveness and sustainability of interventions. The Centers for Disease Control and Prevention (CDC) has found through its Racial and Ethnic Approaches to Community Health (REACH) and Steps programs that interventions that involve multiple partners may also be more likely to close the gap in intermediate outcomes (such as diabetes or lipid control).[19]

The experiences of organizations in working toward fulfillment of the IOM's equity aim call into question whether all interventions require a strictly defined business case and force us to reconsider, also, the social case for doing so. They highlight the reality that even if making the business case for addressing disparities is ultimately necessary, accurately determining the business case in the current environment will continue to be challenging. Further complicating the calculation is the likelihood that the ratio of returns to costs will improve, as routine collection and use of race/ethnicity data become more common and widespread in quality monitoring and improvement efforts and more effective interventions and supporting infrastructure are developed. What is more clear is that the business case for any one plan or other health care entity to further engage in addressing disparities could also be helped by changes within and external to the larger health care system—at the individual, health system, employer, and societal levels—that better align incentives, regulations, and interests of various stakeholders in ways that promote elimination of disparities and improve equity along with the other key aims laid out by the IOM.

Editor's Notes

Nicole Lurie (lurie@rand.org) is senior natural scientist and the Paul O'Neill Alcoa Professor at RAND in Arlington, Virginia. Stephen Somers is president and chief executive officer of the Center for Health Care Strategies (CHCS) in Hamilton, New Jersey. Allen Fremont is a natural scientist and sociologist at RAND in Santa Monica, California. January Angeles is a program officer at the CHCS. Erin Murphy is a research assistant at RAND in Arlington. Allison Hamblin is a program officer at the CHCS. RAND and the CHCS are two of the coordinating and managing partners of the National Health Plan Collaborative, whose activities are recounted in this Perspective.

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NOTES

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Making a Business Case for Reducing Racial and Ethnic Disparities in Health Care: Key Issues and Observations

Randall R. Bovbjerg
Harry P. Hatry
Elaine Morley

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Making a Business Case for Reducing Racial and Ethnic Disparities in Health Care: Key Issues and Observations

The persistence of racial and ethnic disparities in American health care is an important problem for society, for medical caregivers, and of course for the people disadvantaged.[1] Numerous remedial efforts have been launched, including the Finding Answers program of the Robert Wood Johnson Foundation (RWJF),[2] along with other public and private initiatives.[3] Central components of the disparities-reform agenda are

- documenting the existence of consequential disparities in treatment or results;
- developing and disseminating information about interventions that successfully reduce disparities in care or improve the quality of care for minority patients; and
- generating supportive business cases for improvement.

This brief report focuses upon the third aspect of building the case for change—the need for disparities-policy innovators and researchers to create business cases that support useful interventions across a wide variety of caregivers and health plans. The core idea is that ways are needed to encourage caregivers and related organizations to spend the time, effort, and money needed to make effective improvements. Thus, this report does not address the difficulties in obtaining solid evidence of significant health improvements for disadvantaged populations, which is arguably the central thrust of RWJF's Finding Answers program.[4] We address the issues and challenges in developing the business case for ongoing implementation of improvements that are found to be effective in improving clinical processes or outcomes.

Our report draws in part upon information and insights developed as we assessed ways to help improve the operations of Finding Answers and its national program office (NPO) at the University of Chicago.[5] Finding Answers projects address disparities in caring for three chronic conditions—cardiovascular disease, depression, and diabetes—which are rather common, have great impact on patients' lives and on healthcare spending, and whose care is believed to feature wide disparities yet relatively clear standards of care.[6]

The goal of this report is to make suggestions about future activities under the Finding Answers program that affect business-case development, as well as to illustrate more general lessons with specifics from early program experience. We seek to lay out the issues involved in establishing a case for wider adoption of promising health care interventions. Developing good business cases is an important aspect of developing the "*practical* blend of strategies and interventions that work to measurably reduce" disparities [emphasis added], which is the goal of Finding Answers.[7]

I. What Is a Business Case and Why Is It Important?

Leatherman and colleagues provide a useful definition of a business case.[8]

> A *business case* for a health care improvement intervention exists if the entity that invests in the intervention realizes a financial return on its investment in a reasonable time frame, using a reasonable rate of discounting. This may be realized as "bankable dollars" (profit), a reduction in losses for a given program or population, or avoided costs. In addition, a business case may exist if the investing entity believes that a positive indirect effect on organizational function and sustainability will accrue within a reasonable time frame.

Caregivers and many other actors in health care likely do not mainly think of themselves as in *business* or as making *investments* in search of a return. They are mainly seeking to provide good care for their patients. Yet this definition usefully focuses attention on the need to support disparity-reducing actions based on some form of "payoff" in the future. The payoff needs to be at least commensurate with the effort needed to implement and operate the intervention in question. Most interventions come with some cost, if only to overcome the inertia of accustomed ways of providing services. In well managed offices, clinics, and other organizations,

there is likely also a new administrative cost associated with overseeing new modes of operation and, one hopes, also tracking their effectiveness in meeting organizational goals, including provision of good care and staying on budget.

Another way to frame the issue is not to use the financial term "investment," which connotes a one time purchase of a tangible asset, but rather to speak of up-front expenses to implement an intervention, followed by ongoing costs over time to continue to affect patient care over time. The expected stream of future operating costs can be thought of as an investment, in that an entity adopting an innovation commits to them in advance, and they have a predictable current value. Thus, there is a business case if the current value of all expected costs is less than the current value of all expected payments, or, in other words, if the net present value of expected cash flows is positive.[9]

This definition also helpfully emphasizes that *a business case must be made from the perspective of the actor undertaking an initiative*. Making a business case implies a narrow framework of assessment—what's in this for us? In the case of health care disparities, particularly for Finding Answers, the usual perspective is that of the health *caregiver* treating a minority patient. For example, a clinic's initiative may promote *professionals'* ethical norms or add value by improving its *patients'* health status or even just making care more convenient for them. However, from the clinic's *business* perspective, those benefits do not matter in and of themselves—unless they somehow generate sufficient revenue, cost savings, or other things of value to the *clinic* to warrant spending on the initiative.[10]

The viewpoint is also narrow in that it is almost wholly a *business* or *fiscal* perspective. That is, what matters most are cash outflows and inflows. (Broader economic or social perspectives are also important in the larger picture, and are considered in the next section.) However, indirect impacts are also relevant, and other things than service-generated or other future revenues may have practical business value from the perspective of an innovator. For example, a disparities-reducing initiative might better align care processes with the entity's mission and better motivate staff productivity, or better quality might attract more paying patients or more talented professionals. Such matters seem likely to be highly situation-specific and hence warrant detailed explication.

The *timeframe* or time horizon is another major point. The longer an entity must wait to cover its expenses, the higher the eventual payoff must be. Formally, this means that business cases compare *present values* of expenses and revenues, after discounting future cash flows for the time value of money and expected inflation.[11]

It is important for disparities reduction to consider business cases because promising interventions, such as those emerging from Finding Answers grantees, almost inevitably add some new costs to the "production" of care. Such expenses may be attributable to adding personnel, better educating patients or providers, or undertaking another activity found to be useful. Especially in this time of very tight funding and increasing focus on controlling health

care costs, any new cost can pose a substantial barrier to a health care organization's willingness to introduce new interventions. This practical reality holds true even though the intervention may be expected to add value, by reducing disparities in care provided, by raising the quality of minority services, by reducing the "downstream" need for services, or by improving the future health of disadvantaged patients.

Finally, as Dunston and colleagues persuasively suggest,[12] just indicating "the right thing to do" to reduce disparities often may not provide enough motivation to act—or the wherewithal for even well motivated entities to take action. Rather, "to be sustainable," changes "may require linking to financial incentives." In short, some form of positive business case is likely to be needed to encourage ongoing use of an initiative among initial innovators and, even more, to encourage others to change accustomed practices and adopt new modes of operation.

II. Business Cases Compared with Broader Perspectives

A business case focuses relentlessly on finances. It may be complained that, as some say about economists, a business case knows the cost of everything and the value of nothing. More precisely, a business case simply seeks to recognize fiscal reality and to help health care actors cope with it. Existing funding mechanisms are arguably the fundamental force in shaping such practical reality for caregivers and other actors in health care. Service-based payment methods and insufficient appreciation of quality differences are widely seen as substantial impediments to creating a business case for better care[13] and for reducing disparities.[14]

To improve care and reduce disparities thus also likely calls for building broader cases for change. These cases need to recognize values beyond increased revenues or decreased costs at the level of an innovation in care. Leatherman and colleagues distinguish two types of such cases, either of which might be used to promote more thoroughgoing change. The first they term the "economic case." This broadens the perspective of a business case to ask whether "discounted financial benefits exceed discounted costs, [regardless of] whether they accrue to patients, employers, providers or payers, or some other segment of society."[15] An analogous example comes from a study of disparities in care between the uninsured and insured: Near-elderly populations that lack health insurance receive less medical care and can be expected to cost the federal government more when they become later eligible for Medicare.[16] A provider taking care of uninsured near-elderly patients has no business motivation to give them uncompensated care so as to benefit Medicare later—but there is an overall economic case for improving insurance coverage.

The "social case" goes even further, to consider the *value* of non-fiscal benefits achieved for patients, families, and society. These include better health and functioning, longer lifespan, and greater contributions to the community. In this context, extending lives is a good rationale for authorizing new funding, even though it may not create fully offsetting savings elsewhere.

Making economic cases calls for assessing more data, over a longer timeframe than are available to the grantees of Finding Answers projects, for example. The method of comparing discounted financial costs and benefits remains the same, however. Making the social case calls for some form of cost-effectiveness or cost-benefit analysis, which use different forms of valuation. The former typically compares two activities, e.g., standard treatment vs. innovation, in terms of their cost per standardized outcome, e.g., number of life years saved, possibly quality-adjusted, again in terms of present values.[17] Cost-benefit analysis calls instead for assigning a monetary value to benefits in order to compare them directly with the costs of any proposed activity, also in present values.[18]

Positive economic or social cases are needed to change private and public funding flows and other rules that affect the delivery of care, e.g., conditions of participation in health plans. Those changes could in turn affect funding flows so as to allow more positive business cases to be made for improving quality generally and for reducing disparities.

III. General Observations about Business Case Perspectives

The main players in a position to take action—or support action—to reduce disparities are the following:

- Health care organizations—the clinics, physician groups, and hospitals that directly provide health care services and routinely interact with patients;
- Patients and their families—who directly bear the non-monetary costs of chronic conditions and also pay for some care themselves, a higher share if they are uninsured;
- Private health plans and workplace groups—the entities that pay for most care of working age people and families through insurance or self-insurance; and
- Public funders—including Medicare, Medicaid, and public health departments, which disproportionately fund care for minorities, mainly through service payments, but also through grants, disproportionate-share hospital payments, and otherwise.

This section sketches some important issues from the perspectives of these groups.

Health Care Organizations

Caregivers are the central actors for many or most initiatives to reduce disparities, including under the Finding Answers program. A particular focus is front-line or primary providers that serve as regular sources of care for people with chronic conditions. Their decisions influence patient education, directly determine the routine and preventive services that hold promise of improving health, and indirectly influence other care via their referrals to specialists and inpatient care. Hence they seem to be central to reducing disparities in care and in outcomes and perhaps also in modifying patient behavior in positive ways. Almost all of the Finding Answers projects in the first two rounds of grants were health care providers.

Much of the discussion above of business cases took the perspective of caregivers, who need to be able to pay for disparities initiatives. A number of challenges are notable. A key issue is how providers are paid. Almost all grantees interviewed appeared to receive fee-for-service payment

from third-party health plans, private and public, and many initiatives involved using non-traditional staff to help educate patients or help them navigate their treatment. A key issue for such interventions is thus simply whether that additional service is billable on its own or as part of a clinic or office visit, and thus increases revenues.

If, on the other hand, an improvement reduces the need for future services provided by the entity itself, the improvement will reduce its own future revenues. In that case, the financial impact or effect on the business case will depend upon whether the lost service would have earned net revenues. (Analogously, hospitals can lose financially by improving quality and reducing readmissions.[19]) Capitated providers, in contrast, benefit by providing good care through fewer services. Most Finding Answers grantees have been safety net clinics and hospitals. Some of them seem to receive grants or other blocks of funds in recognition of their key role in serving uninsured people, including minorities; the fiscal incentives of such blocks of funds are similar to capitation, in that the entity benefits by reducing utilization through better care.

If an improvement reduces the need for future services provided by other health organizations, the innovator will still not benefit. The fiscal benefits created by an intervention will then mainly go to others, a form of what public finance terms "externalities." A classic example is preventable hospitalizations. Better diabetes management may reduce hospitalization rates, which may be professionally satisfying for a clinic's care team, but only the payer for hospitalization and, often, the patient benefit financially from this effect.

Savings from an intervention will be most obviously helpful to the intervening entity if they take the form of reducing the cost of producing a service. For example, improved patient-educational materials, the use non-physician staff, or other changes in the process of care might reduce the physician time needed to provide a service or care for a patient. If the same fee-for-service payment is earned, the provider will benefit. Lowered costs of producing care will be most helpful of all if they occur in the short run.

Otherwise, where future savings or other benefits occur too far into the future, they will not be of much help to innovators' business case, as already noted. This effect is a kind of temporal externality. The time discount already mentioned is one reason for this, but there are at least two others. One is that the fiscal year is often the decisionmaking time horizon for providers, especially safety-net facilities that receive line-item or grant funding of some kind. Another is that staff and management often seem to expect that their patients are sufficiently transient that some other provider is apt to reap any future benefits achieved by the first provider's efforts.

On the face of it, chronic illnesses cause great harm and high health spending but do so over a patient's whole lifetime. Accordingly, the payoffs from better care or modified behavior may occur much later in life. The very high costs of diabetes, suggested one interviewee, were sufficient to offset the time delay. The accuracy of that observation goes beyond the scope of this brief. It also goes beyond what Finding Answers grantees can address in their short-term

projects. But estimating reasonable time series of effects of reducing disparities ought to be a priority for others at the foundation or the NPO.

Patients with Chronic Conditions

Minority patients, like others, have a role to play in improving their health status and health care. However, the "business case" for living healthier lives and seeking out better treatment—seemingly strong for people who suffer directly from shortcomings—appears insufficient. If patients could act effectively on their own, disparities in care and outcomes would not be the problem that they are. Many interventions seek to engage patients in better managing their conditions or better navigating health services. Some interventions involve a financial incentive, typically a positive one, as an encouragement to patients. In Finding Answers projects, such incentives included bus vouchers to cover transit to health care and a free DVD player on which to watch educational materials. The business case for such efforts seems best assessed from the perspective of the provider of the incentive—likely a health provider or public health program—than of the patient-recipient of any incentives. The practical and ethical aspects of using negative financial incentives as a motivator go beyond the scope of this report.

Private Payers and Workplace Groups

For working Americans and their families, private insurance pays for the bulk of care.[20] Although one cause of racial and ethnic disparities is that minorities are disproportionately likely to be uninsured and hence underserved, disparities exist even where minorities are insured. Accordingly, a business case may exist to make quality improvements for insured people, especially for minority enrollees and especially for chronic illnesses.[21]

The Finding Answers program sought to attract health plans as demonstrators of the effectiveness of disparities interventions. Only a single plan participated in the program's first two rounds of grants, however.

Some general observations about health plans can still be made. The good news is that insurers pay for most health care services, so cross-provider externalities are not a problem, and any utilization savings achieved should be reflected in reduced benefit claims. Moreover, insurers have data systems that should be able to track changes in patterns of spending. However, whether cost-of-production savings will be passed through in lower provider fees is uncertain. Moreover, insurance contracts run only year to year, so health plans that themselves sell to individuals and small employer groups that frequently change carriers lack a long time horizon for cost recovery as the basis of a business case.

Workplace health plans, however, reflect the interests of their employer purchasers, and self-insured plans *are* the employers. Moreover, larger employers can expect employee-patients to remain with the firm for longer periods (perhaps especially so if they have chronic medical conditions that make it difficult to shift medical plans). Further, employers also internalize the added costs of sub-optimal health care, including disparities. Shortcomings in care may not only

raise employees' medical/insurance costs but also likely increase absenteeism and reduce their productivity while on the job. Fellow workers' productivity may also be affected.[22]

The less good news is that tracking race and ethnicity is more of a challenge, and so is crafting effective interventions. Prominent large employers and some large insurers have supported disparities reduction.[23] It may well be that working in tandem with health care providers could have the most effect, as health plans would appear able to create strong incentives but to have fewer direct levers over patient care or behavior. Employers, however, do have direct influence over workers, although issues of confidentiality arise over generating person-specific information.

For efforts like those of Finding Answers, a key to attracting employers may well be to provide evidence that available interventions are sufficiently promising to warrant employer/insurer investigation of their business cases from the health plan's perspective.

Governments and Public Health Plans

The final perspective of interest is that of government. Medicare, Medicaid, and lesser public health plans pay for over a third of American health care.[24] Moreover, government departments of public health address population health as well as care for the disadvantaged. Across levels of government, public entities disproportionately fund care for minorities, mainly through service payments, but also through grants, disproportionate-share hospital payments, and otherwise.

Medicaid and Medicare also serve as the ultimate funder for people whose chronic conditions worsen to the point of disability or other exit from the workforce. Within those programs, chronic care claims a dominant share of spending.[25] Furthermore, only government can adopt a lifetime perspective on chronic conditions, can redistribute resources across sectors of care and timeframes, and has a clear responsibility for promoting general welfare. Government regulation also addresses social norms of equity through licensure, conditions of participation in public coverage, and in other ways.

For all these reasons, government can play many roles in addressing disparities. Numerous government agencies have already begun to address disparities.[26] Descriptive analysis suggests numerous potential federal influences or controls.[27]

Finding Answers does not involve governments directly, although at least one grantee is a public hospital system. It reported that the Los Angeles County Health Department has indicated interest in the Round 1 grantee experiments with the use of regular screening of patients for depression.

IV. Specific Observations about Finding Answers Business Cases

Round One Projects' Cost Assessments and Relevance to Business Cases

Findings Answers projects that we reviewed in the course of our interim assessment faced large challenges in making strong business cases for their intervention under existing financing mechanisms. Our central observations follow.[28]

One difficulty was built in from the start of the first round of grants. The program began with the assumption that grants could either be made to "projects or initiatives that are underway in different health care settings" or that grantees would have secured "other funding sources for the bulk of program start-up and implementation costs."[29] Such projects could be expected either to have funding and other supports already in place or to have already "sold" the project to another internal or external source of new support—either of which suggests that the implementer would already have developed a business, economic, or social case for their intervention. But interviews suggested that business cases were not prominent in innovators' thinking.

Our interim interviews done toward the end of round one found that almost all those grantees were new start-ups, so that their projects were essentially pilots rather than mature operations. As pilots, the projects appropriately had to be most focused on the myriad issues of implementation of the intervention itself and of the research on effectiveness. Large efforts were often needed to win staff acceptance and to recruit and retain adequate numbers of patients. When interviewed, first-round grantees were all aware in a general way that they would need to document the costs of what they were doing. However, this effort was not seen as a high priority, or a difficult undertaking, compared with running the project and seeking to document health benefits.

Grantees generally were planning to track the costs of their interventions as an adjunct to reporting on how they spent RWJF grant funds. However, the main costs of intervention were by design to be borne elsewhere. Some appeared to constitute in-kind "donations" of staff time, others piggy-backing on implementation efforts under a separate research grant, yet others possibly general institutional funds related to safety net funding. How well grantees' final reports will be able to account for such support was not clear.

Another difficult issue appeared to be distinguishing between start-up costs and ongoing costs of operation at the demonstration site. This seems especially hard for pilots, many of which seemed to involve mid-course corrections in processes, especially for patient recruitment and retention, which appeared to overlap somewhat with general communication with chronic patients. Moreover, there seems to be a learning curve for implementing new processes, not a clear line of demarcation between start-up and routine operations.

Two interviewees raised an important point for their projects, on diabetes and depression: New patient support and education provided by a form of new health coach or by enhanced

screening seemed to be reducing the physician time needed to provide good care. It was unclear how well projects could track such secondary effects on care processes not directly involved in the intervention. Such effects could be positive like this perceived savings in time, or they could be negative, like the additional record-keeping work for staff nurses cited at another project, or the potential that better educated patients could be more demanding of their physicians' attention.

The short time frame of the interventions and their siting largely within primary care delivery both appear to complicate full assessment of the interventions' potential downstream impacts on care and on health care spending. A partial exception here was the health plan, which was prepared to do health-system-wide accounting, but which had severe problems in obtaining patient participation.

Finally, the main point of documenting the costs of disparities-reducing interventions is to encourage other entities to follow or improve upon the interventions being demonstrated. This calls for clarifying how costs might change past the pilot stage or in other sites that might have different staffing patterns, cost structures, or revenue sources. Grantees interviewed generally appreciated that it is appropriate to document costs in terms of actual resources (e.g., staff time) and not just dollars spent.

However, clarifying the nature of the enterprise within which the initiative was undertaken remains important. For instance, were there diseconomies of scale as the project geared up? Did the intervention benefit from economies of scale because of a clinic's size, for example, that might not exist for subsequent adopters? Was there some "slack" in staffing patterns that facilitated adding responsibilities for some staff? Was the physical layout conducive to altering patient flow? Did the entity have computerized billing and accounting, medical records, and patient communication modalities that facilitated caregiver decision support or some other intervention?[30]

In short, substantial challenges looked likely for the first round of grantees to contribute information fully suitable for building business cases. This should not be too surprising. Assessments of quality-promoting interventions evidently seldom produce the information needed.[31] Moreover, making a business case as such was not a requirement for the projects. Formal guidance on how to do cost analyses was issued after our interviews occurred, at the end of the initial grant period. Accordingly, subsequent efforts may be better placed to track expenses and revenues and contribute to business cases.

Other Observations

Many interviewees clearly felt that research evidence and business cases were not the only or the best way to promote change. Such qualitative indications suggest that that some progress is feasible without strong empirical justification.

Many small elements may make a big difference in receptiveness to change. The following points emerged from interviews:

- Key staffs at innovating institutions were unanimously glad to have participated in Finding Answers, even though grantees almost without exception believed their projects had been underfunded. A substantial pool of professionalism and altruism appears supportive of initiatives, certainly within the self-selected group of safety net leaders and researchers with whom we met. (We talked with fewer lower level staff, some of whom showed less enthusiasm.) This pool can be tapped if circumstances are right.

- The perception of management and medical staff that a substantial health care gap exists is influential. Some healthcare professionals (many, said some round one grantees) believe that disparities in healthcare do not exist in their organizations, or at least that they themselves do not discriminate. Others may believe that even if such disparities exist, they are not an important influence on patient well being.

- One intervention featured a survey of the entity's physicians about perceived racial disparities in providing diabetes care. Prior to the intervention, just over half (57 percent) of intervention group physicians felt disparities in diabetes care existed somewhere within their system of health care providers, fewer in their own health center or among their own patients (45 percent in each case). Perceptions of disparities increased following the intervention, including perceived disparities in treatment of their own health center and patient panel.[32]

- Many Finding Answers participants believed that such consciousness-raising has a role in changing behavior, even if that was not the focus of their effort. The size of the perceived gap was also seen as influencing staff responsiveness.

- Physician belief is important because the level of support from the medical staff seems a key to achieving change. So reassuring them that new processes will be helpful to doctors matters—perhaps save them time, provide them more information they are likely to want, or encourage patient compliance with recommendations for exercise, medication, and diet. In addition, keeping new burdens low is important.

- In general, perceived new costs need to be small, especially in projects like those in round one, which did not feature new financial incentives (e.g., pay for performance). An important element here is the initial start-up costs, both money and effort. So the availability of existing start up materials is important, such as training materials, software, questionnaires, in appropriate languages. Even for attractive interventions, large initial efforts can discourage adoptions. A particular dislike that medical staff mentioned is added paper work.

- Not surprisingly, most round one efforts were designed to have low costs, or to create materials usable by subsequent adopters at low cost.

- One grantee, for example, used existing depression screening tools (the PHQ-2 and PHQ-9) for its intervention which involved administering the tool to adult patients when they arrive

at the clinic for their appointment. The intervention was designed for settings that have little or no funding available for introducing an intervention. The main added costs were for reproducing the screening tool and training for clinic personnel on the purpose of the intervention, how to score the instrument, and cultural sensitivity regarding depression, all low cost items. Refresher training was provided in the first year of the intervention, but on-going training has not been needed.

- DVDs were developed in another project to promote patient self-care, medication adherence, and communication with doctors to reduce cardiovascular disease. Designers explicitly sought to create materials that might be used "as is" by other providers serving low-income African American clients. The DVDs would likely need to reach other minority groups, as the depicted patients are all African Americans and recommendations are culturally targeted. Nonetheless, these DVDs could serve as a model for content and approach for other groups, which should lead to substantial savings in time for other adopters.

- Similarly, another project created training and patient self-care materials on diabetes and translated them into Spanish and Vietnamese for its coached-care intervention. Developing the materials took a considerable amount of time, both to revise them so they can be understood by those with lower literacy levels and to translate them. The availability of materials in three languages was reported to be of interest to the California Medical Association.

- Some flexibility in the way an intervention can be implemented is likely to make it more attractive to other organizations. That way, an intervention be "adjusted" to better fit new circumstances.

- One depression screening intervention was implemented somewhat differently in the two clinics where it was used. One clinic used a two-step screening process. A two-question version of the instrument was administered to all patients. The full instrument was then administered only to those whose responses indicated depression might be present. The other clinic found the two-step process to be too cumbersome and administered the full instrument to everyone. Additionally, one of the clinics had a computerized disease registry that enabled it to track when patients had been screened. That clinic only administered the screening tool at three month intervals. The other clinic administered the instrument at each visit.

- Two of the three DVDs developed by one project were intended for home viewing, with the first video to be viewed at the clinic. Intervention staff indicated that an alternative approach other organizations could use would be to play the videos in clinic settings rather than give them to patients. This would avoid the project's cost of giving patients DVD players to use at home.

- Finding Answers seeks to generate strong research evidence on the effectiveness and affordability of interventions. This is not the only approach supported by grantee-interviewees.

- Important as research evidence may seem, some grantees contemplating how to "sell" their ideas to others suggested that the inherent logic of their intervention and consistency with professional norms carry great weight. Even some of the *unsuccessful* interventions observed seem to hold appeal for other health care organizations, which assume that future implementation procedures can be improved.

- The simplicity and understandability of the innovation is also believed to facilitate subsequent dissemination.

- Dissemination should not be limited to medical literature but should include networking, publicity, and media support (both the professional media and public media) for a successful innovation. These efforts focus on persuading medical organizations and the public, not researchers.

- Gaining researcher support should make it easier to implement innovations. However, this was felt by a number of the grantees we visited that this was considerably less important. Of course, negative assessments of the innovation by researchers could become a major obstacle.

- Availability of revenues to pay expenses of the new intervention is much desired, notably from Medicaid in the case of these grantees. However, even small outside funding to cover out-of-pocket costs seemed important, including for items that insurers will not cover, such as donated merchant gift cards to encourage patient participation.

V. Concluding Discussion

Finding Answers projects faced great challenges in generating strong business cases for their interventions as of the end of their initial grant periods. This is not surprising: most quality initiatives fail to generate all needed data. Moreover, Finding Answers projects had limited timeframes, and the innovating organizations oversee only a modest share of medical spending on chronic care. For round one grantees, lack of cost-assessment guidance early enough to affect data collection planning was an additional handicap.

Improvements should occur under rounds two and three. Still, it is difficult to capture all cost impacts, including indirect ones, even within the implementing entity. Estimating likely costs for future implementers also adds a degree of difficulty.

Our encouragement is to supplement formal analysis with other approaches. One way is to have grantees also provide substantial qualitative information to allow others to interpret whatever level of quantitative estimates they can generate on effects on clinical measures and on organizational finances. It is very important simply to provide a detailed description of the intervention and of the innovating organization's circumstances. Such information includes, for example,

- the logic of the intervention;
- what mid-course corrections occurred;
- why it was attractive or not to different staff and decision makers within the organization;
- what revenue flows support the organization, both earned by services provided and obtained in other ways; and

• key attributes of the organization, especially with regard to staffing.

Another approach to thinking about the business case of a project is to observe its aftermath. The best evidence about the true nature of cash flows and other costs and benefits may come from observing whether the interveners decide to continue using the innovation rather than from their production of peer-review-ready research findings about their results. For a start, observing people's actions often more reliably shows their beliefs than does what they write or say. Moreover, interveners may have strong and justified beliefs that are simply not well documented because of shortcomings in the project design or an unexpected byproduct of the intervention. Another good indicator is whether they are proselytizing for their innovations and with any success.

Moreover, the presence of successful *replications* of a successful innovation is likely to help to provide more convincing, more credible, evidence that a particular approach works—and was affordable. RWJF does not appear to have provided for this, though provision may have been included in the proposed new grant to Chicago.

Given the somewhat constrained perspectives and timeframes of the projects, it may be appropriate to develop the economic and social cases for disparities reduction in a broader context. Such effort might address, for example, the likely effects of a change in payment methods that may occur under national health reform or private insurers' efforts to promote evidence based medicine and value based benefits. Disparities reformers need to assure that pay or performance and like ideas contain risk adjustors that recognize the differential needs of minorities. If it is harder to obtain the same quality for minority patients within a fixed quantum of payment, a new disincentive will be created to care for disadvantaged patients.

It could be also helpful to assess the prospects for enhancing revenues in a broader context. Grantees may not have the best expertise in how to maximize insurance payments, especially from Medicaid and Medicare. In light of the literature-review finding that nurse led initiatives show great promise, the ability to use nurse interveners could be investigated; states different in the extent to which nurses can operate rather independently and bill for their services. Finding Answers explicitly separates itself from how to help the uninsured and finance their access to care. This is also a big issue for minority populations. The extent to which care is funded, however, influences the development of a business case for reducing disparities.

Business case assessment by caregivers may seem callous or even unethical. It's a practical reality, however. No entity can remain in business, whether with an altruistic mission or otherwise, if it consistently operates at losses that funders are not willing to subsidize. To quote one safety-net mantra, "no margin, no mission."

On the other hand, the social case is also important, including the ethical dimension of disparities. Medicare does not cover end-stage renal disease because it saves money by paying for ESRD care. It pays for dialysis and transplantation because they save lives, disproportionately minority lives. Despite the focus in this report on business cases and net fiscal impacts, developing the value proposition for improving minority care remains important.

In the long run, the most important perspective may indeed be that of government. Financially, government pays for over a third of American health care, including most safety net care; and its

payment reforms and rules often drive private methods. Public programs also end up caring for people whose chronic conditions keep them from working. Finally, only government can adopt a lifetime perspective or redistribute resources, and it has a clear responsibility to promote general welfare.

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1 Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, Eds, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care (Washington, DC: National Academies Press, 2003); John K. Iglehart, ed. Racial & Ethnic Disparities, *Health Affairs* (symposium issue) 24(2):312-521 (March/April 2005); Agency for Healthcare Research and Quality. *2008 National Healthcare Disparities Report* (Rockville, MD: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality; March 2009) AHRQ Pub. No. 09-0002 http://www.ahrq.gov/qual/nhdr08/nhdr08.pdf.

2 Finding Answers: Disparities Research for Change, program webpage http://www.solvingdisparities.org; Amy E. Schlotthauer, Amy Badler, Scott C. Cook, Debra J. Pérez, and Marshall H. Chin, "Evaluating Interventions To Reduce Health Care Disparities: An RWJF Program," *Health Affairs* 27(2):568-73 (2008).

3 See, for example, the National Center on Minority Health and Health Disparities (NCMHD), legislated in 2000 within the National Institutes of Health http://www.ncmhd.nih.gov/; the AHRQ National Health Plan Collaborative http://www.chcs.org/info-url_nocat3961/info-url_nocat_show.htm?doc_id=253141; and the National Partnership for Action To End Health Disparities http://www.omhrc.gov/npa/.

4 See note 2 above.

5 Harry P. Hatry, Randall R. Bovbjerg, and Elaine Morley, *Interim Assessment of Finding Answers: Disparities Research for Change*, Washington, DC: The Urban Institute, Final Report to the Robert Wood Johnson Foundation, Draft of December 15, 2008. This assessment was done to suggest improvements based on observations of much of one round of grantee experience. At the time of this additional report, even the first round of grantee experience remained incomplete, as final reports had not yet been delivered.

6 RWJF 2006, above.

7 RWJF, *Finding Answers: Disparities Research for Change, Call for Proposals*, Proposal Deadline March 16, 2006, page 3 http://www.solvingdisparities.org/media/file/Finding_Answers_CFP.pdf.
8 Sheila Leatherman, Donald Berwick, Debra Iles, Lawrence S. Lewin, Frank Davidoff, Thomas Nolan, and Maureen Bisognano, "The Business Case for Quality: Care Studies and an Analysis," *Health Affairs* 22(2):17-30 (2003), at p.18.

9 Reiter KL, Kilpatrick KE, Greene SB, Lohr KN, Leatherman S, "How to Develop a Business Case for Quality," Int J Qual Health Care 19(1):50-5 (Epub 2006 Dec 15); Nicholson S, Pauly MV, Polsky D, Baase CM, Billotti GM, Ozminkowski RJ, Berger ML, Sharda CE, "How to Present the Business Case for Healthcare Quality to Employers," *Appl Health Econ Health Policy* 4(4):209-18 (2005). There are other ways to measure return on investment, as Reiter et al. discuss; the cash flow approach is the most straightforward and readily interpretable.

10 Kilpatrick and Brownson discuss such values in "Beyond Return on Investment: Other Financial and Nonfinancial Business Cases for Self-Management Support in Diabetes Care," chapter 2 in Kerry E. Kilpatrick and Carol A. Brownson, *Building the Business Case for Diabetes Self Management: A Handbook*

for Program Managers, St. Louis, MO: Diabetes Initiative National Program Office at Washington University School of Medicine, report for the Robert Wood Johnson Foundation, February 2008) http://www.diabetesinitiative.org/lessons/documents/BusinessCasePrimerFINAL.pdf.

11 See, for example, "Time value of money," in *Dictionary of Financial Terms* Lightbulb Press, Inc., accessed via http://financial-dictionary.thefreedictionary.com/Time+value+of+money.

12 Frances J. Dunston, Andrew C. Eisenberg, Evelyn L. Lewis, John M. Montgomery, Diana Ramos, and Arthur Elster, "Making a Business Case for Small Medical Practices to Maintain Quality While Addressing Racial Healthcare Disparities," *Journal of the National Medical Association* 100(11):1318-1325 (2008), at page 1320.

13 Molly Joel Coye, "No Toyotas In Health Care: Why Medical Care Has Not Evolved To Meet Patients' Needs," *Health Affairs* 20(6):44-56 (2001).

14 Nicole Lurie, Stephen A. Somers, Allen Fremont, January Angeles, Erin K. Murphy, and Allison Hamblin, "Challenges to Using a Business Case for Addressing Health Disparities," *Health Affairs* 27(2):334-8 (2008).

15 Leatherman et al., above, at pages 18-19.

16 Jack J. Hadley and Timothy Waidmann, "Health Insurance and Health at Age Sixty-five: Implications for Medical Care Spending on New Medicare Beneficiaries," *Health Services Research* 41(2):429-451 (2006).

17 See note 11 above and accompanying text.

18 Ibid.

19 Reed Abelson, "Hospitals Pay for Cutting Costly Readmissions," *New York Times*, May 9, 2009. An aside: Where hospitals receive lump sums of DSH payments, it may be cost effective for them to shift uninsured inpatient care or emergency room care to an outpatient setting, as revenues are unaffected and costs are lowered. The same holds true for improvements in disparities that may reduce utilization; the key is that revenues not be reduced thereby.

20 John Holahan and Allison Cook, "The U.S. Economy and Changes in Health Insurance Coverage, 2000-2006," *Health Affairs* 27(2):w135-44 (Epub 2008, Feb 20); CMS (Centers for Medicare and Medicaid Services). 2008. National Health Expenditures by type of service and source of funds, CY 1960-2006, accessible from http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp.

21 "Nearly three-quarters of the money spent by private insurers goes to treat people who suffer with chronic illnesses such as diabetes, asthma, heart conditions, and depression." RWJF, "Quality & Equality in U.S. Health Care: A Message Handbook," May 2009, p.25.

22 Nicholson S, Pauly MV, Polsky D, Baase CM, Billotti GM, Ozminkowski RJ, Berger ML, Sharda CE. How to present the business case for healthcare quality to employers, *Appl Health Econ Health Policy* 4(4):209-18 (2005).

23 National Business Group on Health, Eliminating Racial and Ethnic Health Disparities; A Business Case Update for Employers, February 2009, http://www.businessgrouphealth.org/pdfs/Final%20Draft%20508.pdf; Patricia Hassett, "Taking on Racial and Ethnic Disparities in Health Care: The Experience at Aetna," *Health Affairs* 24(2):417-20 (2005).

24 CMS (2008), above.

25 Kenneth E. Thorpe and David H. Howard, "The rise in spending among Medicare beneficiaries: the role of chronic disease prevalence and changes in treatment intensity," *Health Affairs* 25(5):w378-88 (Epub 2006 Aug 22).

26 See sources in note 1 above.

27 Nicole Lurie, Minna Jung, and Risa Lavizzo-Mourey, "Disparities and Quality Improvement: Federal Policy Levers," *Health Affairs* 24(2):354-64 (2005).

28 Our interim review covered the period of Finding Answers' first round grants, made to 11 entities. These comments are based on examination of project applications, grant reviews, and other written documentation, augmented by on-site or telephone interviews with important staff for 9 grantees, plus interactions with first and second round grantees at the national program meeting in November 2008. Almost all grantees evidently received time extensions, and at the time this report was undertaken, no final reports were available from the first round of projects.

29 RWJF (2006), at page 3.

30 Kilpatrick and Brownson, above note 10, discuss some of these issues under "Reporting the Effects of Capacity Constraints," at page 7.

31 "Only 15 of 1968 articles identified contained sufficient information on both the costs of implementing quality-enhancing interventions and the resultant changes in costs of care or revenues to permit the calculation of a return on investment," according to the systematic review of Kerry E. Kilpatrick, Kathleen N. Lohr, Sheila Leatherman, George Pink, Jean M. Buckel, Caroline Legarde, and Lynn Whitener, "The Insufficiency of Evidence to Establish the Business Case for Quality," *Int J Qual Health Care* 17(4):347-55 (Epub 2005 Mar 23).

32 Summary findings presented in 2008 Annual Grantee Conference Materials, Finding Answers: Disparities Research for Change (November 20-21, 2008, Chicago, Il.). Based on Sequist, T.D., Ayanian J.Z., Marshall, R. Fitzmaurice GM. Safran D.G., "Primary Care Clinician Perceptions of Racial Disparities in Diabetes Care." *Journal of General Internal Medicine* 2008.

"The Case for Diversity and Inclusion" on page 6 is a very brief summary of a deep and interesting subject. The literature is drawn from public health, health care, and business. It is not exhaustive by any means but might be a starting point for additional reading in several directions: finance-based evidence (strong and weak), the social case, and, a thread running through most articles, the importance of organizational climate as a necessary first step in achieving improvements in diversity and inclusion. We did not find a consolidated paper that provided quantitative evidence of drivers of diversity and inclusions in schools of public health. For students who are looking for an interesting thesis or dissertation topic, take note!

A summary of "business case" definitions, methods, issues, and value as a tool for making and measuring change in healthcare is a report to the Robert Wood Johnson Foundation by Bovbjerg, et al. "Making a Business Case for Reducing Racial and Ethnic Disparities in Health Care: Key Issues and Observations" (June 2009) cites the work of several faculty members in the Health Policy and Management Department, including Sheila Leatherman, Sandra B. Greene, and Kristin Reiter. "Building a business case for diversity" by Gail Robinson and Kathleen Dechant (*The Academy of Management Executive*, August 1997 v11 i3 p21(1), pp 1-8, is slightly old but cites specific data about costs (turnover, absenteeism, lawsuits) of poor diversity as well as evidence that improving diversity can improve business growth, innovation, problem-solving, and leadership effectiveness. Several specific business examples are included. "The business case for diversity: is diversity cost effective?" by Stephen B. Knouse, provides references for diversity's contributions to a number of qualities important to any organization, including customer service, problem solving, critical analysis, innovation, financial performance and market performance. This is a publication of the Military Leadership Diversity Coalition (http://mldc.whs.mil/download/documents/Business%20Case/The_Business_Case_for_Diversity-Knouse.pdf).

"What gets measured gets done: achieving results through diversity and inclusion," by Maureen Giovannini (*The Journal for Quality & Participation*, Winter 2004, pages 21-27) discusses the difficulty of evidence, the importance of culture (including behavior change and managers' skills at promoting teamwork and cooperation across differences), evaluation criteria, and how-to advice. "Is there a business case for diversity? Yes -- But it's not in the numbers," published: January 10, 2007 in *Knowledge@Wharton*, summarizes a panel discussion by business professionals about business practices, personal experience, and the importance of culture and active discussion of diversity. "The enemies of trust," by Robert Galford and Anne Seibold Drapeau (*Harvard Business Review*, February 2003, pages 89-95), is not specifically about diversity and inclusion, but it speaks to the power of organizational climate. Michele Jayne and Robert Dipboye ("Leveraging diversity to improve business performance: research findings and recommendations for organizations" in *Human Resource Management*, Winter 2004, Vol 3, No 4, pp 409-424) challenge some traditional arguments about the benefits often attributed to diversity, but they proceed to identify success factors in effective programs (such as commitment at the top of the organization, skills required by managers, effective metrics, and a realization that change takes time).

Personal stories and insights from faculty and business people make compelling and informative stories. See, for example, "Broadening participation: hiring and developing minority faculty at research universities, by Richard Tapia, in *Communications of the ACM* (Vol 53, No 3, March 2010). Also, "Re: president's message: making the case for nursing workforce diversity," by Roy L. Simpson (*Nur Outlook* 59 [2011] page 5); and "The importance of diversity to public health," by former surgeon general David Satcher, in *Public Health Reports* 123:263, 2008.

Finally, the experiences and stories of the hundreds of people in the SPH community who contributed to the task force provide important evidence in these recommendations.

Appendix K: Examples of SPH Recommended Practices from the HPM Department

HPM Annual Report 2009 – Integrating Diversity into HPM

The Department of Health Policy and Management (HPM) is committed to training and promoting future leaders in health care management and research by applying innovative approaches to learning and teaching. This goal is consistent with the department's mission to advance knowledge, translate knowledge into policy and practice, and to educate individuals for leadership roles in health management, policy-making and research to improve health-related quality of life domestically and globally. Achieving this goal will require attention to issues of diversity, using synergistic strategies that will change the culture of the department. These include:

1). Initiate monthly diversity reporting at faculty meeting

2). Include summary of diversity goals and accomplishments in faculty members' annual reports

3). Report annually to School, students, staff and faculty on departmental diversity goals and major accomplishments

Synergistic Strategies:

Leadership (Department Chair, Administrative and Executive Committees) - inclusion, mentoring and promotion of individuals of diverse racial and ethnic backgrounds, genders, ages (as well as geographic origins, academic backgrounds, and work experiences); promotion of linkages with other departments to recruit minority faculty; integrate diversity into curricula and build capacity in diversity initiatives

Faculty – (As above)

Staff – inclusion, mentoring and promotion of individuals of diverse racial and ethnic backgrounds, genders, ages (as well as geographic origins, academic backgrounds, and work experiences)

Study Body – inclusion and mentoring of individuals of diverse racial and ethnic backgrounds, genders, ages (as well as geographic origins, academic backgrounds, and work experiences)

Service – integration of values that address diversity and cultural competency

Teaching – integration of values that address diversity and cultural competency, using multiple methods to support a culture that values diversity, including small- and large- group discussions special guest lectures, seminars, assignments, and games or simulations pertaining to issues of

diversity. Cultural competency can be measured through attitudes, knowledge and skills assessed throughout the learning process.

Research – inclusion of research into methods to improve quality of care, reduce health disparities, and attract new segments of the health care market.

Special Lectures & Seminars – these should integrate values that address diversity and cultural competency; funding must be directed toward support of these events

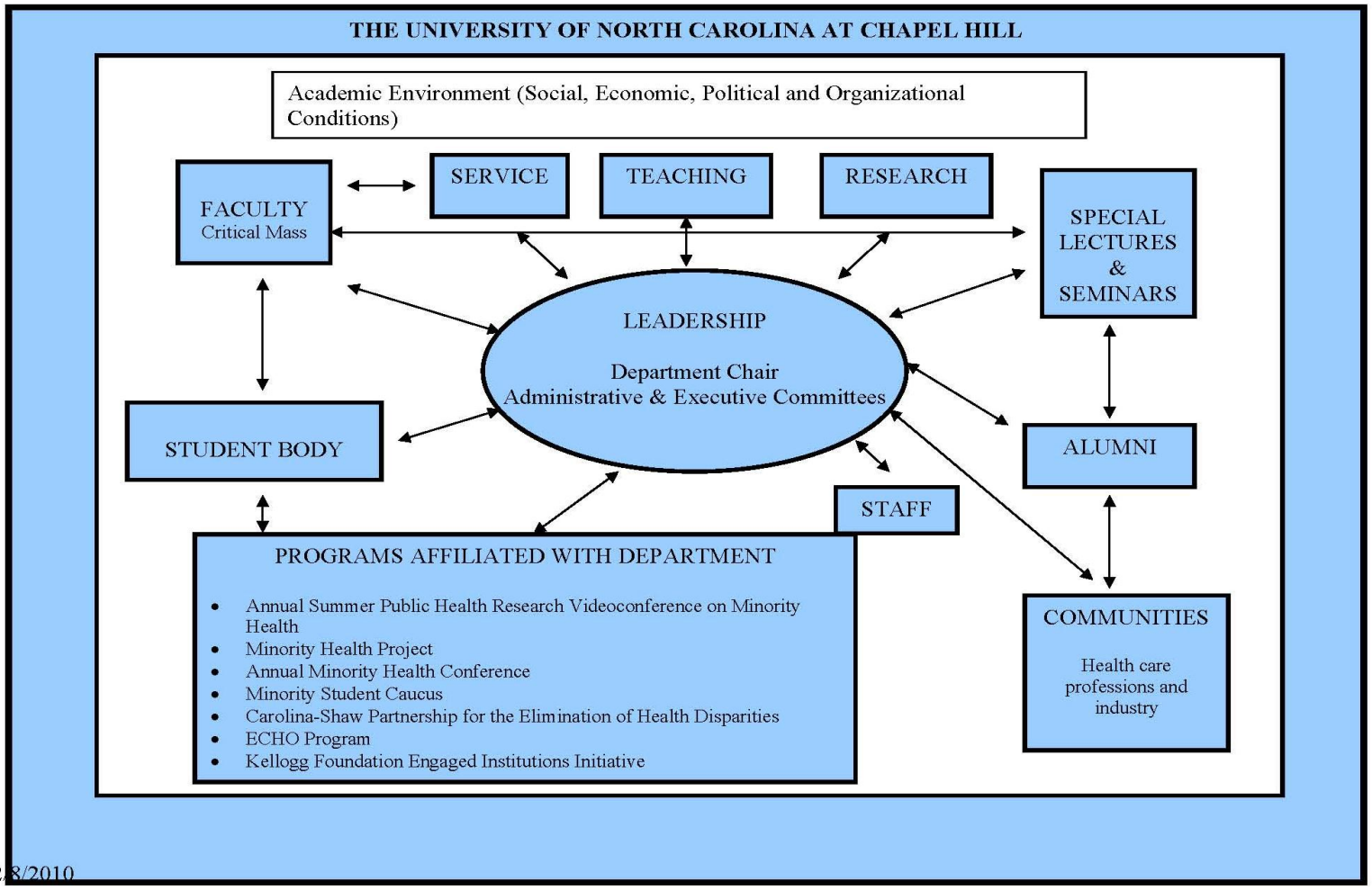
Alumni – engage alumni in efforts to increase the recruitment and retention of minority faculty; include alumni in classroom discussions about real-world experiences with diversity on the job and in mentoring students

Communities – engage communities in efforts to increase the recruitment and retention of minority faculty

Programs Affiliated with HPM – Annual Summer Public Health Research

Videoconference on Minority Health, Minority Health Project, Annual Minority Health Conference, Minority Student Caucus, Carolina-Shaw Partnership for the Elimination of Health Disparities, Kellogg Foundation Engaged Institutions Initiative HPM Annual Report

Framework for Integration of Diversity into the Department of Health Policy and Management (Dilworth-Anderson, Hobbs and Hacker)



2/8/2010

II. Faculty and Staff Goals for Diversity

GOAL 7: RECRUIT AND RETAIN A DIVERSE FACULTY AND STAFF

Objective 7a: Define strategies for maintaining and increasing diversity (gender, age, race, ethnicity, sexual orientation, and/or others).

This objective ties to Criteria IV.A. 2 requirements 1 and 2.

Benchmark to be met	Measurement Description	Recent Assessment	Met	Measurement Results	Actions Based on Results
Develop a diversity strategy	Conceptual model and strategy on diversity	Spring 2009	Yes	Strategy and conceptual model approved by the faculty	• Plan to hold a faculty planning day on diversity • HPM Diversity Reporting Tool
Faculty Diversity Planning Day	Meeting held	**Fall 2008**	Yes, **11/7/08**	Increased awareness and undocumented changes in individual faculty behavior	• Establishment of the Diversity Committee
Implementation of the Diversity Reporting Tool	Monthly report	Spring 2009	No	Lack of participation	• TBD
Development of the (Faculty & Student) Diversity Committee	Committee developed	Spring 2009	Yes	A committee comprising six faculty members and five students meets monthly	• Student orientation activities for Fall 2009 • Syllabi review and revisions for 2009-2010 academic year • Plans to facilitate the implementation of the approved diversity strategy

Objective 7b: Increase the percentage of under-represented minority faculty based on the national pool of minorities and also the pool of minorities within the discipline or areas of expertise.

This objective ties to Criteria IV.A. 2 requirements 1 and 2.

Benchmark to be met	Measurement Description	Recent Assessment	Met	Measurement Results	Actions Based on Results
Maintain, or increase by one FTE per year	Maintain status quo or increase by one FTE	Spring 2009	Yes	One minority faculty member was hired in October 2008	• Diversity Committee is trying to develop a strategy to increase the applicant pool for minority faculty • Create a climate of inclusivity within the Department

Objective 7c: Increase the percentage of under-represented minorities on staff through multiple recruitment methods using a diversity approach.					
Benchmark to be met	**Measurement Description**	**Recent Assessment**	**Met**	**Measurement Results**	**Actions Based on Results**
Maintain, or increase by one FTE per year	Maintain status quo or increase by one FTE	Spring 2009	No	The Department was affected negatively because of the state budget and a reduction in funds resulting in the elimination of two positions, one of which was a minority staff member	• Attempt to recruit minority staff members for vacant positions within our Department as funding is available for the creation of positions.

Valuing, Recognizing and Encouraging Diversity

Promoting and valuing diversity in the classroom enriches learning and broadens everyone's perspectives. Inclusion and tolerance can lead to respect for others and their opinions and is critical to maximizing the learning that we expect in this program. This may challenge our own closely held ideas and personal comfort zones. The results, however, create a sense of community and promote excellence in the learning environment.

Diversity includes consideration of (1) the variety of life experiences others have had, and (2) factors related to "diversity of presence," including, *among others*, age, economic circumstances, ethnic identification, disability, gender, geographic origin, race, religion, sexual orientation, social position.

This class will follow principles of inclusion, respect, tolerance, and acceptance that support the values of diversity.

Appendix K.iv: HPM Inclusion Checklist for the Classroom

Developed by: Drs. Peggye Dilworth-Anderson & Laura Files

Co-Chairs, Committee on Diversity & Inclusion

Department of Health Policy & Management

University of North Carolina – Chapel Hill

"Inclusive classrooms are classrooms in which instructors and students work together to create and sustain an environment in which everyone feels safe, supported, and encouraged to express her or his views and concerns. In these classrooms, the content is explicitly viewed from the multiple perspectives and varied experiences of a range of groups. Content is presented in a manner that reduces all students' experiences of marginalization and, wherever possible, helps students understand that individual experiences, values, and perspectives influence how they construct knowledge in any field or discipline. Instructors in inclusive classrooms use a variety of teaching methods in order to facilitate the academic achievement of all students. Inclusive classrooms are places in which thoughtfulness, mutual respect, and academic excellence are valued and promoted." [1]

Web links provide resources that can support developing and expanding an inclusive classroom. If you have other web links or resources, please add them to list at the end of the checklist.

So, how am I doing?

	Question	**Yes**	**No**
1	Does my syllabus reflect language that denotes a safe and open environment to discuss diversity? http://www.uww.edu/learn/diversity/approachdiversity.php		
2	Have I assured that my syllabus contains no language that might be perceived as marginalizing, stereotyping, or otherwise discomforting to any groups?		
3	Have I recognized that my own views, values and/or beliefs may affect my choice of readings, assignments, and other critical aspects of the course? http://www.uww.edu/learn/diversity/approachdiversity.php		
4	Have I mapped, as much as possible, the demographics in my classroom and assessed how they may affect creating an inclusive classroom?		

5	Have I made choices regarding readings and assignments in my syllabus on diverse people, situations, and experiences that will support an inclusive classroom? http://cfe.unc.edu/teaching/topics/diversity.html		
6	Have I identified specific responses that I will be comfortable using to "diffuse" or respond to possible sensitive issues in class relating to diversity? http://www.uww.edu/learn/diversity/approachdiversity.php		
7	Have I developed and incorporated into my syllabus "focused" positive discussions that lead to learning about and integrating diversity in the content of the course?		
8	Have I structured my course so that students learn from each other regarding diversity through relevant exercises, projects, and exams that extend student's understanding of diversity? [1]http://www.crlt.umich.edu/gsis/P3_1.php		
9	Have I identified outside speakers (e.g. alumni) that can extend the focus of diversity in the classroom?		
10	Do I have a plan in place to assess how well diversity was addressed in my course?		

Some Relevant Resources to the 10 item Checklist

1. Center for Research on Learning and Teaching. 2010. Creating Inclusive College Classrooms. Available at: http://www.crlt.umich.edu/gsis/P3_1.php. Retrieved on: February 24, 2011.

University of North Carolina at Chapel Hill. Center for Faculty Excellence. Available at: http://cfe.unc.edu/teaching/topics/diversity.html.

University of Wisconsin Whitewater Learn Center. An Approach for Teaching Diversity. Available at: http://www.uww.edu/learn/diversity/approachdiversity.php

Appendix L: Additional Resources

Links to resources, groups and organizations around the issue of Diversity and Inclusion, both at UNC and outside the university.

Please note that there are many other resources available and that the list we provide is only a sample

1. History of the School, UNC Gillings School of Global Public Health Web Page.

2. An Evolving History of Minority-Related Activities at the UNC Gillings School of Global Public Health.

3. History in the Making, Carolina Public Health Magazine, Winter 2006.

4. "Lesbian, Gay, Bisexual, and Transgender (LGBT) Health is Public Health: Looking towards the future for the University of North Carolina Gillings School of Global Health." *By SPH students within the Health Sciences LGBTQ Alliance*. (DITF Blackboard)

5. "Dreaming of a Time: the School of Public Health, the University of North Carolina at Chapel Hill," 1939-1989. *Robert Rodgers Korstad*. 1990.

6. "Breaking the Barriers, Making History: Timeline of Women's Education at UNC." Prepared by the Southern Oral History Program by *Jenner Donnally and Jessie Wilkerson*. (DITF Blackboard)

7. Communications with Carolina Indian Circle. (DITF Blackboard)

8. "UNC researchers: Smoking rates significantly higher among homosexual men, women". UNC Gillings School of Global Public Health, News and Events, July 27, 2009.

9. OMB Standards for Data on Race and Ethnicity
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=172

10. UNC Chapel Hill's Diversity Plan Report 2010-2011
http://www.unc.edu/carolinacovenant/files/Diversity%20Report%202011.pdf

11. SPH 2020 plan http://www.sph.unc.edu/SPH2020

12. UNC's Diversity and Multicultural Affairs office: http://www.unc.edu/diversity/

13. Brooklyn College Diversity and Inclusion Plan 2008-2013
http://www.brooklyn.cuny.edu/bc/offices/diversity/pdf/diversity08.pdf

Relevant Literature

1. Alexander R. Cultural competence models in nursing. *Crit Care Nurs Clin N Am*. 2008; 20: 415-421.
2. Alexander R. Shifting paradigms of cultural competency. *Imprint*. 2008; 55(5): 34-5.
3. Barnett K, Hattis P, Eaglen R. Health professions accreditation and diversity: A collaborative approach to enhance current standards. Commissioned by W.K. Kellogg Foundation and the California Endowment. August 2010.
4. Batts V. Is reconciliation possible? Lessons from combating "Modern Racism". 2002. http://www.visions-inc.org/Is%20Reconciliation%20Possible.pdf
5. Burleson, D. US Information Technology Racism, URL: http://www.dba-oracle.com/oracle_news/news_technology_racism.htm
6. Evans D. Black pioneers appreciate university's racial progress. *Carolina Alumni Review*. May/June 2002.
7. Jones CP. Levels of racism: A theoretic framework and a gardener's tale. *Am J Pub Health*. 2000; 90(8): 1212-1215.
8. Puhl R, Heuer C. Obesity Stigma: Important considerations for public health. *A J Pub Health*. 2010; 100(6): 1019-1028.
9. Shapiro S, Floam J. A new model for fostering diversity. *Johns Hopkins Medicine Alumni*. Spring/Summer 2010.
10. Shaw-Ridley M, Ridley C. The health disparities industry: Is it an ethical conundrum? *Health Promotion Practice*. 2010; 11(4): 454-464.
11. Kreuter M, Griffith D, Thompson V, et al. Lessons learned from a decade of focused recruitment and training to develop minority public health professionals. [published online ahead of print May 6, 2011]. *Am J Pub Health*. 2011. http://ajph.aphapublications.org/cgi/doi/10.2105/AJPH.2011.300122
12. Sue DW, Lin AI, Torino GC, et al. Racial microaggressions and difficult dialogues on race in the classroom. *Cultur Divers Ethnic Minor Psycho*l. 2009; 15(2): 183-190.
13. Sue DW, Capodilupo C, Torino G, et al. Racial microaggressions in everyday life: Implications for clinical practice. *Am Psychol*. 2007; 62(4): 271-286.
14. Thompson A. Tiffany, friend of people of color: White investments in antiracism. *Qualitative Studies in Education*. 2003; 16(1): 7-29.

Appendix M: Membership Rosters

Co-Chairs: Bryan Weiner and Rumay Alexander

Rumay Alexander
Co-Chair, DITF

Ana Alvarez
Health Policy and Management

Alice Ammerman
Nutrition

Stephanie Baker
Health Behavior and Health Education

Kathy Barboriak
SPH Information Technology

Mae Beale
SPH Dean's Office

Nadya Belenky
Epidemiology

Danny Bell
UNC American Studies

Maggie Carlin
Health Behavior and Health Education

Michelle Collins
Nutrition

Steve Couch
Office of External Affairs

David Couper
Biostatistics

Lana Dial
UNC Minority Alumni Committee
Graduate Education Advancement Board

Pam Dickens
FPG Child Development Institute

Peggye Dilworth-Anderson
Health Policy and Management

Rachael Dooley
Health Behavior and Health Education

Brandon Edmond
Health Policy and Management

Eugenia Eng
Health Behavior and Health Education

Paige Eppenstein Anderson
Health Behavior and Health Education

Francesca Florey
Carolina Public Health Solutions

Elizabeth French
Health Behavior Health Education

Erica Hamilton
Maternal and Child Health

Matt Herr
Epidemiology

Jon Hussey
Maternal and Child Health

Dio Kavalieratos
Health Policy and Management

Beth Lamanna
School of Nursing

Leena Mehta
Health Policy and Management

Melody Levy
Environmental Sciences and Engineering

Laura Loehr
Epidemiology

Jared Lowe
Health Policy and Management

Robert McConville
Health Policy and Management

Felicia Mebane
Health Policy and Management
Office of Student Affairs

Christin Minter
Office of Research

Angelo Mojica
Nutrition

Alex Nance
Health Policy and Management

Shu Wen Ng
Nutrition

Christine Ngaruiya
Emergency Medicine

Elyse Nieves
Health Policy and Management

Charlotte Nunez-Wolff
Business and Finance

Chris Perry
Communications

George Pink
Health Policy and Management

Patsy Polston
Environmental Sciences and Engineering

John Preisser
Biostatistics
jpreisse@bios.unc.edu

Annette Raines
Human Resources

Shyanika Rose
Health Behavior and Health Education

A. Justin Rucker
Health Policy and Management

Diana Maria Sanchez
Epidemiology

Victor Schoenbach
Epidemiology

David Steffen
Public Health Leadership Program

Nicole Taylor
Public Health Leadership Program

Melissa Troester
Epidemiology

Anissa Vines
ECHO
Epidemiology

Dianne Ward
Nutrition

Bryan Weiner
Co-Chair, DITF

Jordan Wong
Nutrition

Diversity and Inclusion Task Force

Change Team Roster

Co-Chairs: Bryan Weiner and Rumay Alexander

Ana Alvarez
Health Policy and Management

Rumay Alexander
Co-Chair, DITF

Stephanie Baker
Health Behavior and Health Education

Danny Bell
UNC American Studies

Maggie Carlin
Health Behavior and Health Education

David Couper
Biostatistics

Peggye Dilworth-Anderson
Health Policy and Management

Lloyd Edwards
Biostatistics

Paige Eppenstein Anderson
Health Behavior and Health Education

Elizabeth French
Health Behavior and Health Education

Tiana Garrett
Epidemiology

Felicia Mebane
Health Policy and Management
Office of Student Affairs

Shu Wen Ng
Nutrition

George Pink
Health Policy and Management

Patsy Polston
Environmental Sciences and Engineering

Annette Raines
Human Resources

Victor Schoenbach
Epidemiology

Anissa Vines
Epidemiology

Bryan Weiner
Co-Chair, DITF
Health Policy and Management

Staff Support
Brenda Motsinger
Managing Director, DITF
Dean's Office -Special Projects

Christin Minter
Management & Resource Support, DITF
Office of Research

Nicole Chenault
Administrative Support, DITF
Office of Student Affairs

Randall Teal
Qualitative Data/Resource Support DITF
UNC Comprehensive Cancer Center
Rteal@schsr.unc.edu

Appendix N: DITF Member Survey Summary

The Charge

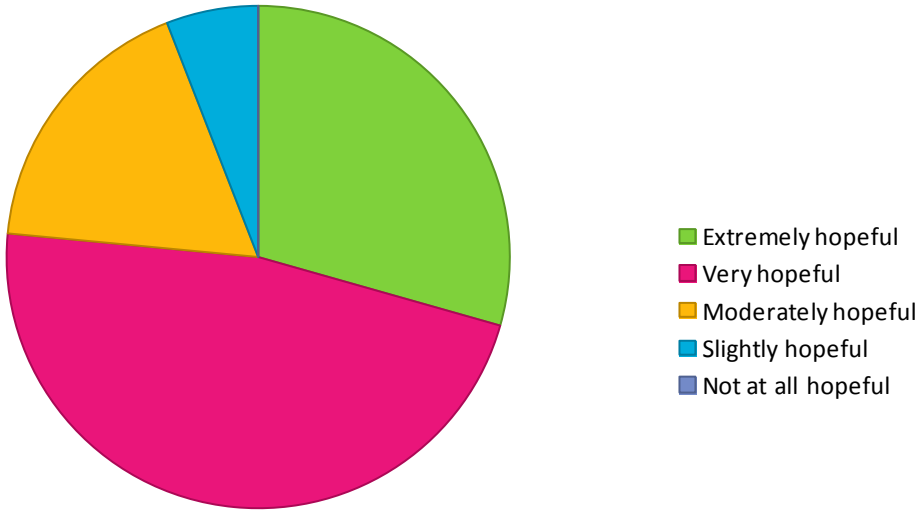
The Planning Team is seeking feedback from members of the DITF on the task force process and the report itself: "In our hands…13 Recommendations on Diversity and Inclusion to the UNC Gillings School of Global Public Health Community".

Your help is requested to achieve enhanced diversity and inclusion in the School. Please respond to this brief 3-4 question survey with your overall perceptions about our process and the attached report. Thank you for your support.

The Results

Question 1.

How hopeful are you that these recommendations will lead to meaningful results?		
Answer Options	**Response Percent**	**Response Count**
Extremely hopeful	29.4%	5
Very hopeful	47.1%	8
Moderately hopeful	17.6%	3
Slightly hopeful	5.9%	1
Not at all hopeful	0.0%	0
	answered question	**17**
	skipped question	**0**



Question 2.

This set of recommendations provides a roadmap for diversity and inclusion at SPH. Which two recommendations are the foundation upon which the other recommendations build (and therefore, we should do first)?

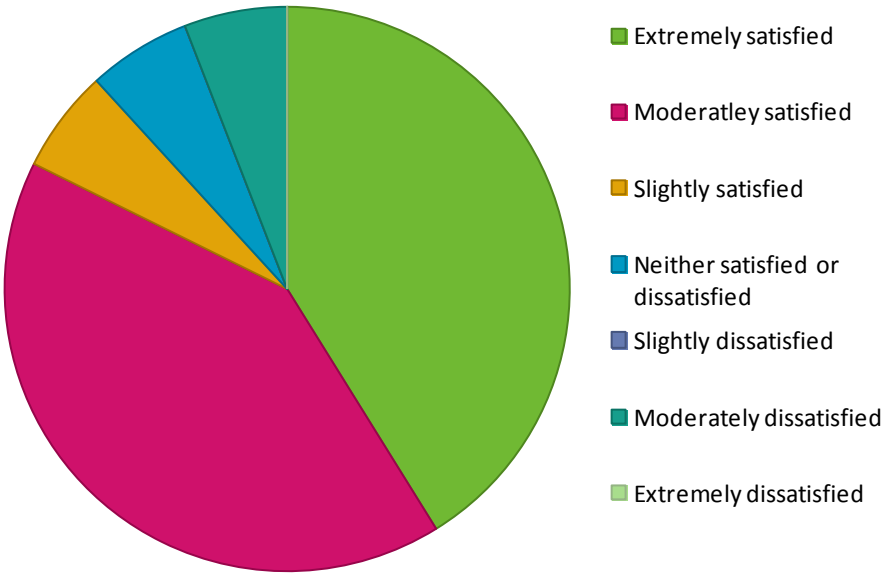
Answer Options	Response Percent	Response Count
1. Issue a strong statement from Dean's Council in support of diversity and inclusion	29.4%	5
2. Develop a model and process for spreading diversity and inclusion principles and practices in SPH	52.9%	9
3. Appoint a school-level designated champion to oversee diversity and inclusion efforts	41.2%	7
4. Strengthen links with campus and community resources to foster diversity and inclusion	11.8%	2
5. Support an Ombuds dedicated to addressing diversity and inclusion issues	23.5%	4
6. Take greater "recruiting" advantage of the Annual Minority Health conference	5.9%	1
7. Engage alumni from minoritized groups in recruitment, training, and placement	0.0%	0
8. Promote cross-departmental sharing of best practices	5.9%	1

9. Encourage admission & support of students with exceptional potential but not traditional admissions profiles	5.9%	1
10. Require greater specificity in departments' diversity goals, plans, and reports	23.5%	4
11. Increase course content to address the health issues of diverse populations	11.8%	2
12. Increase cultural relevance and opportunities to discuss diversity topics productively	0.0%	0
13. Coordinate diversity in SPH content and approaches in core courses	17.6%	3
answered question		**17**
skipped question		**0**

Question 3.

Overall, what is your level of satisfaction with the Task Force process for achieving our results.

Answer Options	**Response Percent**	**Response Count**
Extremely satisfied	41.2%	7
Moderatley satisfied	41.2%	7
Slightly satisfied	5.9%	1
Neither satisfied or dissatisfied	5.9%	1
Slightly dissatisfied	0.0%	0
Moderately dissatisfied	5.9%	1
Extremely dissatisfied	0.0%	0
answered question		**17**
skipped question		**0**


Extremely satisfied
Moderatley satisfied
Slightly satisfied
Neither satisfied or dissatisfied
Slightly dissatisfied
Moderately dissatisfied
Extremely dissatisfied

SPH Community/Public Survey Summary

The Charge

The Diversity and Inclusion Task Force (DITF) seeks public feedback on the report: "In our hands…13 Recommendations on Diversity and Inclusion to the UNC Gillings School of Global Public Health Community."

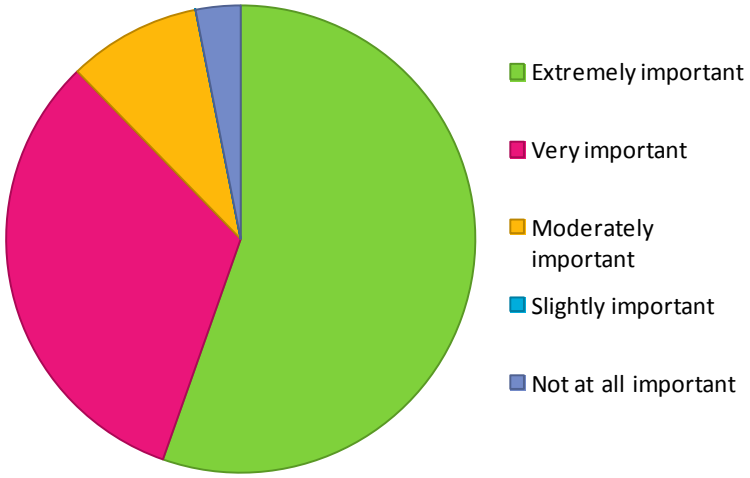
At SPH, diversity and inclusion means we welcome, value, and learn from individual differences and perspectives. We believe that by cultivating an atmosphere of inclusion within the School, we better prepare our students, faculty, staff, and the public whose health we want to improve for the diverse world that awaits them -- a world that seeks culturally relevant people to serve as its leaders.

Your help is requested to achieve enhanced diversity and inclusion in the School. Please respond to this brief 6-7 question survey with your perceptions about the attached report. Thank you for your support.

The Results

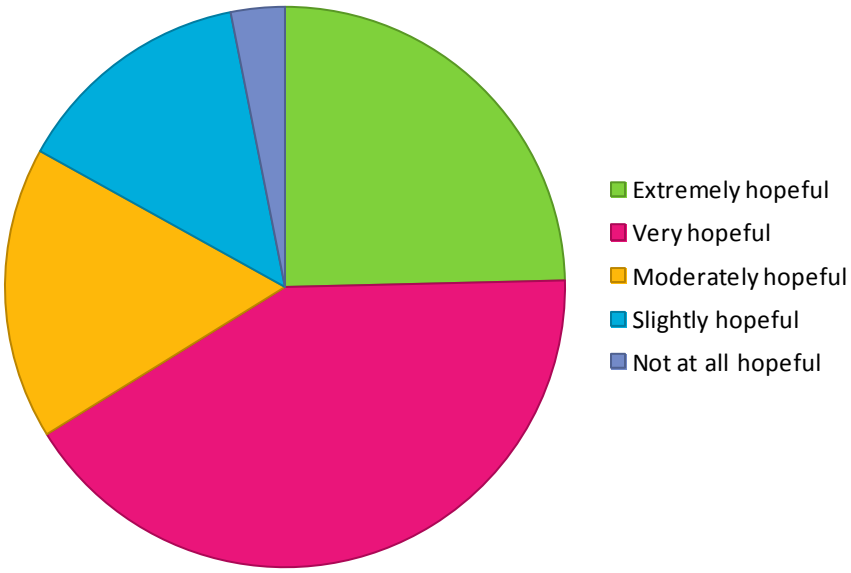
Question 1.

How important is diversity and inclusion to you?		
Answer Options	**Response Percent**	**Response Count**
Extremely important	55.4%	36
Very important	32.3%	21
Moderately important	9.2%	6
Slightly important	0.0%	0
Not at all important	3.1%	2
answered question		**65**
skipped question		**0**



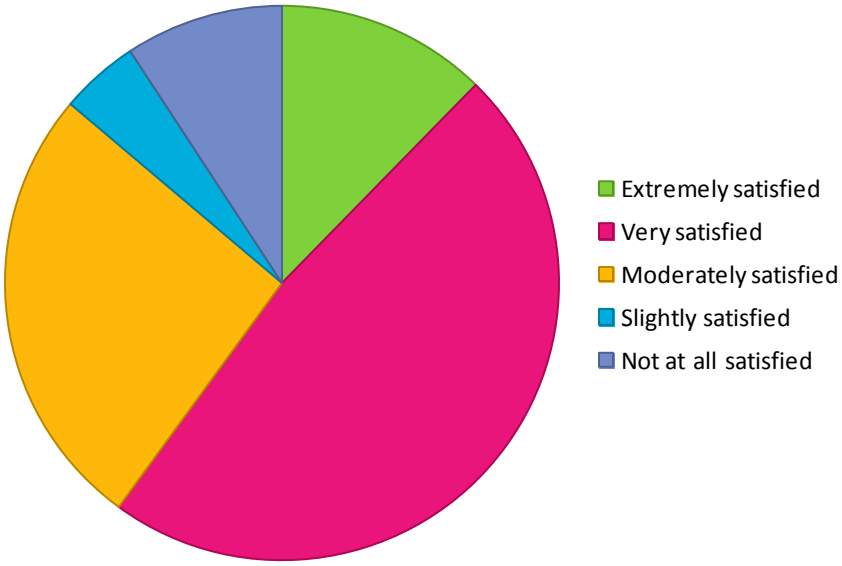
Question 2.

How hopeful are you that these recommendations will lead to meaningful results?		
Answer Options	**Response Percent**	**Response Count**
Extremely hopeful	24.6%	16
Very hopeful	41.5%	27
Moderately hopeful	16.9%	11
Slightly hopeful	13.8%	9
Not at all hopeful	3.1%	2
	answered question	**65**
	skipped question	**0**



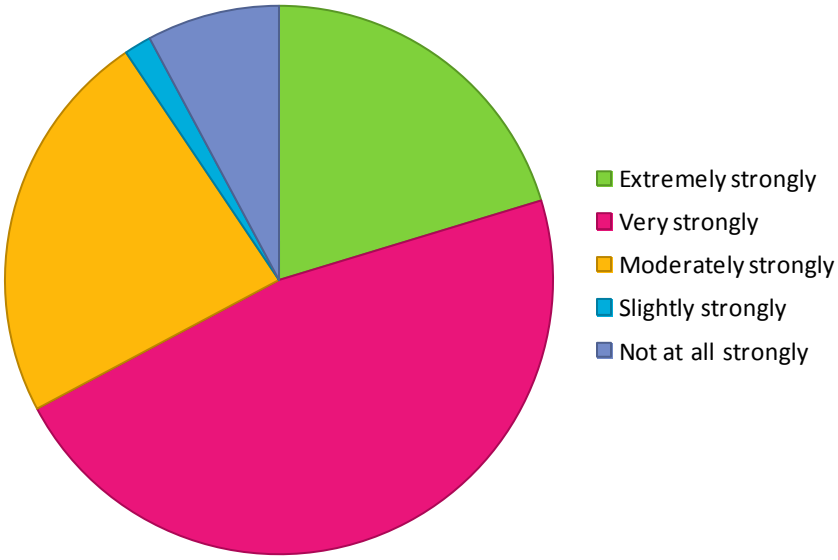
Question 3.

Overall, what is your level of satisfaction with the Task Force's recommendations for enhanced diversity and inclusion at the School?		
Answer Options	**Response Percent**	**Response Count**
Extremely satisfied	12.3%	8
Very satisfied	47.7%	31
Moderately satisfied	26.2%	17
Slightly satisfied	4.6%	3
Not at all satisfied	9.2%	6
	answered question	**65**
	skipped question	**0**



Question 4.

How strongly do you endorse these recommendations?		
Answer Options	**Response Percent**	**Response Count**
Extremely strongly	20.3%	13
Very strongly	46.9%	30
Moderately strongly	23.4%	15
Slightly strongly	1.6%	1
Not at all strongly	7.8%	5
answered question		**64**
skipped question		**1**



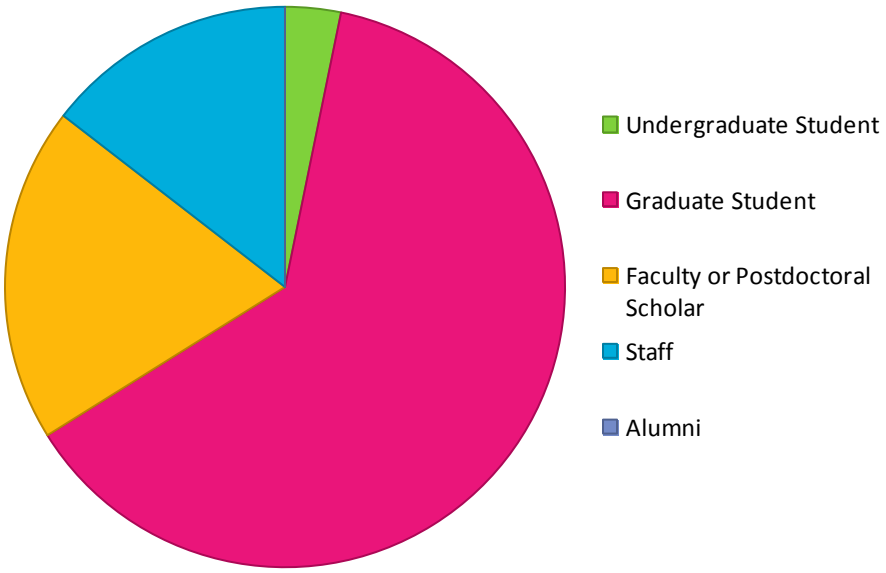
Question 5.

This set of recommendations provides a roadmap for diversity and inclusion at SPH. Which two recommendations are the foundation upon which the other recommendations build (and therefore, we should do first)?		
Answer Options	**Response Percent**	**Response Count**
1. Issue a strong statement from Dean's Council in support of diversity and inclusion	21.0%	13
2. Develop a model and process for spreading diversity and inclusion principles and practices in SPH	29.0%	18
3. Appoint a school-level designated champion to oversee diversity and inclusion efforts	11.3%	7
4. Strengthen links with campus and community resources to foster diversity and inclusion	32.3%	20
5. Support an Ombuds dedicated to addressing diversity and inclusion issues	3.2%	2
6. Take greater "recruiting" advantage of the Annual Minority Health conference	6.5%	4

7. Engage alumni from minoritized groups in recruitment, training, and placement	14.5%	9
8. Promote cross-departmental sharing of best practices	8.1%	5
9. Encourage admission & support of students with exceptional potential but not traditional admissions profiles	32.3%	20
10. Require greater specificity in departments' diversity goals, plans, and reports	11.3%	7
11. Increase course content to address the health issues of diverse populations	22.6%	14
12. Increase cultural relevance and opportunities to discuss diversity topics productively	21.0%	13
13. Coordinate diversity in SPH content and approaches in core courses	9.7%	6
	answered question	**62**
	skipped question	**3**

Question 6.

Please indicate your current affiliation with the UNC Gillings School of Global Public Health:		
Answer Options	**Response Percent**	**Response Count**
Undergraduate Student	3.2%	2
Graduate Student	62.9%	39
Faculty or Postdoctoral Scholar	19.4%	12
Staff	14.5%	9
Alumni	0.0%	0
	answered question	**62**
	skipped question	**3**



Comments*

1. If not already available at UNC, develop web-based training modules and/or in-person class on Diversity Awareness; coordinated with UNC personnel training opportunities.
2. I totally and completely agree with number 9. I am a mom of four kids and I have been trying to keep abreast of public health issues going on locally and globally. I am not working professionally at the moment. Yet, I work day in, day out as a woman, wife, mother, and powerful contributor to the society through the power of volunteer work. I know I have exceptional potential to succeed. However, the only thing affecting my entrance to UNC is my GRE scores. I am going to retake it and I will make sure I "slam-dunk" my scores this time around. Yet, that score should not be a determinate of admission to the UNC School of public health.
3. Define minoritized in the beginning of the report. What is meant by "under-represented" in the definition for minoritized? Also, how is cultural competence being defined? In addition to increasing course content that addresses diversity, I think that increasing practicum opportunities to engage and work within diverse communities should be encouraged.
4. To increase recruitment and retention of a diverse body of students, faculty, and staff: I don't think there is ANY (minoritized student/faculty) recruiting advantage through the partnership with the Minority Student Caucus and the annual Minority Health Conference. Have you surveyed minoritized students, minoritized community professionals, SPH alumni, or do you have any data to support that approach? To promote diversity and inclusion through the SPH curricula: It may be wishful thinking that you will be able to address the lack of cultural competence without experienced culturally competent resources. Might be helpful to have new (and old) faculty seek advice when designing curricula.
5. The state of NC has the largest American Indian population in the east of the Mississippi River. As the mission of the school is "to improve public health, promote individual well-being, and eliminate health disparities across NC & around the world," in my humble opinion, the school should make the health issues that face our Native community in NC a priority instead of a recommended line item. The report accurately mentioned the importance of educating, employing, and deploying "people who reflect the diversity of experiences in the practice of public health" in order to effectively solve the problems that these populations

face. In order to do so with the American Indian population in NC it is vital that specific efforts are made to recruit, educate, and serve this population beyond the placation level. The first step in doing so would make a course on American Indian health issues a part of the core curriculum instead of an elective. For the students who will graduate from the program and work in NC, the likelihood that they will come into contact with a Native person throughout their careers is very significant. As such, the school should do more to ensure that these students will have a basic knowledge of best practices when working with Native peoples.

6. Although mentioned in the opening remarks, the issue of increasing faculty and staff diversity was not specifically addressed in the recommendations. My sense is that increasing the diversity among the faculty and staff would be the first step in naturally creating a more diverse and inclusive curriculum and in attracting a more diverse student body. I favor this idea over having a single appointed "Diversity Champion", an idea I see as inherently contrary to diversity--how can 1 person represent and thus champion diversity? To champion diversity is to incorporate and represent a range of perspectives, something that can only by accomplished by a group of people. The best way to show that we support diversity is to BE diverse, not to appoint one person to tell people how to be more inclusive. As for recruiting a more diverse applicant pool, why not look beyond the Minority Health Conference to other local sources of students? Community colleges, NCCU, the Friday Center all have access to students from a wide range of academic and SES backgrounds and could help identify potential SPH applicants. Furthermore, these schools could help bridge some of the academic gaps for promising applicants.
7. I have a major problem with the assumption that diversity and inclusion efforts will mitigate the racial micro aggressions that occur every day on campus and in classrooms. If the goal is to truly learn from diverse individuals, then a space that is critical of white privilege, heterosexism, and classism is necessary. I would highly recommend specific "unlearning racism" curriculum as well as incorporating critical race theories into the course work.
8. Recommendations to increase student, faculty and staff recruitment could help African American student recruitment, but will not increase the inclusion and diversity of other ethnic and racial student groups. The Minority Student Caucus sort of identifies itself as a Black (students/people of color) organization. Minority Health Conference recently had a good focus on Native American Health. It is hard to see any native course content and research or interest in Native American health.
9. Overall I think that this serves as an outstanding basis for inclusion. I think that the statement is strong and the need for campus and community support is key. Great initiative SPH!
10. Must simultaneously foster an inclusive environment at the school (& curriculum/practices) while recruiting (doing # 7) to increase enrollment of diverse student body, as overlap will create change faster than sequential approach.
11. Have the undoing racism workshop speak more directly to racism and other –isms
12. Inclusive policy is close to Nature, policy of exclusion is unnatural
13. Don't need to continue to study, instead need to make efficient use of available UNC resources and engage the SPH community
14. I strongly recommend that the School implement a school wide position to address diversity and inclusion. The responsibilities for this position should include diverse faculty recruitment, support, and retention; holding department chairs accountable for setting and meeting/exceeding diversity goals; and assessing the climate of the school related to diversity and inclusion with continuous anonymous hotlinks and periodic open conversations (as the Office of Student Affairs and Dean's Office have done for the past several years).
15. I am Mexican funded by the Mexican government. These scholarships have a top of $21,000 USD per year, so that means that I still have a gap in funding. The SPH could have a co-inversion program (through tuition remission- in state fees) to promote people coming from other countries to study here. If this doesn´t happen, it is almost impossible for an international to come. Even with UNC being a public university, middle-income families from any developing country CAN´T come up with a $45,000 USD budget per year. Priority should be given in TA-RA allocation as well, for people with scholarships from other sources.
16. A professor can encourage different perspectives in class discussions. It can be clearly stated in the syllabus. However, offering a different perspective might not necessarily be supported in the grading scheme. For example, how does a professor measure exceptional thoughtfulness? What if the professor disagrees with

the opinion or the experiences or the "thoughtfulness" of the student and this is reflected in the grade? The result: the student is unwilling to participate or offer any different perspectives.

17. As a woman of color, and one of a handful of students of color in my program, I was disappointed to see very little funding, besides funds set aside for students of color going to these talented men and women. Many of us didn't have the high test scores and grades as others did in our program that got funding. This SHOULD NOT be a reason to discredit a student's ability to perform. Also, some of us come from other countries where communications with staff and faculty aren't the best, just because we didn't come to the campus doesn't mean that we should not be considered for funding or research opportunities. I was told I received money ear marked for students of color. I felt as if I was put into a label and given the "token" funding. I felt that it was my race only that qualified me to be thought of for funding. When I look at the racial representation of the students fully funded vs. those not and who are also students of color, it is disproportionate. I don't think students of color should get all the funding, but I think we should have equal accessibility to ALL funds. I don't like feeling boxed in by my race. I don't like feeling as if the only money I can get is because of my race. I am more than a number or a quota that fills a box to meet UNC's diversity requirements.
18. All of those recommendations are excellent and should be pursued with enthusiasm and support. I believe that leadership is the key to keeping diversity and inclusion at the forefront of our efforts. We need a commitment at the highest level, along with actual models and processes to ensure that words become actions. If we have those two things, I believe all else will follow. The Dean should make it a point to ensure that ALL departments are on board and actively participating, beginning with the Chairs. Again, it's about leadership. If the Chairs do not participate or promote the message within the Departments, then the efforts will become stagnant and no palpable change will be realized. As a minority student, I still experience some marginalization from a minority of Faculty members. All Faculty members should exhibit a proactive commitment to participating in diversity events and getting to know students from diverse backgrounds. Too often the responsibility falls on the student, when a shared model of responsibility should be promoted. If there are a handful of minority students in a program, then there should be no excuse for any faculty member in that Department not to know each one of them by name. That's the type of academic climate I expect from a School and University as great as ours. It is achievable.
19. I think the recommendations to encourage admission of non-traditional admissions profiles is great. I also think that it's important for all classes to address issues of diversity and inclusion and for students to be engaged in learning about these issues as well as brainstorming the role of diversity in public health. While it is essential to have support and vision from the Dean and other councils, the biggest effect will be for individual students in classrooms to read, learn, and embody these principles. A strong network with other campus and community resources will also help to strengthen our attainment of these goals and expose us to new ideas.
20. I don't really like the idea of a champion. I think it's too easy then for everyone to see the primary responsibility as that of the champion. I feel pretty much the same about ombuds--why do we keep creating more administrative levels? I think a task force model might be better. We need more widespread responsibility for change.
21. I am concerned about the recommendations that affect the content of the Minority Health Conference, e.g., the expectation that the number of partner conferences will expand. I hope that the MHC remains a student-driven enterprise and that the report will not put undue pressure on student leaders. I agree with the general recommendation that student, faculty and staff leaders should collaborate to leverage the MHC in pursuit of our diversity and inclusion goals.

22. Many institutions are trying to recruit a small pool of minority students and faculty. The key is to increase the pool by finding ways to partner with the community and encourage public health as a career option. Successfully recruiting minority students requires money, since we are competing with other institutions. In terms of staff, finding ways to bring in minority community members for internships and mentoring opportunities is key. UNC tends to fill most staff positions internally because the systems are so

complicated. Bringing in minority candidates to learn the UNC systems would increase the likelihood of hiring at entry level jobs, which in turn would, long-term, increase the number of minority staff on campus.

23. For many talented ethnic minority students, funding guarantees are extremely important. With budgets and NIH funding tightening, UNC SPH is losing promising minority students because of insufficient funding for them.
24. Continue focus on diversity and inclusion issues in the School. Without ongoing focus we will all become backsliders.
25. Having faculty workshops is a great idea; I would like to see those offered early on. Would be great if they include specific examples of successful practices to help faculty rethink existing courses.
26. 1) Make the recommendations easier to cut and paste into an email. I had a hard time doing this. 2) I don't really know what you mean by diversity. It often seems to mean racial or ethnic diversity and then it means traditionally underprivileged minorities. Please state what you mean and why we should care. We are doing this in HBHE's admissions committee, and getting agreement on the issues is a lot harder than I expected.

27. Thanks to everyone who put great effort into this project.
28. Due to time constraints I was only able to quickly scan the document. However, I don't believe I saw anything addressing two of our biggest roadblocks to successful recruitment of top students: (1) money, money, money; (2) perception that "the south" is still racist. Also, the focus of the report seems to be on people of color. There are many other types of diversity that were discussed at meetings, and I barely saw them reflected in this document.
29. The resources required in all recommendations have been vastly understated by not including the costs of the assessment/measurement of the metrics to assess results. For example, Recommendation 3.3 section 6 requires 4 measures, the first being an "Assessment of deployment and use of best practices..." which will likely cost in excess of $10K (analyst labor and other resources) to staff. The other 3 metrics will have similar costs based on the quality and time limits required, while the recommendation as a whole has been billed as a "no cost" recommendation. This is erroneous and the cost of evaluation should be included in the recommendation.
30. [This is a] waste of time on a subject that is 40 years old but I guess makes someone feel good. Ultimately, no impact.

**Comments were edited for grammar but not content. Identifiable information was removed.*