Underrepresented Minorities in the Health Professions

Chapter 5

Minority populations comprise almost one-third of the state's population. African Americans, American Indians, and Hispanics have lower per capita incomes and, as a result, are more likely to lack health insurance[1] or rely on publicly-funded health insurance than are whites.[2] These groups also have lower reported health status and are more likely to suffer from certain chronic health problems.[2] Despite their greater healthcare needs, they are more likely to report health access barriers. Some underserved minority groups face discrimination in healthcare settings and may be distrustful of some healthcare providers and institutions.[3,4] Fortunately, some of these issues can be ameliorated by making it easier for members of underserved minority groups to select providers with ethnic backgrounds similar to their own. Healthcare providers from underrepresented minority, ethnic, and racial groups are more likely to serve patients of their own ethnicity or race and patients with poor health.[5,6,7]

Not only are underrepresented providers more likely to serve patients of their own ethnicity or race, they also are more likely to practice in underserved areas.

When given the option, individuals of all racial and ethnic groups are more likely to pick providers who share their racial and ethnic backgrounds.[7,8] Minority patients have lower levels of trust in providers of other racial groups.[5] Studies suggest minority patients are generally more satisfied with care received from providers of similar race and/or ethnicity (racial and ethnic concordant patient-physician relationships)[3,7,9] and are more actively involved in making decisions about their own care when visiting providers of their own race and ethnicity. In addition, patient-centered care (ie, respect for the patient's preferences and coordination of care) is emphasized more during visits in which the patient and provider are of the same race compared to when they are not.[3] The duration of visits to the physician is considered an important proxy measure for determining quality of care. Studies indicate that visits are longer for both African American and white patients when the provider and patient are of the same race/ethnicity.[4]

Not only are underrepresented providers more likely to serve patients of their own ethnicity or race, they also are more likely to practice in underserved areas. North Carolina has 11 whole-county and 27 part-county persistent health professional shortage areas (PHPSAs).[a] The significant number of areas in North Carolina lacking sufficient health providers makes it particularly valuable to have providers who are willing to serve the state's minority populations and underserved communities. In North Carolina, nonwhite physicians, physician assistants (PAs), and nurse practitioners (NPs) are more likely than white providers to practice in whole-county PHPSAs.[b]

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a The Bureau of Health Professions in the US Department of Health and Human Services has designated certain communities, population groups, or medical facilities as health professional shortage areas (HPSAs). Areas that are designated as HPSAs must define and justify a rational service area for the delivery of health services (often a county), have a sufficiently low provider-to-population ratio, and show evidence that nearby resources are overutilized, too distant, or otherwise inaccessible.

b Persistent health professional shortage areas are those that have been designated as HPSAs in six of the last seven years. An entire county or part of a county can qualify as a HPSA. Whole-county HPSAs refer to entire counties that qualify as HPSAs.

Ratio of North Carolina Minority Providers to Population

Minority populations comprise 30% of North Carolina's population, but they account for only 18% of physicians, 12% of PAs, and 10% of NPs in the state. Graph 5.1 illustrates the race of North Carolina's population compared to the race of the state's providers, including physicians, NPs, and PAs. Of the state's 8.5 million residents, 69% are white, non-Hispanic; 21% are African American or black, non-Hispanic; 6% are Hispanic; 2% are Asian or Pacific Islander; and 1% are American Indian. By comparison, whites account for 82% of the physician population (17,090), Asians 7%, African Americans 6%, and Hispanics 2%. Similarly, whites account for 90% and 88% of the NP and PA populations, respectively, while African Americans account only for 5%, and Hispanics account for 1-2% of each group.

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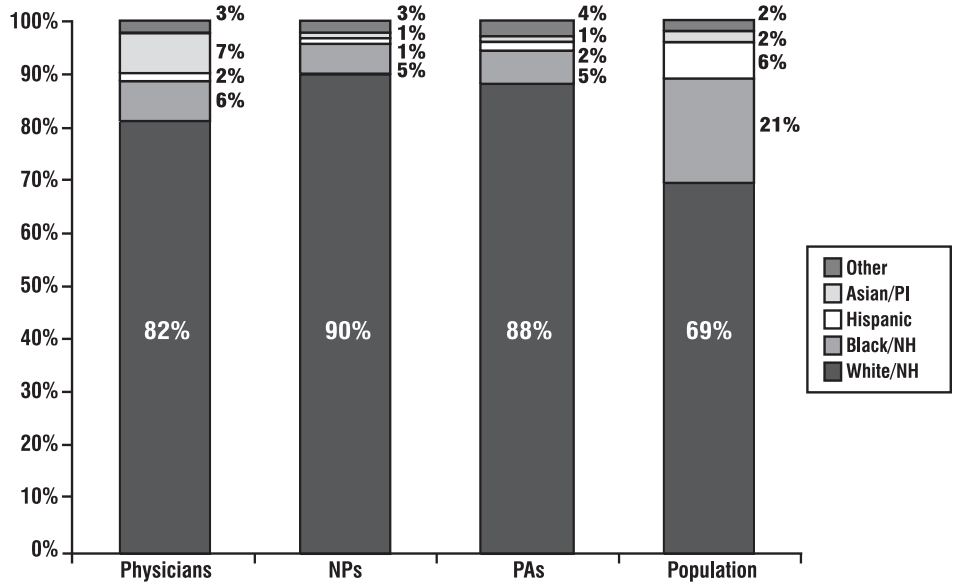
Graph 5.1
Race of Population and Providers, North Carolina, 2004

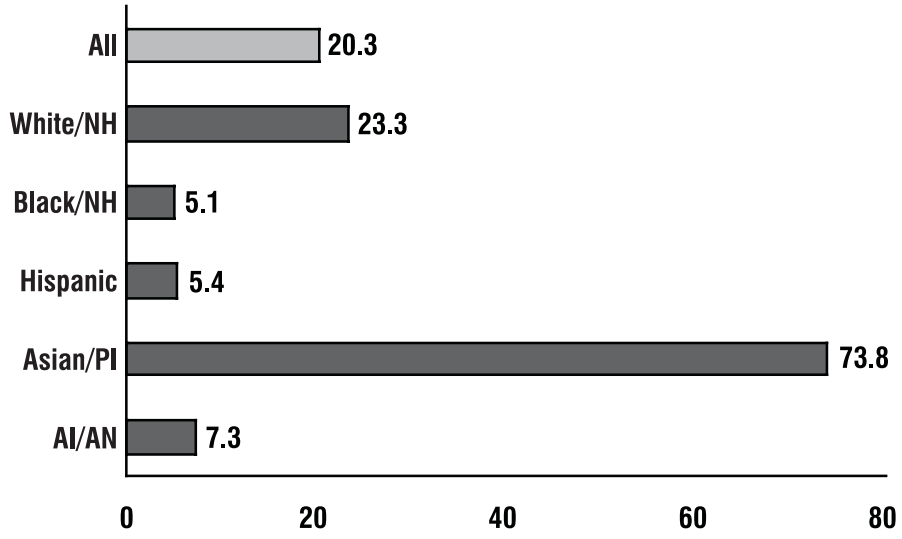


Source: NC Health Professions Data System and US Census. Other includes American Indian.

Availability of providers from a variety of ethnicities and races is important because studies indicate patients are more likely to choose providers of the same race or ethnicity[9] and are more satisfied with visits to providers of the same race or ethnicity.[4] Racial and ethnic differences in provider-patient relationships often create barriers and limit effective communication.[10] Underrepresented minority providers (African American, Hispanic, and Native American) are more likely to practice in persistent health professional shortage areas (39% for minority providers compared to 29% for white providers).

Graph 5.2 compares physician to 10,000 population ratios by race. There are only 5.1 African American, 5.4 Hispanic, and 7.3 American Indian physicians per 10,000 population compared to 23.3 white physicians per 10,000 population. The ratio of Asian physicians to population is high (73.8 per 10,000 population) due to lower numbers of Asians in the state and because a high proportion (58%) of Asian physicians in the state move to the US as international medical graduates (IMGs).

Graph 5.2
Total Physicians per 10,000 Population of the Same Race, North Carolina, 2004



Source: NC Health Professions Data System and US Census.

Evaluating the same data for physicians who practice primary care show similar results. There are 3.2 African American, non-Hispanic primary care physicians per 10,000 population, with 2.6 Hispanic and 4.7 American Indian primary care physicians per 10,000 population, compared to 9.4 white and 36.8 Asian/Pacific Islanders. Ratios of NPs and PAs to 10,000 population who practice primary care are approximately five times and four times higher, respectively, for non-Hispanic whites than they are for African Americans and Hispanics. Data indicate that American Indian provider-to-population ratios for these professions are similar to those of whites.

Minority Access to Healthcare and Health Professions Education

Historically, nonwhite individuals faced significant discrimination in access to healthcare services and inclusion in the healthcare professions. Minorities received care in segregated healthcare settings and were excluded from most medical professional training and practice opportunities. Even after the Civil Rights Act in 1965 precluded discrimination in higher education, most African American physicians were trained at Howard and Meharry. It was not until 1969 that the number of black medical students at Howard and Meharry was exceeded by the number enrolled in all other medical programs in the country. Fortunately, after targeted efforts to increase opportunities for minority students in these other medical institutions, underrepresented minorities accounted for 10% of all medical school enrollees in 1974 and 12% in 1994.[3]

Unfortunately, those numbers have since declined,[3] and with a state population that is more than 25% minority, North Carolina has a long way to go before enrollment in medical schools and NP, PA, and certified nurse midwife (CNM) programs mirror the state's population. Furthermore, to create an environment that is attractive to

minority health professional students, the faculty populations of health professions training schools need to include underrepresented minorities. Underrepresented minority faculty also may serve as better mentors to these students. Finally, it is important that these faculty members also serve as department chairs. Department chairs make important decisions regarding curricula and student populations, and minority chairs may be more sensitive to issues related to underrepresented minority student populations. They also may help place greater value on cultural diversity and diverse student bodies.

One of the most direct options for increasing underserved minority providers in North Carolina would be to develop new health professions training programs at historically minority public or private colleges and universities.

One of the most direct options for increasing underserved minority providers in North Carolina would be to develop new health professions training programs at historically minority public or private colleges and universities. Historically, minority colleges and universities educate students of all races and ethnicities, but focus on education of the African American population. North Carolina is fortunate to have a number of historically minority colleges and universities, both public and private, including Elizabeth City State University, Fayetteville State University, North Carolina A&T State University, North Carolina Central University, Winston-Salem State University, Bennett College, Johnson C. Smith University, Livingstone College, Shaw University, St. Augustine's College, and the University of North Carolina at Pembroke. Most of these schools offer strong science curricula, and there needs to be a continued effort to offer health professions training programs through these historically minority colleges and universities. North Carolina Central University offers a Bachelor of Science degree in nursing as does Winston-Salem State University. However, Winston-Salem State University is the only program in the state also to offer training programs in occupational therapy, physical therapy, and clinical laboratory science. Beyond that, the majority of historically minority colleges and universities have psychology majors, but as of 2004 there were few, if any, other health professions training programs in these schools.

One innovative new program initiated in 2005 was a partnership between Elizabeth City State University (ECSU) and the University of North Carolina at Chapel Hill (UNC Chapel Hill) School of Pharmacy. The UNC Chapel Hill/ECSU Doctor of Pharmacy Partnership Program will enroll 10 to 15 students each year.[11] The program provides instruction to students on the ECSU campus through synchronous video-teleconferencing, on-campus seminars, and ancillary web-based instruction. Students in the program will interact through computer-mediated communications with UNC Chapel Hill students, faculty, and advisors. Pharmacy training for ECSU-based students will be the same as that of UNC Chapel Hill-based students, with preferential scheduling for the ECSU students in the northeastern region of the state. Such an innovative program through a historically minority college or university will help increase the number of minority providers in the state and also may have the benefit of increasing the number of providers willing to work in underserved areas of North Carolina. Similar partnerships or satellite programs should be considered or consideration should be given to development of completely new health professions training schools at historically minority colleges or universities. (See Recommendations 2.4, 2.5, and 2.7.) These strategies would increase underrepresented minority enrollment in health professions programs and the number of practicing providers statewide. Other strategies include

increasing the enrollment of minorities in existing health professions schools (Recommendations 2.4 and 2.7), providing financial support to health professions schools that increase their production of minority healthcare professionals (Recommendation 2.8), and additional strategies listed below.

Recommendation 5.1. (Priority Recommendation)

The state and existing medical and other health professions schools should implement strategies to expand the number of underrepresented minority physicians, nurse practitioners, physician assistants, and certified nurse midwives and to decrease professional isolation.

These strategies may include but are not limited to:

a) developing minority-focused health professions schools in historically minority public or private colleges and universities;

b) creating satellite campuses with historically minority public or private colleges and universities;

c) creating and expanding minority scholarship programs, particularly in NP and PA programs;

d) developing healthcare mentorship programs in historically minority public or private colleges and universities to encourage more underrepresented minorities to consider health professions;

e) hiring faculty and chairs in health professions schools who are members of underrepresented minority groups and providing them with professional support to reduce professional isolation;

f) modifying admission policies to facilitate the enrollment of minority applicants; and

g) developing a state strategy to aggressively retain health professional graduates for residency or practice in North Carolina or to specifically attract North Carolina health professions school graduates doing residencies outside the state.

Language Barriers and Cultural Competence

Language differences create additional barriers to access to healthcare services. In North Carolina, approximately 150,000 Spanish-speaking residents do not speak English well or do not speak English at all.[12] Studies show people who do not speak English well (limited English proficiency) are not only more likely to report being in fair or poor health but also are more likely to defer needed medical care, miss follow-up appointments, and experience drug complications.[13,14] Language barriers are more likely to create communication problems leading to medical errors. Multilingual providers can help address language barriers for growing Latino or immigrant populations. Multilingual practitioners who are native speakers are more likely to understand how patients' cultural beliefs and practices can impact their health. They also can help practices meet Title VI requirements to ensure that

services are linguistically accessible.[c] The NC Office of Rural Health and Community Care (ORHCC) has placed a priority on recruiting multilingual professionals; ORHCC can offer providers a bonus if they are multilingual and agree to practice in medically underserved areas. Since July of 2001, ORHCC has recruited 88 multilingual health professionals into North Carolina.

In addition to recruiting native Spanish-speaking practitioners into the health professions and/or into practice in North Carolina, other training models can be used to teach Spanish to health professionals who are native English speakers. Successful models, developed in the state, exist to train health professionals to speak Spanish and thus improve communication between providers and patients. These models include the North Carolina Area Health Education Centers Spanish Language and Cultural Training Initiative, *A Su Salud* intermediate language tapes for healthcare professionals developed by the University of North Carolina at Chapel Hill, Wake Forest Spanish education for medical students, the NC Latino Health Resource Center, and others.

In addition to addressing language barriers, it is also important to ensure providers are trained to respect and understand cultural differences of diverse populations. Research demonstrates that cultural sensitivity training for healthcare providers improves knowledge, skills, and attitudes of providers while increasing patient satisfaction.[15,16] Thus, cultural sensitivity training has overall benefits for the provider-patient relationship. However, medical students often are not required to complete cultural diversity training.[17,18] With assistance from the American Medical Student Association, two of the four North Carolina medical schools are participating in the Achieving Diversity in Dentistry and Medicine (ADDM) contract awarded by the US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Medicine and Dentistry.[19] The University of North Carolina at Chapel Hill School of Medicine is part of the pilot testing of a cultural competency curriculum. Brody School of Medicine at East Carolina University is part of the pilot testing of an ethnogeriatrics[d] curriculum.

Additionally, the Brody School of Medicine at East Carolina University received a Pre-Doctoral Training in Primary Care grant from the Health Resources and Services Administration of the US Department of Health and Human Services. The goal of this project is to decrease health disparities for the Spanish-speaking population of eastern North Carolina. The proposed program is designed to plan, implement, and evaluate a cultural literacy/fluency curriculum that would improve the ability of medical students to deliver care to the Spanish-speaking population.[20]

Some low-cost models for improving cultural competency or at least cultural awareness are available on the Internet. For example, America's Health Insurance

c Title VI of the Civil Rights Act requires that federal fund recipients (eg, healthcare providers who receive federal Medicaid/Medicare funds) make their services linguistically accessible to people with limited English proficiency (LEP). 42 U.S.C. §2000d-1; 45 CFR §80.3(b)(2).

d Ethnogeriatrics integrates the influence of race, ethnicity, and culture on the health and well-being of older adults.

Plan's (AHIP) "Quality Interactions: A Patient-Based Approach to Cross-Cultural Care" is a free continuing medical education course for physicians. Through an interactive patient case study, physicians can improve their ability to effectively communicate with and care for patients from diverse backgrounds. This module also discusses the business, medical, and legal reasons why cultural competence is essential in the practice of medicine. Although institutional approaches such as integrating cultural competency into medical school curricula would likely be more effective and have greater impact, low-cost models offer some alternatives if no more intensive program is available.

Recommendation 5.2. (Priority Recommendation)

a) North Carolina medical and other health professions schools including university and community college programs should:

   i) recruit and admit more multilingual and multicultural students into health professions classes;

   ii) offer and encourage students to take Spanish medical language courses as part of health professions training;

   iii) develop innovative programs to prepare more multilingual and multicultural graduates; and

   iv) build cultural sensitivity training into curricula.

b) North Carolina foundations should create through a competitive process a Center for Excellence to inventory, evaluate, and disseminate best practices in healthcare professional programs.

Recommendation 5.3.

The NC Area Health Education Centers Program should work collaboratively with key partners including the Center for New North Carolinians and the Office of Minority Health and Health Disparities to:

a) expand existing Spanish language programs to train more interpreters and practicing health professionals; and

b) expand cultural competency and cultural sensitivity training for all health professionals.

Recommendation 5.4.

The NC General Assembly should create a grants program to incentivize medical schools and other health professions training programs to produce more multilingual and multicultural healthcare professionals.

For example, grants could be awarded for programs that create opportunities for intensive language training and immersion courses to produce multilingual and multicultural healthcare professionals or that offer loan forgiveness or scholarships tied to students who meet certain multilingual and cultural competency requirements.

Recommendation 5.5.

The NC Community College System should place greater emphasis on recruiting and training multilingual and multicultural medical office staff, nurses, and allied health professionals.

Other strategies include those listed in Recommendation 5.2.

North Carolina Programs to Promote Representation of Underrepresented Minorities in Healthcare Professions

Many programs throughout North Carolina are focused on promoting the representation of underrepresented minorities in healthcare professions. These programs target a variety of students including those in grades K-12, undergraduate programs, and medical schools. Two examples of such programs, which are particularly successful in reaching larger numbers of students, include the NC Health Careers Access Program (NC-HCAP) and programs conducted by the NC Area Health Education Centers (AHEC) Program.

NC-HCAP has campus-based health career centers at the University of North Carolina at Chapel Hill, Elizabeth City State University, North Carolina Central University, and the University of North Carolina at Pembroke. Campus-based activities involve identifying, recruiting, motivating, and strengthening the academic and basic skills of disadvantaged students in health training and professional health programs. NC-HCAP also offers programs in conjunction with several other campuses, school systems, organizations, and agencies. NC-HCAP offers activities for upper elementary through undergraduate students, including programs such as the Clinical Health Summer Program, health careers information and enrichment workshops, health professions forums, Inspirational Speakers in Science lecture series, NC-HCAP Ambassador Program, NC-HCAP enrichment seminars, parent workshops, and Science Enrichment Preparation program. (See Appendix B.)

The large number of students involved in precollege activities makes tracking difficult for NC-HCAP, but there is focused tracking for students involved in its undergraduate programs.[21] Since 1979, NC-HCAP has supported 935 students in college enrichment programs targeted at rising college sophomores and juniors; approximately 60% of those students now are health professionals, and approximately 39% are continuing along the pathway to becoming health professionals.[22] In the future, NC-HCAP hopes to develop a statewide directory for tracking participants in all North Carolina programs promoting health careers for underprivileged or underrepresented youth.

Unfortunately, NC-HCAP is currently struggling to support its existing programs. The federal government recently cut funding for Title VII of the Public Health Service Act, which supported programs aimed at increasing the representation of underrepresented minorities among the health profession disciplines. NC-HCAP received Title VII funds for its programs and that support was eliminated as a result of the federal cuts.

AHEC also conducts activities to increase minority representation in healthcare professions through its Health Careers and Workforce Diversity initiatives. In

2002-2003, 39,000 individuals participated in these programs.[23] See Appendix A for a list of North Carolina agencies and groups providing programs focused on promoting representation of underrepresented minorities in health professions.

Recommendation 5.6. (Priority Recommendation)

The NC Area Health Education Centers (AHEC) Program should work collaboratively with key partners to explore issues that need to be addressed in creating a statewide, uniform student tracking and evaluation system of federal and state funded programs across the educational pipeline. AHEC should report findings back to the Health Policy Workforce Board. The goal of this report should be to determine how best to:

a) evaluate existing minority health professions pipeline programs and expand the most successful programs, particularly those with a focus on intensive, longitudinal programs that work with small numbers of students over a longer period of time;

b) develop a statewide, uniform student tracking and evaluation system and program inventory of formal and informal programs across the educational pipeline which is shared by precollege and university health career advisors and counselors.

Future state funding should be tied to programs found to be the most successful in increasing underrepresented minorities in health professions.

Recommendation 5.7.

The Office of Rural Health and Community Care in collaboration with minority professional associations, such as Old North State Medical Society and other key partners, should provide practice support to underrepresented minority health professionals who choose to practice in underserved areas. Support can include, but not be limited to, creation of community mentoring programs or other strategies to support retention of underrepresented minorities in underserved areas.

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