

INCREASING DIVERSITY IN THE HEALTH PROFESSIONS

*Recommendations to Improve Title VII of the*

*Public Health Service Act*

Report of a summit convened by the

NATIONAL HISPANIC HEALTH FOUNDATION

and the

JOSIAH MACY, JR. FOUNDATION

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## Foreword

The United States is experiencing major demographic changes as the general population ages and grows more diverse. At the same time, the nation faces a severe shortage of physicians and other members of the health care workforce, especially in primary care. With the recent call for an increase in medical school enrollment, the time is right to develop policy recommendations that can increase the diversity of the medical profession.

The Josiah Macy, Jr. Foundation, a leader in supporting medical education diversity programs, in collaboration with the National Hispanic Health Foundation, convened a historic meeting in the summer of 2009 to discuss the Public Health Service Act Title VII programs of the U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA), with respect to diversity in health professions education. Minority health experts, medical education experts with experience leading Title VII diversity programs, and thought leaders from foundations and government public health agencies, gathered for this one-day summit held at the New York Academy of Medicine.

Participants (listed in Appendix A) were charged with developing consensus policy recommendations geared toward increasing diversity in the health professions through improved administration of Title VII funds. Recommendations address pre-medical education, medical education, health professions data collection and federal policies.

We hope that the recommendations in this report will assist policymakers and medical education leaders as they shape the health professions workforce components of the new federal health care reform law, The Affordable Care Act. The face of America is changing, and the face of medicine must align accordingly if we are to effectively meet the health needs of our society, now and for the future.

Elena Rios, MD, MSPH

President

National Hispanic Health Foundation

[www.nhmafoundation.org](http://www.nhmafoundation.org)

*“We will not be able to have a workforce that is sufficient in number, sufficient in orientation, sufficient in skills to meet the needs of the public unless that workforce is diverse.”*

—George Thibault, President, Josiah Macy, Jr. Foundation

## **Why Diversity? Why Now?**

The U.S. health system has very limited cultural competence and language services, and lacks adequate numbers of minority researchers, health care providers, and leaders in both the public and private sectors. While the number of women enrolled in health professions education has continued to increase of the last thirty years, the overall percentage of minorities is lower in health professions education than the percentage of minorities in the national population. Currently underrepresented in the medical profession are African Americans, Hispanics, and Native Americans. These groups also have the highest rates of health disparities in quality of health and health care. Yet by the year 2042, racial and ethnic minorities will comprise more than 50 percent of the U.S population. There is a clear need for new approaches to increase the number of underrepresented minorities in the health professions, and to enhance overall cultural competence training about the needs of minority populations. While building new programs is one approach, the National Hispanic Medical Association (NHMA) advocates supporting and expanding Title VII of the Public Health Service Act to facilitate recruiting and training health care professionals from underrepresented minority populations.

This is an important and potentially transformational time for the U.S. health care system, **Jo Ivey Boufford**, president of the New York Academy of Medicine said as she welcomed participants to the summit. A recurring theme in the ongoing health care reform debate is the disconnect between the health professions education enterprise and the needs of the health system. While individual institutions are testing new approaches to address this issue, there has been limited attention at a systems level. As we enter another period of medical education expansion, it is very timely to be considering strategies to ensure that diversity is realized.

**George Thibault**, president of the Josiah Macy, Jr. Foundation, said that in many ways, medical education has not changed very much over the past 30 years. While that stability is a testament to standard setting and to the quality of education, overall it has been an inward-looking process. He agreed that the medical establishment has not effectively addressed whether its physicians, who are well trained and meet all of the required standards, are really meeting society's needs. The alignment of health professions education with the needs of society has many dimensions. Diversity of the workforce is one key tool to help accomplish this goal of alignment.

## Origins of the 2009 Summit

In 1993, **Elena Rios** was invited to the White House to participate on the National Health Care Reform Task Force. As discussions progressed it became apparent that while there were Hispanic doctors, many of whom were first generation physicians trained in the 1980s through the Health Careers Opportunity Program (HCOP) funded by HHS, actually finding them was a challenge. As a result, in 1994, the NHMA was established to represent the then 36,000 Hispanic physicians in the U.S. Rios, now president and CEO of NHMA, explained that the mission of the organization is to improve the health of Hispanics and other underserved populations. NHMA has established networks linking students through physicians, across a broad range of health care disciplines. The foundation arm of NHMA, the National Hispanic Health Foundation (NHHF) also led by Rios, develops and supports research and education activities.

In 2007 and 2008, the NHMA in collaboration with the HHS Office of Minority Health, held a series of three regional stakeholder summits to develop consensus recommendations on how to increase diversity in the health professions (see Box). In April 2008, these were provided to the health policy advisors to the leading candidates for the presidential nomination.

NHMA also developed policy recommendations for health care reform, including calling for a regional approach to recruitment of disadvantaged students for primary care health professions training. This would require development of new regional HRSA training programs focused on current societal challenges such as primary care, aging, health disparities, prevention,

### **Hispanics in the Health Professions**

#### **Consensus Recommendations from the 2007-08 Summits**

- Build the necessary political will
- Strengthen the educational pipeline
  - Improve K-12 education in minority communities; target funds to low-income school districts; increase counseling and faculty awareness in the low-income school districts; establish health career tracks in high schools
  - Provide Hispanic mentors and role models in health professions at all educational levels
  - Support Hispanic students in higher education
  - Provide more scholarships and loan repayment options
- Conduct outreach to students and parents in low-income neighborhoods about health careers
  - Develop understanding of the value of education and an awareness of available financial aid
  - Link programs to places where people could be inspired to think about a health careers (e.g. clinics, libraries, science museums)
- Develop media and marketing campaigns about health careers
- Establish public/private partnerships
- Change the health professions schools
  - Support and expand the focus of the COEs and HCOPs
  - Change institutional admissions processes to increase focus on students' backgrounds, leadership potential, and interest in working in underserved areas versus MCAT scores or grades
  - Increase minority representation on the admissions committees
  - Link recruitment with minority medical alumni and medical societies

medical home, patient-centered care, leadership, communications, and health information technology (IT). Such programs would involve coordination with and funding from the National Institute on Minority Health and Health Disparities; the Centers for Disease Control and Prevention; the Centers for Medicare and Medicaid Services; the Office of the National Coordinator for Health Information Technology; the Veteran's Administration; the Department of Labor; the Department of Education; and the Department of Defense.

To achieve a diverse health professions workforce, the NHMA recommended that the HHS Office of Minority Health establish a national council of public and private entities to coordinate and disseminate cultural competency training programs to medical and nursing associations. There is also a need for more incentives for incorporation of cultural competence and language training into health professions (not just primary care) education, leadership development programs, and service delivery. Rios noted that NHMA has developed a leadership fellowship that has been highly successful in engaging mid-career doctors in public service.

Moving forward with its workforce diversity advocacy efforts, in November 2008, NHMA met with President Obama's transition team, and subsequently with the White House Health Reform Team, HHS leadership, and members of Congress. Following on NHMA's earlier recommendations, these groups requested input on specific strategies for realizing the vision of diversity in the health professions. As a result, on June 22, 2009, the NHHF and the Josiah Macy, Jr. Foundation convened this summit of national experts in health professions education. With the base assumption that we, as an ever diversifying society, are best served by a comparably diverse healthcare workforce, participants focused on how optimal implementation of Title VII of the Public Health Services Act (see Box) could be a key tool for achieving diversity in the health care workforce.

#### **Title VII of the Public Health Services Act**

Enacted in 1963, Title VII was drafted to address a shortage of health care providers in the U.S. at the time.

The goals of Title VII are to increase the numbers of:

- health care workers in underserved areas,
- primary care providers,
- minority and disadvantaged students enrolling in health care programs, and
- faculty in health care education and training programs.

Subsequent amendments to the Act have authorized HRSA funding of various programs to address critical workforce shortages (e.g. traineeships in specific disciplines).

## The Rationale for Diversity

In the wake of the civil rights movement, the basic rationale for diversity was *fairness*, a concept that is embedded in the foundations and culture of this country, explained **Marc Nivet**, chief operating officer and treasurer of the Josiah Macy, Jr. Foundation. In the 1970s, this evolved into a more *demographic rationale* based on the concept of population parity. As a result of increasing diversity in the U.S., advocates stressed the importance of an increasingly diverse workforce. This demographic rationale has been sustainable, and Nivet cited several recent programs that grew out of this rationale, for example “Project 3000 by 2000” launched in 1991 by the Association of American Medical Colleges (AAMC) with the goal of enrolling 3000 underrepresented minority students in U.S. medical schools by the year 2000. While the target number was not achieved, enrollment was increased and useful lessons were learned. A third, more current evolution of the rationale for diversity is the *dividends of diversity rationale*. In 2003, the University of Michigan cited the dividends of diversity as support for its racially conscious admissions policies that were being challenged in the Supreme Court as unconstitutional. Increasing diversity, the university argued, provides dividends for the education of all students. From a health perspective, diversity is a tool that can be used to help address issues of cultural competency, quality of patient care, and health care disparities. These are tangible benefits of diversity.

While these three core rationales for diversity continue to be valid and important, the time has come for a new rationale for diversity, Nivet said. Quite simply, diversity is part of the foundation of *excellence*. This is not excellence for a certain subset of the population. It is about the benefit a diverse educational environment can offer the individual who will become a physician, or nurse, or other health care practitioner. Unfortunately, the benefits of the excellence model for an institution are not readily apparent to academic leadership. Deans of medical schools are rarely asked at governance meetings how the school is faring with regard to diversity, Nivet said, and no administrator has been fired because of limited success in fostering diversity.

Ultimately, it comes down to limited accountability. An institution will point to an isolated diversity effort that was accomplished with HRSA funding or Macy funding, for example, and believe they have checked off the diversity box on the to-do list. Academic institutions have a particular view of what diversity is and the importance of it, but diversity is not considered to be a driver of institutional excellence. Diversity and excellence run parallel, not joined or intersecting. In the ongoing debate about affirmative action some say that diversity actually competes with excellence. This model needs to change, Nivet said, and institutions need to determine how to better incorporate diversity efforts into the drive for excellence.

The health professions workforce diversity paradigm for the past 40 years has been one of recruitment and retention. A better model is one of attraction — changing the culture within the health professions so that health careers become attractive to minority individuals. Once on board, we must shift from simply retaining these

employees to helping them thrive. Academic institutions need to move beyond the grant application rationale that more minorities coming into the institution will lead to more minorities coming out of that institution. Instead, more minorities coming into an institution will, hopefully, foster a change in culture, drive excellence, and benefit all of society. In the current conceptual framework, however, diversity is not an important qualifier of success of the institution. Worse, diversity may still be viewed as “charity work” in some respects.

Another aspect of diversity Nivet addressed is accountability. HRSA continues to fund the same institutions that have done quality work for 15 to 20 years or more. Instead, Nivet said that HRSA should recognize that quality work means that the institution has accomplished the goals set out in the grant, and these practices should now be institutionalized. HRSA can then move on to other pressing needs, such as perhaps funding pipeline initiatives. There is a wealth of talented minority students up and down the pipeline in grades K through 12, and in community and four-year colleges, Nivet said. The problem is that many of these individuals are not, for a variety of reasons, attracted to the health professions. What is needed, he suggested, is a ladder approach toward a health professional career, one that can be taken a step at a time. Many students in community colleges, who individually are capable of becoming health professionals, are deterred by system that (with the exception of nursing) lacks clear pathways to the various health professions.

Under a new diversity paradigm, if we are now hiring diversity to work toward excellence, we need to change the way programs are developed and funded. In that regard, Nivet explained that the Macy Foundation will no longer fund programs that simply seek to increase the number of minority medical students by some number, or by reaching out to a particular school. The Macy Foundation is looking for innovation.

The renewed enthusiasm for diversity, by itself, is not enough, Nivet concluded. We must shift our thinking about what we are trying to accomplish with diversity; how can we tightly tether diversity to excellence.

## **Overview of Diversity in Medical Education**

In 2008, Black/African American, Hispanic/Latino, American Indian/Alaskan Native, and Native Hawaiian/other Pacific Islander individuals together comprised 15% of the medical school applicant pool, and Asian applicants made up another 20% of pool. **Laura Castillo-Page**, director of research at AAMC, noted that while the number of Asian applicants has been increasing steadily in recent years, this is not the case for other racial and ethnic minorities who are considered underrepresented compared to their representation in the general U.S. population. From 2007 to 2008, there was a slight increase in the number of Hispanic applicants, however the number of African American and Native American applicants declined. So even though the total medical school applicant pool is increasing, the number of

underrepresented racial and ethnic minority applicants is relatively unchanged. The data on matriculated medical school students is similar. In 2008, 59% of the matriculants were white, while 14% were Black, Hispanic, American Indian, or Native Hawaiian.

About 16,000 students graduated from U.S. medical schools in 2008. Again, underrepresented racial and ethnic minorities accounted for about 15% of graduates. Interestingly, 65% of the African Americans who graduated from medical schools were women, as were 52% of the Hispanic graduates.

The disparity among medical school faculty was more pronounced. In 2008, of the approximately 124,000 faculty members, 67% were White and 7.5% were non-Asian racial and ethnic minorities. Male faculty members, regardless of race, were more likely to be full professors, while female faculty were more often instructors and assistant professors. Similarly, Black, Hispanic, American Indian, or Native Hawaiian doctors made up about 10.8% of the physician workforce. Together, these data paint a bleak picture of the current lack of diversity in medical education, Castillo-Page said.

In terms of recruitment, AAMC sought to understand whether there is a sizable group of underrepresented racial and ethnic minorities that could apply and be accepted into medical schools. Every year 1.3 million students in the U.S. graduate from college with Bachelor's degrees, and between 2.5% and 4% apply to medical schools. The peak in applications occurred in the mid 1990s, prior to California's Proposition 209 and the U.S. Fifth Circuit Court of Appeals Hopwood decision; however today only about 2.9% will apply for medical school admission. Castillo-Page suggested that 4% reflects the potential for increasing diversity in medical education.

About 63% of medical students come from doctoral-granting institutions and about 16% come from master's-granting institutions. About 55% of those accepted to medical schools have undergraduate degrees in biology. However, Black and Hispanic biology majors are not pursuing medicine to the extent that they did a decade ago. Castillo-Page highlighted both graduates of master's-granting institutions, and minority biology majors, as two groups where focused recruiting could foster diversity. In the early 1990s, 83% of African American biology majors who graduated from doctoral-granting institutions, and 45% who graduated from master's-granting institutions, applied to medical school. However, by 2004 only 44% from doctoral-granting institutions and 27% from master's-granting institutions applied to medical schools. Similarly, 74% of Hispanic biology majors who graduated from doctoral-granting institutions, and 34% of those from master's-granting institutions, applied to medical schools in the early 1990s. By 2004, only 39% of Hispanic graduates from doctoral-granting and 16% from master's-granting institutions applied. During this time, the number of minority students pursuing law and social sciences increased, but the number of medical school applicants steadily declined.



The research literature on higher education and social science over the last 20 years supports diversity in the classroom and AAMC cites over 200 studies that support the broad benefits of diversity in the school environment. However, there is not much research that specifically addresses medical education. Many of the studies that do exist focus on perception issues; how students and faculty feel about diversity. There is also research looking at tracking, which suggests that underrepresented racial and ethnic minorities are more likely to practice in underserved areas. But research looking at the benefits of diversity in the medical education environment is clearly lacking.

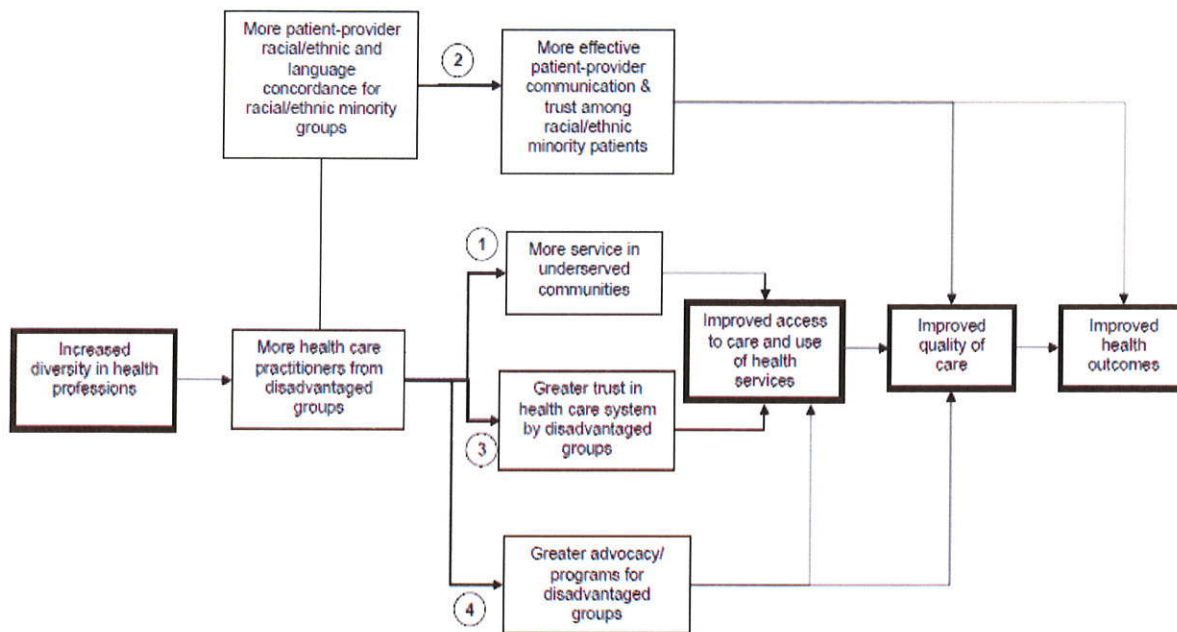
What is clear from the general undergraduate literature is that we need to move away from simply focusing on numbers. In order to reap the educational benefits of diversity, diversity must be pervasive. It must be part of the curriculum, apparent in the faculty, embraced by the administrative and governance bodies, and incorporated in policies. In addition, there must be infrastructures in place where people can have safe dialogues around diversity issues.

AAMC has been addressing issues of diversity for 40 years. As a recent example, Castillo-Page described the *Aspiring Docs Campaign*, which is a marketing campaign focused on sparking an interest in medical education in students from diverse backgrounds. The concept is being expanded to market faculty, research scientists, and other health science careers as well. The current AAMC president has made diversity a priority focus for the entire organization. We can no longer ship everything off to the “Diversity Office.” Diversity has to be everyone’s business, Castillo-Page concluded.

### **HRSA Title VII Diversity Programs**

A perspective on the diversity accomplishments thus far as a result of Title VII was provided by **Joan Weiss**, Director of the Division of Diversity and Interdisciplinary Education (DDIE) in the Bureau of Health Professions at HRSA. Greater diversity in the health professions provides increased opportunities for minority patients to see a practitioner with whom they share a common race, ethnicity, or language, which contributes to improved patient choice and satisfaction, and better communication between health professional and patient. Diversity also provides for better educational experiences for all students while in training. In addition, the data show that minority health professionals are more likely to serve disadvantaged populations such as indigent and poor patients, the Medicaid population and the uninsured, and geographically underserved areas (i.e. where there are shortages of health care providers). Overall, diversity helps to foster increased access to care for underserved populations and improves public health (see Figure).

## Framework for Linking Health Professions Diversity to Health Outcomes



(Source: Weiss presentation, taken from *The Rationale for Diversity in the Health Professions: A Review of Evidence*, HRSA/BHPr, October 2006.)

The HRSA Bureau of Health Professions training programs are designed to build a diverse workforce that will provide access to care for all Americans. HRSA is working to accomplish this through: building a pipeline of racially diverse and qualified applicants; funding those institutions that are successful in placing graduates in underserved areas and having a racially diverse student mix; providing financial assistance and training to students who are highly likely to work in underserved areas; and providing continuing education in community-based settings.

In this regard, the Bureau of Health Professions administers three federally funded programs: the **Centers of Excellence (COE)** and the **Health Careers Opportunity Program (HCOP)** authorized under Title VII of the Public Health Service Act, and the **Minority Faculty Fellowship** program under Title III.

The Centers of Excellence serve as innovative resource and education centers to recruit, train and retain underrepresented minority students and faculty at health profession schools. Funding for COEs in 2007, 2008, and 2009 was \$11.8M, \$12.7M, and \$20.6M, respectively, with the President's fiscal year 2010 budget calling for \$25.6M. Four COE grants were awarded in 2006, 2007, and 2008.

In administering and using COE funding, HRSA and COE grantees must comply with the legislative requirements of Title VII (See Box). With the exception of COEs at the four Historically Black Colleges and Universities that are mandated with the first \$12M, applicants for COE funding must be an accredited health profession

school in one of the following disciplines: medicine, osteopathic medicine, dentistry, pharmacy, or graduate programs in behavioral mental health.

The Health Careers Opportunity Program was started in 1963 with the enactment of Title VII and is a student-focused program designed to build diversity in the health fields by providing students from educationally or economically disadvantaged backgrounds an opportunity to successfully enter and graduate from health professions schools. The program was funded at \$3.9M for 2007, \$9.8M for 2008, and \$19.13M for 2009, with the President's 2010 budget calling for \$22.13M. Four HCOPs were funded in 2006 and 2007, and as a result of increased funding, 14 were funded in 2008.

Entities eligible for the HCOP include health profession schools, allied health profession schools, and other public or private nonprofit health or educational entities. Training programs and institutions must be accredited (associate degree or higher). Per the legislation, HCOP funds may be awarded for projects addressing recruitment; facilitation of entry into health professions training; counseling, mentoring, and other services; education and research training prior to enrollment in health professions training; dissemination of financial aid information; exposure to

### Legislative Requirements for Centers of Excellence

COE Grantees must have:

- A **competitive applicant pool** through linkages with institutions of higher education, local school districts, and other community-based entities, and establish an educational pipeline for health professions careers
- **Student performance programs** to enhance the academic performance of underrepresented minority students attending the school
- **Faculty development** programs to improve the capacity of such schools to train, recruit, and retain URM faculty including payment of such stipends and fellowships as the Secretary may determine is appropriate
- **Information resources, clinical education, curricula, and cultural competence** as they relate to minority health issues
- **Faculty/student research** on health issues particularly affecting underrepresented minority groups, including research on issues relating to the delivery of health care
- **Student training in providing health care services** to a significant number of URMs at community-based health facilities that provide such health care services and are located at a site away from the main teaching facilities of the school

(Authorizing legislation: Public Health Service Act, Title VII, Section 736, and the Health Professions Education Partnerships Act of 1998. Public Law 105-392)

primary health care at community-based providers; and expansion of the competitive applicant pool.

While not eligible for COE or HCOP, schools of nursing are covered under Title VIII of the Public Health Service Act, which authorizes the Nursing Workforce Diversity Program that has many parallel activities addressing recruitment and retention, scholarships, counseling, and mentoring.

Finally, the Minority Faculty Fellowship program assists health profession schools in identifying and recruiting minority individuals into faculty positions. (The grant applicant is the school, who then selects the fellow who will be funded). Eligible applicants include accredited health professions schools of allopathic and osteopathic medicine, nursing, dentistry, veterinary medicine, optometry, allied health, public health, podiatric medicine, pharmacy, and schools offering graduate programs in behavioral and mental health. Fellows must be from an underrepresented minority background and must be a U.S. citizen, non-citizen national, or foreign national who possesses a visa. For the years 2006 through 2009 one Minority Faculty Fellowship was awarded each year (and at the time of this summit an award was planned for 2010).

For fiscal year 2009, Weiss explained that HRSA's priorities for diversity programs are to provide national leadership in the development, distribution, and retention of a diverse culturally competent health professions workforce, and to collaborate with stakeholders to develop a new three to five year strategic plan to increase diversity.

## **Data Collection on the Health Care Professions Workforce**

The mission of the Center for Health Workforce Studies, housed at the School of Public Health at SUNY Albany, is to collect timely, accurate workforce data and to conduct policy-relevant research about the health workforce, for the purposes of

### **Current Health Workforce Issues**

- Health workforce shortages
- Fewer new dollars and the high cost of more workers limit response options
- Concerns with medical errors and quality
- Frustration with paperwork and regulation
- Racial and ethnic imbalances in health professions
- Lack of systematic data on supply and demand for health workers

informing public policies, the health and education sectors, and the public. Center director, **Jean Moore**, listed some of the current health workforce issues (See Box), highlighting the lack of diversity in health professions and lack of systematic data on the supply of and demand for health workers, as issues for the summit.

Moore reiterated that the health care professional workforce in the U.S. is not as diverse as the general population. Diversity is lacking across the range of health professions (see Table). There are several key reasons to increase diversity in the health professions.

## Many Health Professions Lack Diversity

	Race/ethnicity, 2007				
	Non-Hispanic white	Non-Hispanic Black	American Indian	Asian & Pacific Islander	Hispanic
Registered Nurses	77%	9%	0%	8%	4%
Physicians & Surgeons	72%	5%	0%	18%	5%
Pharmacists	75%	4%	0%	15%	5%
Physical Therapists	82%	5%	0%	9%	4%
Dentists	76%	3%	0%	13%	6%
Dental Hygienists	89%	2%	0%	3%	5%
Physician Assistants	76%	8%	0%	6%	8%
Aides	50%	32%	1%	4%	12%
Licensed Practical Nurses	66%	22%	1%	3%	7%

Source: Center for Health Workforce Studies, based on the 2007 American Community Survey (U.S. Census Bureau)

First, while cultural competence in health care can certainly be improved through training, having a culturally diverse staff is really the more expedient way to infuse cultural competence into the health professions. Second, diversifying now can help to avert future workforce shortages. As the demographics of the country evolve and minorities collectively become a majority, recruiting underrepresented minorities into health professions will be necessary just to keep the staff numbers at sufficient levels. And, as discussed earlier, diversity in the health care workforce has been shown to increase access to care for the underserved.

As we try to move forward in our efforts to enhance diversity, we are missing key data to inform those efforts. More data is needed to answer basic questions such as how many minorities are in the health care professions workforce; when do they enter and leave practice; where do they practice; and what do they practice? Moore noted that there is not a great deal of policy and resource support for independent longitudinal health professions workforce research to obtain answers to these questions. Another aspect is identifying the right level for analysis. For example, health professions shortages may be national in scope, but effects are local and it is often states that are left to find solutions for health professions workforce planning and development.

Although the available national data can provide a general picture of the health professions workforce, state-level research is increasingly necessary to be able to fully understand health care workforce issues. States have a vested interest in the health workforce given the different roles they play in licensing health professionals, regulating facilities, designating medically underserved and health professional shortage areas for licensure of state/federal clinics, overseeing health professions education programs, running colleges and universities, and setting reimbursement policies and rates. The state of New York, Moore said, has been very supportive of the Center's efforts to collect and analyze data on the state's health workforce. New York has an extensive graduate medical education system with about 5,000 graduates each year, and 15,000 residents and fellows in the system overall. The Center has been conducting surveys to monitor physicians, including a

physician licensure re-registration survey and a survey of residents completing training, to better understand the new physician job market and the demand for physicians. The Center also conducts registered nurse (RN), dentist, dental hygienist, physician assistant, nurse practitioner, and midwifery license re-registration surveys.

Another Center project is the annual physician profile, which describes the supply and distribution of physicians in New York State, county-by-county, and profession-by-profession. These data are useful for a variety of analyses. Every few years, for example, the Center releases a profile of underrepresented minority physicians in the state. Mirroring the nationwide picture, the demographics of the physician workforce in New York State are not representative of the state's general population.

Underrepresented minority physicians in New York State, compared to all other physicians in the state, are:

- slightly younger on average (50 vs. 52 years);
- more likely to be female (37% vs. 30%);
- more likely to practice in hospitals versus solo or group practices;
- more likely to report a primary care specialty;
- more likely to serve Medicaid patients; and
- more likely to practice in areas where there are health professional shortages.

A resident exit survey conducted by the Center also found that newly trained, underrepresented minority physicians enter the workforce with higher educational debt.

These workforce trends are not limited to physicians. A workforce analysis of nurse practitioners done by the Center in 2000 found that representation and practice patterns followed similar trends to those of physicians. Underrepresented minority nurse practitioners were much more likely than all other nurse practitioners to work in inner city areas downstate (69% vs. 28%), and were more likely to practice in hospitals and community health centers. Black/African-American nurse practitioners were much more likely than all other races or ethnicities surveyed to be practicing in health professional shortage areas in the state (40% vs. 17% for Hispanic, 18% for White, and 17% for Asian).

In 2006, the Center conducted a survey of more than 5,000 RNs working in 99 New York hospitals. The study was designed to assist hospitals and other stakeholders in planning for future nursing needs. As with other health professions, the analysis showed that minority hospital nurses were generally underrepresented in the nursing workforce. Interestingly however, while non-Hispanic Asians comprise only 7% of the general state population, non-Hispanic Asian nurses accounted for 17% of the nursing workforce surveyed. Further analysis revealed that most of the Asian nurses were Filipino and were foreign-trained. Another analysis showed that Black and Asian RN's comprised 60% of the public hospital workforce in the downstate area

(in and around New York City). Again, minority nurses were more likely to work in hospitals that were located in health professional shortage areas than were all other nurses.

Together, the data sets the Center is collecting regarding under-represented minorities in the health workforce show some very distinctive characteristics. Moore concluded that increasing health professions workforce diversity in New York has the potential to expand capacity for basic health services, increase the availability of health services to underserved populations, reduce health disparities, and improve cultural competence.

In closing, Moore said that there is a need for a better understanding of issues and options related to improving health professions workforce diversity. What is clear is that we must reinvest in the programs that have been successful thus far, and any future efforts should be collaboratively and carefully evaluated. Return on investment, in the form of improved access to and quality of health care for all populations, should be the primary focus.

## **General Discussion**

Following the introductory presentations, participants expanded on the issues of diversity as a component of institutional excellence; the challenges of developing a more diverse pool of pre-medical student applicants; the need for data to support and guide diversity efforts and the challenges of collecting that data; and the relationship of institutions of medical education with the communities they serve, including the tracking of graduates in service to the underserved..

Participants noted that over the last decade, the political environment has been somewhat hostile toward diversity programs. The lack of diversity in the health professions has been well documented, and there is an expectation that there should be more funding to address the issue given the increasing diversity in our society. The reality, however, has been that under every President in the past decade, diversity programs were reduced in the federal budget and then reinstated by Congress. A narrow, historically civil rights-focused mindset about why workforce diversity is important persists, and proponents of diversity programs often find themselves in a defensive posture.

A more modern and broad rationale involves tethering workforce diversity to excellence, and the AAMC is working toward redefining institutional excellence, moving beyond the current emphasis on GPA and MCAT scores. The focus is less on “affirmative action” and more on institutional and government leadership support for programs that foster the career success of underrepresented populations.

The AAMC *Road Map to Diversity* was developed with the goal of helping medical school deans understand how they could incorporate diversity into their admissions

policies and processes. The document covers legal issues, and discusses the value diversity brings. But AAMC cannot force an institution to adopt a particular policy or process. And more research is necessary to be able to provide evidence of the benefits of a diverse student population.

Moving forward, it will be important to have common definitions or standard language as “excellence” may not have the same meaning for everyone. In addition, the metrics of excellence are different for different institutions. Some institutions seek to develop leaders in medical research, while others strive to address primary health care needs. If these medical schools can consistently meet their stated mission, and do so with a diverse population, they can be excellent institutions. If they do not achieve their mission with a diverse student body, they are not truly meeting the needs of society. It was noted that excellence is often defined by the media, such as in the U.S. News and World Report ranking of hospitals, medical schools, and law schools.

There is still a need for more research to be able to move beyond the rationale for diversity, and discuss the evidence for improved outcomes of care given both diversity in the medical profession and cultural competence training about diversity in patient populations.

Data collection and evaluation across the COEs is varied, and it was suggested that HRSA or AAMC could help foster conformity and standardization, reviews of outcomes, and documentation and sharing of best practices. What is needed is quantitative and qualitative data to guide decisions regarding the non-academic factors that predict whether a potential health professions student will be successful. It was noted that privacy restrictions present a challenge for tracking where health professions students end up in practice. General categorical information can be collected, but any data that could be used to tie information back to a specific person cannot be collected (e.g. birth date, social security number). The exception is loan repayment programs, and it was suggested that perhaps there is a way to make use of the data held by scholarship and loan programs. In an effort to enhance analysis, the New York State Center for Health Workforce Studies is currently expanding the type of diversity data it collects and reports, beyond the four traditional racial and ethnic minority groups (e.g. minority subgroups, socioeconomic status, sexual orientation).

Participants noted that a federal focus on diversity in the health professions workforce can work toward changing the perspective of academic medicine leaders, but it is regulatory mechanisms that ensure that change will happen. In this case, the regulatory mechanism is the accrediting agency, and the language of accreditation must mesh with the terminology of excellence. The Liaison Committee on Medical Education (LCME), which is the accrediting authority for U.S medical education programs, has begun such changes, but it was noted that there is a need for stronger change that incorporates accountability and enforcement at national, state, and local levels. Many institutions still see cultural competence training as something they have to add on, rather than something to incorporate holistically into the curriculum. It was suggested that if accrediting bodies issued citations for lack of diversity, it would send a strong message about accountability.



A participant raised the rationale of local excellence, that is, the ability to meet the needs of the people in the communities you serve. Institutional involvement in the community can have its challenges. For example, Chicago has the third largest public education system with about 420,000 students, 90% of whom are Latino or African-American. But the Chicago public schools do not produce the kind of graduates that can succeed at the University of Illinois at Chicago (UIC). This is where federal dollars can help in closing the gap between professional and graduate schools and the K-12 system. The true definition of excellence would be an integrated system that addresses incentives at every level of education and every level of outcome in terms of the community that is being served.

The Hispanic Association of Colleges and Universities (HACU) found that many Hispanic-serving institutions do not include service to the Hispanic community in their mission statement. Part of the challenge is that, compared to historically Black colleges and universities and tribal colleges, the nation's Hispanic-serving institutions have traditional, non-minority governance bodies. HACU has been working to encourage members to include this in their missions. HACU is also fostering collaboration between K-12 schools, and colleges and universities. The pool of successful health professions students will increase if we can increase the success of K-12 students. A participant offered the *Early College High School Initiative* (funded by the Bill & Melinda Gates Foundation and others) as a model that could be applicable to linking health profession schools with local high schools. The initiative generates partnerships so students in their last two years of high school can take courses at the local community college. Often these courses can be counted towards their community college degree.

In closing the discussion, Rios called attention to the public health workforce provisions in the proposed 2009 House and Senate health care reform bills (Note: Since the time of this summit, these provisions were incorporated into the Affordable Care Act, signed into law by President Obama in March 2010). The draft legislation calls for a national healthcare workforce strategy that would be led by a national workforce council. Priority areas for the council would include, for example, diversity and cultural competence in the workforce, and the health care needs of underserved areas. As such, the programs of Title VII are part of the vision for the emerging health care system. State systems are also very much a part of this transformation. As health reform moves forward, there is an opportunity to develop strategies, launch demonstration projects, and draft legislative and regulatory language that will enhance and improve the administration of Title VII funding.

## **Recommendations**

The primary purpose of this summit was to develop recommendations for policy makers on how to strengthen Title VII of the Public Health Service Act to achieve much needed diversity in the health care professions. Summit participants broke into working groups to review barriers to progress and develop consensus recommendations.

Overall, participants agreed that minority students are often not made aware of career opportunities in the health professions, and many are ill-prepared by their K-12, and even college-level educational experiences to successfully be admitted to and graduate from health professions schools. To remedy this, the first set of recommendations focuses on increasing the number of diverse applicants for health professions training by preparing teachers to better mentor their students, developing flexible educational pathways that facilitate entry into the health professions, and involvement of parents and teachers in promoting health care as a career.

Participants were supportive of the emerging concept that diversity is a driver and core component of institutional excellence. To reshape medical education institutions to be more diverse, and to better train medical students to meet the needs of a diverse population, the recommendations provided address diversity benchmarking, faculty development, and institutional accountability.

Participants agreed that to improve support for federal policies, there is a need for better student tracking and health outcomes data relative to diversity in the health professions workforce.

The final set of recommendations advocate for better alignment and coordination of federal policies and programs to increase diversity in the health professions.

## ***Filling the Pipeline: Recommendations for Pre-Medical Education***

### **Create training opportunities for high school teachers, counselors, and college advisors, including summer programs that provide stipends.**

Many of the teachers that work with minority populations are poorly trained, and often their expectation levels for students are quite low. While it is beyond the scope of this discussion to try to change how teachers are prepared during their undergraduate and graduate level education, what can be done is to offer those teachers that work with potential health professions students an intensive several week program in the health sciences. Enhancing teacher skills translates to students who are better prepared to enter and complete health professions training. One examples of such a training program for educators is a summer program at Baylor that provides stipends for teachers.

### **Fund programs that mentor and support undergraduate and K-12 students following a cohort model.**

Some of the programs funded by Title VII accept several hundred students, hoping that in the end, a few will enter a health professions school. Rather, grantees should be required to advise students in smaller cohorts so that students can receive more focused attention and have more opportunities to take advantage of the support that is offered. In this way it is hoped that outcomes (i.e. interest and enrollment in health professions schools) will be greater.

### **Fund regional collaborations among high schools, community colleges, universities, and medical schools, to create health professions career pathways.**

There is a need for innovative collaborations spanning the educational spectrum from high school through professional school. Health professions education need not be a direct, uninterrupted flow from point A to point B; an aspect of the educational “ladder” that can help foster diversity is the ability to get on and off, and on again, as many students have life situations that may interrupt their education. Evaluation of programs should take into account the fact that students may need to complete training in segments, or may alter paths along the way.

### **Create a national parent/teacher health professions career ambassador program that would promote the health professions in the community.**

This ambassador project, operating on the “community health worker” model, would bring parents and/or teachers to a one to three day training program, and then send them back to their respective communities to promote health careers to other parents and/or teachers in their local schools and communities, thus increasing awareness to more minority students about health careers.

### **Eligibility for receiving funds or participating in Title VII-funded programs should not require U.S. citizenship.**

While not under the purview of Title VII, The Development, Relief and Education for Alien Minors (DREAM) Act could help facilitate this, and the NHMA should advocate for passage of this proposed legislation.

## ***Training the Workforce: Recommendations for Reshaping Medical Education***

### **Redefine institutional excellence such that it includes diversity as a critical component; implement diversity benchmarking and incentives.**

The AAMC Tool for Assessing Cultural Competence Training (TACCT) could be used to help institutions determine their priorities and the core elements of a diversity component of excellence. Accrediting bodies (such as LCME; the Accreditation Council for Graduate Medical Education, ACGME; the Joint Commission) should develop achievable institutional diversity benchmarks and incorporate them into their standards for accreditation.

### **Develop program funding eligibility criteria that require institutions to define their baseline diversity and outline their plans to improve it to the next level.**

Funding program criteria should also encourage joint applications and/or horizontal collaborations (e.g. among medical schools, across the continuum of educational institutions preparing students for health careers).

### **Increase federal funding for faculty development.**

Make funding more attractive and more available to minority health professionals to pursue the spectrum of faculty roles (e.g. research, education, practice).

### **Build accountability for diversity into health professions education programs; increase accountability of institutional leadership at the highest levels.**

Institutions should be held accountable for building a diverse student and staff population. The diversity across institutional boards of trustees, deans, and senior faculty should mirror that of the faculty, staff, and student population of the institution. Leadership must drive the diversity agenda. Encourage discussions at the leadership level to forge connections and address diversity across the entirety of the institution. Include diversity in the institutional mission statement. Accrediting bodies should play a role in ensuring institutions achieve diversity. Participants also discussed the soon to be formed AAMC Group on Diversity and Inclusion, which will serve as a resource to AAMC member institutions as they work to advance diversity.

***Closing the Data Gap:  
Recommendation for Measures and Metrics***

**Develop metrics to gauge the effectiveness of diversity programs; measure the health outcomes associated with having a diverse community health care workforce.**

New metrics are needed to be able to characterize and describe the real impact a diverse health care workforce has on health care quality and, downstream, on the health outcomes in a community. To build support for diversity programs and to demonstrate the potential for return on investment, we need to be able to answer questions about why professional workforce diversity matters for a community, a health care delivery system, a medical school, or a health professions education program. Systematic approaches to standardized data collection, analysis, and reporting are essential. Legislation may be needed to ensure the development of both quantitative and qualitative standards and measures.

***Increasing Federal Coordination:  
Recommendations for Efficiency***

**Align federal programs and policies that affect the health professions workforce.**

There is a need for better coordination across the numerous federal agencies involved in health professions workforce issues so that redundancy of efforts can be reduced and resources better leveraged to achieve greater impact.

**Link Primary Care Extension Hubs with Centers of Excellence (COE) and Health Careers Opportunity Programs (HCOP) to bring diversity into Hub activities.**

Primary Care Extension Hubs (as proposed, and since the time of this summit, authorized under the Affordable Care Act) will help support primary care providers in meeting the new demand from the new insured populations. Linking COE and HCOP to Hubs could help create mentorship opportunities, facilitate outreach to a broad group of primary care provider role models, and provide opportunities to expose students to careers in primary care. This program has been assigned to the HHS Agency for Healthcare Research and Quality.

**Closing Remarks**

It is time to think about diversity in a different way. HRSA is funding a variety of excellent projects and individual institutions are making strides. But the reality is that this is not enough. We need to move beyond helping individual institutions develop successful programs, to broader, more coordinated efforts that will bring greater benefit to more people. As the nation implements health care reform, there are opportunities to use Title VII to achieve more widespread diversity among health professionals, and to better meet the health care needs and improve the health of our increasingly diverse society.

## **Appendix A: Summit Participants**

**Jo Ivey Boufford, M.D.**

President  
New York Academy of Medicine

**Carolyn B. Britton, M.D., M.S.**

President  
National Medical Association  
Professor of Clinical Neurology  
Columbia University College of  
Physicians and Surgeons

**Gary Butts, M.D.**

Associate Dean for Diversity  
Programs, Policy, and Community  
Affairs  
Director, Center for Multicultural  
and Community Affairs  
Mount Sinai School of Medicine

**Laura Castillo-Page, Ph.D.**

Director of Research  
Diversity Policy and Programs  
Association of American Medical  
Colleges (AAMC)

**Virginia Davis Floyd, M.D.**

**M.P.H.**

Associate Professor  
Clinical Community Health and  
Preventive Medicine  
Morehouse University School of  
Medicine

**Dale P. Dirks**

President  
Health and Medicine Counsel of  
Washington

**Katherine Flores, M.D.**

Director  
UCSF–Fresno Center for Medical  
Educational Research  
California Area Health Education  
Center & Health Education  
Training Center

**Ana Garcia, M.P.A.**

Senior Policy Associate  
The New York Academy of  
Medicine

**Jorge Alberto Girotti, Ph.D.**

Associate Dean and Director  
Special Curricular Programs  
Director, Medical College  
Admissions, Director, Hispanic  
Center of Excellence  
University of Illinois at Chicago

**René A. Gonzalez**

Executive Director of Student  
Services  
Hispanic Association of Colleges  
and Universities

**Gerald Hill, M.D. (invited)**

President  
Association of American Indian  
Physicians

**Jean Moore, M.S.**

Director  
The Center for Health Workforce  
Studies  
University at Albany, SUNY  
School of Public Health

**Fernando Mendoza, M.D., M.P.H.**

Associate Dean  
Stanford University School of  
Medicine

**Raymond Morales, MD/PhD  
Candidate**

Co-President, Midwest Regional  
Board Latino Medical Student  
Organization  
University of Illinois, Urbana-  
Champaign

**Marc Nivet, Ed.D.**

Chief Operating Officer and  
Treasurer  
Josiah Macy Jr. Foundation

**Elena Rios, M.D., M.S.P.H.**

President  
National Hispanic Health  
Foundation  
President & CEO  
National Hispanic Medical  
Association

**Maria L. Soto-Greene, M.D.**

President  
Hispanic-Serving Health  
Professions Schools, Inc.  
Professor and Vice Dean  
UMDNJ- New Jersey Medical  
School

**Hal Strelnick, M.D.**

Principal Investigator  
Hispanic Center of Excellence  
Albert Einstein College of Medicine  
at Yeshiva University

**Ciro Sumaya, M.D.,**

**M.P.H.T.M.**

Chairman, National Hispanic  
Medical Association  
Dean, Texas A & M University  
System Health Science Center  
School of Rural Public Health

**Wilma Sykes-Brown, M.A.**

President  
National Association of Medical  
Minority Educators, Inc.  
Assistant Dean, Medical College of  
Georgia School of Medicine

**George E. Thibault, M.D.**

President  
Josiah Macy, Jr. Foundation

**Joan Weiss**

Director  
U.S. Health Resources and Services  
Administration, Division of  
Diversity and Interdisciplinary  
Education

**Beverly Williams, M.S., J.D.**

Secretary and Counsel  
National Council for Diversity in  
Health Professions  
Deputy Director, Center of  
Excellence for Diversity in Health  
Education and Research  
University of Pennsylvania School  
of Medicine

**Jacqueline R. Wynn, M.P.H.**

Associate Director  
North Carolina Area Health  
Education Centers (AHEC)  
The University of North Carolina at  
Chapel Hill

## **Appendix B: Resources**

*The following materials were provided to participants in preparation for the summit:*

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