The University of Kansas Medical Center

Diversity Initiative Strategic Plan

Prepared by the Diversity Advisory Council
The University of Kansas Medical Center
Diversity Initiative Strategic Plan

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Diversity Strategic Plan
Executive Overview

September, 2003

In 2002, the Diversity Advisory Council was tasked to begin developing a set of long term goals and objectives to facilitate KUMC’s Diversity Initiative. The first platform laid in building the strategic plan was a day long retreat in October 2002. The purpose of the retreat was to identify ideas and perspectives; and for the DAC to arrive at some consensus concerning the form the Diversity Initiative should take in future years. The results of the retreat were clear.

The DAC almost unanimously held that KUMC should strive for national recognition in the area of diversity and cultural competence. Moreover, the group felt the time had come for the campus to move beyond cultural celebrations and holiday recognition into a broader set of educational activities for faculty and staff as well as conducting a self-assessment to measure progress.

Following the retreat, KUMC engaged Nancy Hedrick a former Vice President of Strategic Planning for Farmland Industries. Taking the results from the DAC retreat, her charge was to draft KUMC’s first Diversity Strategic Plan document. We believe the resulting document provides an overarching set of goals and objectives pertaining to diversity and cultural competence that will serve as a roadmap for KUMC’s schools and departments.

The responsibility for diversity programs, education, and seminars is endemic to each campus entity. Through the support of the Diversity Advisory Council (DAC), all campus diversity issues are conveyed to the office of the Executive Vice Chancellor. The DAC members serve in advisory roles and help set the tone for the diversity initiative at KUMC. The overall objectives listed in the Strategic Plan document pertain to the entire campus community and focus on matters necessary to achieve cultural competency at KUMC.

The Diversity Strategic Plan is, in effect a general guideline for the campus community to develop programs relevant to diversity and cultural competence. KUMC must reinforce the message that we care about all forms of diversity which reflect on the broad range of human experience and which contribute to the healthy and scholarly exchange of ideas on campus — which in addition to factors such as race, sex, age, religion, and disability, include such things as socioeconomic status, cultural background, sexual orientation, and political views, etc.

To this end, the DAC believes it becomes the responsibility of all KUMC executive and management staff to provide the leadership for implementing the goals and objectives set forth in the Diversity Strategic Plan. Each school at KUMC is encouraged to establish consultation advisory groups which will be a pro-active voice in fostering ideas, programs, and culture that advance and enhance diversity. Thus, the diversity initiative embodies the institution’s commitment to broaden the idea of access, inclusion, and diversity at KUMC.
The DAC planning process working with Nancy Hedrick identified the following goals for KUMC’s Diversity Initiative:

- Create and maintain an internal environment with a sense of community that understands, values and pro-actively supports diversity in systems, structure, attitudes and behaviors;
- Support our external community and gain the recognition/reputation as a caring and involved neighbor;
- Increase the effective communication and visibility of our diversity successes internally, locally and nationally;
- Seek extramural funding; insure adequate resources devoted to diversity initiative
- Become nationally recognized for our diversity efforts and success;
- Overall, establish and maintain a relationship between the Diversity Initiative and the KUMC community

While the DAC proposes adopting the above diversity goals, their intent is clearly that individual schools and department should decide how best to achieve progress toward meeting them. The DAC and Human Resources will provide departments with training programs, resources and materials as well as continue to seek extramural funding to support campus diversity activities.

The Diversity Strategic plan is intended to be an enduring and dynamic structure. The DAC will continually review and recommend plan revisions to the Executive Vice Chancellor as needed to reflect changing national mores and university culture. We sincerely hope the plan will assist schools and department in improving the cultural competence of faculty, staff and students.

More detailed information and supporting data may be found in the plan document itself. The DAC respectfully recommends adoption of the Diversity Strategic Plan.
The University of Kansas Medical Center
Mission Statement

The University of Kansas Medical Center, an integral and unique component of the University of Kansas and the Kansas Board of Regents system, is composed of the School of Medicine (located in Kansas City and Wichita) the School of Nursing, the School of Allied Health, the University of Kansas Hospital in Kansas City, and a Graduate School. The KU Medical Center is a complex institution whose basic functions include research, education, patient care, and community service involving multiple constituencies at state and national levels. The following paragraphs chart the KU Medical Center’s course and serve as a framework for assessing programs, setting goals, developing initiatives and evaluating progress.

The University of Kansas Medical Center is a major research institution primarily serving the State of Kansas as well as the nation, and the world, and assumes leadership in the discovery of new knowledge and the development of programs in research, education, and patient care. The KU Medical Center recognizes the importance of meeting the wide range of health care needs in Kansas — from the critical need for primary care in rural and other underserved areas of the state, to the urgent need for highly specialized knowledge to provide the latest preventive and treatment techniques available. As the major resources in the Kansas Board of Regents system for preparing health care professionals, the programs of the KU Medical Center must be comprehensive and maintain the high scholarship and academic excellence on which the reputation of the University is based. Our mission is to create an environment for:

**Instruction.** The KU Medical Center educates health care professionals to primarily serve the needs of Kansas as well as the region and the nation. High quality educational experiences are offered to a diverse student population through a full range of undergraduate, graduate, professional, postdoctoral and continuing education programs.

**Research.** The KU Medical Center maintains nationally and internationally recognized research programs to advance the health sciences. Health related research flourishes in a setting that includes strong basic and applied investigations of life processes, inquiries into the normal functions of the human body and mechanisms of disease processes, and model health care programs for the prevention of disease and the maintenance of health and quality of life.

**Service.** The KU Medical Center provides high quality patient-centered health care and health related services. The University of Kansas Medical Center will be the standard bearer in the development and implementation of model programs that provide the greatest possible diversity of proven health care services for the citizens of Kansas, the region and the nation. (5-28-89; 12-17-92).

Note: Since the creation of this mission, another important milestone came in 1998 when the hospital separated from state control, with the establishment of the Hospital Authority. The hospital is now known by a name long familiar to area residents: KU Med.
Background Summary
Data Highlights: Appendices A/B

In this new millennium, we must face the challenges of providing the best health care for our increasingly diverse country, state and city. Diversity in medical education and application is necessary to serve diverse populations regardless of gender, race, age or economic status. We must work to close the disparities of health and disease across ethnic, social, and other groups. We must recognize that illness and disease vary by culture, and diverse belief systems exist on health, healing and wellness. Minority physicians and health care providers are key to the nation’s diverse and underserved populations.

As the only Medical Center in the state of Kansas, we must meet our state’s needs. Despite a substantial and consistent improvement in health over the past several decades (similar to the general trends in the other 49 states), there remain important differences in the various demographic, socioeconomic, and geographic groups. Generally, Kansas ranks in the middle of the fifty states, on some indicators better and on some less good, but with room for substantial improvement.

KUMC has a long history of serving not only the residents of the state of Kansas, but also residents of the bi-state Greater Kansas City Area. In our own backyard, in the metropolitan areas of Wyandotte (KS) and Jackson (MO) counties (population: 800,000) the percent of underrepresented minorities (URM) is 38% and 28%, respectively. It is, therefore, important that our students, faculty and staff are trained to serve a population who resides at or near our “doors” that includes 28% - 38% African American, Hispanic, Vietnamese and other URM, including Asian and Native Americans.

In addition to serving and meeting the varied health care needs of the diverse populations of our country, state and city, at KUMC we must serve and meet the diverse needs of those we recruit, educate, and employ. Opportunities include: development of more consistent, fair and equitable standards; clear communication of standards, expectations, and accountabilities with less duplication of efforts; more openness and trust in communication/more expression of appreciation and respect; strengthening, in particular, the perception of non-whites about KUMC’s diversity commitment.

The University of Kansas Medical Center will abide by all federal and state laws relating to diversity. Importantly, we recognize that understanding, valuing, and proactively supporting diversity is essential in serving our country’s, state’s and city’s medical and health care needs and closing the health care disparities gap of minority groups. We must do this not only in our instruction and research but in all of our services and with all of our people.
The University of Kansas Medical Center
Diversity Initiative Vision and Mission

Diversity Defined
Diversity is reflected in the many ways and dimensions we each walk and talk, think and behave. It is complex, which contributes to its value. Diversity includes, and is not limited to: culture, gender, age, ethnicity, nationality, geography, lifestyle, education, income, health, physical appearance, pigmentation, language, personality, beliefs, faith, dreams, interests, aspirations, skills, professions, perceptions, and experiences. We are each multifaceted individuals interacting with other multifaceted individuals within a multifaceted environment.

Our Vision
The University of Kansas Medical Center is nationally recognized as the standard where diversity is understood, valued, and pro-actively supported as an essential component to the successful advancement of our instruction, research, service, and people.

Our Mission
The University of Kansas Medical Center strives to constantly and consistently move forward systems, actions, attitudes, behaviors, and assessments that advance and enhance diversity.

We will:

- reflect the changing demography of our society to better serve its medical and health care needs,
- recruit and retain people of diverse backgrounds to enrich the collaborative efforts in the ongoing research, healthcare, and teaching missions of KUMC,
- create and foster work and learning environments that support growth, enhance potential, and promote acceptance and respect of every individual,
- create and maintain systems and practices that promote a positive and equitable environment,
- assess the environmental climate formally and informally by staying attuned to the day-to-day events and the impact on attitudes and well-being.

We desire to recruit and retain employees, faculty, and students who:

- feel that health care is a noble and ennobling career,
- are proud of their abilities and respect the abilities of others,
- care about people,
- delight in the environment of higher education,
- care about the health of all citizens,
- feel an obligation to pursue and maintain competency,
- feel an obligation to work and serve with professionalism,
- will abide by our Diversity Guiding Principles.
**Diversity Guiding Principles**

Diversity is a precious strength we seek to value and proactively support. Our different organizations under the KUMC umbrella are diverse in our varying missions, yet we all will abide by these guiding principles in our relationships with all those with whom we interact and serve in our internal and external communities.

**Leadership**
- Our leadership understands that a diverse workforce will embody different perspectives and approaches to work.
- Our leadership values variety of opinions in insight.
- Our leadership recognizes both the learning opportunities and the challenges that the expression of different perspectives presents for an organization.
- We are all leaders in the fostering and upholding of our diversity vision, mission, and guiding principles.

**Integrity, Honesty, and Authenticity**
- We will operate with honesty and integrity.
- We will be authentic, practicing what we preach.
- We will insist on quality and high professional standards

**Opportunity, Fairness, and Equity**
- We encourage and welcome ideas from all.
- Our decisions will be based on the merit of ideas.
- We will provide opportunity for those affected to participate in decision making before making changes.
- We expect fairness and equity in our attitudes, behaviors and actions, and will examine the processes by which we accomplish our goals to ensure that none of us is afforded special privilege or preferential treatment, overtly or by default.
- We will maintain an environment that fosters personal and professional development, where individuals feel free to pursue their potential and advancement opportunities.
- We will have zero tolerance for harassment, violence and discrimination.

**Responsibility and Accountability**
- We will empower, as well as expect, each of us to take responsibility for ourselves and our actions in fostering a productive, hospitable, and culturally competent work environment.
- We will take responsibility for our mistakes versus blaming, recognizing that mistakes are part of a growing, learning, risk taking environment.

**Trust and Openness**
- We will promote open discussions and communications that are clear, trustworthy, and timely.
- We will provide a safe and trusting atmosphere.
• We will be good listeners and communicators, premature eliminating critical judgmental opinions that foster turf oriented thinking, feelings of isolation, fears of retaliation, and lack of trust.
• We will maintain an environment that is open to change, flexibility, creativity, and innovation.
• We will not be silent regarding diversity issues and opportunities.

Respect, Appreciation, and Celebration
• We will maintain an environment that respects, appreciates, and values diversity.
• We will respect the rights of each of us.
• We will respect and celebrate individuals and teams for their work and positive contributions so that they feel appreciated as a vital part of the organization.
• We will encourage each of us to believe in ourselves and each other with the confidence to contribute the best we have to offer.
• We will treat every person in a professional manner.

Learning and Education
• We will be a learning organization: motivated, curious, open to new and diverse ideas and continuous improvement.
• We will provide training and education on diversity and its value.

“Positivity”
• We will create and maintain a positive, dynamic working environment full of hopefulness, positive attitudes, and pride.
• We will maintain a supportive sense of humor and perspective.

Connectivity and Teamwork
• We will be unified in our mission and goals, clearly communicating and all working together.
• We will maintain strong and healthy communication, keeping ourselves connected at all levels and avoiding duplication of effort.
• We believe in the synergy of our diversity and our collaboration as a team united.
• We will foster teamwork with engaging leadership.

Community
• We care for our community knowing our differences provide the opportunity to gain from their insights and perspectives.
• We believe that our responsibility to the community goes beyond providing health care; we must also be the best neighbor in the neighborhood.

Note that our internal and external communities include, but are not limited to: faculty, staff, students, researchers, patients, families, vendors and suppliers, members of our local, regional, and national communities, and members of medical and health care related fields.
The Diversity Advisory Council

The Diversity Advisory Council (DAC) is an institutional organization created as part of Executive Vice Chancellor Donald Hagen’s KUMC Diversity Initiative.

The overall purpose of the DAC is:

- to provide input to the Executive Vice Chancellor and KUMC on the Diversity Initiative,
- to be the pro-active voice at KUMC in fostering the ideas, programs, and culture that advance and enhance diversity,
- to support the pursuit of our vision, mission, guiding principles, and strategic planning,
- to foster and ensure synergistic support and communication across the campus in the diversity efforts.

Specifically, the roles and functions of the Diversity Advisory Council include:

- communicate to the Medical Center about diversity initiatives and the outcomes,
- meet monthly to evaluate the effectiveness and success of such initiatives,
- work with the Medical Center departments and staff who are responsible for the implementation of diversity related activities,
- encourage and foster support for Diversity groups,
- determine issues, trends and/or opportunities that need to be addressed with matters of diversity,
- advocate open communication and collaboration among all employees to create a culturally proficient work environment,
- furnish current information and concepts in support of inclusion and cultural proficiency,
- support diversity management by assisting in the creation of tools and methods to assess cultural proficiency,
- provide guidance into the selection of subject matter and/or educational models to be used by KUMC in fostering and embracing diversity management.
Strategic Plan
Objectives — 2003

Objective #1: Create and maintain an internal environment with a sense of community that understands, values and pro-actively supports diversity in systems, structure, attitudes and behaviors

Objective #2: Support our external community and gain the recognition/reputation as a caring, involved neighbor

Objective #3: Increase the effective communication and visibility of our diversity successes internally, locally and nationally

Objective #4: Increase resources (time, people, and money) devoted to diversity

Objective #5: Become nationally recognized for our diversity efforts and success

Objective #6: Overall, establish and maintain a relationship between the Diversity Initiative and the KUMC Community
University of Kansas School of Medicine
Office of Cultural Enhancement & Diversity

We are committed to promoting diversity in our students and faculty so that we can better understand and serve our patients. We value the pursuit of new knowledge and perspectives as a means to discover not only better ways to understand, diagnose, prevent and treat disease, but as a means to improving health care in our state and our nation.

Background
The Office of Cultural Enhancement and Diversity (OCED) were established in the spring of 1998 under the leadership of Deborah E. Powell, MD Executive Dean of the KU School of Medicine and Vice Chancellor for Clinical Affairs. OCED focuses on those critical issues that relate to the art, science, learning and “humaness” of medicine.

OCED exists to take a leadership role in addressing broad issues of diversity that affect academic health science centers, medical students, faculty, resident trainees, patients and their surrounding communities. Through the creation and continued support of the OCED, the KU School of Medicine institutionalizes the Dean’s belief that a diverse student body and faculty, as well as broad reaching programs and innovative curriculum are educationally and socially advantageous.

We recognize that diversity, and the appreciation of it:
- allows for the robust exchange of ideas,
- enables the breakdown of stereotypes,
- fosters world class excellence in medical education, research and patient care,
- facilitates a strong presence in our community and promotes the intercultural competency needed to prepare our students for leadership roles in society.

We will support an educational environment that fosters:
- the vigorous exchange of ideas without fear of prejudice or persecution,
- training culturally and clinically skilled physicians and thereby, improve access to high quality healthcare and biomedical research for underserved and special patient populations,
- Preparation of students for leadership roles in medicine.
Why Cultural Competence?

- The people we serve are ethnically and culturally diverse.
- Increased access and reduced disparities are directly linked to cultural competence.
- Improved health outcomes will be eventually linked to cultural competence.
- It is sound business practice.
  - Maximum use of limited resources.
  - Increased customer satisfaction and retention.
  - Increased customer recruitment.
  - Increased access to care.
  - Providing products/services consistent with client needs.
  - Culturally competent management, staff, and practitioners.

Cultural Competency
At the University of Kansas School of Medicine

Cultural competency is part of the “art” of medicine, characterized by awareness, sensitivity, respect and understanding of the human differences those patients seeking healthcare may possess. (i.e. cultures and world views)

Cultural competency requires the physician to be aware and knowledgeable about the following facts or issues:

- Illness and disease vary across cultures.
- Beliefs systems and attitudes about health, healing, and disease are diverse.
- Cultural attitudes affect patient-doctor relationships.
- All aspects of culture are not uniformly expressed or shared within or across groups.
- Optimal patient care requires that the patient-doctor relationship is a trusting one that defies interpersonal or intercultural differences.

Definitions:

**Cultural sensitivity** — helping doctors to achieve:

- awareness (of commonality, difference, and bias)
- knowledge (of culture theory, as well as development and use of open, expectable patterns in lieu of stereotypic information)
- skill (in the areas of communication, assessment and intervention).

**Cultural competency** — helping doctors to understand and be sensitive to the different needs people from various cultures and backgrounds may have when they seek medical care.

**Cultural proficiency** — helping doctors translate cultural sensitivity and cultural competency to excellent patient outcomes.
Background Data Commentary

Data: Appendix C

It has been widely reported by a number of federal agencies and the Association of American Medical Colleges (AAMC) that there is a critical shortage of Black, Hispanic and Native American physicians. There exists a severe shortage in our state of Kansas. Of the 3,836 practicing physicians in Kansas only 80 or 2.90% are Black, 48 or 1.25% are Hispanic, 6 or 0.16% are American Indian, 17 or .45% are Vietnamese and 294 or 7.66% other. Only ten counties of the state’s 105 counties have at least one Black practicing physician, and only seven have at least one Hispanic physician. Research shows that not only are patients from minority groups more likely to consult physicians of the same ethnic group, but that black and Hispanic physicians are much more likely to serve their respective underserved communities (Komaromy M, Gurmbach K, Drake M et al, 1996).

To address this under-representation in the work force one must look at the barriers to minorities and other disadvantaged students entering the profession. When persons from communities are without a practicing physician or have no role models it reduces the potential for young college bound students from these communities (minority or white) to view medicine as an option of choice. The admission and retention requirements are problematic because their educational backgrounds have not prepared them to meet these requirements. These barriers have led to under-representation of health care practitioners, in the applicant pool and subsequently in enrollment. The low numbers are manifestations of the following education-related barriers: 1) Inadequate academic preparation; 2) Inadequate knowledge of admission requirements; 3) Lack of health careers exposure; 4) Exposure to a medical environment; 5) Exposure to role models; 6) Fear that financial barriers cannot be overcome and 7) Inappropriate self concept.

The cost of becoming a doctor plays a significant role not only in whether an under-represented minority student will choose medicine, but also in choice of school (Bazzoli GJ, Adams EK, Thran SL, 1986) and more scholarship programs are necessary to ensure matriculation (Johnson L, 1998). We believe if academically competitive students from underrepresented minority or other health disparity groups are offered scholarships and provided academic support to guarantee timely graduation, thereby reducing their debt burden, they will choose medicine as a career.

There is significant evidence that there is a wide gap in the current health status between whites and underrepresented minorities. There is continuing need for the exploration of the root causes of these disparities. Research dealing with health policy, health services, outcomes and a wide range of other health related issues is currently underway and needs to be enhanced. Since the Black and Hispanic populations continue to grow at a faster rate than the White population, it is even more imperative that future medical professionals recognize the needs for greater research within these growing populations.
Office of Cultural Enhancement & Diversity
Vision and Mission

Our Vision

Our vision is that:

- our graduates will provide the culturally competent care and community, state, and national leadership needed to greatly diminish or eliminate ethnic/racial, socioeconomic, cultural, and gender related disparities in health care outcomes in Kansas,
- we will be a nationally recognized role model in this pursuit.

Our Mission

Our mission is to:

- be the advocate for diversity and address those critical issues that relate to the learning, the science, the art, and “humanness” of medicine,
- foster the recognition that a diverse student body and faculty, a culturally enriched curriculum, and a broad-based research agenda are essential for the best possible educational and personal experiences for our students,
- ensure, through our diversity, the vigorous exchange of ideas, the breakdown of stereotypes, the growth of professionalism, the development of the cultural competence and future physician leaders, and the best health outcomes for our patients,
- attract, train, and retain under-represented minority and rural physicians to serve as faculty, mentors, and role models for medical student’s residents and fellows,
- take a firm leadership role in developing and supporting programs, curricula, and research projects that will accomplish these goals and foster world class excellence in the School of Medicine,
- promote the value that each and every one of our students, faculty and resident trainees contributes to the wonderful diversity that the KU School of Medicine enjoys.
OCED Strategic Plan 2003
Objectives, Strategies, and Tactics

Objective #1A: Successfully recruit, retain, and graduate well-qualified, underrepresented minorities and disadvantaged students

Objective #1B: Successfully recruit and retain minority residents and faculty.

Objective #2: Successfully prepare medical students, residents, faculty and community physicians in knowledge, application, and leadership of culturally competent health-care.

Objective #3: Increase broad-based medical research that addresses medicine and health needs of our diverse population

Objective #4: Increase the academic preparedness of the state’s underrepresented minorities and disadvantaged K-16 students for successful entry into the KUSM

Objective #5: Secure resources to support the OCED programs

Objective #6: Provide access to medical education to the socio-economically strained and underprivileged

Objective #7: Become nationally recognized for our diversity efforts and success
Appendix
Appendix A
Highlights in Market Trends, Data, and Needs

National

- The need for diversity, and the awareness of it, is evident in the population and health center patient trends in race, gender, age and economic status.
- Diversity in medical knowledge and application is necessary to serve the diverse populations.
- Minority physicians and health care providers are key to the nation’s under-served population.
- How do we better address the needs of the under/un-insured.

Health Center Patients by race/ethnicity (1997) Source: BPHC/UDS:

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<tr>
<th>Race/Ethnicity</th>
<th>% of Total</th>
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<td>White</td>
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</tr>
<tr>
<td>Hispanic</td>
<td>31%</td>
</tr>
<tr>
<td>African American</td>
<td>25%</td>
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<tr>
<td>Asian/Other</td>
<td>8%</td>
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- By the year 2000, 39% of the U.S. population will be foreign born or children of foreign born.
- A century from now, 50% of all Americans will be Black, Hispanic, or Asian in origin.

Health Center Patients (8.3MM By Age/Gender (1997) Source: BPHC/UDS:

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<th>Age</th>
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<td></td>
<td>F</td>
<td>600</td>
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<tr>
<td>F</td>
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<td>59%</td>
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Children’s Defense Fund Predictions:

- 5.5 million more Hispanic children
- 2.6 million more African-American children
- 1.5 million more children of other races
- 6.2 million fewer white, non-Hispanic children

Health Center Patients: By Economic Status (1997)

- Below Poverty  66%
- 100 – 200% of Poverty  20%
- +200% Poverty  14%

Patterns in cause of death by minority group (1992)


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<th></th>
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<td>due to</td>
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<tr>
<td>Chemical Dependence</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>aggregated</td>
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<tr>
<td>Diabetes</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>and</td>
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<tr>
<td>Infant Mortality</td>
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<td>Violence</td>
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<td>Un-injury</td>
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<td>AIDS/HIV</td>
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*equals higher death rate than for whites

Reaching the Underserved

Nearly 40 percent of medical school graduates who are African-American, Mexican American, American Indian/Alaska Native and Mainland Puerto Rican elect to practice medicine in underserved areas compared to only 10 percent of all other graduates according to a study published by the Association of American Medical Colleges (1).
The State of Kansas

Demographic Data (2000) U.S. Census Bureau

<table>
<thead>
<tr>
<th>Metric</th>
<th>Kansas</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>2,688,418</td>
<td>281,421,906</td>
</tr>
<tr>
<td>Percent change from 1990</td>
<td>8.5%</td>
<td>13.1%</td>
</tr>
<tr>
<td>Percent Female</td>
<td>50.6%</td>
<td>50.9%</td>
</tr>
<tr>
<td>Percent of persons under 5 years old</td>
<td>7.0%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Percent of persons under 18 years old</td>
<td>26.5%</td>
<td>25.7%</td>
</tr>
<tr>
<td>Percent White</td>
<td>86.1%</td>
<td>75.1%</td>
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<tr>
<td>Percent Black or African American</td>
<td>5.7%</td>
<td>12.3%</td>
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<tr>
<td>Percent Hispanic or Latino</td>
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<tr>
<td>Percent Asian</td>
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<td>3.6%</td>
</tr>
<tr>
<td>Percent American Indian and Alaska Native</td>
<td>.9%</td>
<td>.9%</td>
</tr>
<tr>
<td>Percent Hawaiian and Pacific Islander</td>
<td>Z</td>
<td>.1%</td>
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<td>Percent reporting some other race</td>
<td>3.4%</td>
<td>5.5%</td>
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<td>Percent reporting two or more races</td>
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<td>Persons with a disability, age 5+</td>
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<td>49,746,248</td>
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<tr>
<td>Foreign born persons</td>
<td>5%</td>
<td>11.1%</td>
</tr>
</tbody>
</table>

Health Data

Source: Health and Social Trends in Kansas published in 1998 by the Kansas Health Institute, Topeka, Kansas

Despite a substantial and consistent improvement in health over the past several decades in the state of Kansas, (similar to the general trends in the other 49 states) there remain important differences in the various demographic, and socioeconomic, and geographic groups. Generally, Kansas ranks in the middle of the fifty states, on some indicators better, and on some, less good, but with room for substantial improvement. (Classes)

- 20% (1 out of 5) children lives in poverty, the 16th highest child poverty rate in the country. Except for Missouri, this rate in Kansas is the highest among the Great Plains States.
- The Kansas life expectancy at birth is 76.8 years, 1.4 years longer than that for the U.S. as a whole. Kansas has the 13th highest rate among the states, though lower than most of the North-Central region.
  - Life expectancy varies considerably by sex and race.
    - White Females: 80.3
    - Black Female: 74.8
    - White Males: 74.0
    - Black Males: 67.0
• In 1995 Kansas ranked 17th in infant mortality at 7.0 deaths per 1000 live births versus 7.6 nationally.
  o The infant mortality rate in Kansas is about three times larger for blacks than whites.
  o Infants born to mothers with less than a high school education have more than two times the mortality rate of babies born to mothers with a college education.
  o In general, the lower the educational level of the mother or father, the higher the rate of infant death. The SIDS mortality rate is 4 to five times higher for parents with less than a high school education, and two times greater infant mortality from perinatal conditions.
• 6.4% of babies born in 1995 had low birth weight (<2,500 grams), a slight increase from the 1981 rate of 6.2%. In Kansas, it is twice as likely for a black baby to be born with low birth rate than a white baby.
• 25% of adults in Kansas report that a health professional has told them at least once that they have hypertension (high blood pressure). The national comparison is 22%
  o Hypertension among black and American Indian men is more prevalent than white men three and ten times respectively.
  o The risk of hypertension is double for those with household income less than $10,000 versus those with over $50,000.
• In Kansas, five percent report being told by a doctor that they have diabetes compared to 4.4% nationally.
  o Among Kansas’ blacks and Hispanics, the risk of diabetes is twice that of whites.
  o The risk of diabetes is twice that for those with less than 9 years of schooling versus those with a college degree or more.
• In 1995, the leading causes of death in Kansas were:

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<tr>
<td>Heart Disease</td>
<td>32%</td>
</tr>
<tr>
<td>Cancer</td>
<td>23%</td>
</tr>
<tr>
<td>Stroke</td>
<td>7%</td>
</tr>
<tr>
<td>COPD</td>
<td>5%</td>
</tr>
<tr>
<td>Unintentional Injuries</td>
<td>4%</td>
</tr>
<tr>
<td>Pneumonia &amp; Influenza</td>
<td>4%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2%</td>
</tr>
<tr>
<td>Infectious diseases</td>
<td>2%</td>
</tr>
<tr>
<td>Suicide</td>
<td>1%</td>
</tr>
<tr>
<td>All Other Causes</td>
<td>20%</td>
</tr>
</tbody>
</table>

  o Overall, blacks in Kansas, versus whites, have a 60% higher mortality rate; a twelve times higher risk of homicide and two to three times higher mortality rate in diabetes, cirrhosis, kidney, and infectious diseases. Also, blacks experience higher mortality from heart disease, stroke, cancer, pneumonia and influenza, HIV/AIDS, and unintentional injuries.
Other Health Risk Behaviors Commentary:

- 22% of adult Kansans smoke cigarettes on a daily basis, similar to the national average.
  - A higher percentage of males smoke than females.
  - A higher percentage of blacks and American Indians smoke whites and Hispanics.
  - The rate of smoking decreases with increasing household income and education level.

- Among adult Kansans, about 58% lead sedentary lifestyles, with no recreational physical activity or exercise less than three times per week for less than twenty minutes each time.
  - Versus adults with at least a college degree, those with less than a high school degree are three times more likely to be sedentary.

- About 27% of Adults Kansans are overweight.
  - Middle aged people are more likely to be overweight.
  - Men are more likely than women to be overweight.
  - Blacks and American Indians are more likely to be overweight than whites and Hispanics.

Health Care and Preventive Health Services Commentary:

- 12.4% of Kansans in 1995 were without health care coverage versus the national rate of 15.4%.
  - The age group with the highest percent not having health care coverage is ages 18-24 years (over 24%)
  - Regardless of age, minorities are less likely than whites to have coverage.

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Whites</td>
<td>10.1%</td>
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<tr>
<td>Blacks</td>
<td>16.1%</td>
</tr>
<tr>
<td>Hispanics</td>
<td>19.5%</td>
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<tr>
<td>American Indian</td>
<td>25.6%</td>
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</table>
The Greater Kansas City Area

KUMC has a long history of serving not only the residents of the state of Kansas, but also those who reside in the bi-state Greater Kansas City Area. The greater Kansas City area is located on the Kansas and Missouri state borders encompassing an estimated 300 square miles comprised of seven counties. The population is 1,582,875 with two-fifths residing in Kansas and three-fifths residing in Missouri.

KUMC is located on Rainbow Boulevard at the west and State Line Road at the east (the street that separates Kansas and Missouri). KUMC is closer to many urban Kansas City, Missouri (KCMO) residents than many hospitals in KCMO. The population the metropolitan area (Wyandotte and Jackson counties) is 800,000. The percent of underrepresented minorities residing in Wyandotte County (Kansas City, Kansas - KCK) is 38%, and in Jackson County (KCMO) is 28.1%. It is, therefore, important that our students, faculty and clinical staff are trained to serve a population who reside at or near our "doors" that include 28% - 38% African American, Hispanic, Vietnamese and other UR M Asian and Native Americans. It should also be noted that in the two urban school districts (KCK and KCMO), with total enrollments of 21,266 and 36,750, underrepresented minorities represent 68% and 78%, respectively.
KUMC

Survey 2000 provides insight into the strategic direction for the Diversity Initiative. (The participation rate among Employees and Faculty was 42% from KUMC and KUSM-W)

Implications from the data below includes:

- Development of more consistent, fair and equitable standards
- More clearly communicated standards and expectations
- More openness and trust in communication
- More expression of appreciation and respect
- More recognition and rewards
- More opportunity
- More accountability and expectations
- More clear communication and less duplication of efforts
- Strengthen in particular the perception of non-whites about KUMC’s diversity commitment
- Overall, consider the implications across structure, systems, and behaviors
- Communication tools to consider to improve reach
  - Formalized communication (vs “Grapevine”)
  - E-mail
  - Newsletters, but seek methods to improve readership

Survey 2000 Highlights

Overall statistical areas for improvement

- Poor performance is tolerated
- Employees are reluctant to reveal problems or errors to management above them
- I have a good understanding of how my pay increases are determined
- A chance to be recognized and rewarded
- KUMC has a fair system for evaluating employee performance
- Doing something about employee problems and concerns
- The opportunity for advancement
Communication Sources

- 35% E-mail
- 28% “The Grapevine,” fellow employees
- 13% My own supervisor
- 12% Newsletters
- 5% Department communications
- 5% Administration
- 4% Pulse
- 3% Other
- 1% Radio, TV, Newspapers
- 1% Bulletin Boards

Three Questions from Survey 2000 on the Topic of Diversity

Indicate the extent to which you agree or disagree with the following statements about diversity at KUMC.

1. KUMC is committed to resolving diversity-related problems
2. I am comfortable raising diversity-related problems to management above me
3. Employees are treated the same without regard to race, sex, age, ethnic origin, or disability

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<thead>
<tr>
<th>TOTAL</th>
<th>% Agree/Disagree by Race</th>
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<td>Results</td>
<td>Agree</td>
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<tr>
<td>Q1</td>
<td>65%</td>
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<tr>
<td>Q2</td>
<td>61%</td>
</tr>
<tr>
<td>Q3</td>
<td>57%</td>
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Appendix B
The Law and Regulations

Civil Rights Act of 1964

**Title VII (amended by Equal Employment Opportunity Act of 1972):** Bans discrimination in all terms and conditions of employment (e.g., recruitment, selection, transfer, layoff, discharge; opportunities for promotion; training and development opportunities; wages and salaries; retirement plans and benefits) on the basis of race, color, religion, national origin, or sex. Administered by Equal Employment Opportunity Commission (EEOC); in Kansas, Complaints may also be handled by Kansas Human Rights Commission (KHRC). Covers all institutions with 15+ employees, including state and local governments and labor organizations.

**Title IX (Education Amendments of 1972):** Prohibits educational institutions that receive federal funds from using sex as a classifying tool or criterion for decisions, or to use other bases of classification that disproportionately disadvantage one sex or the other. It is the principal source of law relating to sex discrimination against students in such areas as admissions, employment, financial aid, sexual harassment, student organizations, and athletics. Administered by the Office of Civil Rights (OCR).

Equal Pay Act of 1963

Prohibits sex discrimination in salaried and most fringe benefits for all employees of educational institutions/agencies, including those in professional, executive, and administrative positions. Provides that a man and a woman working for the same employer under similar conditions in jobs requiring substantially equivalent skills, effort, and responsibility must be paid equally, even when job titles and assignments are not identical. Administered by the Wage and Hour Division, U.S. Department of Labor.

Federal Executive Order 11246

Administered by the Office of Federal Contract Compliance Programs (OFCCP), U.S. Department of Labor. Covers federal contractors, and embodies two concepts:

- **Nondiscrimination.** Like Title VII, prohibits employment discrimination on the basis of race, color, religion, sex, and national origin. It requires elimination of existing discriminatory conditions, whether purposeful or inadvertent.

- **Affirmative Action.** Unlike Title VII, requires additional efforts to recruit, employ, and promote qualified members of groups formerly excluded; requires an annual, written Affirmative Action Plan.
Age Discrimination in Employment Act of 1967 (ADEA)

Amended in 1978 and 1986, prohibits employment discrimination on the basis of age against persons age 40+.

Rehabilitation Act of 1973

Applies to federal contractors. Section 503 requires affirmative action for persons with disabilities. Section 504 prohibits discrimination on the basis of disability in employment and education. Enforced by the OFCCP.

Vietnam-Era Veterans Readjustment Act of 1974

Requires employers with federal contracts over $10,000 to take affirmative action to employ and promote qualified disabled veterans and Vietnam-Era veterans. Enforced by the OFCCP.

American with Disabilities Act of 1990 (ADA)

Mirrors section 504 of the Rehab Act, but extends coverage to employers with 15+ employees, public entities, and public accommodations. Requires nondiscrimination, access and reasonable accommodation, but not affirmative action. For public higher education, mandates that all programs, services and activities are accessible by January 26, 1995. Administered by several agencies, including EEOC and Dept. of Justice. Allows for jury trials.

Civil Rights Act of 1991

Amends Title VII of the Civil Rights Act of 1964, ADA of 1990, and Age Discrimination in Employment Act of 1967. Prohibits impermissible consideration of race, color, national origin, religion, sex, or disability. Allows compensatory and punitive damages—previously available only to racial and ethnic minorities—to be sought by victims of intentional discrimination based on sex, religion, or disability. A jury trial may be requested by any party to a case in which compensatory or punitive damages are sought. Administered by the EEOC.

Kansas Act Against Discrimination (KAAD)

Prohibits discrimination on the basis of race, color, national origin, religion, and disability. Applies to any public or private employer with 4+ employees.

Kansas Age Discrimination in Employment Act (KADEA)

Prohibits employment discrimination on the basis of age against any person age 18+. Applies to any public or private employer with 4+ employees.
Appendix C
The School of Medicine Data, Law and Regulations

Under-representation of Minority Physicians in Kansas

- Of the 3,836 practicing physicians in Kansas only 80 or 2.90% are Black, 48 or 1.25% are Hispanic, 6 or 0.16% are American Indian, 17 or .45% are Vietnamese and 294 or 7.66% other.
- The physician/patient ratio in Kansas is 1:679, however the Black physician patient ratio is 1:2235 and the Hispanic is 1:2230 and Vietnamese is 1:2083
- Only ten counties of the state's 105 counties have at least one Black practicing physician, and only seven have at least one Hispanic physician.
- Of the 105 counties in the state of Kansas there are at least twelve in which the physician/patient ratio is greater than 1:3000. To say that health manpower shortages and maldistribution of health manpower personnel are prevalent in the state is an understatement, but in the Black and Hispanic sectors the situation is acute.

Preliminary Studies and Results
Admissions Statistics

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<tbody>
<tr>
<td>Male</td>
<td>97</td>
<td>93</td>
<td>88</td>
<td>101</td>
<td>102</td>
<td>103</td>
<td>107</td>
<td>107</td>
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<tr>
<td>Female</td>
<td>78</td>
<td>82</td>
<td>87</td>
<td>74</td>
<td>73</td>
<td>73</td>
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<td>9</td>
<td>12</td>
<td>15</td>
<td>10</td>
<td>12</td>
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<tr>
<td>Mexican American</td>
<td>4</td>
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<td>4</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>7</td>
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<tr>
<td>Native American</td>
<td>5</td>
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<td>2</td>
<td>3</td>
<td>2</td>
<td>0</td>
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<td>Puerto Rican-Main</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td>1</td>
<td>1</td>
<td>2</td>
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<td>Other Hispanic</td>
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<td>3</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
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1991-2001 Post Baccalaureate Program Minority Participant Tracking

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<th></th>
<th>Black</th>
<th>Hispanic</th>
<th>Asian American</th>
<th>White</th>
<th>American Indian</th>
<th>Total Students</th>
<th>Enrolled Medical School</th>
<th>Graduated</th>
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<tr>
<td>Total</td>
<td>39(32)</td>
<td>18(16)</td>
<td>8(7)</td>
<td>14</td>
<td>4</td>
<td>83</td>
<td>64(63)</td>
<td>29</td>
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<tr>
<td>Participants%</td>
<td>47%</td>
<td>22%</td>
<td>10%</td>
<td>17%</td>
<td>4%</td>
<td>100%</td>
<td>77%</td>
<td>46%</td>
</tr>
<tr>
<td>Grant Population Target%</td>
<td>50%</td>
<td>30%</td>
<td>10%</td>
<td>10%</td>
<td>0%</td>
<td>100%</td>
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</table>
Successful Participants
Graduated 29 (46%)
Still in Medical School 31 (49%)
Total 60 (95%)

Effectiveness in Recruiting Underrepresented Minority Students

<table>
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<tr>
<th>Year</th>
<th>Applied</th>
<th>Accepted</th>
<th>Matriculated</th>
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<td>1993</td>
<td>289</td>
<td>42 (14.5%)</td>
<td>38 (90.5%)</td>
</tr>
<tr>
<td>1994</td>
<td>314</td>
<td>31 (10%)</td>
<td>25 (81%)</td>
</tr>
<tr>
<td>1995</td>
<td>327</td>
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<td>36 (86%)</td>
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<td>1996</td>
<td>266</td>
<td>28 (10.5%)</td>
<td>25 (89%)</td>
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<td>1997</td>
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<td>48 (17.6%)</td>
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<td>1998</td>
<td>254</td>
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<tr>
<td>1999</td>
<td>246</td>
<td>35 (14.3%)</td>
<td>28 (80%)</td>
</tr>
<tr>
<td>2000</td>
<td>288</td>
<td>38 (13.2%)</td>
<td>28 (74%)</td>
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FIRST YEAR ENROLLMENT

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<td>NO %</td>
<td>NO %</td>
<td>NO %</td>
<td>NO %</td>
</tr>
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<td>8.6</td>
<td>14</td>
<td>8.0</td>
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<tr>
<td>Hispanic or Latin Descent</td>
<td>9</td>
<td>5.0</td>
<td>10</td>
<td>5.7</td>
</tr>
<tr>
<td>American Indian or Alaskan native</td>
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<td>1.1</td>
<td>3</td>
<td>1.7</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>7</td>
<td>3.9</td>
<td>8</td>
<td>4.9</td>
</tr>
<tr>
<td>Total Underrepresented Minority Students</td>
<td>33</td>
<td>18.4</td>
<td>35</td>
<td>20.3</td>
</tr>
<tr>
<td>White (Non Hispanic)</td>
<td>146</td>
<td>81.6</td>
<td>140</td>
<td>79.7</td>
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<tr>
<td>Total Non-Underrepresented Students</td>
<td>146</td>
<td>81.6</td>
<td>140</td>
<td>79.7</td>
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<tr>
<td>Total First Year Students</td>
<td>179</td>
<td>100%</td>
<td>175</td>
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TOTAL SCHOOL ENROLLMENT

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<tr>
<td>Black or African American (Not Hispanic)</td>
<td>46</td>
<td>6.5</td>
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<td>7.8</td>
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<tr>
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<td>5.4</td>
<td>37</td>
<td>5.2</td>
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<tr>
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<td>0.9</td>
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<td>Vietnamese*</td>
<td>17</td>
<td>2.4</td>
<td>28</td>
<td>4.0</td>
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<tr>
<td>Total Under-Represented Minority Students</td>
<td>107</td>
<td>15.2</td>
<td>124</td>
<td>17.6</td>
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<td>White (Not Hispanic)</td>
<td>598</td>
<td>84.8</td>
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<tr>
<td>Total Non-Underrepresented Students</td>
<td>598</td>
<td>84.8</td>
<td>584</td>
<td>82.4</td>
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<tr>
<td>Total First Year Students</td>
<td>705</td>
<td>100%</td>
<td>708</td>
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ACADEMIC PROGRESSION

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<td>Black or African American</td>
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<td></td>
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</tr>
<tr>
<td>(Not Hispanic)</td>
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<td>12*+</td>
<td>10</td>
<td>10</td>
<td>10</td>
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<td>13</td>
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<tr>
<td>Hispanic or Latino</td>
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<td>9</td>
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<td>9</td>
<td>3</td>
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<td>Vietnamese</td>
<td>7</td>
<td>7</td>
<td>5</td>
<td>5</td>
<td>5</td>
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<td>Total Underrepresented Minority</td>
<td>35</td>
<td>32</td>
<td>26</td>
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<td>White (Not Hispanic)</td>
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<td>134</td>
<td>134</td>
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<td>Total Class Enrollment</td>
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<td>168</td>
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<td>160</td>
<td>160</td>
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*Students were Pathology Fellows between 2nd and 3rd year.
+Student took leave of absence (LOA) for health reasons.

Effectiveness in Recruiting Underrepresented Minority Faculty

The School of Medicine has a total of thirty-one URM full-time faculty (plus two half-
time faculty) representing 6.12% of the total faculty of 507. (Vietnamese and other
Southeast Asians are not included because all Asian American faculty are grouped
together.) Fourteen new URM faculty have been hired since 1998, thirteen Assistant
Professors (two in the Basic Sciences and eleven in the Clinical Sciences) and one
Associate Professor. Ten have been retained from four to ten years and four have
been retained for over ten years.

Our URM faculty includes one instructor, two half-time and eighteen assistant
professors, seven associate professors and five full professors. One is Associate Dean,
one is Chairman of OB/GYN, one is Interim Chair of Ophthalmology, and one is Chair
of Vascular Surgery. We currently have 41 URM residents and fellows in our post-
graduate program.

These physicians represent one pool from which future faculty can be recruited and
others will be recruited through an external search. Another effort that must be made
is to ensure that our junior URM faculty members are prepared to successfully
progress through the tenure track in a timely fashion.

KUMC Office of Institutional Research/2001

<p>| | |</p>
<table>
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<tr>
<td>Full time KC Faculty</td>
<td>426</td>
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<tr>
<td>Part time KC Faculty</td>
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<tr>
<td>Full time Wichita Faculty</td>
<td>51</td>
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<tr>
<td>Part time Wichita Faculty</td>
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<tr>
<td>% Total Faculty Female</td>
<td>30%</td>
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<tr>
<td>% Total Faculty Minority</td>
<td>18%</td>
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# TABLE IV — NEW AND/OR CURRENT FACULTY

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<tr>
<th>POSITION</th>
<th>Date Hired</th>
<th>% FTE</th>
<th>Black M/F</th>
<th>Hispanic M/F</th>
<th>American Indian M/F</th>
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<td>Assistant Professor/Emergency Medicine</td>
<td>8/98</td>
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<td>Associate Professor/Rehab. Med. Ed.</td>
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<tr>
<td>Assistant Professor/Pediatrics</td>
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<tr>
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<td>100</td>
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<tr>
<td>Assistant Professor/Surgery</td>
<td>7/95</td>
<td>100</td>
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<tr>
<td>Assistant Professor/Surgery</td>
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<td>100</td>
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<tr>
<td>Associate Professor/OB/GYN</td>
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<tr>
<td>Professor/Pathology</td>
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<td>Associate Professor/Chair/Ophthalmology</td>
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<tr>
<td>Professor/Chair/OB/GYN</td>
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<td>7/00</td>
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<td>Assistant Professor/Pathology</td>
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<tr>
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<td>8/98</td>
<td>100</td>
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<tr>
<td>Assistant Professor/Psychiatry</td>
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<td>Professor/Biochemistry</td>
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Effectiveness in Providing Financial Aid

Tuition for in-state medical students is $10,410.00/year and for out-of state medical students - $24,422.00/year. All student receive financial aid packages amounting to $25,368.00 for in-state students and $39,380.00 which cover in full their specified need. During the past year URM students received $905,487 averaging $10,061.00/student in scholarships vs $5,600,645.00 for the total school population, which averages $9,063.00/student.

If one reviews the amount of scholarship aid ($10,061) a URM student received this past year, an in-state student would still incur $15,307/year in debt and the out-of-state student - $29,369/year totaling $61,228 and $117,276 respectively over the four year period. This assumes that the URM student will graduate in a timely fashion. If the student graduates in five years, this amount increases to $76,535 for the in-state student and $146,845.
Revised CLAS Standards
From the Office of Minority Health

1. Health care organizations should ensure that patients/consumers receive care in a manner compatible with their cultural health beliefs and practices and preferred language.

2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

*Note: The standards are organized by three themes.*
1. Culturally Competent Care (Standards 1-5)
2. Language Access Services (Standards 6-7)
3. Organizational Supports for Cultural Competence (Standards 8-14).
We will meet LCME Cultural Competency Standards and Assessment  
(Taken from GSA/GSA-MAS/OSR Handout from 2002 Spring Meeting)

**Standard ED 21.** The faculty and students must demonstrate an understanding of the manner in which diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.

*Annotation:* All instruction should stress the need for students to be concerned with the total medical needs of their patients and the effects that social and cultural circumstances have on their health. To demonstrate compliance with this standard, schools should be able to document objectives relating to the development of skills in cultural competence, indicate where in the curriculum students are exposed to such material, and demonstrate the extent to which the objectives are being achieved.

**Standard ED 22.** Medical students must learn to recognize and appropriately address gender and cultural biases in themselves and others, and in the process of health care delivery.

*Annotation:* The objectives for clinical instruction should include student understanding of demographic influences on health care quality and effectiveness, such as racial and ethnic disparities in the diagnosis and treatment of diseases. The objectives should also address the need for self-awareness among students regarding any personal biases in their approach to health care delivery.

The above version of the standards, with annotations, is scheduled for publication in May 2002 in Functions and Structure of a Medical School and on www.lcme.org/pubs.htm.
Appendix D
Diversity and Cultural Competency Resources

At KUMC

- Office of Cultural Enhancement and Diversity (OCED) website: http://www2.kumc.edu/oced/index.html (see links and MIRC).
- The Center Of Excellence for Minority Medical Education (COE) Information Resource Center is administered by OCED. The COE Resource Center is comprised of books, journals, videos and a collection of articles that deal primarily with health issues of underserved populations. This material is part of the Diversity Resource Center in Dykes Library (see below).
  
  Website: http://www2.kumc.edu/oced/csrembooklist.html

Some Student Groups http://www.kumc.edu/som/medsos/so.html

Students Educating and Advocating for Diversity (SEAD)

SEAD is a campus wide student organization, including students from the Schools of Medicine, Nursing, Graduate Studies and Allied Health. The mission of SEAD is to promote awareness and to internalize the meaning of diversity at the University of Kansas Medical Center. The goals and activities of SEAD are as follows:

- Provide information about diversity activities and initiatives at KUMC and in the surrounding community
- Present information on discrimination issues and the law
- Increase membership in SEAD to reflect KUMC’s diverse population
- Establish and maintain contact with similar student organizations at other institutions
- Promote positive and proactive roles within schools
- Increase awareness of SEAD as a resource for the KUMC community

Student National Medical Association (SNMA) local chapter

Organization for medical students interested in improving the quality of education and health care services for underrepresented minorities and the underserved. The organization’s mission is to create a legacy which fosters an environment of cultural diversity, a high standard of educational excellence, knowledge of minority-related health issues, and a support structure with encouragement to fellows and future generations of medical students.
  
  Website: http://www2.kumc.edu/students/snma/
Latino Midwest Medical Student Association (LMMSA) local chapter

Provides support for Latino medical students, other underserved minority groups and the community by means of education, promotion of quality health care and service to the community.

The Spanish Round Table

The Spanish Round Table meets to speak Spanish and learn/improve medical Spanish.

American Medical Women’s Association

Women’s professional medical organization.

Chinese Students and Scholars Association

Provides support for the Chinese students and scholar community and organizes cultural activities.

KUMC Gay and Lesbian Student Association

Provides a milieu in which students may interact in a social manner for discussion, education, and recreation. GLSA will attempt to insure anonymity of group members beyond the milieu and assist students to utilize campus resources.

KUMC Interfaith Group

Organized in 1994, KUMC Interfaith exists to recognize the diversity of faith and culture at KUMC and to: develop understanding and appreciation of peoples of all faiths; recognize more commonalties than differences; recognize that holistic treatment is important, not only in treating patients but in healing ourselves; recognize that faith should dictate our behavior and interactions with others in the workplace and the classroom; and recognize the essential oneness of humanness. KUMC Interfaith is open to all KUMC employees, students, faculty and staff.

Asian American Medical Student Association (AAMSA)

Meet the specific needs & concerns of Asian American Medical Students in Kansas.

Muslim Student Organization

Teach understanding and tolerance regarding Islam and issues relating to Muslims.
Resources, Activities and Services

Library (including On-line Resources):

The Archie R. Dykes Library for Health Sciences, which opened in 1983, contains more than 150,000 books, journals, and other informational materials in the biomedical and related health sciences. The library serves the educational and research needs of students, faculty and staff at the Medical Center and of the public. Dykes Library houses the Diversity Resource Center. A wide variety of resource materials are available to students, faculty and staff for review and checkout. Resource materials include videotapes, books, and magazines, which support the development of cultural competency and educate regarding diversity issues. The shelving is in a prominent location near the entrance. The Clendening History of Medicine Library is renowned as one of the top five collections of rare medical books in the country. The library contains more than 25,000 first or early editions of almost all important works in medical literature.

The KUMC Bookstore

The KUMC Bookstore strongly values and fosters appreciation for the contributions, perspectives, and insights integral to ethnicity and culture. The KUMC Bookstore regularly schedules author signings and maintains titles reflecting ethnic and cultural diversity by content and/or author. Special displays are created relevant to months, which carry a national designation specific to cultural diversity, i.e. Hispanic Heritage Month, Asian/Pacific American Heritage Month, Native American Heritage Month, Black History Month, and Women’s History Month.

The KUMC Diversity Calendar

The Diversity Calendar was developed in 1996 and is unique to KUMC. The Diversity Calendar provides on-line information regarding national and ethnic/religious festivals, Holy Days and celebrations and is easily accessed through the internet. Extensive information and links to other relevant sites makes the Diversity Calendar an excellent resource for KUMC and the internet community. Often the first site listed in search results for “diversity calendar,” the KUMC Diversity Calendar receives between 6,000 – 7,000 hits per week.

KUMC Wellness Calendar

The Office of Student Resources, Wellness and Diversity supports the Wellness Calendar. The Wellness Calendar encourages students to develop and maintain a balanced approach to life through social, intellectual, emotional, physical, cultural and spiritual wellness. Disseminated in hard copy and over e-mail, students automatically receive the calendar each month.
Web Sites

  WWW.omhrc.gov/clas/frclasZ.htm.

- Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda. 
  http://www.omhrc.gov/CLAS/

- The Dynamics of Race in Higher Education. 
  http://www.stanford.edu/~hakuta/racial_dynamics/

- Research on Implicit Biases. A web site where you can experientially see how strong your implicit biases are towards age, race, gender or politics. 
  www.yale.edu/implicit

- The Equity Continuum. Tool for rating organizations concerning their orientation towards equity in the workplace. 
  http://www.diversityatwork.com/equity_continuum.html

- Fast Company. Numerous articles on diversity in high tech firms. 
  http://www.fastcompany.com/
Books
- Thomas, R. Roosevelt. Beyond Race and Gender — Unleashing the Power of Your Total Work Force by Managing Diversity. AMACOM, 1992
- Thomas, R. Roosevelt. Redefining Diversity. AMACOM, 1996

Papers
Smith, D.G., How to diversify the faculty — get beyond the myths and adopt new hiring practices. Academe. September/October 2000: 48-52. Lists a number of excellent resources regarding various groups of minority faculty.

Videos
Shattering the Silences: The Case for Minority Faculty. Produced by California New Reel, 149th 9th Street, Suite 420, San Francisco, CA 94103. 415-621-6196, 86 minute video that can be used to help faculty recognize obstacles and consider specific changes to make their campuses more welcoming to faculty and students of color.

The Color of Fear. Produced by Lee Mun Wah, Stir Fry Seminars, 3345 Grand Avenue, Suite 3, Oakland, CA 94610. 510-419-3930, Ext. 100. 90 minute powerful video of a several-day dialogue among six men (white, Asian, African American, Hispanic).

Blue-eyed. Produced by California News Reel, 149 9th Street, Suite 420, San Francisco, CA 94103. 415-621-6196, 93 minute video that is a powerful tool to help groups discuss and learn about racism, white privilege, majority-minority relations and other diversity topics.

Through My Lens. Produced by BMC Media Services, University of Michigan Video Services, Center For the Education of Women. 313-998-6140. 30 minute video about women minority faculty.
In the Kansas City Community:

Kansas City Comprehensive Palliative Care Curriculum

There are three medical schools in the greater Kansas City area: Kansas University, University (Kansas); University of Missouri-Kansas City (Missouri); and the University Health Sciences Osteopathic School of Medicine (Missouri). The Midwest Bioethics Center, a community based organization with cooperative ties to each of the medical schools, initiated a joint project to develop the Kansas City Palliative Care Curriculum. The curriculum content of the AMA’s Education for Physicians on End-Of-Life-Care Project was adopted. The project has two specific goals: to teach the curriculum at the level of medical students, resident physicians, fellows, and faculty, and to make the training interdisciplinary.

Kaw Valley Medical Society and Kansas City Medical Society

The Kaw Valley Medical Society (Kansas City, KS) and the Kansas City Medical Society (Kansas City, MO) are groups of black physicians dedicated to increasing the numbers of minority health-care professionals and to ensuring that health professional serve our inner-city communities. Members serve as role models and mentors to medical students and offer preceptor ships and internships within their practices to undergraduate and medical school students.

Black Health Care Coalition

The Black Health Care Coalition, Inc., was born as a subcommittee of the Kansas City Medical Society to expose minority students to minority health issues. It is an independent, grass roots organization dedicated to improving the health care of minority and disadvantaged citizens, to providing preventative health care education and to supporting minority entrance into health professions.

LULAC

LULAC National Educational Service Centers (LNESC) were established in 1973 by members of the League of United Latin American Citizens, the oldest Hispanic organization in the country. LNESC is an independent organization dedicated to increasing educational opportunities for Hispanic Americans through the development and implementation of high quality educational programs throughout the country. Locally, LNESC provides services to twenty-five-area middle and high schools. Educational advisors visit schools on a regular basis to provide students with counseling, financial aid assistance, cultural enrichment activities, ACT preparation and field trips to area colleges and universities. LNESC also provides a summer enrichment program and after school mentoring and tutoring program for middle school students. Leadership development programs are also offered to metropolitan wide Hispanic high school students.
El Centro

El Centro, Inc., a social service agency located in Kansas City, Kansas, provides support services to minority families through the Center for Continuous Family Improvement. These services include after-school care at the El Centro Academy for Children, emergency assistance, migrant education, students-as-teachers programs and job development.

Guadalupe Center

The Guadalupe Center is a 501c 3 corporation serving the needs of Hispanics throughout Kansas City. It provides programs in education (college scholarships, middle school tutoring, literacy training); youth recreation and diversion (summer enrichment, field trips, mentoring); health and social services (food assistance, homeless family case management, substance abuse prevention and treatment); senior needs (nutrition, transportation, translation, escort); and community affairs (job placement, crime prevention, immigration and naturalization assistance).

Richard Cabot Clinic

Cabot Westside Clinic is the leader in providing quality, culturally sensitive, bilingual, primary health and educational services to Hispanic residents of the Westside and the greater Kansas City area, regardless of their ability to pay. It serves about 10,000 patients annually.

Swope Parkway Health Center and Douglass Health Center

Swope Parkway Health Center (Kansas City, MO) and its recently acquired Douglass Health Center (Kansas City, KS) are members of the Model Cities Health Corporation. Their mission is to provide the highest level of service excellence to improve the physical, behavioral, economic and spiritual health of individuals, families and the community. In 1998, Swope Parkway Health Clinic had almost 200,000 patient visits. The ethnic breakdown is 70.6% black, 18.5% white and 10.9% other. Douglass Health center serves a diverse population with a similar ethnic breakdown.

The Heart of America Indian Center

The Heart of America Indian Center is the nation’s oldest, continuously-operating Indian Center in the United States. The center serves a Native American population of more than 20,000 (representing some 57 different tribes and nations) within the seven-county area surrounding Kansas City. The Center features emergency assistance programs of pantry, clothing, utility assistance, temporary shelter and numerous referral services to 25 community organizations with which it has interagency agreements. The center has a credentialed alcoholism and drug counseling program, as well as crafts, youth and cultural programs. Recently relocating to it’s new “campus” at 39th and Pennsylvania, the Indian Center has plans for a new “wellness” center and entrepreneurial expansion. For further information, call 816-421-7608 during standard business hours, Monday through Friday.
Appendix E

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   http://bhpr.hrsa.gov/nhsc/

   http://www.careermd.com/minority/scholarships.shtm

10. National Medical Scholarships, Inc. Special Award and Fellowship Programs.
    http://www.nmf-online.org/students.htm

11. Minority Scholarships, Fellowships & Postdoctoral Awards in Medicine, Health and Related Fields.

12. NHLBI Mentored Minority Faculty Development Award.

13. RWJ Foundation’s Minority Faculty Development Program.
    http://www.mmfdp.org/about.htm