# Embracing Diversity in Academic Medicine:

Maria L. Soto-Greene, MD, FACP
Vice Dean and Professor of Medicine
Director, Hispanic Center of Excellence
UMDNJ-New Jersey Medical School

# Objectives

- To discuss the importance of diversity in the physician workforce
- To describe two unique approaches to cultivating a diverse faculty and leaders
- To describe the importance of targeting underrepresented minority students for development as future academicians

- Having a **diverse physician workforce** is a critical component in making health care and research available to/for those who need it most.

- The lack of **diversity of medical students**, coupled with ineffective cultural competency education, continues to produce training and treatment environments that are biased, intolerant and contributory to health disparities.

AMSA. Enriching Medicine Through Diversity 2012

# *LCME Standards on Diversity Effective July 1, 2009*

- **Revised standard MS-8:** Each medical school must develop programs or partnerships aimed at broadening diversity among qualified applicants for medical school admission.
- Because graduates may practice anywhere**, it is expected that schools recognize their collective responsibility for contributing to the diversity of the profession as a whole.**
  - Should work within their own universities and/or collaborate with others to make admission more accessible to potential applicants of diverse backgrounds.
  - Accomplish this via a variety of approaches:
    - the development and institutionalization of pipeline programs,
    - collaborations with institutions that serve students from disadvantaged backgrounds,
    - community service activities that heighten awareness of and interest in the profession,
    - academic enrichment programs for applicants who may not have taken traditional pre-medical coursework.

Liaison Committee on Medical Education. (2011) Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree.

# *LCME*
# *Standards on Diversity*
# *Effective July 1, 2009*

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

- Future physicians will be best prepared for practice in a diverse society if they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment will facilitate physician training in:
  - Basic principles of culturally competent health care
  - Recognition of health care disparities and the development of solutions to such burdens
  - The importance of meeting the health care needs of medically underserved populations
  - The development of core professional attributes, such as altruism and social accountability, needed to provide effective care in a multi-dimensionally diverse society

  - Each school should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. Schools could include the following elements of diversity in their planning, but not limited to: gender, racial, cultural and economic. Schools should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty members, staff, and others.

Liaison Committee on Medical Education. (2011) Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree.

# Facts

- Population's diversity continues to grow
- Uninsured continues to grow
- Healthcare disparities have long been a reality
- Aging population
- Access remains a concern with people living in HPSA's

(www.aamc.org/reform/workforce.htm - Accessed December 2009)

# Population and Workforce Demographics (2009)

| | US Pop | MS Grad | US Docs | MS Fac |
|---|---|---|---|---|
| White | 65.6% | 65.4% | 75.0% | 69.0% |
| Black | 12.2% | 6.7% | 6.3% | 3.0% |
| Asian | 4.4% | 20.0% | 12.6% | 13.2% |
| Hispanic | 15.4% | 6.7% | 5.5% | 4.2% |
| NA/PI | 0.9% | 0.9% | 0.5% | 0.3% |
| Multiple | 1.5% | | | 2.4% |
| Other | | | | 7.9% |

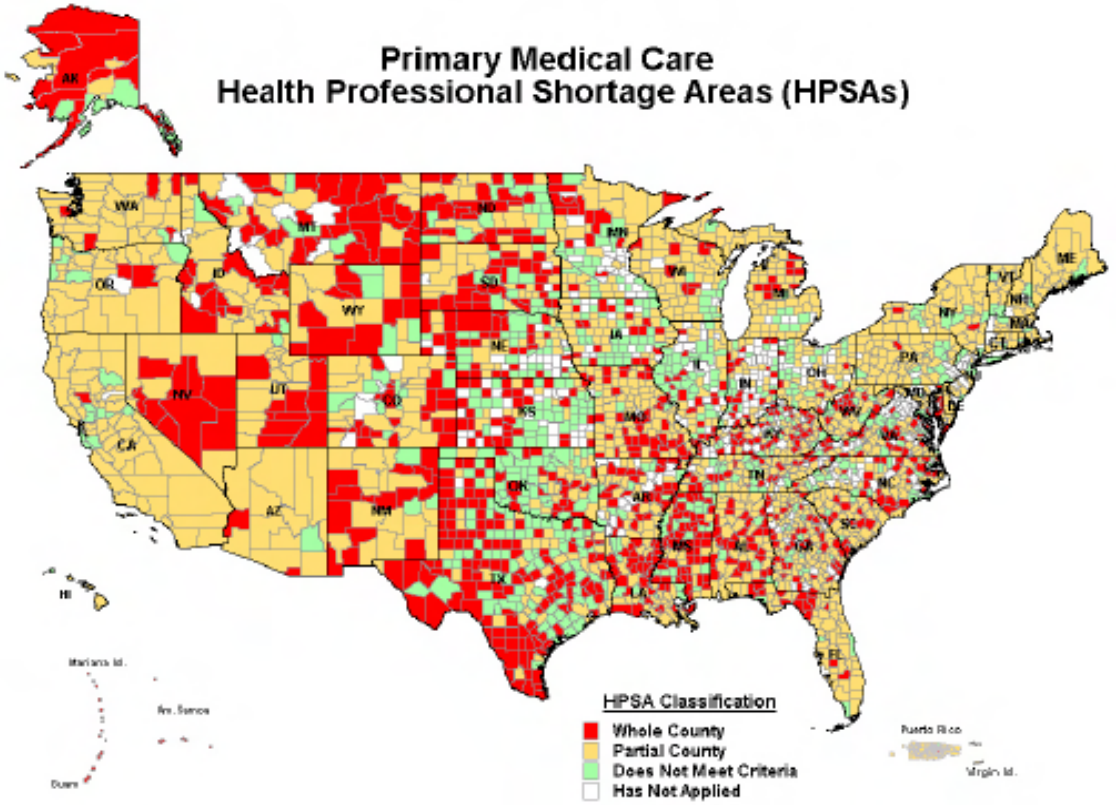
**Slide provided by Cynthia E. Boyd, M.D., MBA, FACP, Associate Vice President, Chief Compliance Officer, Rush Univ Medical Ctr**

# Physician Workforce

- Diversity has not kept pace with the population
- We, too, are aging with 1 in 3 over the age of 55
- Physician shortage predicted to be approx. 141,000 by 2025
- Shortages in Primary Care and Certain Specialties
- Geographic shortages

(www.aamc.org/reform/workforce.htm - Accessed December 2009)

# *Unmet Need Already Exists--30 million People Live in Federally Designated Shortage Areas*




*Source: HRSA/AAFP*

# Clinical and Academic Medicine Workforces

- **Clinical Workforce**
  - Minority physicians tend to practice in underserved areas
  - Growth rate for most underrepresented minorities is greater than the growth of the total population (Hispanics is 4X)
  - Greater satisfaction with racially concordant healthcare provider
- **Academic Medicine Workforce**
  - Located in underserved areas
  - Minorities are increasing in all of our communities
  - Learning environment must prepare student to work with diverse populations (IS-16, ACGME)
  - A diverse faculty impacts an institution's decision-making, policies, practices, role models, research on health disparities, and community engagement

# Academic Medicine Diversity

- To facilitate access and meet the needs of the underserved population, it is imperative that the institutional climate and healthcare workforce seek to resemble the diversity portrayed by our nation's population.
- Diversity should achieve health equity and reduce health disparities through culturally sensitive and patient-centered care.
- Similarly, investigators from racial and ethnic minority groups are more likely to pursue areas of investigation that impact minorities. They experienced greater success in minority research participation which can lead to advancements in medicine. (IOM 2003)
- Accreditation Council for Graduate Medical Education (ACGME): the competencies also recognize the skills needed to care for our communities.

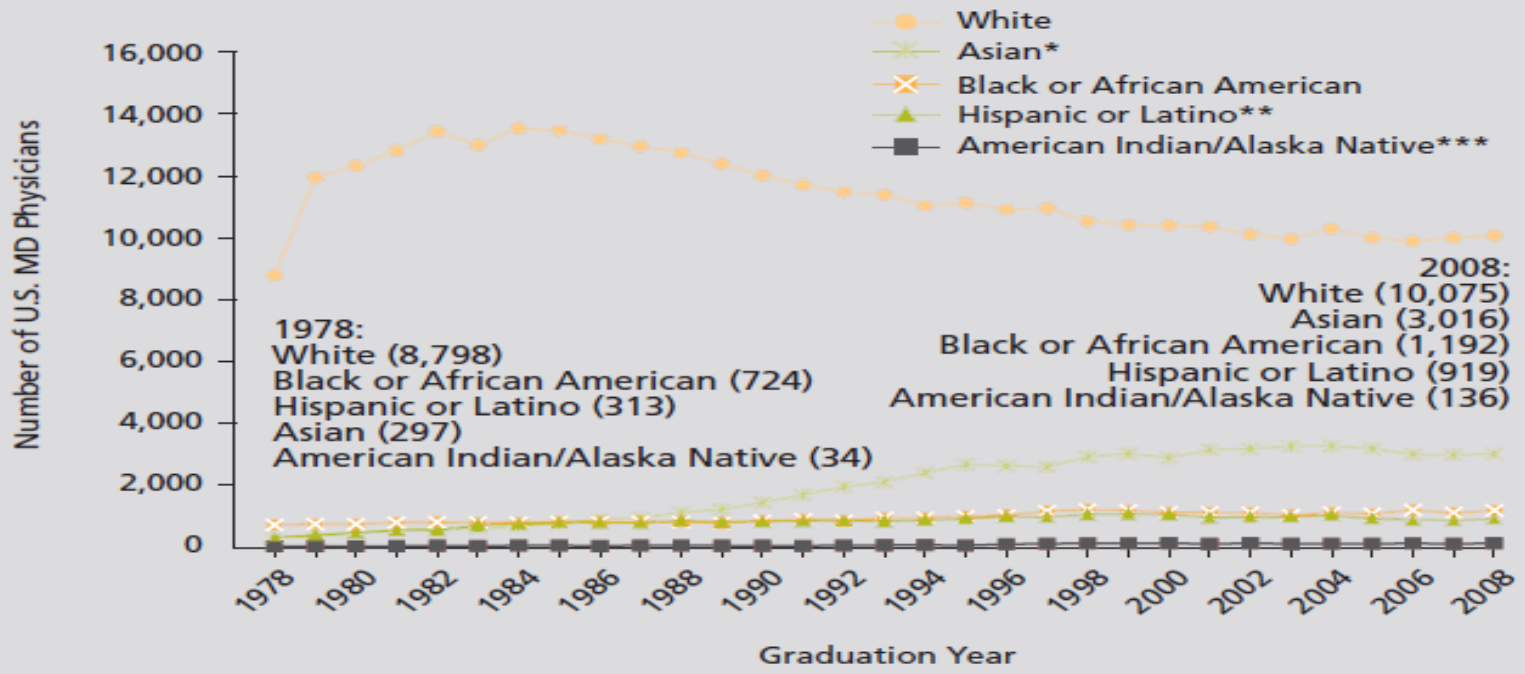
# Educational Benefits of a Diverse Faculty

*"A diverse faculty could affect teaching and learning in a positive fashion…could reach all types of learners and provide respect for needs of diverse learners and respect for diverse scholarship, promote student creativity in scholarship, improve accessibility, provide flexibility such as responding to 'teachable moments,' and improve strategies of teaching."*

Quote by Dr. Martin Marcus in a commentary " The value of diversity in academic emergency medicine," Sept, 2000, vol. 7, #9.

# Physician Workforce: Representation vs. Critical Mass

**Figure 14: U.S. MD Physicians by Graduation Year, Race, and Ethnicity, 1978 - 2008**




Note: The data include U.S. medical school graduates from 1978 to 2008 only. N = 471,409.
*Asian includes Chinese, Filipino, Korean, Japanese, Vietamese, Indian/Pakistani, and Other Asian.
**Hispanic or Latino includes Mexican American, C'Wealth Puerto Rican, Mainland Puerto Rican, and Other Hispanic.
*** From 1997 to 2000, the category "American Indian/Alaska Native" also included Native Hawaiian.
Prior to 1997 and since 2001, this category only includes American Indian/Alaska Native.
Source: AAMC Data warehouse: Minority Physician Database, AMA_Masterfile_R, App_Bio_R, as of 11/30/2009.

# Academic Medicine Faculty

- **6.4%** of medical school faculty are Hispanic and African-American. (AAMC Faculty Roster, 2011)
- Only **1060** Hispanics and **447** African Americans attained rank of full professor. (AAMC Faculty Roster, 2011)
- **30%** of minority faculty in comparison to 46% of white faculty are being promoted from assistant to associate professor within 8 years. (Fang et al. 2000;284(9):1085-1092. doi:10.1001/jama.284.9.1085)
- NIH found that minority investigators are less likely to be funded despite similar achievements. (Ginther et al (2011) Race, Ethnicity, and NIH Research Awards, *Science* 333(6045) 1015-1019, doi : 10.1126/science.1196783)
- URM junior faculty have reported distinct obstacles in comparison to their counterparts to achieving academic promotion. (Palepu et al. JAMA. 1998;280(9):767-771. doi:10.1001/jama.280.9.767)

# AAMC's Commitment to Diversity

- Present since the early 70's with an initial focus on historically underrepresented minorities
  - many campaigns launched throughout the decades including AAMC 's 3000 by 2000
- Definition changed in the 90's: "underrepresented in medicine"
  - provided schools with the opportunity to develop their own definition to meet their mission and community needs
  - continues through today with the ongoing roll out of new initiatives (i.e. Holistic Review, Aspiring Docs)
- Birth of AAMC Group on Diversity and Inclusion (2009)
- Chief Diversity Officer launches Diversity 3.0

# AAMC Group on Diversity and Inclusion (GDI):

- The GDI is a national forum and recognized resource to support AAMC members in their efforts to realize the benefits of diversity and inclusion in medicine and biomedical sciences across all parts of their institutions

- Strategic Plan focused on:
  - Faculty
  - Residents and Fellows
  - LGBT Issues

# Group on Diversity Affairs

"Diversity as a core value embodies inclusiveness, mutual respect, and multiple perspectives and serves as a catalyst for change resulting in health equity. In this context, we are mindful of all aspects of human differences such as socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, disability and age."

"Inclusion is a core element for successfully achieving diversity. Inclusion is achieved by nurturing the climate and culture of the institution through professional development, education, policy, and practice. The objective is creating a climate that fosters belonging, respect, and value for all and encourages engagement and connection throughout the institution."

- There is a substantial body of evidence highlighting racial disparities in the quality of clinical interactions with physicians.
- These disparities are important independent outcomes because they reflect the physicians' abilities (or inabilities) to communicate effectively and foster trust, core elements of the patient– doctor relationship that is at the heart of medical training and health care delivery.
- Unfortunately, racial and ethnic minority patients are more likely to report experiences of discrimination and ultimately a lack of trust in physicians and the health care system.
  - Cooper LA, Beach MC, Johnson RL, Inui TS. Delving below the surface. Understanding how race and ethnicity influence relationships in health care. *J Gen Intern Med. 2006;21 Suppl 1:S21-27.*
  - Trivedi AN, Ayanian JZ. Perceived discrimination and use of preventive health services. *J Gen Intern Med. 2006;21:553-558.*
  - Johnson RL, Saha S, Arbelaez JJ, Beach MC, Cooper LA. Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. *J Gen Intern Med. 2004;19:101-110.*
- Similarly, minority patients are more likely to report decreased satisfaction with health services, mediated by the quality of their interactions with health care providers.
  - Saha S, Arbelaez JJ, Cooper LA. Patient-physician relationships and racial disparities in the quality of health care. *Am J Public Health. 2003;93:1713-1719.*

# The New Jersey Medical School Experience


NEW JERSEY MEDICAL SCHOOL

University of Medicine & Dentistry of New Jersey

# Commitment to Diversity

- Dates back to the move of the school to the city of Newark and manifested in the Newark Agreements
- Launched our first pipeline for undergraduate and pre-matriculated minority and disadvantaged students programs in 1972
- In 1981 we launched our first high school program
- In 1991 we became a federally funded Hispanic Center of Excellence with programs from the precollege to faculty and curricular levels

# Challenges

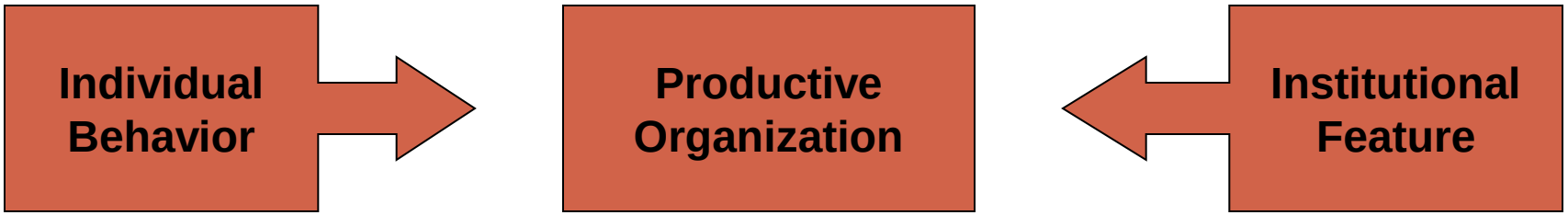
- By 1991, the school had 20 years of experience in minority medical student recruitment/graduation
- Articulated commitment to diversity at the faculty level
- However, it was evident that we did not know what it meant to retain and develop faculty overall and, in particular, minorities
- Openly addressed misconceptions shared by some of what it meant to recruit and retain a faculty member from an underrepresented group

# UMDNJ-New Jersey Medical School
# Hispanic Center of Excellence (HCOE)

- Established in 1991 and funded by Health Resources and Services Administration (HRSA).
- Hispanic graduates tripled over 20 year period:
  - Pre-HCOE (1972-1992) – 104 graduates
  - Post-HCOE (1993-2011) – 311 graduates
- Groom our own: Academic medicine pipeline for medical students and residents.
- Hispanic faculty above national average at 5.5%.
- Robust Hispanic faculty development program which includes research and scholarship.
- Comprehensive cultural competency curriculum, co-curricular activities, grand rounds, and faculty development impacting faculty, staff, administrators, and 700 students.
- Transformed institutional culture.

UMDNJ
NEW JERSEY MEDICAL SCHOOL
University of Medicine & Dentistry of New Jersey

# Model for Success at the Hispanic Center of Excellence




**Creating an environment in which personal traits when added to institutional traits, results in a productive organization while also yielding personal advancement.**

Soto-Greene, M., Sanchez, J., Churrango, J., Salas-Lopez, D. (2005) Latino Faculty Development in U.S. Medical Schools: A Hispanic Center of Excellence Perspective. Journal of Hispanic Higher Education, Vol. 4, No. 4, 366-376.

*"We cannot solve our problems with the same level of thinking that created them."*

(Albert Einstein)

# Lessons Learned

- Effective behaviors of productive faculty occur when the institution provides the proper support towards mutually agreed upon expectations.

- The formula for success is dependent on attaining the appropriate institutional support from the Departmental Chairs, the Dean, and the Hospital.

# Faculty Development

- Effective faculty development programs can **provide an academically and emotionally safe environment for learning behaviors that correlate with academic success**, such as motivation, socialization, competence in their area of interest, competence in research, and teaching and mentoring.

# Maintaining Commitment to Faculty Diversity

- Formation of the Northeast Consortium for Minority Faculty Development
  - Funded by the Macy Foundation for three years ending in September 2009
  - Collaboration between U. Penn, NJMS, Albert Einstein, and Mount Sinai – all had been federally funded COE's
  - Sponsorship of minority faculty development institutes for senior and junior faculty

# Lessons Learned

- The Consortium provided a pooling of expertise on how to develop programs that enhanced diversity, senior role models, a place where faculty felt welcomed, and a hope for the future

- Challenge is how to maintain and sustain a similar model

# Medical Student Talent Search

- Targeting underrepresented minority students for development as future academicians has been key to augmenting the number of Hispanic and African-American faculty at our school.

- In essence, the concept of "Growing Our Own" continues to be important. Of the 79 full and part-time minority faculty, 28 or almost 35% are either alumni and/or residency training program graduates.

# Medical Student Talent Search

- Survey the backgrounds of first year NJMS Hispanic medical students to identify three groups

  1) those with research backgrounds and/or with advanced degrees in the biomedical sciences,

  2) those enrolled in the MD/MPH or MD/PhD track, or

  3) those having an interest in pursuing a career in academic medicine.

# Medical Student Talent Search

- Meet with these students to discuss interest in an academic career.
- Sponsor attendance at national meetings where they can present abstracts or posters, or have the opportunity to serve as co-presenters alongside our faculty.
- Encourage participation in the NJMS Summer Student Biomedical Research Program or other similar programs such as the Howard Hughes Medical Institute and Doris Duke to name a few.

# Talent Search

- Similar process for identification of graduate and resident trainees to discuss interest and explore academic medicine career options.
- This requires collaboration with the Department Chair, GME Deans, and Graduate School Dean.
- Focus on activities that will support development such as participation in research training, research projects, presentations, etc.

# Professional Development

- Mentoring is a key component.
- Building a relationship so that ongoing follow up occurs regularly and at critical times in a career.
- Development of an individualized academic action plan with timelines is critical. This allows the student and resident to monitor progress towards achievement of goals once he/she becomes a faculty.

# As we look into the future

- Both medical students and resident physicians from underrepresented minority groups report plans to work in underserved settings more frequently than white trainees

Saha S, Guiton G, Wimmers PF, Wilkerson L. Student body racial and ethnic composition and diversity-related outcomes in US medical schools. *Jama*. 2008;300:1135-1145.

Weissman JS, Campbell EG, Gokhale M, Blumenthal D. Residents' preferences and preparation for caring for underserved populations. *J Urban Health*. 2001;78:535-549.

# Building the Next Generation of Academic Physicians Initiative (BNGAP)

BNGAP | Building the Next Generation of Academic Physicians

# Objectives

- Conduct an initial and ongoing **assessment** of medical student, resident, and faculty interest in, pursuit of, and success along an academic medicine career.
- Develop and implement a **strategy** to assist a diverse group of medical students, residents, and faculty interested in academic medicine in assessing and achieving their personal and professional goals.
- Facilitate and evaluate the **outcomes and impact** of this initiative.

# Building the Next Generation of Academic Physicians

- Partnership began with: AAMC and HCOE-Einstein
- Purpose of this Initiative
  - Build upon previous HCOE and AAMC work on workforce diversity
- Collaborators: LMSA, NHMA, SNMA, AMA, NMA, NA/PI, and APSA
- Expanded: NJMS, Mount Sinai, Cornell, NYU

BNGAP | Building the Next Generation of Academic Physicians

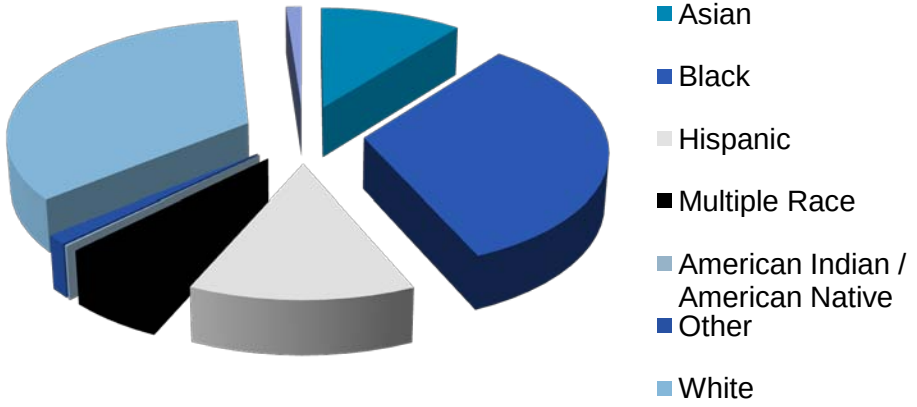
# Medical Students

- 72% of all 1997-2004 AAMC Graduation Questionnaire respondents in the sample who planned at graduation to pursue an academic medicine careers had not indicated this career-setting preference on the MSQ.
- URM graduates were more likely than white graduates to report diminished intent to pursue an academic medicine career based on AAMC Graduation Questionnaire

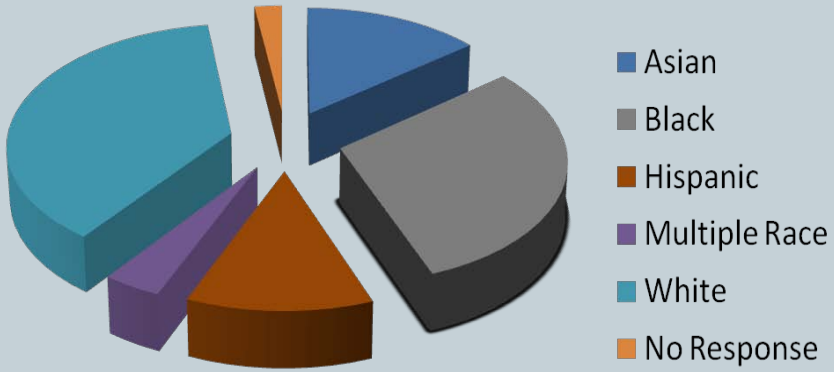
Why is this important…

- Women, MD/PhD program graduates, and graduates who reported a career setting preference for “full-time university faculty” on AAMC GQ were more likely to have a full-time faculty appointment among recent medical school graduates.
- Moreover, Straus et al. in their systematic review of the literature on career choice in academic medicine found that as residents progress through residency they become less interested in this area, highlighting the need to promote academic medicine as a career among trainees earlier in their formative training.

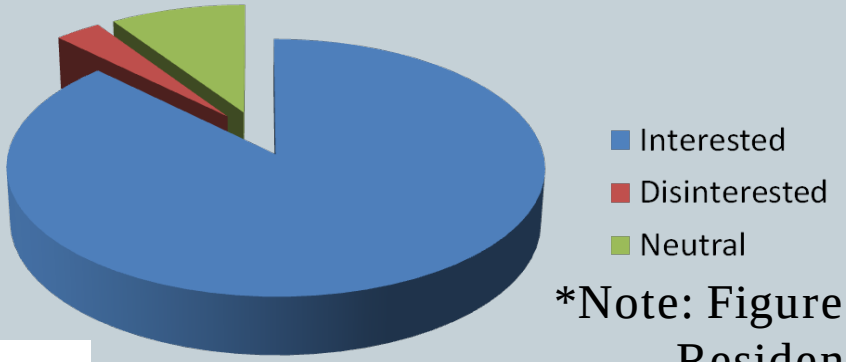
## Medical Students
N = ~600 participants




## Residents
N = ~180 participants




Irrespective of Race and Ethnicity, the majority of medical students and residents were interested in Academic Medicine




*Note: Figure representative of Residents data only (*unpublished*)

BNGAP | Building the Next Generation of Academic Physicians

# Qualitative Study Findings

## Lower Expectation / "Mentorship"

*"…Latinos in general that go into medicine aren't like prepared for a career in medicine from birth. A lot of other people start the process early on. They have mentors early on so they already know their options. I don't think I would have been receptive of that stuff because I was just trying to get through undergrad and hopefully make it to medical school."*

# Qualitative Study Findings

## De-valuing Community

*"... A lot of people of color want to do something like community service or give back, so if there was a way to sort of better way to quantify the impact that they were having or sort of have some promotion based on community service...that might also serve to encourage more people to think about academic medicine because they don't feel like that internal tension of like I do, you know, focus on getting, you know, tenured?"*

# Conclusions

- BNGAP study underscores the great potential for cultivating and attracting the next generation of academic physicians.
- Both URM and majority trainees do not strongly identify community-engaged scholarship with academic medicine — a perspective that may preclude otherwise interested individuals from becoming community engaged researchers.

# Next Steps

- Join the Building the Next Generation of Academic Initiatives (BNGAP) to diversify the academic workforce by targeting URM medical students and residents.
- Specific aim is to develop institution-based infrastructures and to serve as national leaders in stimulating interest, promoting, and developing a diverse medical student academic medicine pipeline.
- Albert Einstein, NJMS, and Mount Sinai will sponsor one of the annual Pre-Faculty Career Development Conferences.

# Next Steps

- Invite students and residents identified through our HCOE talent search, BNGAP institutions, and COE consortium.

- NJMS talent search students interested in residency training will be invited to participate in COE Consortium annual residency fairs as well as visiting electives for students underrepresented in medicine.

- These new partnerships allow students to continue their growth within a community of proposed COE Consortium and BNGAP collaborators who have the knowledge and expertise to foster interest and pursuit of an academic career. We intend to produce a cohort of students who might enter either NJMS or a COE Consortium post-graduate training program, and subsequently be recruited as faculty by any of our institutions.

# Ongoing Challenge

- Fisher v. University of Texas, No. 11-343
  - Race as a factor in the admissions decision, U.S. Supreme Court

*"The question is not whether we want diversity or whether we should accommodate diversity, for diversity is clearly our present and future. Rather, it is time to move beyond old questions and to ask instead how can we build diversity in the center of higher education, where it can serve as a powerful facilitator of institutional mission and societal purpose."*

Daryl Smith, Diversity's Promise for Higher Education, Making it Work

# Is the Military a Unique Culture?

COL John P. Schriver

William Beaumont Army Medical Center

# Disclaimer

- All views and opinions expressed in this presentation are my own.
- They are not intended to represent the policies of the Fort Bliss Command, United States Army, United States Government, or any Federal Programs.

# Outline

- What Constitutes a Unique Culture?
- What Makes the Military Culturally Unique?
- If Unique, how does this impact health care delivery?
- What is TRICARE?
- Cultural Barriers to care.
- Summary

# Who am I?

- Military brat
- Father a Career Army Officer; Vietnam Veteran- Oral Surgeon
- Moved 5 times before starting high school
- Attended military school- The Citadel
- Medical school scholarship- military obligation
- 25 years active Army experience
  - General Surgeon
- Veteran- 4 combat deployments

# Who I am not

- Sociologist
- Socio-cultural Anthropologist
- Psychiatrist
- No kind of “ist”.

# Culture: From “Bing Dictionary”

1. **shared beliefs and values of group:** the beliefs, customs, practices, and social behavior of a particular nation or people "Southeast Asian culture"
2. **people with shared beliefs and practices:** a group of people whose shared beliefs and practices identify the particular place, class, or time to which they belong “Religious culture.”
3. **shared attitudes:** a particular set of attitudes that characterizes a group of people "The company tries hard to avoid a blame culture."
4. **Important for a culture is a common language**

# Major Attributes

- **A group of people with:**
  - **Shared beliefs**
  - **Shared values**
  - **Shared practices**
  - **Shared attitudes**
  - **Common language**

# Military Doctrine

**Shared beliefs**
**Shared values**
**Shared practices**
**Shared attitudes**
**Common language**

- doctrine seeks to provide a common conceptual framework for a military service:
  - what the service perceives itself to be
    - "Who are **we**?"
  - what its mission is
    - "What do **we** do?"
  - how the mission is to be carried out
    - "How do **we** do that?"
  - how the mission has been carried out in history
    - "How did **we** do that in the past?"

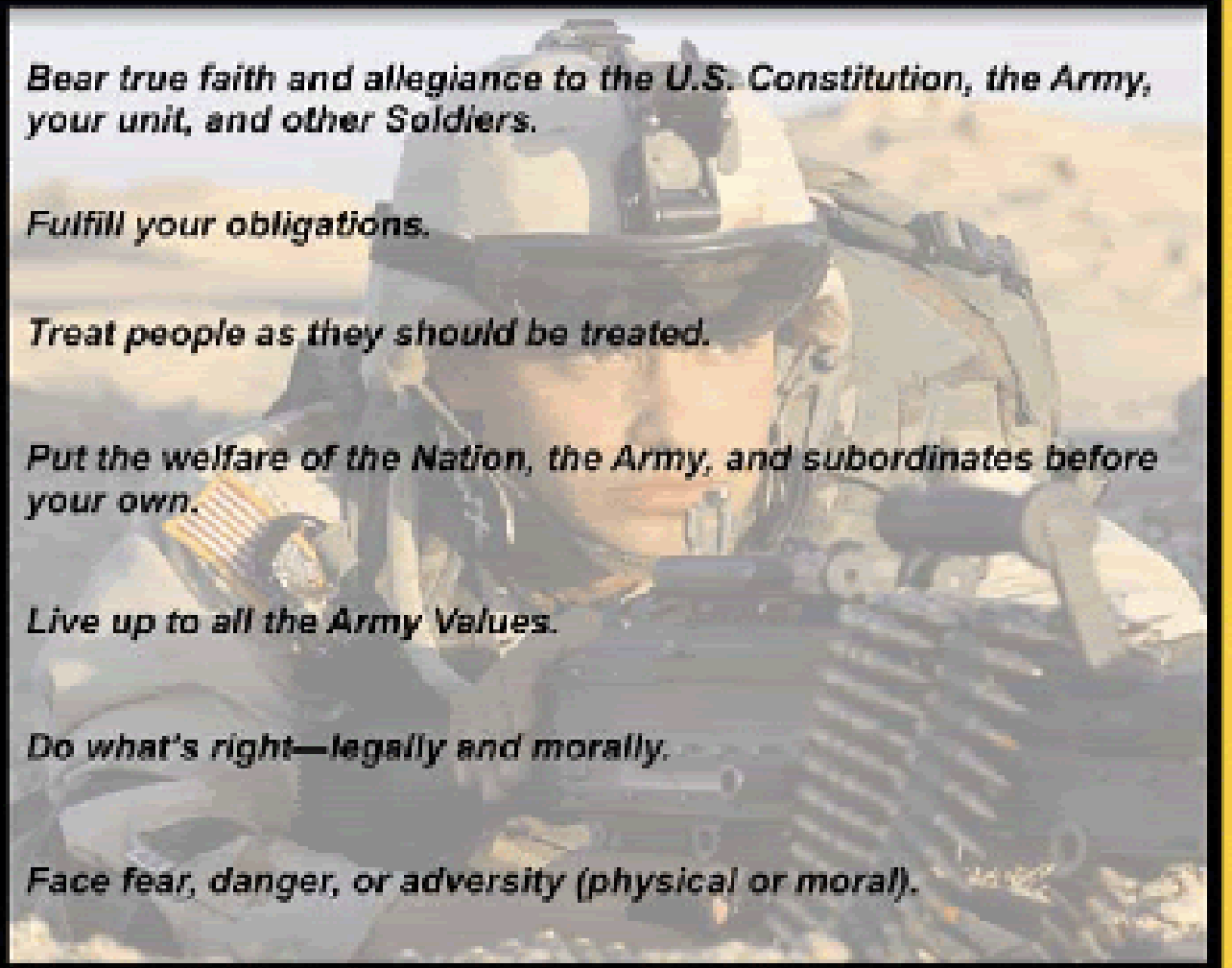
# Attitude of Conforming

**Shared beliefs**
**Shared values**
**Shared practices**
**Shared attitudes**
**Common language**

- Rank and command structure.
- Rendering salute.
- No women in direct combat role.
- Do not accommodate disabilities.
- Don’t ask, don’t tell.
- Uniform Code of Military Justice

# Army Core Values

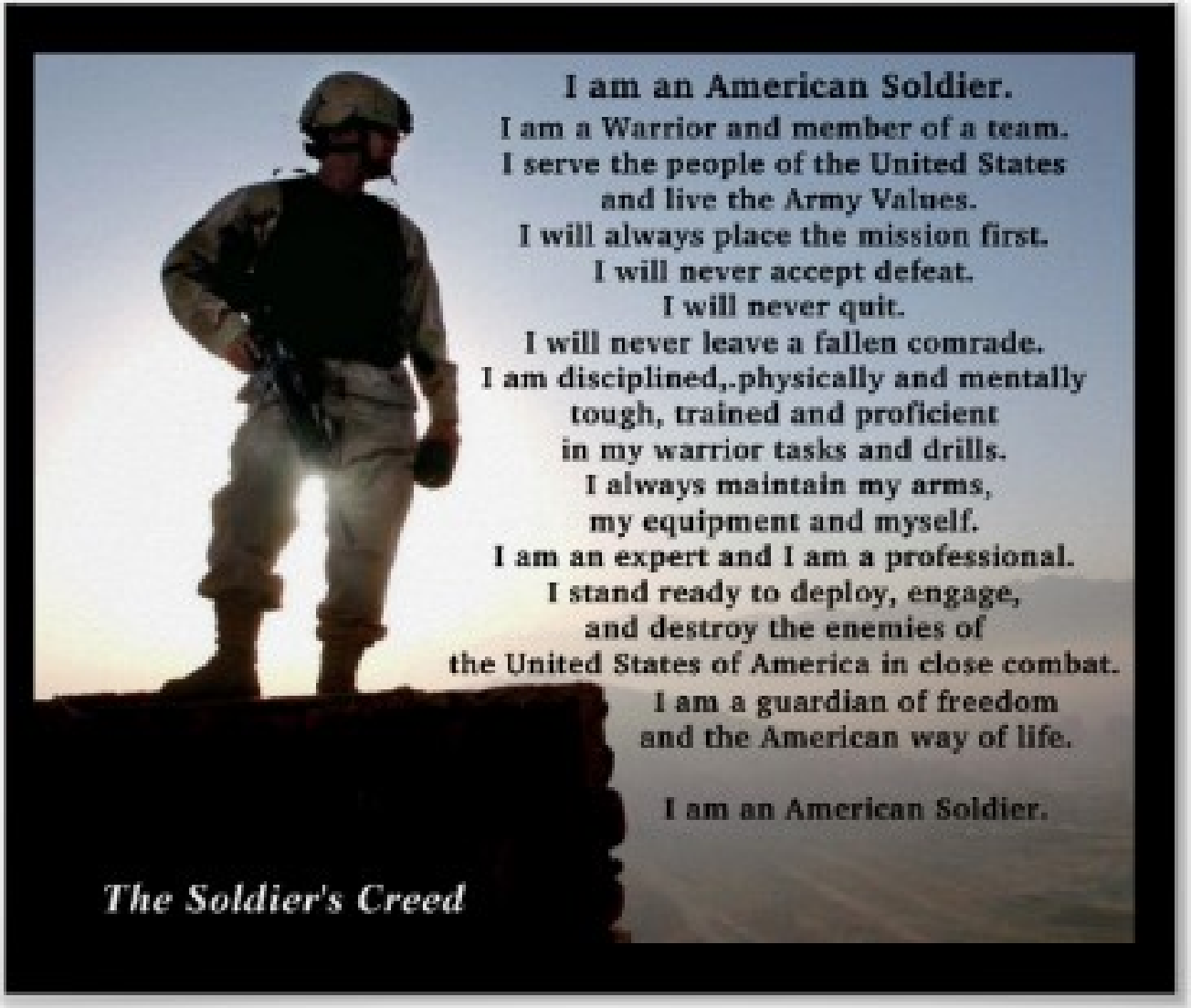
Shared beliefs
**Shared values**
Shared practices
Shared attitudes
Common language



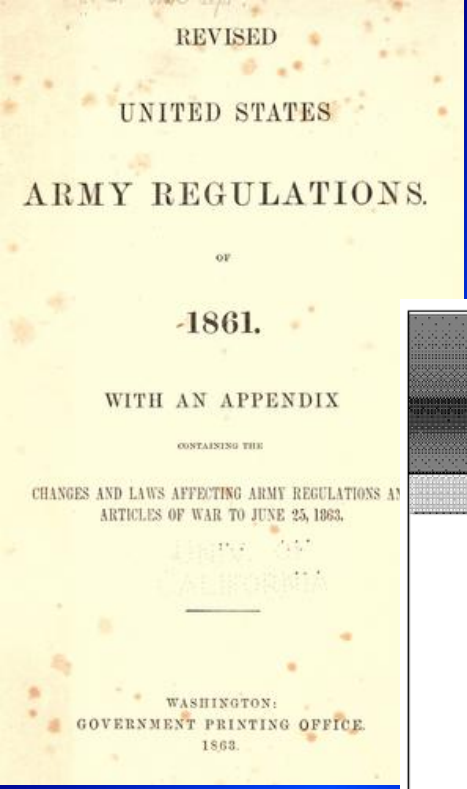
| | |
|---|---|
| LOYALTY | *Bear true faith and allegiance to the U.S. Constitution, the Army, your unit, and other Soldiers.* |
| DUTY | *Fulfill your obligations.* |
| RESPECT | *Treat people as they should be treated.* |
| SELFLESS SERVICE | *Put the welfare of the Nation, the Army, and subordinates before your own.* |
| HONOR | *Live up to all the Army Values.* |
| INTEGRITY | *Do what's right—legally and morally.* |
| PERSONAL COURAGE | *Face fear, danger, or adversity (physical or moral).* |

# Shared Practices

# Warrior Ethos



# Shared Practices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UNITED STATES

ARMY REGULATIONS

OF

1861.

WITH AN APPENDIX

CONTAINING THE

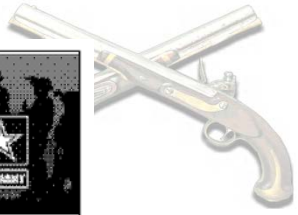
CHANGES AND LAWS AFFECTING ARMY REGULATIONS AN
ARTICLES OF WAR TO JUNE 25, 1863.

WASHINGTON:
GOVERNMENT PRINTING OFFICE.
1863.

# Shared Practices

89TH Military Police Brigade

AWARDS SOP





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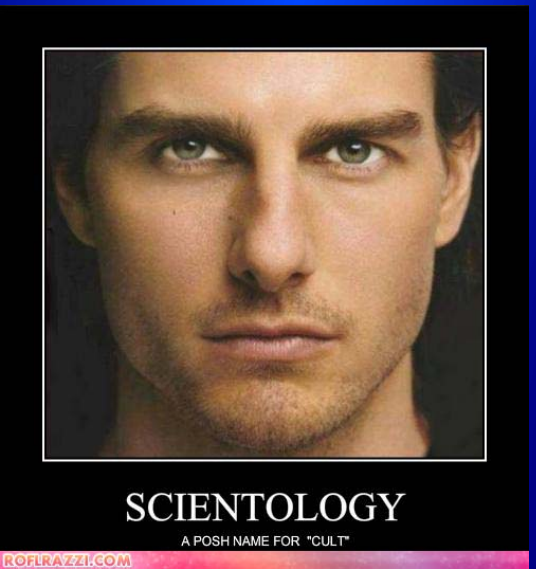
| DA Letterhead and Instructions | DA Memorandums | DA Pamphlets | HQDA Letters |
| Engineering Admin Publications | Medical Admin Publications | Principal Official Guidance | MCM - Manual for Courts-Marti |
| Joint Admin Publications | Joint Table of Allowances (JTA) | Army ALARACT Messages | Rapid Action Revisions |
| PCO & FMO Directory | | Staffing Table for Publications | |
| **EForms** | | | |
| DA Forms | DD Forms | GPO Forms | JCP Forms |
| GSA Forms | OGE Forms | OPM Forms | SF - Standard Forms |
| **Technical and Equipment** | | | |
| TM - Technical Manuals | HR - Hand Receipts | LO - Lubrication Orders | MWO - Modification Work Orde |
| | TB - Technical Bulletins | | |
| **Doctrine and Training** | | | |
| ARTEP - Army Training And Evaluation Program | | ATTP - Army Tactics, Techniques, and Procedures | |
| ADP - Army Doctrine Publicatio | ADRP - Army Doctrine Reference Publications | | ATP - Army Techniques Publicatior |
| Common Table Of Allowances | FM - Field Manuals | GTA - Graphic Training Aids | MTP - Mission Training Plan |
| Officer Foundation Standards | SB - Supply Bulletin (Technical) | SB - Supply Bulletin (Medical) | Soldier's Manual Of Common Task |
| Soldier's Manual | Technical Manuals | STP - Soldier Training Publicati | TC - Training Circular |
| **Engineering** | | **Medical** | |
| Engineering Technical Manual | | TB MED | Other Medical Pubs |

# Language

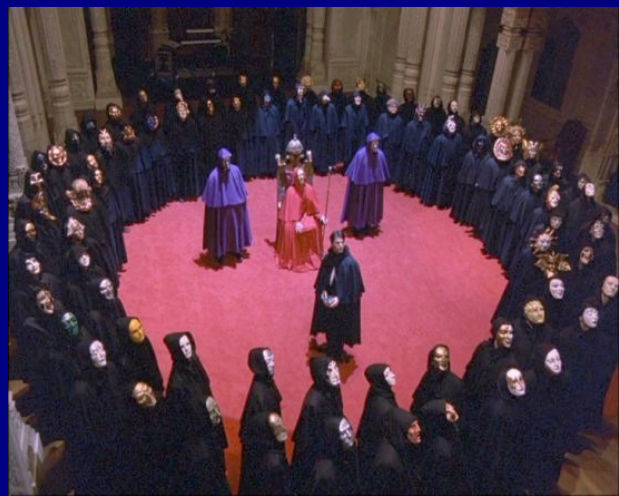
- I’m undergoing an MEB but haven’t talked to my PEBLO yet about this. My PCM at the WTU says I am FFD. I have a P3 profile for my back, but since you did my colectomy, I have had bad diarrhea. I need documentation of NMRS per AR 50-401.
  - Acronymlist.com
    - Medical Acronyms= 922
    - Military Acronyms= 3,196

# Cult or Culture?

- Cult
  - Use mind control
  - Potential for harm
  - Screening before joining, recruitment
  - Often barriers to leaving




From- Wikipedia



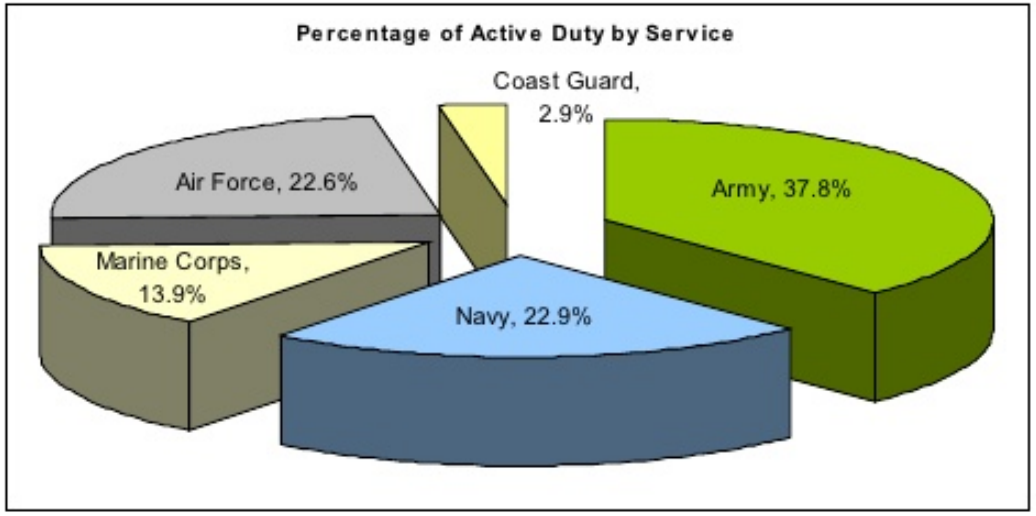
# How Big a Culture?



## Assigned Strength of Active Duty Force

**September 2008**

| Service | Enlisted | Officers* | Total | Percentage |
|---|---|---|---|---|
| Army | 452,065 | 87,610 | 539,675 | 37.8% |
| Navy | 275,296 | 51,388 | 326,684 | 22.9% |
| Marine Corps | 178,213 | 20,202 | 198,415 | 13.9% |
| Air Force | 258,095 | 64,805 | 322,900 | 22.6% |
| Coast Guard | 33,228 | 8,134 | 41,362 | 2.9% |
| Total | 1,196,897 | 232,139 | 1,429,036 | 100% |



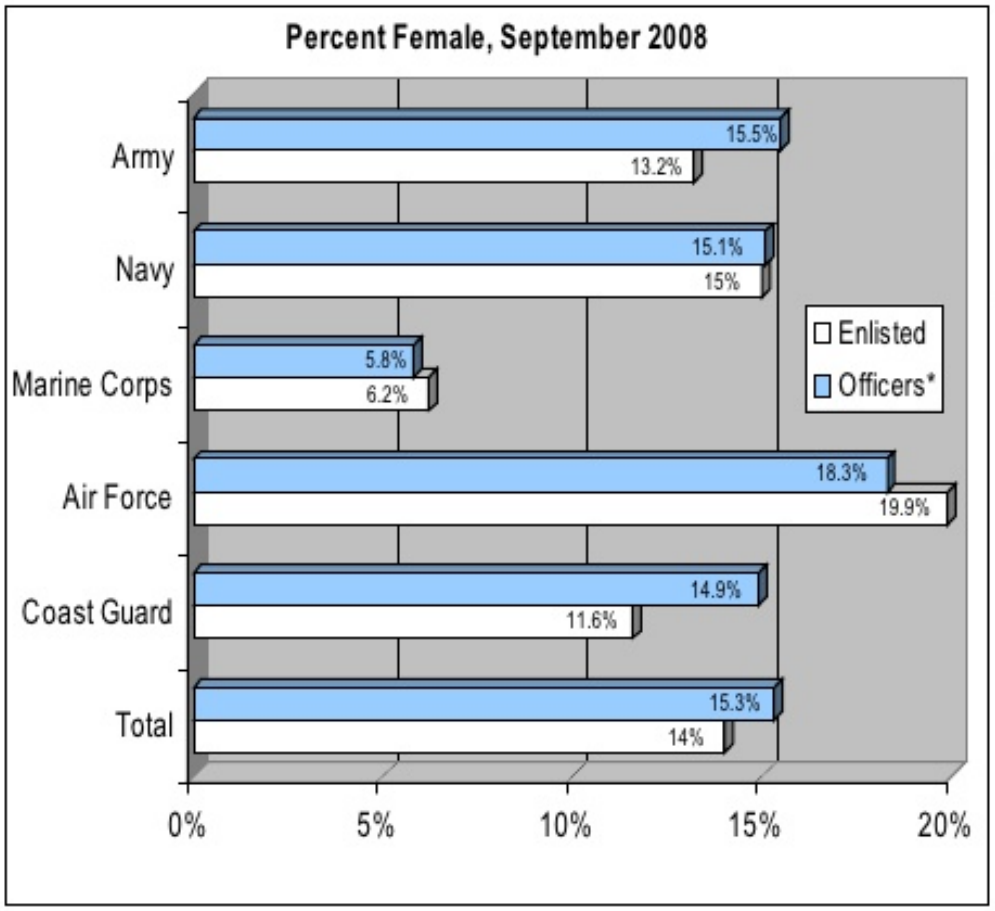

***1.4 Million Assigned***

* *Includes Warrant Officers*
* *Includes Marine Corps*

# Most Are Male



## Active Duty Gender Distribution




One-Seventh Are Female

- Air Force has highest percent of women
  - 18% Officers
  - 20% Enlisted

* Includes Warrant Officers
* Includes Marine Corps

# No Single Racial Background



## Race Profile of Active Duty Force

Race Distribution, September 2008

| Service | % White | % Minorities* | % Black | % Other |
|---|---|---|---|---|
| Army | 73.9% | 26.1% | 21.5% | 4.6% |
| Navy | 66.2% | 33.8% | 19.3% | 14.4% |
| Marine Corps | 83.7% | 16.3% | 11.1% | 5.2% |
| Air Force | 78.1% | 21.9% | 15.6% | 6.3% |
| Coast Guard | 82% | 18% | 6.1% | 11.9% |
| Total | 74.6% | 25.4% | 17.8% | 7.6% |

- Over one-fourth are race minorities (25%)
- Blacks comprise nearly one-fifth (18%) of active duty force

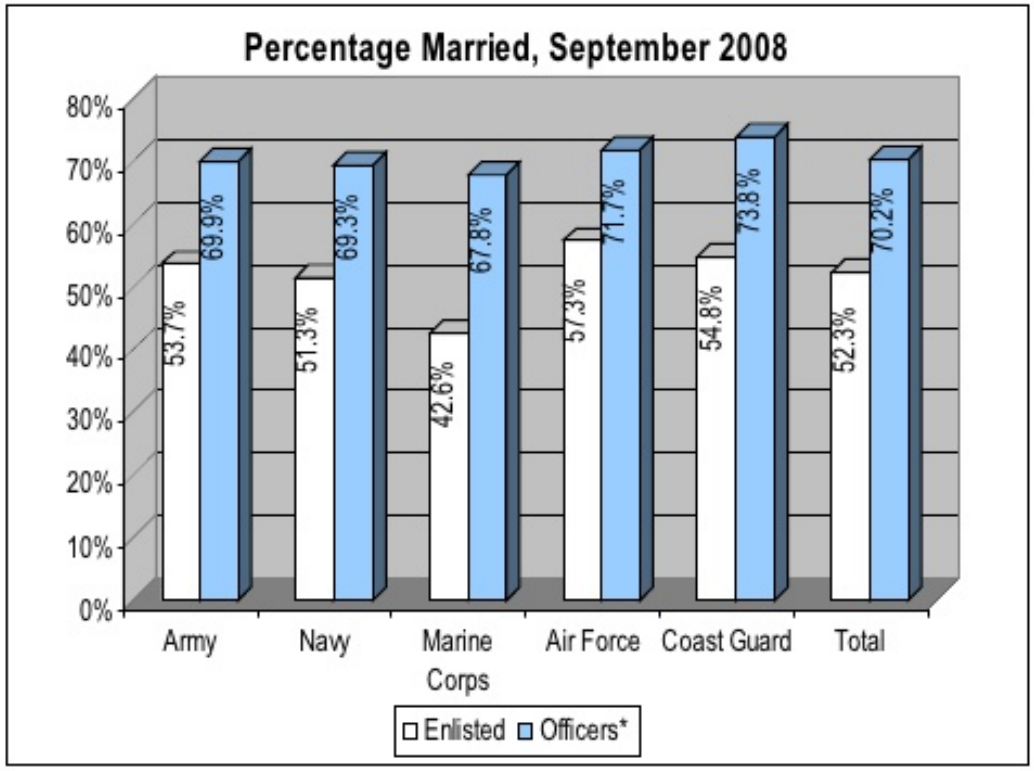
- U.S. population
  - White = 72%
  - Minorities = 28%
  - Black = 13%

** Includes Black & Other*
** Includes Marine Corps*

# Majority Married



## Marital Profile of Active Duty Force




**Half Are Married**

- Total active duty rate is 55%
  - Ranges from 45% in Marine Corps to 60% in Air Force
- Half of enlisted force (52%) are married
- Five-sevenths (70%) of officers are married

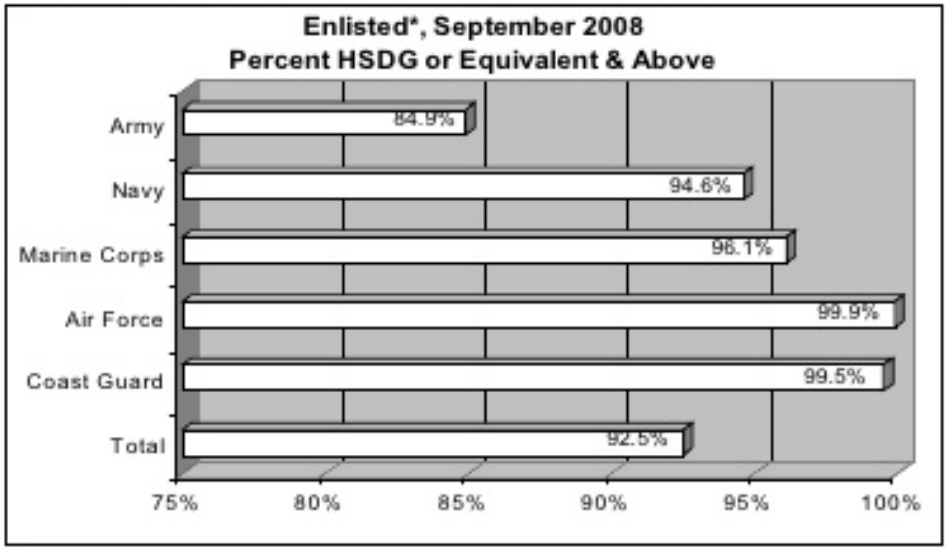
** Includes Warrant Officers*

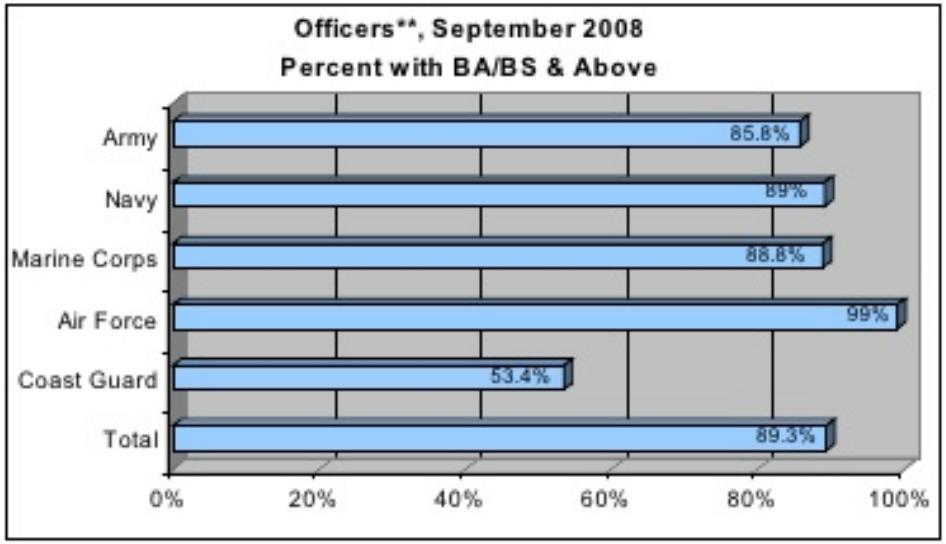
*** Numbers do not equal 100% because other marital status not listed.*

# Education Profile of Active Duty Force

## Almost All Enlisted Are High School Grads

- 93% of total DoD enlisted* earned High School Diploma or equivalent and above
- 90% of total DoD officers** have a college degree or higher




* *Unknowns: Army: 1.4%*

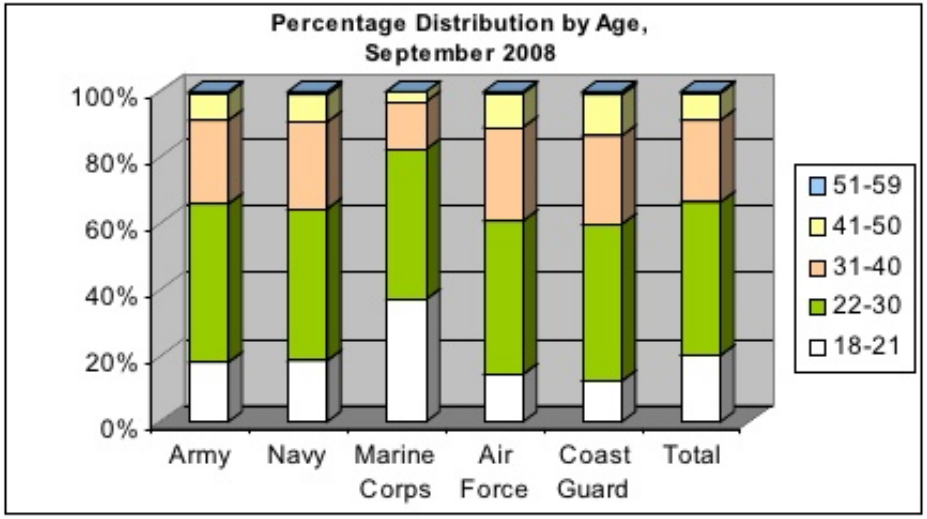
** *Includes Warrant Officers; Unknowns: Navy: 14.6%, Air Force: 2.9% and Coast Guard 1.1%*

* *Includes Marine Corps*

# Active Duty Population Young



## Age Distribution of Active Duty Force




| Service | 18-21 | 22-30 | 31-40 | 41-50 | 51-59 | Average Age |
|---|---|---|---|---|---|---|
| Army | 18.3% | 48% | 25.6% | 7.9% | 0.7% | 29 |
| Navy | 18.6% | 46% | 26.3% | 8.3% | 0.8% | 29 |
| Marine Corps | 36.9% | 46% | 14% | 3.1% | 0.2% | 25 |
| Air Force | 14.4% | 46% | 28.3% | 10% | 0.6% | 30 |
| Coast Guard | 12.2% | 48% | 27% | 12% | 1% | 30 |
| Total | 19.9% | 47% | 24.8% | 8% | 0.6% | 28 |

**Almost Half Are Between 22-30 Yrs**

- Marine Corps has highest percentage of 18-21 year olds (37%)
- Average age of total active duty force is 28

** May not add to 100.0% due to rounding*
** Includes Marine Corps*

# Military Family Background

- Higher middle class
- Higher High School graduation (GED)
- Minority rate similar
  - Slight Black over representation
  - Asian and Hispanic under representation
- Increased rural population
- Slight increased representation from the South

» Tim Kane. Who Bears the Burden?. Heritage Foundation, Nov. 7, 2005; CDA05-08.

# The Military is a Sub-Culture

- We are drawn from all over the U.S.
- We speak both “American” and “Military”.
- We are all different, but:
  - **Shared beliefs**
  - **Shared values**
  - **Shared practices**
  - **Shared attitudes**

# Is This Really Important

- Do we have unique disease processes?
- Do our practices affect our health in a predictable manner?
- How does being of Military Culture impact health care delivery?

# Particular Stressors for the Military Family

- Nature of dangerous work for the military parent
- “Family Service and Sacrifice” in time of war and crisis
- Deployment Stress
- Relocation Stress
- Isolation from extended family support
- Suddenly “Military Family” status for NG/ R
- Military parental injury and death
- Financial constraints

# Moving on when mom is killed at war

By Wayne Drash, CNN
updated 8:25 AM EST, Tue November 8, 2011

# Challenges for the Military Family

- <0.5% of U.S population actively serves
- 2,000,000 children have lived through a deployment
- 800,000 children have lived through 2 or more
- Family and child functioning decrease in proportion to increasing months of deployment
- Shorter “dwell time”= family instability, decreased coping

» Data from- Home Base Program: Toolkit for the Well Child Screening of Military Children

# Military Families

- Recent study of children 3-8 during deployment of parent:
  - BH visits to pediatrician- increased 11%
  - For behavioral disruption- increased 19%
  - For stress disorders- increased 18%

» Gorman et al. Wartime military deployment and increased pediatric mental and behavioral health complaints. Pediatrics 2010; 126, 1058-1066

# Maltreatment

- Historically military family maltreatment less than civilian.
- Increase since OIF and OEF.
- Likelihood of maltreatment, primarily neglect, increases during deployment- 42%.


- Gibbs et al. Child Maltreatment in Enlisted Soldiers' Families during combat-related deployments. JAMA 2007; 298, 528-535.

# Re-Integration

- Family reorganization during deployment.
- Disruption with return and re-integration.
- Magnified with soldier physical or mental injury:
  - Veteran's Administration estimates
    - approximately 20% PTSD
  - 60% do not seek treatment*

* Casey et al. Comprehensive Soldier Fitness: A Vision for Psychological Resilience in the U.S. Army. American Psychologist 2011; 66, 1-3.

# Screening for mental health concerns –the need is there

- **Half of all mental health conditions begin by age 14, three fourths by age 24**
- **11% of American youth have a diagnosable mental health condition causing significant functional impairment**
- Estimated 12-20% of pediatric patients have behavioral health issue as they present to their **primary care provider for other concerns**

# 7 Year old girl with abdominal pain

- Noted that she has also been missing a lot of school

# The Rest of the Story

- Patient lives on military post
- Recent tragedy in dad's unit
- Several service members killed or injured
- Everyone in the neighborhood is talking about it
- She hears mommy's worried conversations
- Will her daddy be alright, what if something happens to mommy?

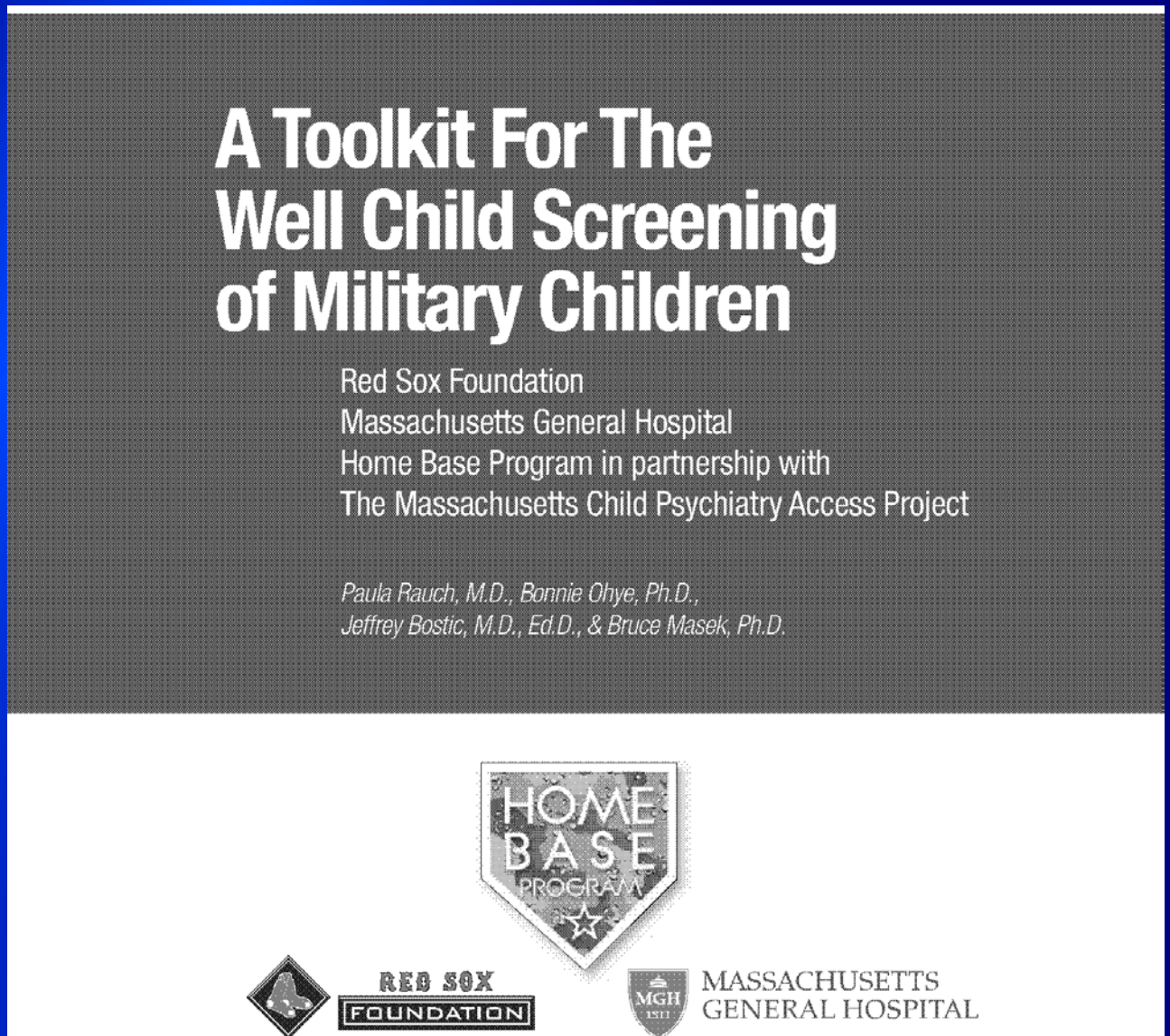
# What Can Pediatricians do to Support Military Youth?

- Work to understand military youth culture
- Screen for deployment stress in youth
- Provide resources such as prevention and support
- Recognize and Respond

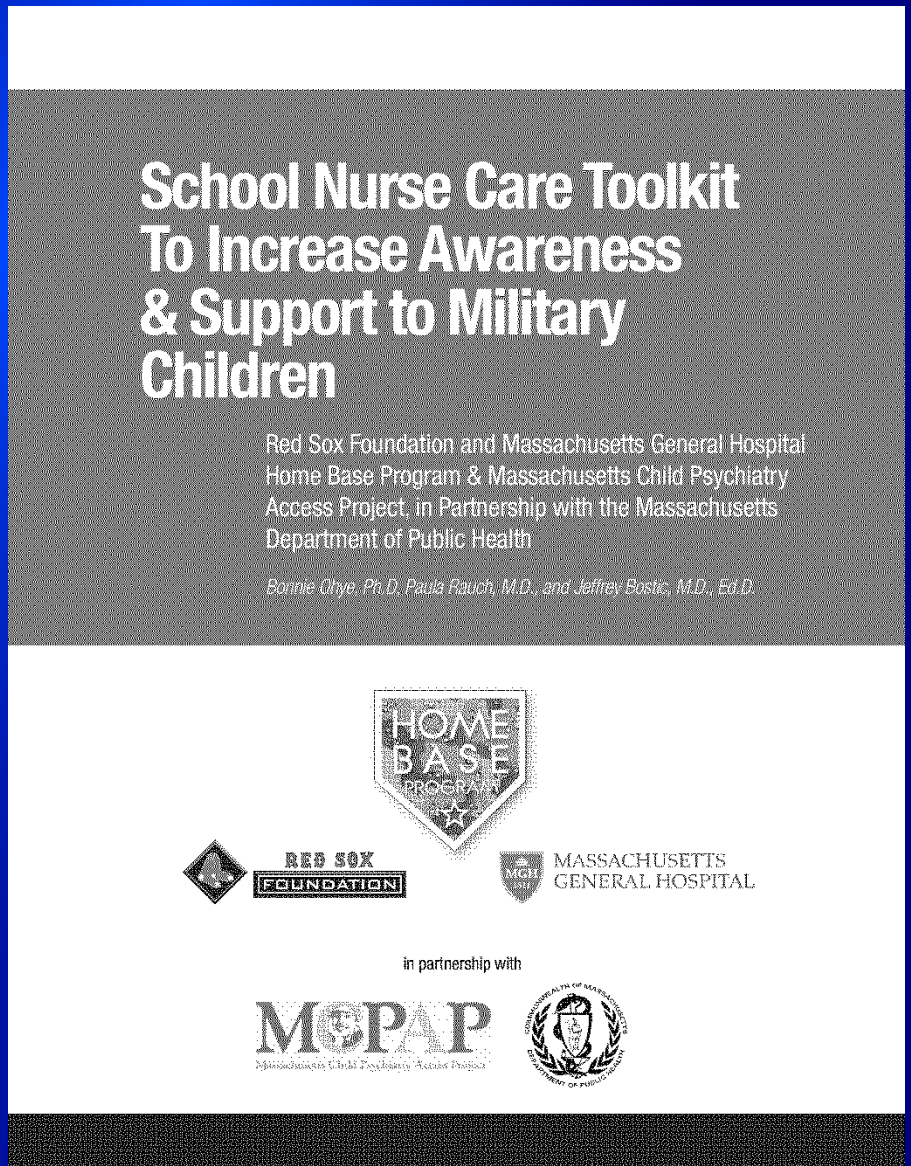
# Behavioral Health Screening instruments

- Pediatric Symptom Checklist PSC
- Youth Self Report Y-PSC
- Patient Health Questionnaire 9-Modified PHQ-9M (for adolescents)
- CRAFFT adolescent alcohol and drug abuse
- Depression Severity Index-Suicide Subscale
- Edinburgh postnatal depression screen
- Patient Health Questionnaire 2

# Many Provider Resources Online



# Online Provider Resources



# But How Do I Do This?

- At patient check-in:
  - Does anyone in your family serve our country
    - Yes- screening tool for child or parent
  - Health care provider:
    - Incorporate the information obtained into the Well Child Exam
  - Consider referral for further evaluation as appropriate
  - Provide educational materials as appropriate

# Ask Questions

- Is anyone in the family military?
- Is anyone showing signs of distress?
- Does any family member need additional help or support?
- **Is everyone safe at home?**

# TRICARE

- 1956- Dependents Medical Care Act
- 1967- became CHAMPUS
- 1988- initiatives morph into TRICARE

# What Is TRICARE?

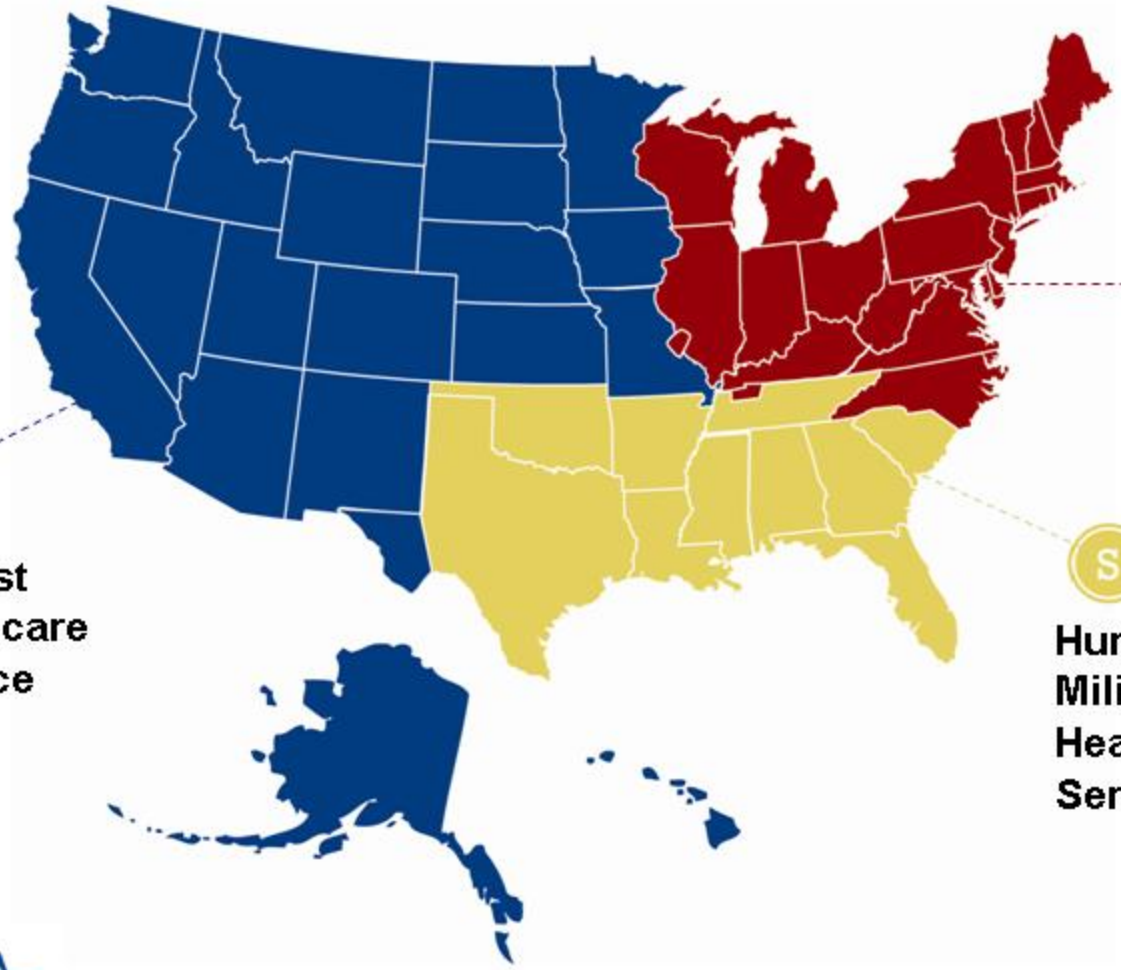
**TRICARE is …**

… the **health care program** for active duty service members (ADSMs), active duty family members (ADFMs), National Guard and Reserve members and their family members, retirees and retiree family members, survivors, and certain former spouses worldwide.

… a **network of military and civilian health care professionals** working together to foster, protect, sustain, and restore health for those entrusted to their care.

## What Is TRICARE?

# TRICARE Stateside Regions (*United States and Washington, DC*)



Program Options

# TRICARE Prime

| Topic | Description | |
|---|---|---|
| Eligibility | • ADSMs, ADFMs, retirees and their family members survivors, certain former spouses, and others in Prime Service Areas (PSAs) | |
| Enrollment | • Enroll via the BWE Web site or by filling out the *TRICARE Prime Enrollment Application and PCM Change Form* (DD Form 2876)<br>• Submit initial enrollment fee with application (*if required*)<br>• Choose a PCM | |
| Costs | ADSMs and ADFMs:<br>• No enrollment fees/deductibles<br>• ADFMs have cost-shares for some prescriptions | All others:<br>• Annual enrollment fee required<br>• Copayments for health care services and some prescriptions |
| Getting Care | • Your PCM delivers most routine care, coordinates all other care and referrals, and files claims on your behalf. | |

Program Options

# TRICARE Standard and TRICARE Extra

| Topic | Description |
|---|---|
| Eligibility | • ADFMs, retirees and their family members, survivors, certain former spouses, and others |
| Enrollment | • No enrollment necessary; eligible beneficiaries are covered when they update their information in DEERS. |
| Costs | • There are no enrollment fees, but annual deductibles and cost-shares apply. |

Program Options

# TRICARE For Life (TFL)

| Topic | Description |
|---|---|
| Eligibility | • TRICARE beneficiaries who have premium-free Medicare Part A coverage and have Medicare Part B coverage. |
| Enrollment | • No TRICARE enrollment necessary; DEERS is updated monthly with Medicare enrollment data received directly from the Centers for Medicare and Medicaid Services. |
| Costs | • No TRICARE enrollment fees.<br>  • Services covered by TRICARE and Medicare: TFL beneficiaries generally have no out-of-pocket expenses.<br>  • Services covered by Medicare: TFL beneficiaries are responsible for the Medicare deductible and cost-shares.<br>  • Services covered by TRICARE: TFL beneficiaries are responsible for the TRICARE deductible and cost-shares. |

# Barriers To Care

- Mobility
- Job qualification
- Deployment
- Stigmata of psychiatric illness
- Fear of costs
- Possible family separation- EFMP

# Barriers: Mobility

- Family member with special needs:
  - May move from one TRICARE to another
    - Different coverage of condition, e.g. home health nurse
- Moving to Japan in 2 months:
  - Good time for a gastric by-pass?
- Standard health screening mailers:
  - Returned for changed address
- Medical records issues
  - AHLTA

# Job Qualification

- Will your diagnosis affect their security clearance?
  - If so, they may be out of that job.
- Are they on flight status?
  - Many no fly medications.
- They are a combat diver:
  - Treat the spontaneous pneumothorax differently?

# Deployment

- They have had knee pain for 6 years:
  - Do they need a arthroscopy now? The unit deploys in one week.
- Husband is in a critical MOS and deployed:
  - Is it wise to do a moderate risk elective procedure now?
- Are their symptoms deployment related?
  - Feigned psychiatric illness
  - Exacerbation of real psychiatric illness

# Psychologic Stigma

Survey of soldiers with behavioral health issues asked about seeking treatment=> physical vs. BH :

- Only 18 percent thought treatment would be embarrassing
- Only 24 percent thought receiving help would harm their career
- Only 31 percent thought they would be perceived as weak
- Only 33 percent thought that leadership would treat them differently after they received help

- 41 percent thought receiving help would be embarrassing
- 50 percent thought receiving help would harm their career
- 65 percent thought they would be perceived as weak
- 63 percent thought that leadership would treat them differently after they received help

# Fear of Cost

- Many soldiers have limited financial resources.
- New to town, not made friends:
  - Childcare may be expensive during convalescence.
  - Nobody to pick up the kids from school- the mammogram can wait.
- Most understand TRICARE to a very limited extent.
- Concern real vs. perceived:
  - Not really important

# Possible Family Separation

- Exceptional Family Member Program
  - 16% of Army families have members with special needs.
  - When isolated assignments are made- evaluation of adequate health care resources.
  - If not available:
    - Consider other assignment.
    - Possible unaccompanied tour.

# How to Become "Military Culture Competent"

- Patient Centered Focus
  - The patient (and family if appropriate) is the center of focus; not the culture.
  - Recognize the difference between "disease" and "illness".
  - Understand the factors that may influence the patients perception of their illness.

# How to Become "Military Culture Competent"

- Communicate:
  - Berlin & Fowkes' LEARN Model (1983)
    - **Listen** with sympathy and understanding to the patient's perception of the problem.
    - **Explain** your perceptions of the problem.
    - **Acknowledge** and discuss the differences and similarities.
    - **Recommend** treatment.
    - **Negotiate** agreement.

# How to Become "Military Culture Competent"

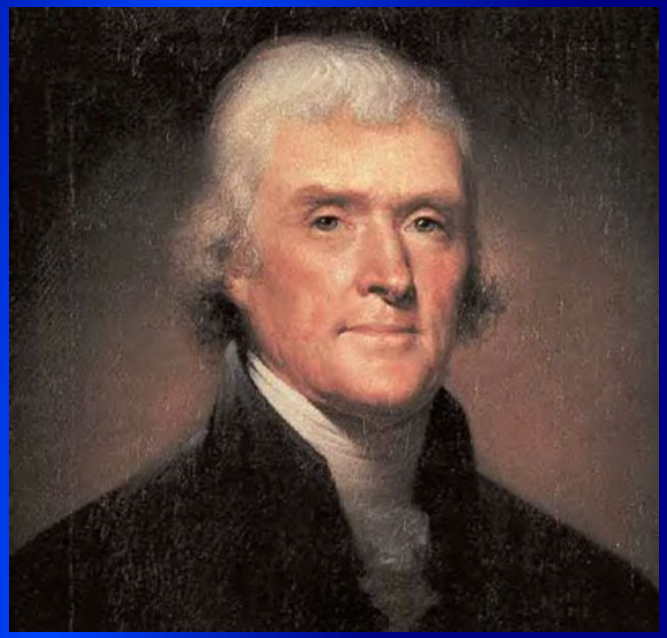
- Fact Centered vs. Skill Centered
  - Fact centered: relies on learning generalities about the culture studied
    - Risks stereotyping
  - Skill centered: based on physician patient interaction and good communication with recognition of the sociocultural context of the individual
- Balance of these leads to Cultural Competence

# Potential Resources

- Army One Source
- Home Base Program (homebaseprogram.org)
- Texas Health and Human Resources Commission on-line resources
- Real Warriors
  - On-line military cultural competence course
    - » www.realwarriors.net/healthprofessionals/militaryculture/onlinelearning.php
- National Center for PTSD (DoVA)
- Center for Deployment Psychology

# Parting Thought

- Thomas Jefferson gave his instructions to Lewis and Clark via a letter in 1803. This included some of the following instructions:



# Parting Thought


- "The commerce which may be carried on with the people inhabiting the line you will pursue, renders a knowledge of those people important. You will therefore endeavor to make yourself acquainted, as far as a diligent pursuit of your journey shall admit, with the names of the nations & their numbers;"

# Endeavor to learn:

- the extent & limits of their possessions; their relations with other tribes of nations; their language, traditions, monuments;
- their ordinary occupations in agriculture, fishing, hunting, war, arts, & the implements for these;
- their food, clothing, & domestic accommodations;
- the diseases prevalent among them, & the remedies they use;
- moral & physical circumstances which distinguish them from the tribes we know; peculiarities in their laws, customs & dispositions;
- and articles of commerce they may need or furnish, & to what extent.

# Parting Thoughts

- “In all your intercourse with the natives, treat them in the most friendly & conciliatory manner which their own conduct will admit; allay all jealousies as to the object of your journey, satisfy them of its innocence, make them acquainted with the position, extent, character, peaceable & commercial dispositions of the U.S. …”

# Parting Thought

- “As it is impossible for us to foresee in what manner you will be received by those people, whether with hospitality or hostility, so is it impossible to prescribe the exact degree of perseverance with which you are to pursue your journey …”

# Parting Thought

- If Lewis and Clark could face the Cultural Competency Challenges of working with almost completely unknown societies;

- Certainly we can learn to be Culturally Competent towards a sub-culture of our own society: The Military

Thank you all for caring enough to be here today!

Paul L. Foster School of Medicine
Texas Tech University Health Sciences Center
Cultural Competence Seminar

# Communicating Effectively Across Cultures and Managing Generational Differences



June 8, 2012

Seton Healthcare Family

# Reflection

*"Don't ask what the world needs. Ask what makes you come alive, and go do it. Because what the world needs is people who have come alive."*

Howard Thurman (American minister activist and mentor to Dr. Martin Luther King Jr.")

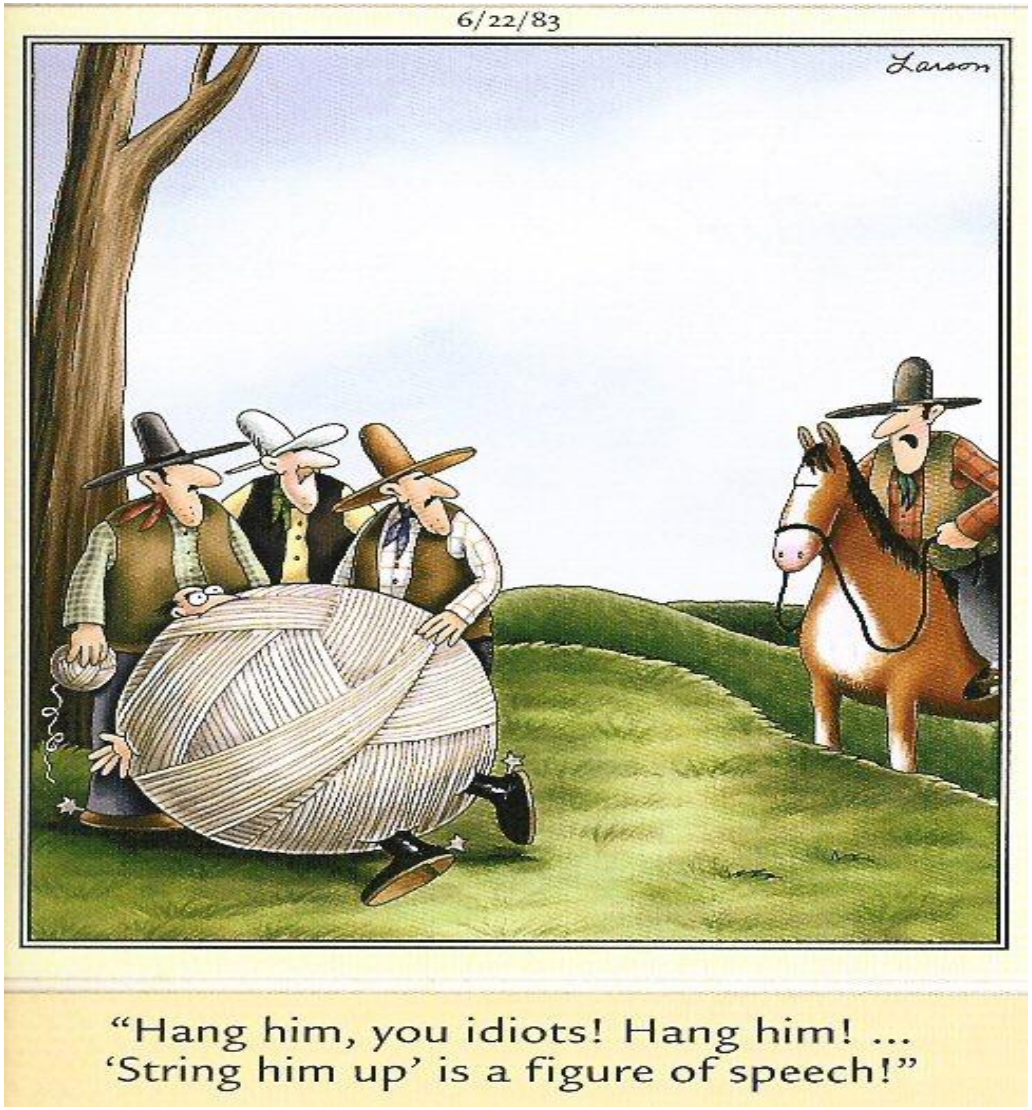
# Reflection Questions

**Please define the following terms from your perspective**

- **Diversity:**
- **Inclusion:**
- **Cultural Competence**:

**What do you see as diversity challenges within your team/workgroup?**

# Communication






Seton Healthcare Family

# What some businesses are saying

- Merck's general counsel, Kenneth Frazier, who said, "We are in the fortunate position of having many highly capable law firms lining up to work with us. And it was hard in some ways to differentiate among these firms. **But we found that diversity was something that would allow us to make that differentiation**."

- Shell Oil General Counsel Catherine Lamboley, "**We no longer do business with [some] firms because they were simply giving lip service to diversity**."

# What some are saying on city-data.com about Austin

- I agree with the last two posters. The OP seemed to be saying that there is only one kind of diversity: black vs. white, and that Austin is short on that. This may be somewhat true, as there seems to be a smaller AA community than in many cities. But there is so much more to diversity that that. **How one defines "diversity" will answer the question as to whether Austin has it.**

- Austin has more racial diversity (fewer whites) than a lot of people realize. **As far as economic diversity**, not as much, especially compared to biggies **like Houston and Dallas that have more very wealthy but also more poverty.**

- It's not just population counts and percentages. **One dimension of diversity is tolerance.** On that axis, I rate Austin highly. **When I hit the neighborhood supermarket and see cowboy hats and yarmulkes and hajibs and turbans and trucker hats and scarfs and newsboy caps, etc., all side by side, interacting, talking to each other, all comfortable, that says a lot to me about the diversity of the community.**

## What Seton founders are saying

**"Change is inevitable; growth is optional."**

*-St. Elizabeth Ann Seton*

**"I must assist my neighbor to the best of my ability both corporally and spiritually for the love of God."**

*-St. Louise de Marillac*

**"Allow yourself to be led by the Lord."**

*-St. Vincent de Paul*

# Objectives

- How to create a Strategic Diversity Initiative
- Discuss Diversity, Inclusion, and Cultural Competence Strategy at Seton Healthcare Family
- Learn about communicating effectively across cultures
- Describe the four generations, including the major influences, core values, work ethic and messages that motivate each generation.
- Call to Action
- Encourage the confidence to engage by creating a Personal Action Plan to translate seminar learnings back on the job.

# Conceptually

**EEO/Affirmative Action**

- Government initiated
- Legally driven
- Quantitative
- Problem-focused
- Targeted
- Reactive

**Diversity and Inclusion**

- Voluntary
- Productivity driven
- Qualitative
- Opportunity-focused
- Inclusive
- Proactive

# Diversity Strategic Initiative: Where to Start

- Identify the Current State
  - Desire to do the right thing
  - Reality Check
    - Dysfunctional teams/conflict
    - High turnover
    - Distant management
    - Higher recruiting costs
    - EEOC complaints/lawsuits on the rise
    - Poor execution
    - Productivity/creativity down

# Conduct Assessments

- Internal Assessment
  - What do we look like:  Demographics
  - What do we believe:  Mission/values
  - Who are we: Leader/employee
- External Assessment
  - Who are the clients:  Market demographics
  - What does the community I live in look like: Community relations/advocacy
  - What is our differentiator: Competition
- Self Assessment
  - What do I think: https://implicit.harvard.edu/implicit/demo/selectatest.html

# Supporting a Respectful Workplace

- Regardless of your role at work, harassment and discrimination prevention begins with you on an individual level.
- You have the ability to influence others.
- Apply the Seton Values to your own daily work environment (your own words & actions).
- Seton expects you to treat those you interact with (patients, coworkers, customers, physicians, etc.) with respect and courtesy.
- Don’t allow yourself to violate these expectations with inappropriate behavior.

# Code of Conduct

- Seton has adopted and expects a high standard or code of professional performance and conduct. This standard is in alignment with the Seton Mission and Values and supports the care and safety of patients, families, visitors, associates, physicians, contractors and volunteers.

- Based on our belief in the dignity of each human person, our standard requires all members of the Seton community to provide mutual support for the purpose of improving the safe performance of our professional duties. This includes holding ourselves accountable for respectful and collegial conduct. The standard applies to everyone in the Seton community, regardless of position or employment status.

# Code of Conduct (cont'd)

- **Acceptable Conduct** - consists of respectful communication and behaviors consistent with a culture of safety and grounded in the Seton Mission and Values.

- **Inappropriate Conduct** - is conduct that does not support and optimize a safe environment of care, and is inconsistent with the Seton Mission and Values.

- **Procedure -** If an individual believes the Seton Code of Conduct has been violated, he or she will immediately report the suspected violation to his/her direct supervisor. If the suspected violation of the Seton Code of Conduct involves the associate's direct supervisor, he/she should report the suspected violation to the next level in the associate's chain of command and/or the Values Line.

# Definitions/Business Case

- Define Diversity*
- Define Inclusion*
- Define Cultural Competence*
  - ✶ Ask the organization
  - ✶ Specific to the organization's culture

- Define business case
  - Write it down
  - Share it with leadership for agreement and support.
  - Identify priorities/policies
  - Link to mission/values
  - http://www.roygingsburg.com/diversity-makes-cents-the-business-case-for-diversity

# What is Diversity?

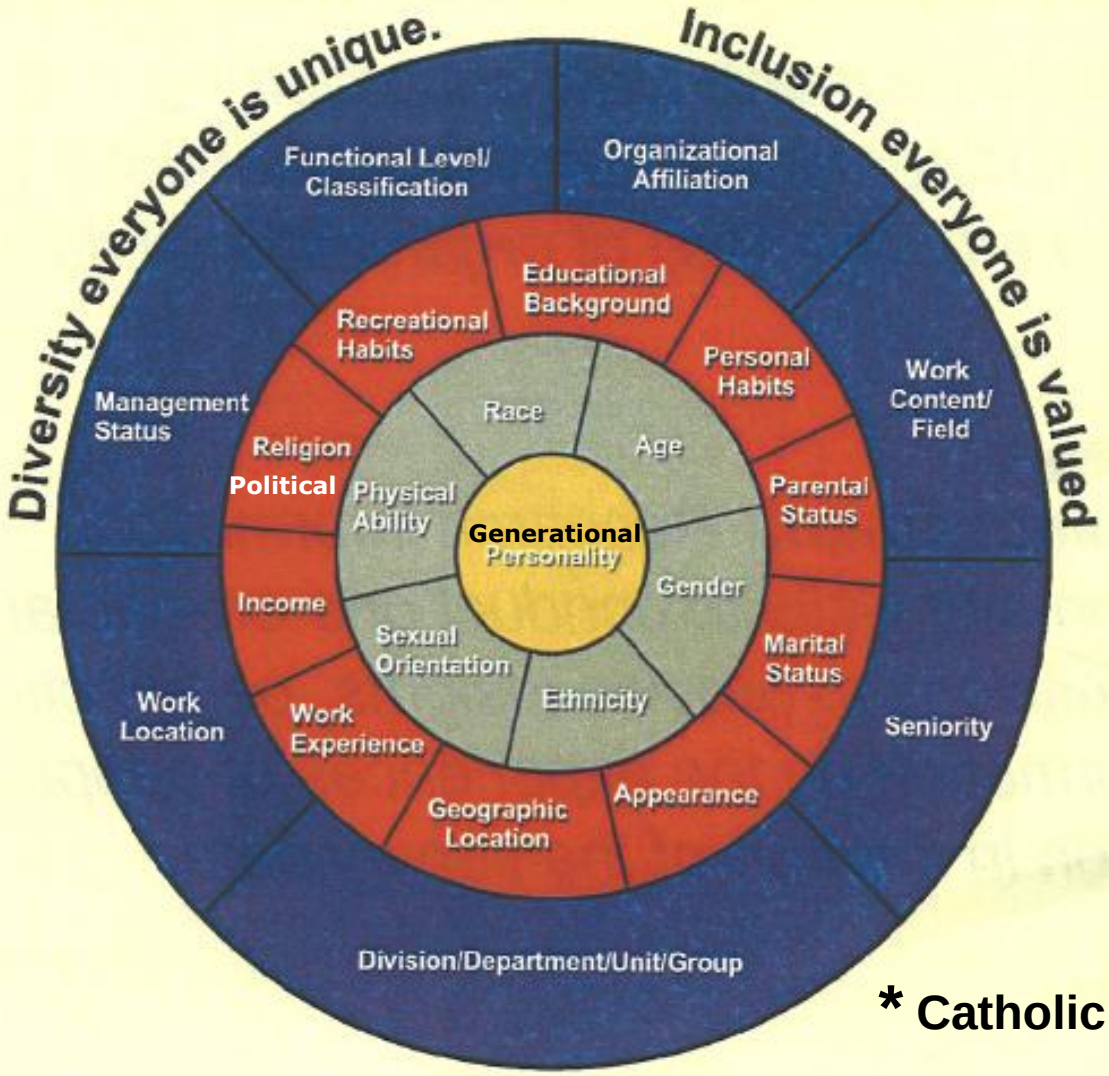
**Recognizing** the differences, inclusive of diverse ideas and backgrounds, each individual brings to their work at Seton

**Utilizing** the varied dimensions, experiences and ideas of our talented workforce to deliver culturally competent patient care.

# What is Inclusion?

- **Valuing** our universal human "oneness" and interdependence.
- **Accepting** the whole person and being free to bring our whole selves to work.
- **Ensuring** an understanding, appreciation, and respect of cultural differences and similarities within, among and between groups.

# Dimensions of Diversity & Inclusion*




Internal Dimensions

External Dimensions

Organizational Dimensions

*** Catholic Healthcare Partners**



(Based upon Gadrenschwarz & Rowe)

Seton Healthcare Family

# What is Cultural Competence?

- ***Skills, behaviors, policies and practices*** that enable Seton staff to work and communicate effectively across cultures in situations that involve team members, patients, families, partners and other visitors.

- ***The ability to acquire and use knowledge*** of health-related beliefs, attitudes, practices and communication patterns with patients and their families, team members, partners and visitors.

# What Makes Someone Culturally Competent?

***The Golden Rule:*** ***Treat others as you would have them treat you***

***The Platinum Rule:*** ***Treat others as THEY would have YOU treat THEM***



Seton Healthcare Family

# Who's With Me? Connectors, Mavens, Leaders

- Checking along the way…
  - Identify who is in charge
  - Identify champions
  - Identify Influencers/Supporters/Doubters
  - Identify stakeholders
  - Identify resources

# State the Strategy: Begin the Journey

- Make it clear/concise/actionable
- Prioritize and integrate the plan elements
  - Representation
  - Training
  - Client focus
- Gain approval
- Implement!

# Business Case

- Competitive Advantage
- Demographics
- JCAHO
- MAGNET
- EEO complaints
- Risk Management
- Reduces likelihood of unionization
- Increase retention

# What it is NOT…

- Affirmative Action program
- Quota System
- Preference system
- Short-term solution (quick fix)
- Focus on just race and gender
- My issue
- “Check the box”
- “Program of the month”

# What It Is…

- Integrated into Mission, Vision and Values
- A focus on respect and dignity at all levels
- Healthcare imperative
- Organizational journey
- A personal journey
- Leadership accountability
- Leader-led initiative
- Support for teamwork and innovation
- Integrated into every Seton process and service

# Vision

We envision a strong, diverse and inclusive health ministry in Central Texas that aspires to be the healthcare provider of choice and the preferred workplace for associates and physicians. We will fully utilize our “likenesses” and “differences” to continuously improve services, strengthen programs, increase community participation, and to be a catalyst to address health disparities among all groups.

# Who is involved?

- **Stakeholders:**
  - Patients & Families
  - Associates
  - Physicians
  - Leadership
  - Board of Trustees
  - Communities we serve
  - Community Partners
  - Diversity Advisory Council
  - Volunteers
  - Joint venture partners
  - Suppliers

# Key Strategy Components

- We will institutionalize the changes necessary to become a culturally competent healthcare organization.
- We will enhance all existing systems and business processes so that Diversity, Inclusion and Cultural Competence become an integral part of each key process- including:
  - **Talent Acquisition**
    - **Recruitment support/Policy Integration/Federal Contractor Status**
  - **Talent Development/Education**
    - **Diversity skills workshop series**
  - **Patient Access/Patient Care**
    - **Language assessment/policy**
  - **Communications, Advocacy, Marketing and Planning**
    - **Branding support**
  - **Community Outreach**
    - **Partnerships/collaborations**
  - **Supplier Diversity**
    - **Partnerships/policy**
  - **Workforce Development**
    - **Current & next generation (intern programs)/policy**

# Global Seton Family of Hospitals by Availability and Gender

## Central Texas Labor Pool (2007)

| Female | Male |
|---|---|
| 48.10% | 51.90% |

## Seton Family of Hospitals (Q1FY10)

| Female | Male |
|---|---|
| 77.55% | 22.45% |

# Global Seton Family of Hospitals by Availability and Race

## Central Texas Labor Pool (2007)

| White | Asian | Hispanic | African American | American Indian | Other |
|---|---|---|---|---|---|
| 58% | 5% | 30% | 7% | 0.00% | 0.00% |

## Seton Family of Hospitals (Q1FY10)

| White | Asian | Hispanic | African American | American Indian | Other |
|---|---|---|---|---|---|
| 61.41% | 5.41% | 22.12% | 10.00% | 0.67% | 0.39% |



Seton Healthcare Family

# Global Law Firm by Availability and Gender

**Central Texas Labor Pool (2007)**

| Female | Male |
|---|---|
| 48.10% | 51.90% |

**Statewide Texas State Bar**

| Female | Male |
|---|---|
| **32%** | **68%** |

**Law Firm**

| Female | Male |
|---|---|
| XX% | XX% |



Seton Healthcare Family

# Global Law Firm by Availability and Race

## Central Texas Labor Pool (2007)

| White | Asian | Hispanic | African American | American Indian | Other |
|---|---|---|---|---|---|
| 58% | 5% | 30% | 7% | 0.00% | 0.00% |

## Statewide Texas Sate Bar

| White | Asian | Hispanic | African American | American Indian | Other |
|---|---|---|---|---|---|
| 84% | 2% | 7% | 4% | <1% | <1% |

## Law Firm

| White | Asian | Hispanic | African American | American Indian | Other |
|---|---|---|---|---|---|
| XX% | XX% | XX% | XX% | XX% | XX% |



Seton Healthcare Family

# ACC Student Demographics – Spring 2010

| | |
|---|---|
| Total Headcount | 41,050 |
| Male | 43.99% |
| Female | 56.01% |
| White | 55.48% |
| Black | 9.08% |
| Hispanic | 24.88% |
| Asian | 5.2% |
| All Others | 5.36% |
| | |

| Age | |
|---|---|
| 16 – 18 yrs | 14.44% |
| 19 – 21 yrs | 26.74% |
| 22-24 yrs | 16.01% |
| 25 -30 yrs | 19.29% |
| 31 - 35 | 8083% |
| 36 - 50 | 11.79% |
| 51 and over | 2.9% |
| **Average age** | **26.17** |

**Source:** Spring 12th Class Day Data



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# Diversitv and Inclusion in Action

Project | SEARCH

Project SEARCH offers an innovative approach to the vocational rehabilitation model, which views employment for individuals with intellectual disabilities from a business perspective while maintaining focus on each individual's unique abilities, skills and interests.

- **The Goals of Project SEARCH**
  - Career Exploration
  - Enhanced Employability Skills
  - Advancement and Documentation of Marketable, Job-Specific Skills
  - Increased Independence
  - Competitive Employment

- **Results**
  - Twenty-four interns completed the job training
  - Eighty-three percent placement!
  - Twelve currently in training (six each at SMCA & DCMCTT)
  - 2008 Health Care Heroes Employer/Business Leader Award
  - 2009 Governor's Committee on Employment of People with Disabilities Award
  - 2010 Austin Mayor's Committee on Employment of People with Disabilities



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# Call to Action

- Leadership Matters
  - Communicate Diversity importance to your staff
  - Put on your agenda
  - Support Personal Action Plans
- Assess the gender, age, and ethnicity
  - It’s a journey, a starting point
- Diversity Skills for all people managers
  - Communication key
  - 100% participation

# Sample Personal Action Plan

**(from our Effective Communication Across Cultures Diversity Skills Workshop)**

1.How will I communicate the importance of Diversity and Inclusion to my staff?

2.What new strategies will I use to communicate more effectively across cultures?

3. How will I help/coach others to communicate more effectively across cultures?

# Example Call to Action (FY08)
## Seton Leaders and Managers

- Support cultural competence and D&I training for you and your staff.
  - Communicating Effectively Across Cultures
  - Spirituality in the Workplace
  - Cultural Sensitivity training for Nurses in Versant
  - Generational Diversity

- Review and identify opportunities within your workgroup(s) for widening the net.
  - Development/mentoring
  - Succession planning

- Utilize the process for generating a diverse final candidate pool for grades 19+.

- Increase your personal visibility and communication with your site.

# Diversity FY11

- Talent Acquisition
  - Federal Contractor Issue
- Workforce Development
  - Intern Management Policy
  - Consulting on Diversity Dashboards by site, department and unit
- Talent Development/Associate Engagement
  - Identifying Victims of Human Trafficking
  - Identifying Illiterate Patients
  - Micro-Messaging
  - Continue over 2500 associates participating in monthly cultural celebrations/observances at ten or more Seton sites
- Patient Care and Patient Access
  - Language Services
    - Spanish Bilingual Assistant Course
    - Phone Interpreter issues
    - Command Spanish for Respiratory Therapists
    - English at Work
    - Spanish at Work

# Why Diversity & Inclusion?

- ✓ **Right thing to do**
  - Supports the Mission, Philosophy and Values
  - Community Outreach
- ✓ **Good for Patient care**
  - Provides a strategic advantage
  - Provides competent care
  - Enhances the Seton brand
- ✓ **Good for our stakeholders**
  - Supports recruitment and retention
  - Promotes teamwork and innovation
  - Builds loyalty
  - Solid business case
  - Has stakeholder/leadership support

# Our Newest Stakeholder - You

- Stakeholder Responsibilities
  - Be accountable to the Mission
  - Respect each other
  - Celebrate the differences
  - Take advantage of learning opportunities

# Exercise

**Break into pairs:**

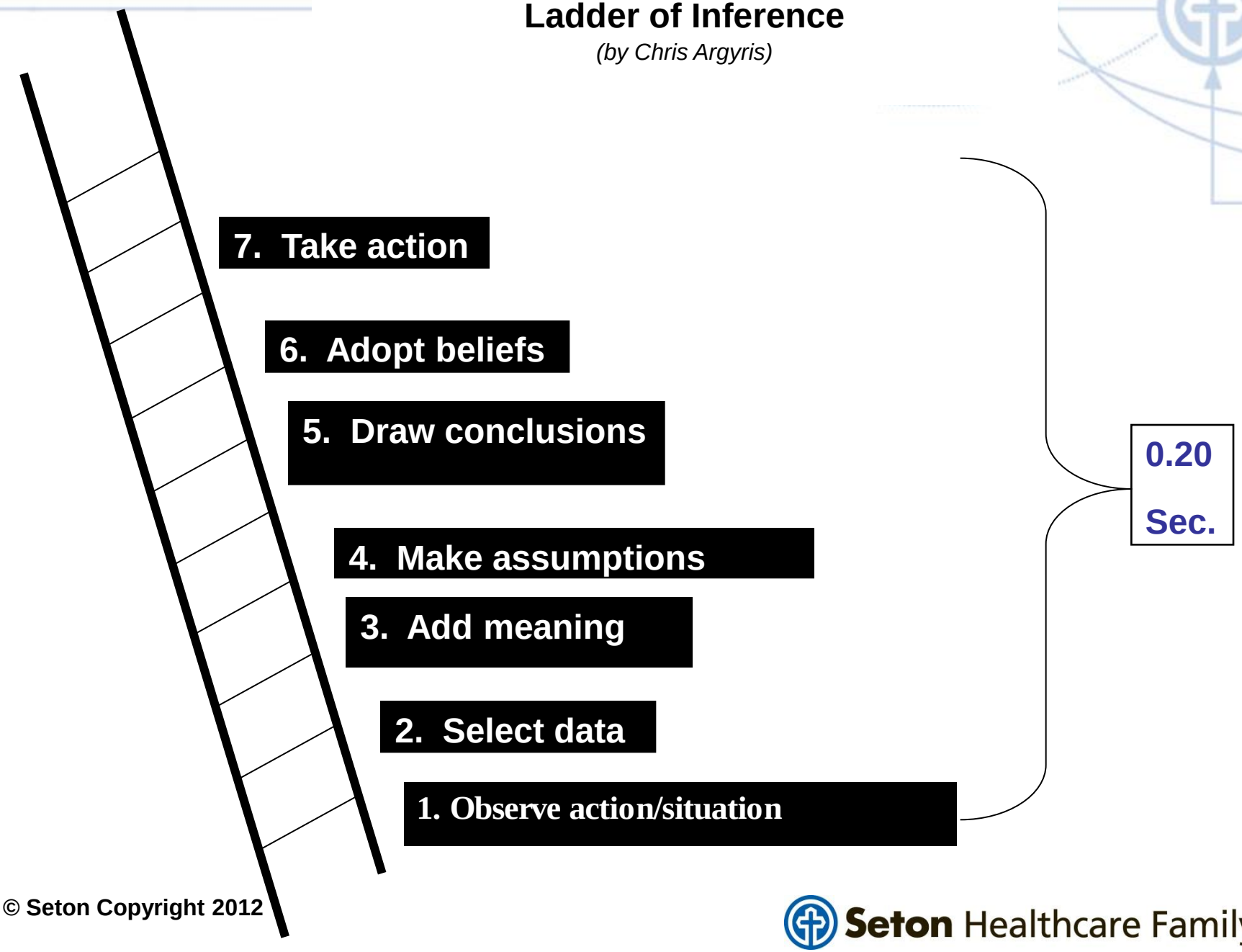
**By Observation only…**

- **Determine favorite music genre**
- **Determine favorite type of food**

**Report to the group**

# Ladder of Inference

*(by Chris Argyris)*



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# A Word of Caution*

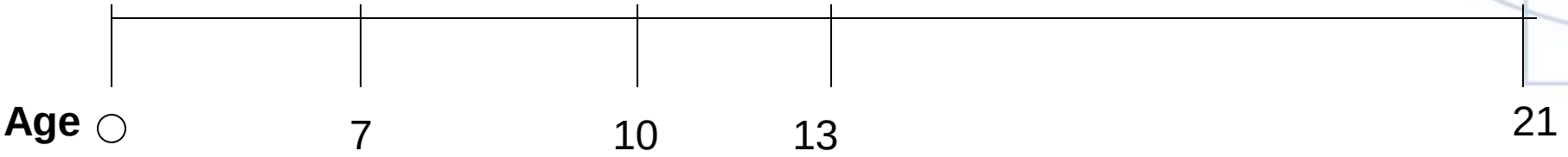
If I met Rosa, a Mexican woman, and say to myself, "Rosa is Mexican; she must have a large family." I am stereotyping her. But if I think Mexicans often have large families and then ask Rosa how many people are in her family, I am making a generalization.

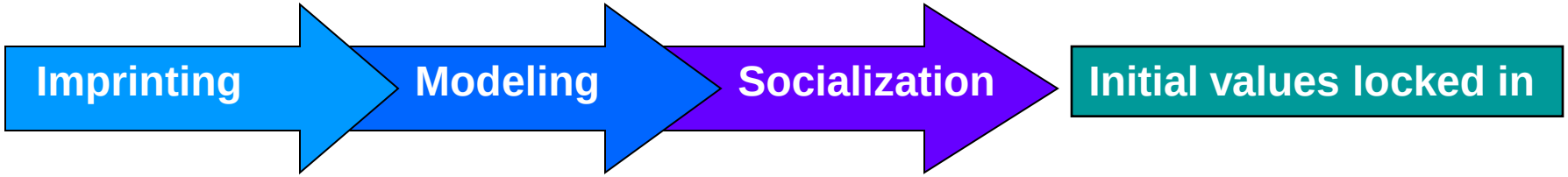
A **STEREOTYPE** is an ***ending*** point. No attempt is made to learn whether the individual in question fits the statement. Stereotyping anyone can have negative results.

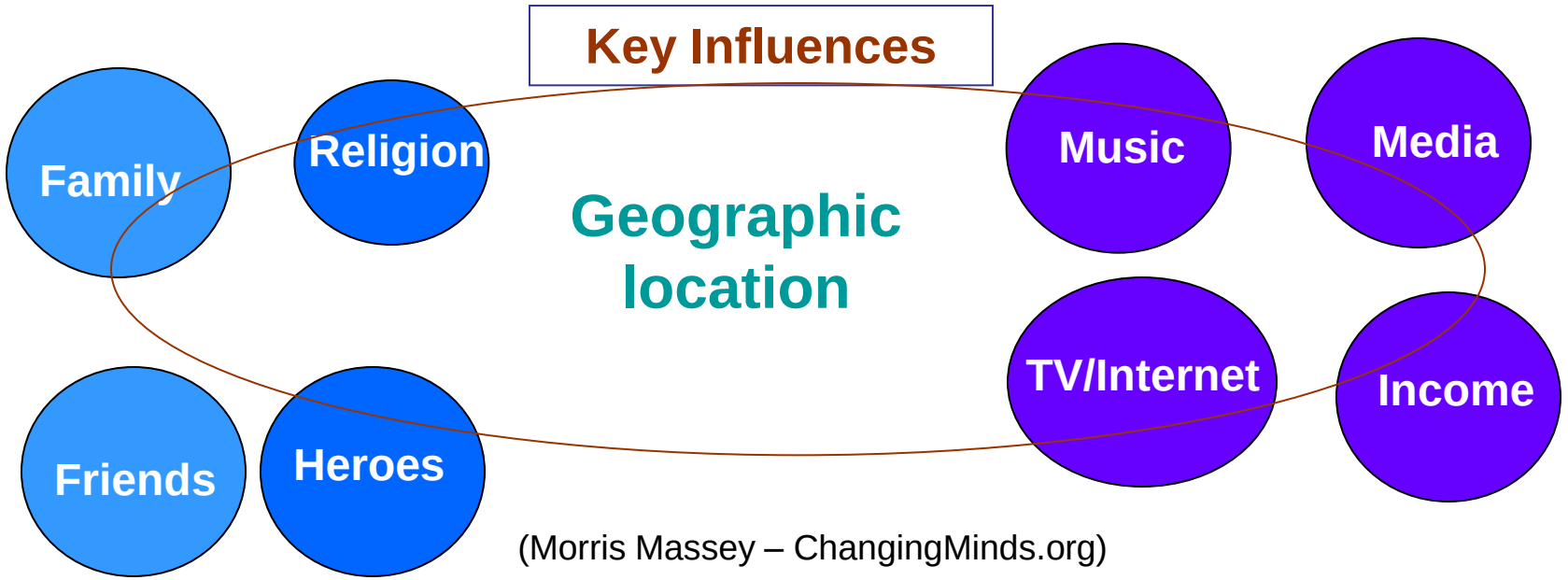
A **GENERALIZATION** is a ***beginning*** point. It indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual. Generalizations may be inaccurate when applied to specific individuals, but when applied broadly, can indicate common behaviors and shared beliefs.

*Entire text taken from:
"Cultural Sensitivity: A Pocket Guide for Health Care Professionals"
A Joint Commission Resource, By Geri-Ann Galanti, Ph.D.; 2007

# Values/Beliefs Development Process




(Morris Massey – ChangingMinds.org)



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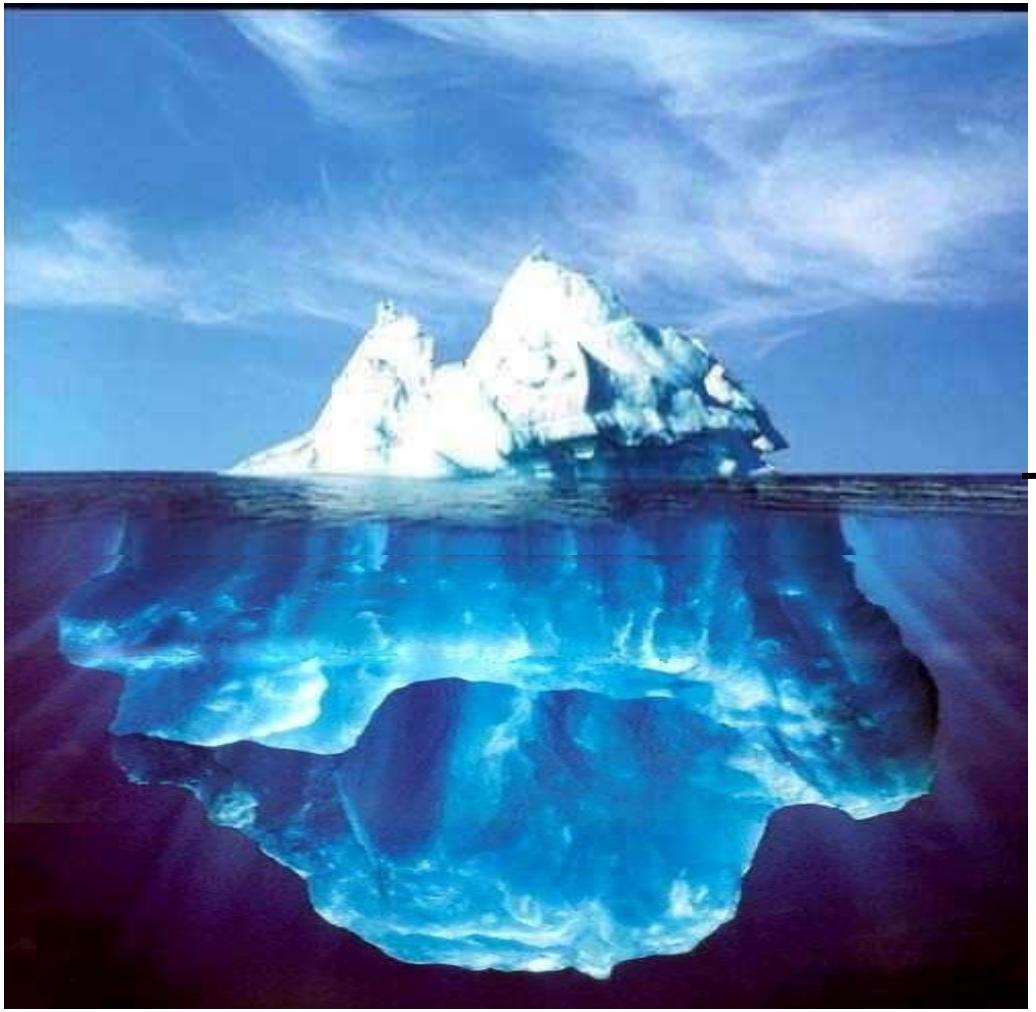
# The Iceberg
## *Explicit vs. *Implicit Culture*



**What I observe**

**What I assume**

**What I cannot see**

**What I do not know**



***Implicit Association Test***
https://implicit.harvard.edu/implicit/

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# The Three "V's"
# How We Get Our Message Across

| | | |
|---|---|---|
| **VERBAL** | = | **8%** |
| **VISUAL** | = | **55%** |
| **VOCAL** | = | **37%** |
| **Total Impact** | = | **100%** |

*(Source: Silent Messages by Albert Mehrabian)*



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# Top 5 Non-English Languages Spoken in Travis County

1. Spanish*
2. Vietnamese
3. Korean
4. Chinese Mandarin
5. Urdu

*Spanish is also the top non-English language spoken in the rest of Central Texas

# Why are we talking about generational differences?

- To provide knowledge we can use to work more effectively with all stakeholders from different generations.

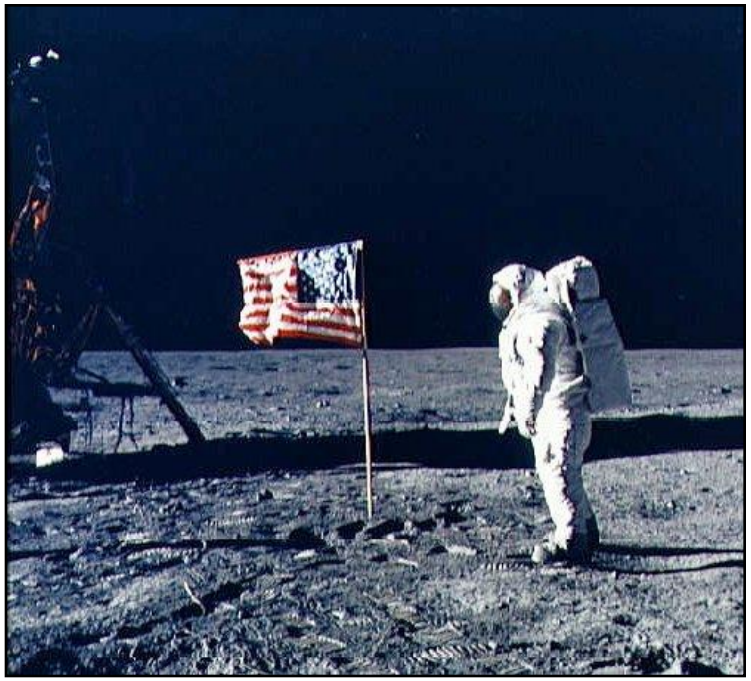
- To identify strategies to bridge generational gaps
  - Common purpose (mission; quality clinical care)
  - Understand communication styles
  - Develop multigenerational teams
  - Leverage the differences
  - Minimize/avoid personal storytelling
  - Adapt/tailor teaching/preceptor style to the generation

# An Older and More Diverse Nation…

- Blacks, Asians, Hispanics, Native Americans are now one-third of U.S. population, and will be the majority by 2042. BY 2023, fifty-percent of all children will be diverse.
- In 2030, nearly one in five residents will be 65 and older. Projected 88.5 million by 2050 (38.7 million in 2008)
- The "working ages" (18 to 64) population will decrease from sixty-three percent (2008) to fifty-seven percent in 2050.
- Working ages population projected to be more than fifty percent diverse in 2039 (up from thirty-four percent in 2008)

(Source: U.S. Census Press Release August 2008)

# Which of these life events impacted your generation?



# Generations in the workplace

- **Veterans** (born 1922 to 1945)
- **Baby Boomers** (born 1946 to 1964)
- **Generation "X"ers** (born 1965 to 1980)
- **Millennials/Nexters** (born 1981 to 1991)

***(Generations at Work: Managing the Clash of Veterans, Boomers, Xers, and Nexters in Your Workplace)***
***Ron Zemke***



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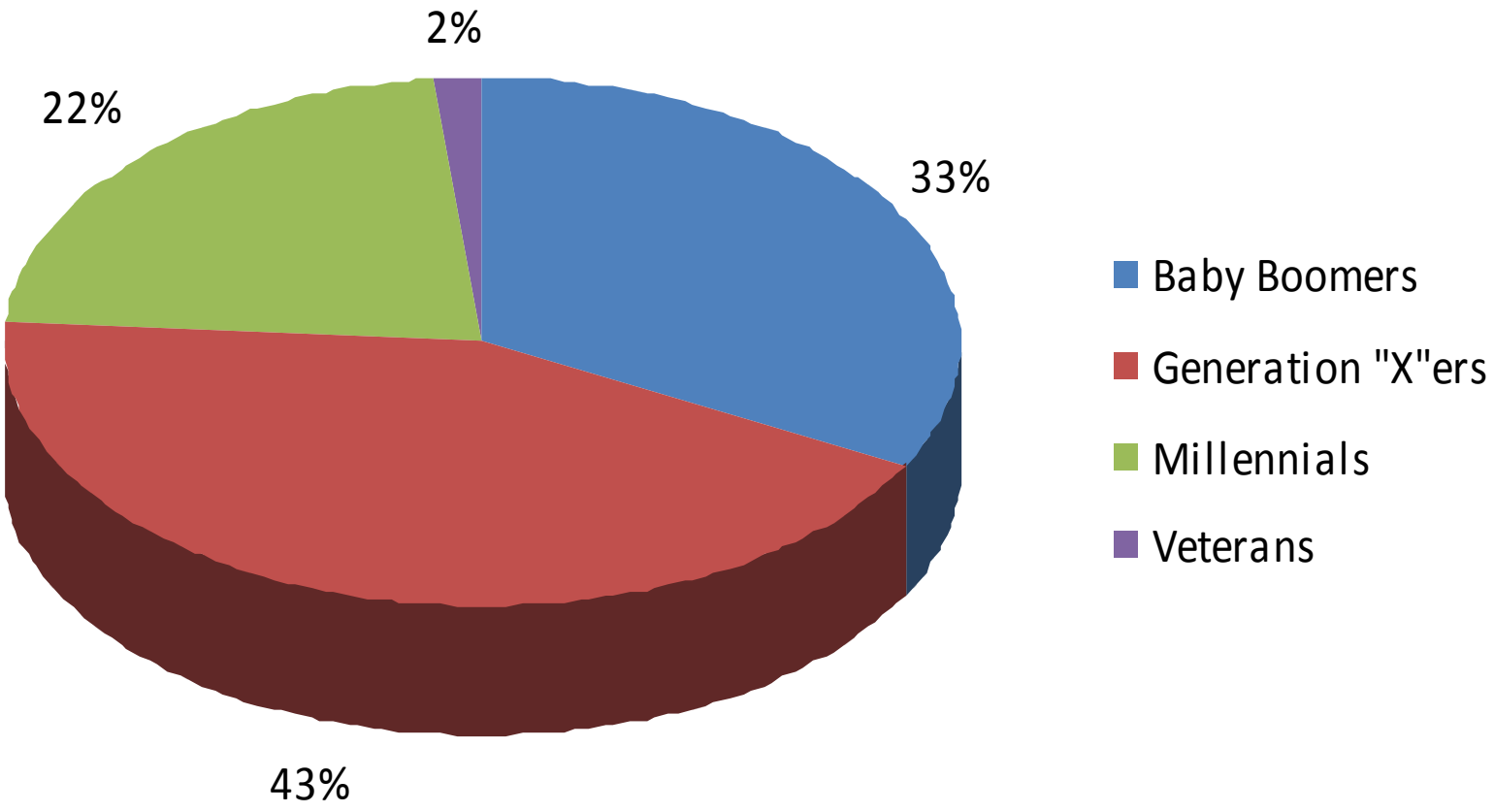
# All Associates Generations



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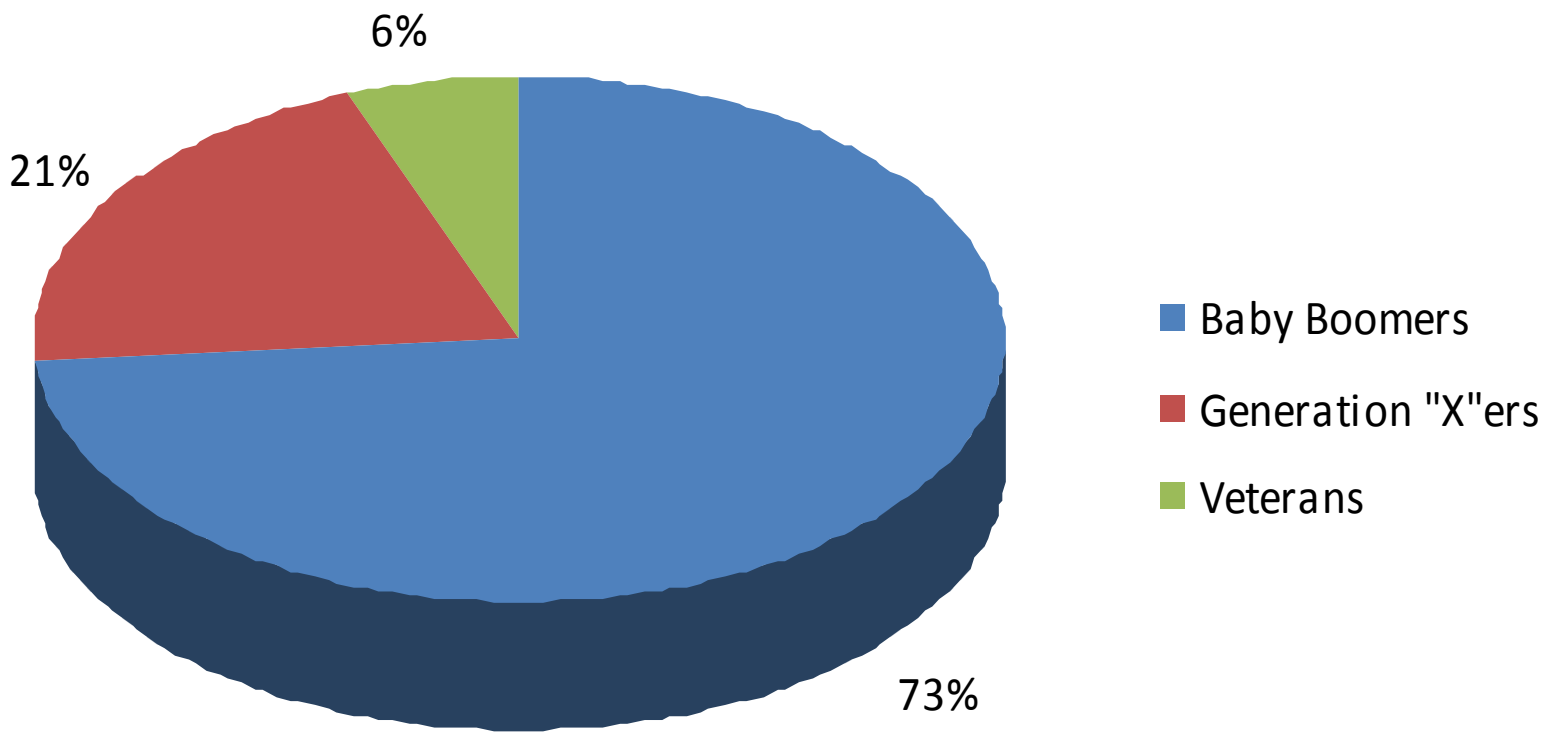
# SLT Generations



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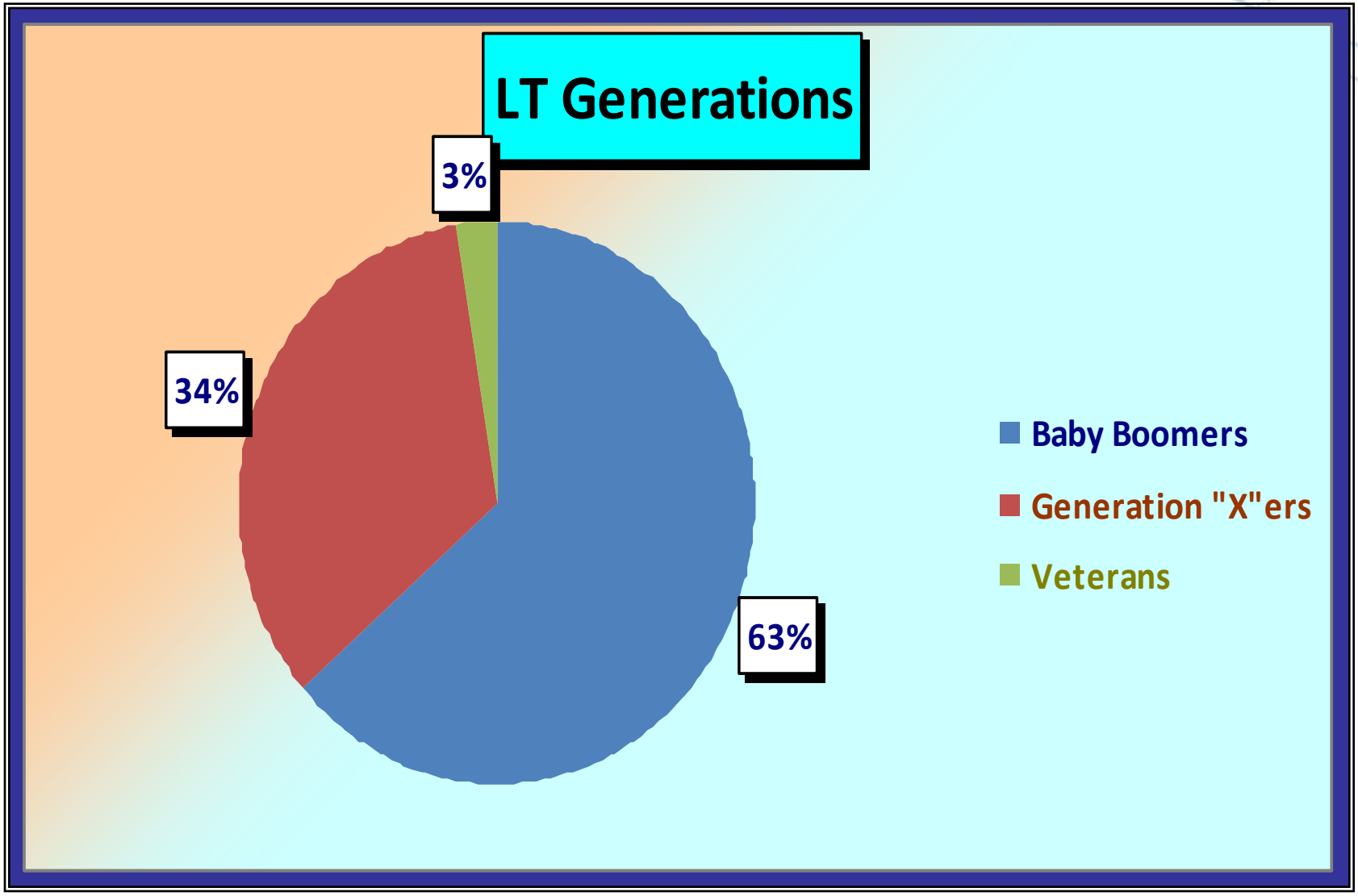




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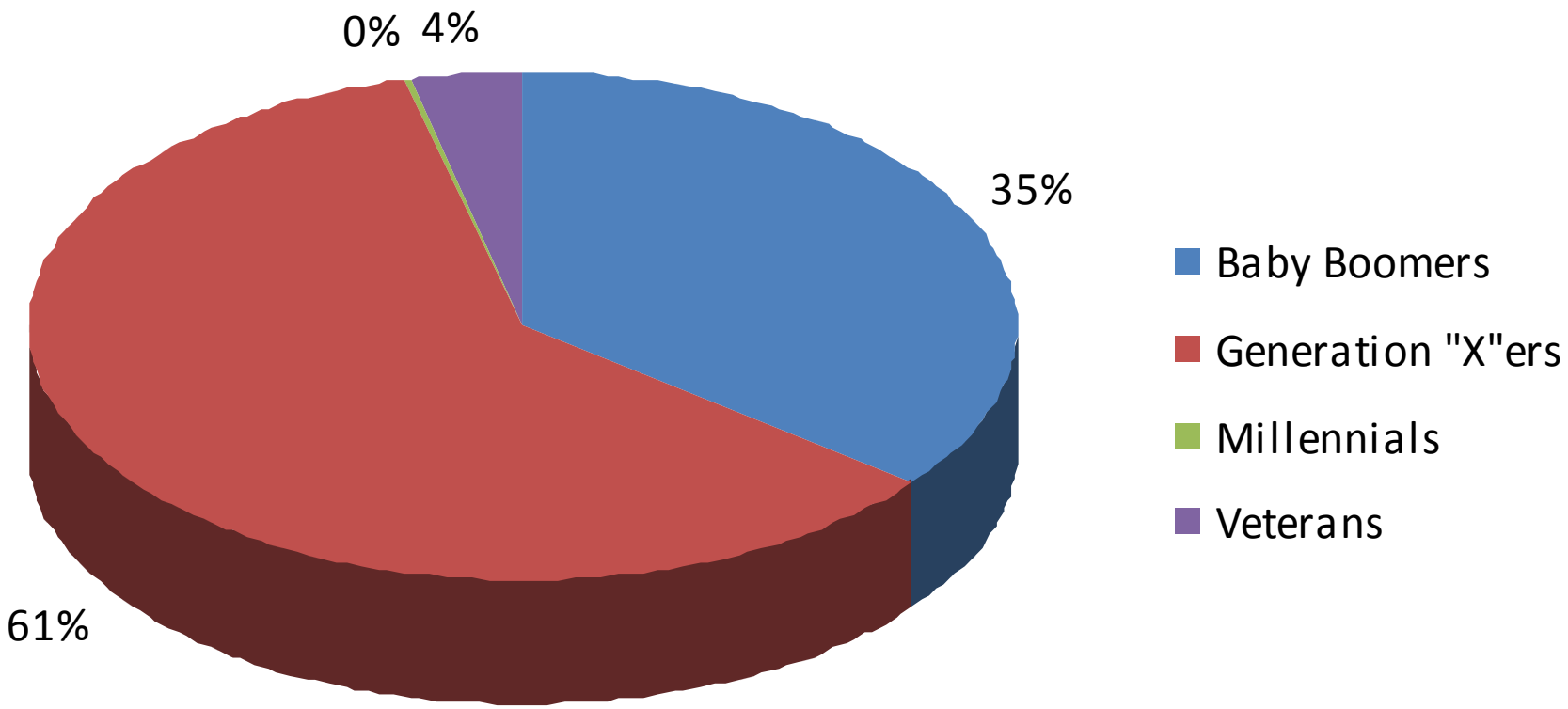
# Physician Generations



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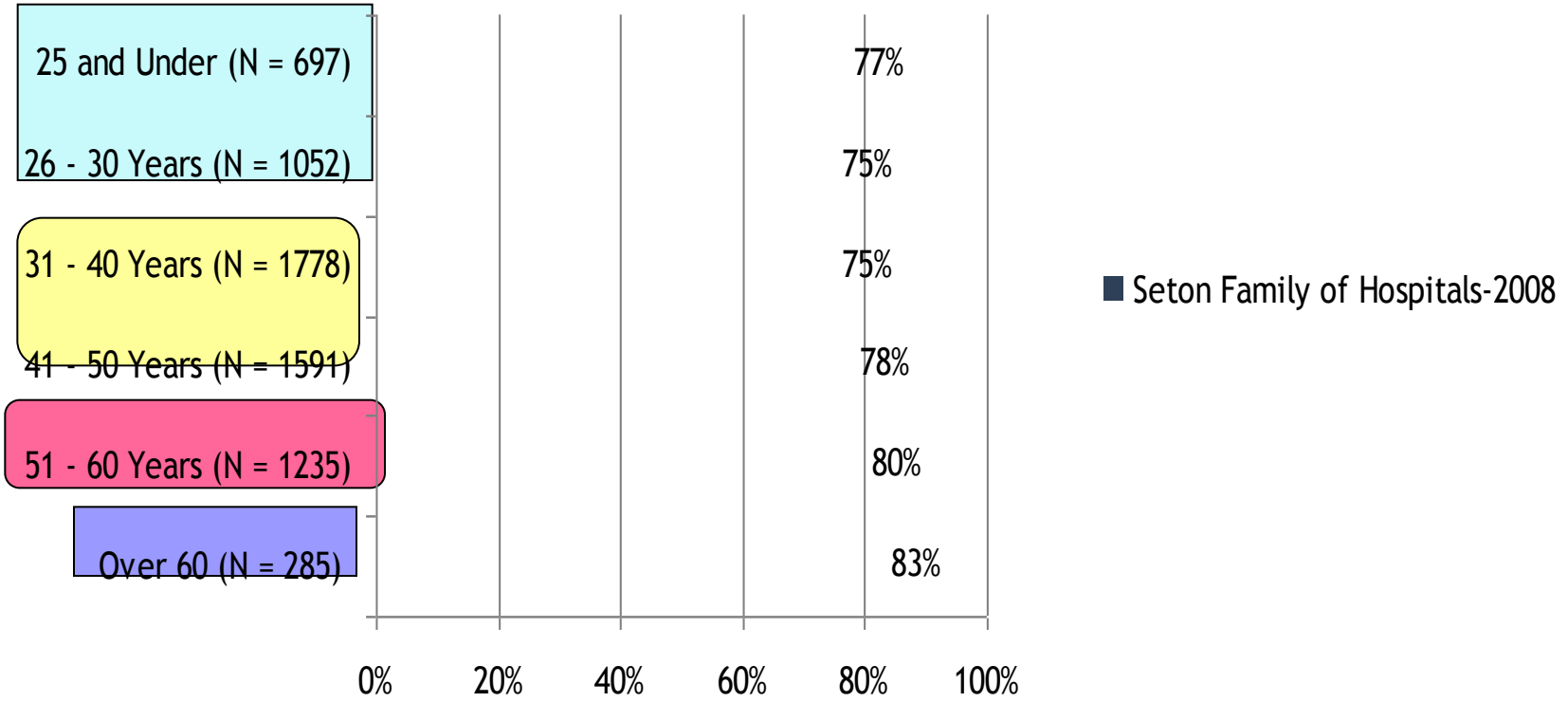
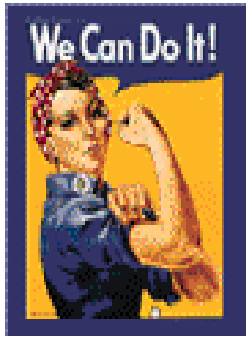
# Overall Results by Age Demographic

## Seton Family of Hospitals by Age




Represents Overall % Favorable (all core items)

# SUPPORT THE ROSIE TRUST




**TO SUPPORT THE ROSIE THE RIVETER TRUST OR TO HONOR A ROSIE, PLEASE CLICK HERE**

**WITH YOUR HELP, WE CAN DO IT!**

**WHO SUPPORTS ROSIE THE RIVETER TRUST?**
**VISIT OUR HALL OF HONOR >>**

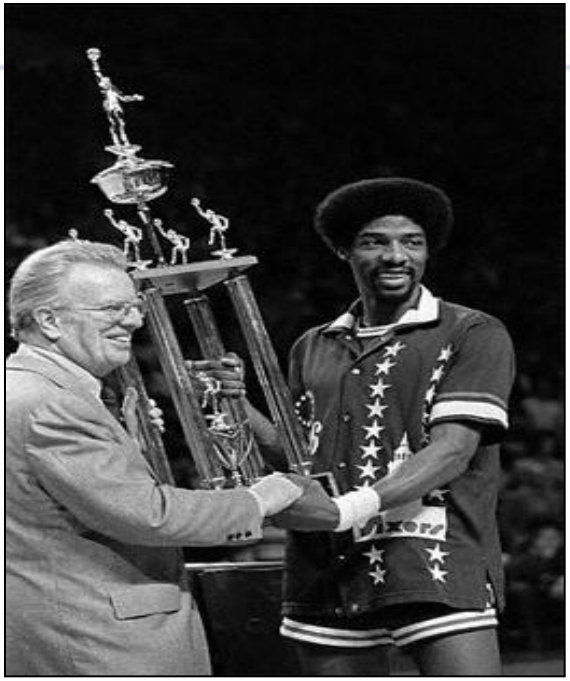


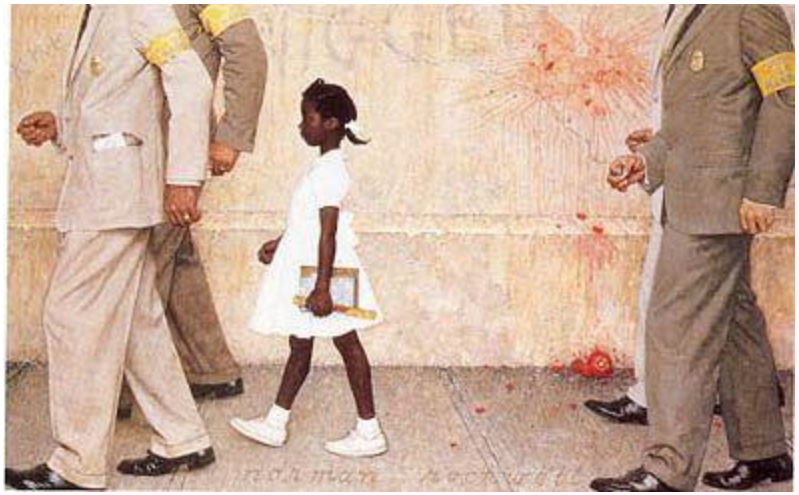
Seton Healthcare Family

# Veterans

- The oldest of the four generations (born 1922 and 1943). **(52 million workers)**
- Veterans tend to be very conservative in their workplace actions as well as their recreational behaviors.
- Veterans are the least diverse (ethnic and gender) of the four generations.
- **Values**
  - Most employ a **"Work First"** attitude.
  - Loyal, disciplined and appreciate courtesy
  - Strong work ethic
- **Motivations**
  - Will skip email and faxes in favor of written notes and talking to others. Veterans work best with real human beings.
  - Veterans can be as productive as younger employees.
  - Give them respect.

*(Zemke et al. 2000).

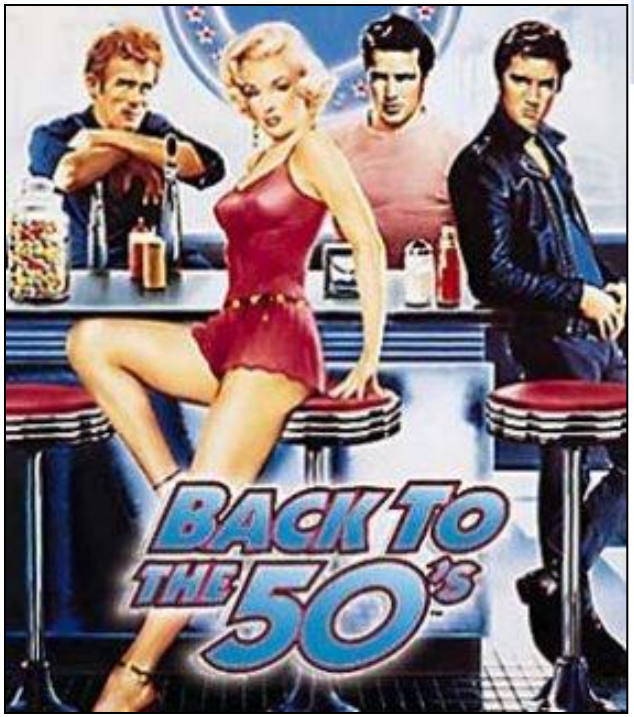




"*The-problem-we-all-live-with"* Norman Rockwell



http://youtube.com/watch?v=We8P_Ww27hY




*1950's Poster*

http://youtube.com/watch?v=9ibX3TejlZE

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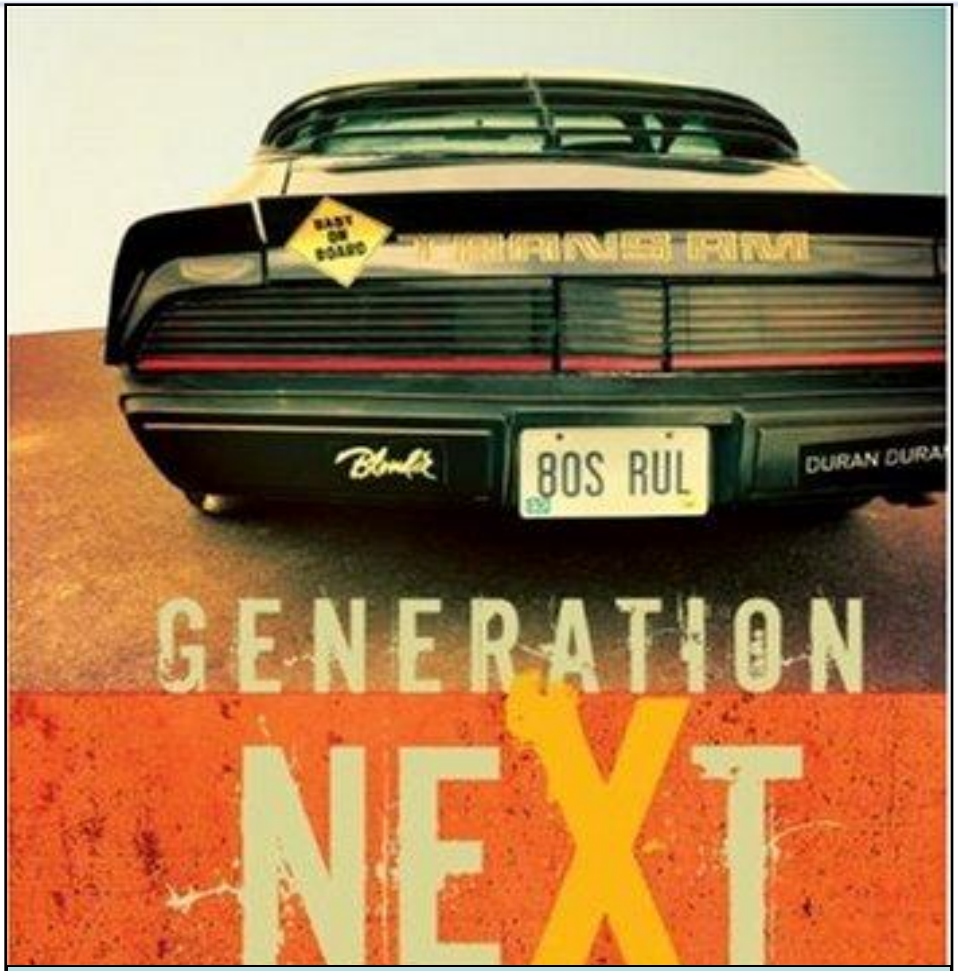
# Baby Boomers

- Baby Boomers (1946 – 1964) **(76 million workers)** grew up during tumultuous times.
  - End of WWII, Civil Rights Movement, Vietnam War.
- **Values**
  - **Boomers "Live to Work".**
  - Very strong work ethic and team oriented
  - They lean toward consensual leadership styles and fairness is very important.
  - Today's organizational leaders.
- **Motivations**
  - At work Boomers can be into personal gratification.
  - 60-70 hour work week.
  - Likes rewards and recognition
- Boomers tend to be less diverse (ethnic and gender) than Gen-Xers and Millennials.




http://youtube.com/watch?v=Dzp0JETG0Pw

LinkedIn®

eHarmony®

http://youtube.com/watch?v=n9xY_cPenSs

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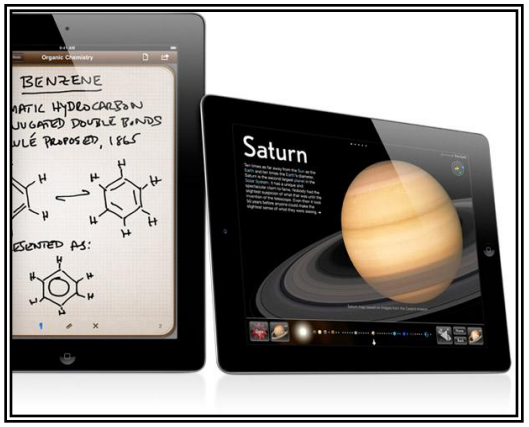
# Generation X

- Gen-X-ers (1965 -1980).**(70 million workers)**
- independent, diverse, flexible, creative, confident, outcome oriented and focused on having a life – today.

- **Values**
  - **"Work to Live"!**
  - They work best when there are clearly defined goals and the freedom to achieve them in their own way.
  - Gen Xers make their own rules.
  - They tend to be technologically savvy and to work well on their own.
- **Motivations**
  - They do not like to be micro-managed and prefer to prioritize projects their own way.
  - Balance between work & home is important.
  - They tend to appreciate constructive feedback and like to feel their bosses are available.
  - Skip the pep talk. Be straightforward.
  - Reward with training, mentoring and increased responsibility.


twitter




facebook

(600m members)


TAGGED

(100m members)

YouTube

MySpace.com

(34m members)

http://youtube.com/watch?v=7OhJgJVfZ5g



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# Millennials/Nexters

- Newest generation (1981 – 1996) to begin entering the workplace. **(69.7 million workers)**
- Best educated and most diverse of all the generations and were born to the most child-centric parents in history.*
- **Values**
  - **"Live, Then Work"**
  - They are team-oriented, interpersonal and gregarious multi-tasking overachievers.
  - Willing and able overachievers
  - Technological innovation readily available to them since childhood.
  - Most mirror their grandparents' (veterans) belief in hard work in setting goals as being the key to success.
- **Motivations**
  - Will take on many responsibilities and work to succeed.
  - Like a well-supervised and structured work environment

*(Thielfoldt & Scheef 2004).

# Work Ethic

- How would you describe the work ethic of each generation?
  - Veterans
  - Baby Boomers
  - Gen X-ers
  - Millennials/Nexters

# Rewards and Recognition

- How might rewards and recognition look different for each generation?
  - Veterans
  - Baby Boomers
  - Gen X-ers
  - Millennials/Nexters

# Preferred Communication

- How might preferred communications look different for each generation?
  - Veterans
  - Baby Boomers
  - Gen X-ers
  - Millennials/Nexters

# Engaging and Managing Veterans

- Explain the organization's expectations and culture
- Do not question their loyalty
- Provide a stable learning environment
- Show how the organization's structure works

# Engaging and Managing Boomers

- Show you are an equal
- Use respect – without elevating
- Ask questions and probe
- Show them how to grow and innovate
- Don’t blame Boomers for the 70 hour work week☺
- Encourage new learnings

# Engaging and Managing Generation X

- Don't micromanage
- Ask questions to solicit input
- Be serious about coaching/mentoring
- Provide learning options
- Implement leadership development programs that allow Gen X associates opportunities to advance
- Provide clear constructive feedback

# Engaging and Managing Millennials

- Provide appropriate supervision and structure.
- Show how the organization's structure works.
- Allow and encourage collaborative and collective work.
- Pair with older (veteran/boomers) workers.
- Forget about traditional gender roles.

# Tips on Managing Multigenerational Differences

- Respect Individuality
  - Assume the best from everyone, and treat everyone as if they have great things to offer. Make the workplace a magnet for excellence
- Balance
  - Respect work-life balance issues
- Attention
  - Get to know each person individually
- Open Communication
  - Be open, direct, allowing for feedback. Encourage input and consultation
- Show appreciation
  - Reward/recognize appropriately
  - Be generationally inclusive

(Generations@Work – Zemke)

# Personal Action Plan

1.How will I communicate the importance of multigenerational diversity to my peers, staff, and leaders?

2.As a result of attending this workshop; what new strategies will I use to be more inclusive and effective across generations?

3.How will I help/coach others to be more inclusive and maintain a positive multigenerational team?

# References and Resources


- ***Multiple Generations: Multiple Expectations*** **-Jeanetta Garmon Darno & Greg Pellegrini – The Conference Board 2006**
- **Hicks, Rick and Kathy (1999). *Boomers, Xers, and Other Strangers: Understanding the Generational Differences that Divide Us.* Wheaton, IL: Tyndale House Publishers.**
- **Lancaster, Lynne C and Stillman, David (2002). *When Generations Collide. NY*: Harper Collins Publishers, Inc.**
- **Martin, Carolyn and Tulgan, Bruce (2002). *Managing the Generation Mix From Collision to Collaboration.* Amherst, MA: HRD Press.**
- **Zemke, Ron, Filipczak, Bob, and Raines, Claire (2000). *Generations at Work: Managing the Clash of Veterans, Boomers, Xers, and Nexters in Your Workplace.* NY: American Management Association.**
- **Bonnie D. Monych, *"Get Your Shift Together" The Secret to Working with Multiple Generations in the Workplace* Better World Books**

# Seton Diversity Office Resources

**Geronimo M. Rodriguez Jr.**
**Vice President, Diversity and Community Outreach**
**(512) 324-5986**
**grodriguez1@seton.org**

**Mel Greene**
**Director, Diversity**
**(512) 324-5985**
**mvgreene@seton.org**

**Tina Hickman**
**Executive Assistant**
**(512) 324-5987**
**thickman@seton.org**

**www.seton.net/diversity**



Seton Healthcare Family

# KEY LGBT HEALTH RESOURCES

**This is just a sampling of the wealth of LGBT health resources now available—
you'll find many additional resources online for your particular interest(s)!**

## General information about LGBT people and issues:

- **Human Rights Campaign** (HRC): www.hrc.org
- **National Gay & Lesbian Task Force**: www.ngltf.org
- **National Center for Transgender Equality**: nctequality.org
- **Parents, Families & Friends of Lesbians & Gays** (PFLAG): www.pflag.org

## National LGBT health initiatives and organizations:

- **National Healthcare Equality Index** (HRC's annual hospital survey): www.hrc.org/hei
- **UCSF Center for LGBT Health & Equity:** lgbt.ucsf.edu
- **Gay & Lesbian Medical Association (GLMA)**: www.glma.org
- **American Medical Association GLBT Advisory Committee**: www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee.shtml
- **American Medical Students Association Gender & Sexuality Committee**: www.amsa.org/AMSA/Homepage/About/Committees/GenderandSexuality.aspx
- **National LGBT Health Coalition**: lgbthealth.net
- **Straight for Equality in Healthcare** (PFLAG): www.straightforequality.org/healthcare
- **Fenway Institute:** www.fenwayhealth.org/site/PageServer?pagename=FCHC_ins_fenway_home
- **World Professional Association for Transgender Health** (WPATH): wpath.org
- **National LGBT Cancer Network:** www.cancer-network.org/

## Selected LGBT health publications:

- **Joint Commission *LGBT Field Guide*:** www.jointcommission.org/lgbt/
- **HHS LGBT health pages**: www.hhs.gov/secretary/about/lgbthealth.html
- **SAMHSA's *Top Health Issues for LGBT Populations Information & Resources Kit*:** store.samhsa.gov/product/Top-Health-Issues-for-LGBT-Populations/All-New-Products/SMA12-4684?WT.ac=EB_20120328_SMA12-4684
- **Institute of Medicine's *The Health of LGBT People***: www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx
- ***Fenway Guide to Lesbian, Gay, Bisexual & Transgender Health***, American College of Physicians: www.acponline.org/atpro/timssnet/catalog/books/fenway.htm
- ***LGBTQ Cultures: What Health Care Professionals Need to Know About Sexual & Gender Diversity,*** Michele J. Eliason et al. (online text with nursing CE credits): www.nursingcenter.com/prodev/static.asp?pageid=928987
- **Kaiser Permanente *Provider's Handbook on Culturally Competent Care: LGBT Population*:** www.madisonstreetpress.com/cgi-bin/shop.shtml?id=25
- **Clinical Guidelines for Care of LGBT Patients,** Gay & Lesbian Medical Association: http://www.glma.org/_data/n_0001/resources/live/Welcoming%20Environment.pdf
- ***When Health Care Isn't Caring***, Lambda Legal: www.lambdalegal.org/health-care-report
- **CAP Report on LGBT Health Disparities**: www.americanprogress.org/issues/2009/12/lgbt_health_disparities.html

# KEY LGBT HEALTH RESOURCES (continued)

### Information & materials for creating a welcoming environment:

- **American Cancer Society** (brochures on LGBT cancer & smoking): contact local ACS office
- **GLBT Health Access Project** (posters and protocols): www.glbthealth.org
- **Transgender Law Center** (tips for welcoming transgender patients): transgenderlawcenter.org

### Population- and issue-specific LGBT health information:

- ***Primary Care for Lesbians and Bisexual Women***, Sally Mravcak, MD: www.aafp.org/afp/20060715/279.html
- ***Lesbian Health 101: A Clinician's Guide***, Patty Robertson, MD & Sue Dibble, DNSc, eds.: nurseweb.ucsf.edu/public/npress/ord-lh.htm
- **Primary Care for Gay/Bisexual Men & Other MSM**, Fenway Institute conference: www.fenwayhealth.org/site/PageServer?pagename=FCHC_ins_HIV_Prevention2011
- **Optimizing Primary Care for Men Who Have Sex with Men,** Harvey Makadon, MD & Ken Mayer, MD: jama.ama-assn.org/content/296/19/2362.full
- **UCSF Anal Cancer Screening Information**: id.medicine.ucsf.edu/analcancerinfo/
- ***Bisexual Health: An Introduction & Model Practices*:** www.thetaskforce.org/reports_and_research/bisexual_health
- ***Bisexual Invisibility* Report,** SF Human Rights Commission: www.sf-hrc.org/index.aspx?page=1
- **UCSF Center of Excellence for Transgender Health**: transhealth.ucsf.edu
- **Trans Care Project,** Vancouver, Canada: www.vch.ca/transhealth/resources/careguidelines.html
- **Endocrine Society Guidelines for Treatment of Transsexual Persons**: www.endo-society.org/guidelines/Current-Clinical-Practice-Guidelines.cfm
- **American Psychological Association Division 44**: www.apadivision44.org/
- **National LGBT Tobacco Control Network:** www.lgbttobacco.org/

### Information for/about LGBT youth, families, elders, and servicemembers:

- **HRC Family Project** (fostering, adoption & school initiatives): sites.hrc.org/issues/parenting/10475.htm
- **Family Acceptance Project** (resources for families of LGBT youth): familyproject.sfsu.edu/
- **Groundspark** (materials about family diversity): www.groundspark.org
- **Family Equality Council** (resources for LGBT families): www.familyequality.org
- **COLAGE** (children of LGBTQ parents): colage.org
- **The Trevor Project** (suicide hotline for LGBTQ youth): www.thetrevorproject.org/
- **National Resource Center on LGBT Aging:** www.lgbtagingcenter.org/
- ***The Aging & Health Report: Disparities & Resilience Among LGBT Older Adults:*** caringandaging.org/
- **Gen Silent** (film about LGBT seniors): stumaddux.com/GEN_SILENT.html
- **Servicemembers Legal Defense Network:** www.sldn.org/

**Prepared by Shane Snowdon | EdgeWork | edgwrk@gmail.com**