

MISSING PERSONS: MINORITIES IN THE HEALTH PROFESSIONS

A REPORT OF THE SULLIVAN COMMISSION ON
DIVERSITY IN THE HEALTHCARE WORKFORCE



THE SULLIVAN COMMISSION

Contents

- About the Sullivan Commission i
- Acknowledgments iii
- Preface iv
- Executive Summary 1
- Chapter 1: Rationale for Increasing Diversity in Today’s Health Workforce 13
- Chapter 2: The Historical Roots of Today’s Disparities 32
- Chapter 3: State of Diversity in Today’s Health Professions Schools and Workforce 48
- Chapter 4: The Pipeline to the Health Care Professions 72
- Chapter 5: Financing Education in the Health Care Professions 92
- Chapter 6: Accountability 102
- Glossary 118

- Appendices
 - a. Commissioned Paper: “Increasing Workforce Diversity and Addressing Health Disparities: Strategies for Hospitals in Health Professions Educational Practice Partnerships” 119
 - b. Commissioned Paper: “Diversity of Students and Faculty: An Assessment of Health Profession Schools” 158
 - c. The Charge to the Sullivan Commission on Diversity in the Healthcare Workforce 179
 - d. W.K. Kellogg Foundation Health Professions Grant Program 182
 - e. Sullivan Commission Field Hearings 184
 - f. Diversity Resources 193

ABOUT THE SULLIVAN COMMISSION

The Sullivan Commission on Diversity in the Healthcare Workforce is an outgrowth of a grant from the W.K. Kellogg Foundation to Duke University School of Medicine. Named for former U.S. Secretary of Health and Human Services, Louis W. Sullivan, M.D., the Commission is composed of 16 health, business, higher education and legal experts and other leaders. Former U.S. Senate Majority Leader Robert Dole and former U.S. Congressman and Congressional Health Subcommittee Chairman Paul Rogers serve as Honorary Co-Chairs. Established in April 2003, the Sullivan Commission will make policy recommendations to bring about systemic change that will address the scarcity of minorities in our health professions.

The work of the Commission comes at a time when enrollment of racial and ethnic minorities in nursing, medicine, and dentistry has stagnated despite America's growing diversity. While African Americans, Hispanic Americans, and American Indians, as a group, constitute nearly 25 percent of the U.S. population, these three groups account for less than 9 percent of nurses, 6 percent of physicians, and only 5 percent of dentists. A study by the Institute of Medicine recommends increasing the number of minority health professionals as a key strategy to eliminate health disparities. Examining the education and training environment in which health professionals learn and develop is critical to efforts to increase the number of health care providers who can, and will, address the health care needs of our nation.

The lack of minority health professionals is compounding the nation's persistent racial and ethnic health disparities. From cancer, heart disease, and HIV/AIDS to diabetes and mental health, African Americans, Hispanic Americans, and American Indians tend to receive less and lower quality health care than whites, resulting in higher mortality rates. The consequences of health disparities are grave and will only be remedied through sustained efforts and a national commitment.

In a series of field hearings across the country, the Sullivan Commission gathered testimonies from health, education, religion and business leaders; community and civil rights advocates; health care practitioners; and students. Drawing upon the expertise and experience of the Commissioners, and the witnesses who provided valuable testimony, the Commission's report, *Missing Persons: Minorities in the Health Professions*, provides the nation with a blueprint for achieving diversity in the health professions.

For more information, visit: www.sullivancommission.org.

**The Sullivan Commission on Diversity
in the Healthcare Workforce**

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PREFACE

There is an imbalance in the makeup of the nation's physicians, dentists, and nurses. This imbalance contributes to the gap in health status and the impaired access to health care experienced by a significant portion of our population. The Sullivan Commission on Diversity in the Healthcare Workforce finds that African Americans, Hispanics, American Indians, and certain segments of the nation's Asian/Pacific Islander population are not present in significant numbers. Rather, they are missing! While some outstanding physicians, dentists, and nurses are minorities, access to a health professions career remains largely separate and unequal. This report, *Missing Persons: Minorities in the Health Professions*, examines the root causes of this challenge and provides detailed recommendations on how to increase the representation of minorities in the nation's medical, dental, and nursing workforce.

Our nation has made tremendous progress in the health sciences. Today, we stand apart from the rest of world with our many advances in the biomedical sciences. Mapping and sequencing the Human Genome is essentially complete, putting us at the threshold of a new era of discovery and therapeutic promise. However, that promise will not be fully realized if we fail to make similar progress in opening wide the doors of the health professions to all of our citizens.

In 2003, the Institute of Medicine (IOM) warned of the "unequal treatment" minorities face when encountering the health system. The data in that report are compelling and alarming. Cultural differences, a lack of access to health care, combined with high rates of poverty and unemployment, contribute to the substantial ethnic and racial disparities in health status and health outcomes. Health services research has shown that minority health professionals are more likely to serve minority and medically underserved populations. Despite this fact, there is a severe underrepresentation of minorities in our health professions. The IOM recommends increasing the number of minority health professionals as a key strategy to eliminating health disparities.

The path to diversity in the health professions is a long and complicated one. Working with the W.K. Kellogg Foundation and Duke University School of Medicine, I have the honor and challenge of chairing a commission that aims to shorten that path by breaking down the barriers that confront minority students who aspire to become health professionals.

The Commission, composed of 16 leaders in health, business, higher education, law, and other fields, accepted the charge from the W.K. Kellogg Foundation to serve as the focus for strategies to increase diversity in the health professions through a multidimensional approach and to advance national efforts to eliminate disparities in health status and access to health care among the nation's racial and ethnic minority populations.

The time is right, and our citizens are anxious for solutions and action. There have been many reports, studies, and initiatives that have examined the problem. We understand the dimensions of the problem. Our goals are designed for action.

Our work is part of an evolution in the health system. The nation is in a state of unprecedented demographic transformation. We are getting older and growing more diverse. Therefore, our health needs are changing dramatically. The choices we make and the actions we take today will determine the makeup of the health professions we will have for generations to come. The health professions must keep pace with the changing demographics of our nation.

In January 2004, the Commission completed the last of six national hearings designed to bring forward vital testimony on key challenges and proposed solutions. The Commission traveled the country to gather evidence, learn from previous attempts, and move beyond what has been tried, to develop new approaches, and a new model for making the health professions workforce more diverse.

The report that has emerged from this process integrates findings from testimony, health sciences literature, and two commissioned studies, and draws upon the expertise and experience of the members of the Commission. In all, the Commission puts forth 37 recommendations for multiple actions to address the root causes of underrepresentation of minorities in the health professions. Developed to attract broad public support and to encourage academic and professional leadership to share the Commission's vision for a health system that focuses on excellence, equal opportunity, and ensures delivery of high-quality care for the entire population, the Sullivan Commission's recommendations are based upon three overarching principles: 1) To increase diversity in the health professions, the culture of health professions schools must change; 2) New and nontraditional paths to the health professions should be explored; and 3) Commitments must be at the highest levels of our government and in the private sector.

We call upon leaders in the public and private sectors in our country, including key stakeholders in the health and education systems, to act on these recommendations and to solve this crisis by utilizing the strategy of inclusion in crafting solutions. It is time to correct the imbalance in our health professions. If we fail to do so, we risk catastrophe in view of the rapid demographic changes occurring in our society. We must work hard and we must dream again!

Louis W. Sullivan, M.D.
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U.S. Secretary of Health and Human Services, 1989-1993
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Atlanta, GA
September 2004

EXECUTIVE SUMMARY

By many measures, America has an exceptional health care system. Tremendous advances have made the U.S. health system the most technologically advanced in the world. Yet that system is in trouble. Basic quality care is beyond the reach of far too many Americans. As the population has become increasingly diverse, glaring disparities in the quality of care, especially for racial and ethnic minorities, have led to thousands of premature deaths each year and incalculable hours of lost productivity, pain, and suffering.

Many complex factors are at play. One is rooted in economics and a system that leaves far too many Americans lacking adequate, if any, health insurance. For many reasons—not the least of which is cost—a record 44 million Americans now have no health insurance and untold millions more have inadequate or limited coverage. Those numbers are growing.

The fact that the nation's health professions have not kept pace with changing demographics may be an even greater cause of disparities in health access and outcomes than the persistent lack of health insurance for tens of millions of Americans. Today's physicians, nurses, and dentists have too little resemblance to the diverse populations they serve, leaving many Americans feeling excluded by a system that seems distant and uncaring. In future years, our health professionals will have even less resemblance to the general population if minority enrollments in schools of medicine, dentistry, and nursing continue to decline and if health professions education remains mired in the past and—despite some improvements—inherently unequal and increasingly isolated from the demographic realities of mainstream America. Failure to reverse these trends could place the health of at least one-third of the nation's citizens at risk.

Recognizing the crisis, and continuing its national effort to counter the lack of diversity in medicine, nursing, and dentistry, in 2003 the W.K. Kellogg Foundation issued a grant to Duke University School of Medicine to plan and convene the Sullivan Commission on Diversity in the Healthcare Workforce. Composed of 16 health, education, legal, and business leaders and headed by former U.S. Health and Human Services Secretary Dr. Louis W. Sullivan, this Commission was given the formidable, and unique, task of identifying and understanding the barriers to achieving diversity in the health professions and then to finding solutions.

Working without the constraints often confronting government or quasi-government panels, Commission members examined existing research, commissioned studies, and traveled the country to gather information. The Commission held six field hearings and a nationally broadcast town hall meeting, and heard from more than 140 witnesses in order to bring the problems into clearer focus and to identify existing models and workable solutions.

This report, *Missing Persons: Minorities in the Health Professions*, emphasizes the need for leadership, commitment, and accountability at the highest levels in institutions of learning and professional organizations, and at the national level in the form of legislation and a Presidential task force to give urgency and focus to the problem. A number of strategies are identified to make education and training in the health professions more attainable and affordable for minority students, including shifting from student loans to scholarships; reducing dependency on standardized tests for admission to schools of medicine, nursing, and dentistry; and enhancing the role of two-year colleges. In all, 37 separate recommendations are put forward to remedy the lack of diversity among health professionals, warning that failure to act quickly will only exacerbate the current disconnect between health care providers and the populations they serve.

Statistics reviewed by this Commission highlighted the diversity gap. Together, African Americans, Hispanic Americans, and American Indians make up more than 25 percent of the U.S. population but only 9 percent of the nation's nurses, 6 percent of its physicians, and 5 percent of dentists. Similar disparities show up in the faculties of health professional schools. For example, minorities make up less than 10 percent of baccalaureate nursing faculties, 8.6 percent of dental school faculties, and only 4.2 percent of medical school faculties.

If the trends continue, the health workforce of the future will resemble the population even less than it does today. Viewed in the context of demographic projections showing that no racial or ethnic group will comprise a majority by the year 2050, that decline could be catastrophic.

Support for a direct link between poorer health outcomes for minorities and the shortage of minority health care providers came from the Institute of Medicine's landmark study, *Unequal Treatment*. That study documented the lower quality of health care and higher rates of illness, disability, and premature deaths among minority populations.

The evidence this Commission reviewed and the testimony heard led its members to conclude that the condition of the nation's health professions workforce is critical and demands swift, large-scale change to protect the future health of the nation. Transforming the system will require changing the face of the American health care system.

The conclusions provide a new vision of health care for America, one that focuses on excellence and that ensures true equality of high-quality care for the entire population. Diversity is a key to excellence in health care. To achieve that new vision, care must be provided by a well-trained, qualified, and culturally competent health professions workforce that mirrors the diversity of the population it serves.

The Sullivan Commission's recommendations were developed to attract broad public support and to encourage academic and professional leadership to share the Commission's vision for a health system modeled on excellence, access, and quality for all people. Three overlying principles are essential to fulfilling that vision.

1.) To increase diversity in the health professions, the culture of health professions

schools must change. Our society is experiencing a significant and rapid demographic shift. The culture of our nation is changing. So too must the culture of our health institutions. As colleges, universities, health systems, and others examine these recommendations, they must also examine the practices of their own institutions.

2.) New and nontraditional paths to the health professions should be explored.

In some health professions, it takes between 10 and 12 years to fully educate and train a provider. This Commission calls for major improvements in the K-12 educational system, with the realization that the degree of diversity in health professions schools cannot remain stagnant while these improvements take shape.

3.) Commitments must be at the highest levels. Change can happen when institutional leaders support the change. In 1966, Duke University School of Medicine was one of the last two medical schools in the South to admit a black student. Today, Duke University School of Medicine has become a model of diversity and has used its leadership to bring other institutions along a new and inclusive path toward excellence.

In brief, the following summarizes the Commission's specific findings and recommendations:

Chapter 1: Rationale for Increasing Diversity in Today's Health Workforce

The rationale for increasing diversity in the health workforce is evident: increased diversity will improve the overall health of the nation. This is true not only for members of racial and ethnic minority groups, but also for an entire population that will benefit from a health workforce that is culturally sensitive and focused on patient care.

Diversity in the health workforce will strengthen cultural competence throughout the health system. Cultural competence profoundly influences how health professionals deliver health care. Language is a critical component, with two out of ten Americans speaking a language at home other than English. The cultural challenges posed by a shifting patient demographic can best be addressed by health professionals educated and trained in a culturally dynamic environment.

The business community has long recognized that workforce diversity is essential to success and maintaining competitiveness in the marketplace. Corporate executives as well as local chambers of commerce describe the economic benefits of developing a workforce that reflects the customer base. Business support for diversity was demonstrated in the unprecedented number of amicus curiae briefs filed with the Supreme Court in support of the University of Michigan's affirmative action admissions policies. Business leaders find diversity in higher education necessary to the development of skills required to compete in a global economy, skills such as the ability to understand, work, and build consensus with individuals of different ethnic and cultural backgrounds.

Some business benefits from diversity are specific to the health care sector. Poor health outcomes for members of racial and ethnic minorities, attributable to a lack of diversity in the health workforce, translate to a loss of productivity, unnecessary absenteeism, and increased health care costs. The business community recognizes that promoting diversity in the health workforce, as well as in the general workforce, is essential to a strong economy.

Chapter 2: The Historical Roots of Today's Disparities

Many people living today remember a time when admission to college and to professional schools was systematically limited by race, sex, national origin, and religion. The civil rights movement of the 1960s eventually ended the more visible racial and ethnic barriers, but it did not eliminate entrenched patterns of inequality in health care, which remain the unfinished business of the civil rights movement.

Historically, racial and ethnic minorities have always been underrepresented in the health professions in America (Smith, 1999; Byrd & Clayton, 2002), just as members of these populations have always been more likely to receive a lower quality of care, experience higher rates of illness and disability, and die at earlier ages than members of the white population (IOM, 2003; PHR, 2003).

Schools of medicine, dentistry, and nursing have been among the last to integrate their classrooms, and their professional organizations have been equally slow in recruiting minorities into their ranks. Significant improvements have been made. In many health professions, including some medical specialties, women have achieved parity and due recognition. Further, some of the most accomplished and highly respected people in the health professions are members of minority groups who overcame the barriers of a once-segregated medical establishment.

Today, talented minority students are among the most sought-after applicants at some leading universities and professional schools. Strong steps must be taken to expedite inclusion of underrepresented minority groups among the various health professions. The Commission recommends:

- 2.1 The complementary strategies of increasing diversity and ensuring cultural competence at all levels of the health workforce should be endorsed by all in our society, with leadership from the key stakeholders in the health care system.
- 2.2 There should be increased recognition of underrepresented minority health professionals as a unique resource for the design, implementation, and evaluation of cultural competence programs, curriculums, and initiatives.
- 2.3 Public and private funding entities, including U.S. Public Health Service agencies, foundations, and corporations, should increase funding for research about racial disparities in health care and health status, including, but not limited to: research on culturally competent care, how to measure and eliminate racial bias and stereotyping, and strategies for increasing positive health behaviors among racial and ethnic groups.
- 2.4 Health systems should set measurable goals for having multilingual staff and should provide incentives for improving the language skills of all health care providers.
- 2.5 Health professions schools should work to increase the number of multilingual students, and health systems should provide language training to health professionals.
- 2.6 Key stakeholders in the health system should promote training in diversity and cultural competence for health professions students, faculty, and providers.

Chapter 3: State of Diversity in Today's Health Professions Schools and Workforce

The ghosts of segregation continue to haunt the health professions. Appropriately, the Commission began its field hearings in Atlanta, a key landmark of the civil rights movement. Testimony there highlighted the problems confronting efforts to improve diversity among the health professions workforce. For example, in 1997, the incoming class at the state-sponsored Medical College of Georgia included only one black student, even though approximately 30 percent of the citizens of Georgia are black. The problem in Georgia is not unique. The nation's upcoming medical school graduating classes for 2007 include only 2,197 black, Hispanic, and Native Americans out of a total of more than 16,000 students. The picture in nursing and dentistry is similar.

Enrollment of minority students in health professions schools increased slightly during the 1960s, 1970s, and 1980s. However, the numbers have failed to keep up with the growth of minority populations, particularly in medicine where minority enrollment is now declining. This situation makes it more difficult for students at many of the nation's leading health professions institutions to share different socioeconomic and cultural experiences so essential to the training of health professionals destined to work with an increasingly diverse population.

Excellence in health professions education is difficult to achieve in a culturally limited environment. Missing the experience of cultural diversity diminishes the overall quality of health professions education and adversely affects the health status of minority populations.

The limited pool of leaders and mentors in the health professions needs to be addressed. Currently, underrepresented minorities account for only 4.2 percent of medical school faculties in the United States, less than 10 percent of the baccalaureate and graduate nursing school faculties, and 8.6 percent of dental faculties. This lack of leadership and sparse representation among faculties sends a chilling message to current and potential minority students.

Chapter 4: The Pipeline to the Health Care Professions

Collectively, the nation's medical, nursing, and dental schools have not succeeded in their efforts to achieve greater diversity among their students and, in turn, to develop a health professions workforce with the skills and diversity needed to maintain the nation's position as a world leader in health care. Few models of successful minority student development and recruitment efforts exist despite the frequent, and loudly voiced, agreement that this is a problem that can, and must, be solved.

The problem is seen at the beginning of the pipeline where primary and secondary schools are failing too many students. On average, when compared with white students, racial and ethnic minority students receive a K-12 education of measurably lower quality, score lower on standardized tests, and are less likely to complete high school. Those who do graduate from high school are far less likely to graduate from a four-year college than white students. Approximately 30 percent of white students graduate with a four-year degree, compared with 17 percent of African American, and 11 percent of Hispanic students (U.S. Census Bureau, 2003).

Even talented minority students who do succeed at primary, secondary, and collegiate levels, and who are committed to pursuing a career in one of the health professions, often find it difficult to gain admission to a health professions school. The barriers they encounter include an over-reliance on standardized testing in the admissions process, unsupportive institutional cultures, insufficient funding sources, and leadership without a demonstrated commitment to diversity.

A number of strategies to broaden the health professions pipeline were identified, including efforts to provide extra support for disadvantaged and minority students through strategies such as mentoring, counseling and training in test-taking and interviewing skills, and efforts to include more students from two-year colleges and allied health professionals seeking second careers. The Commission recommends:

- 4.1 Health professions schools, hospitals, and other organizations should partner with businesses, communities, and public school systems to: a) provide students with classroom and other learning opportunities for academic enrichment in the sciences; and b) promote opportunities for parents and families to increase their participation in the education and learning experiences of their children.
- 4.2 The U.S. Public Health Service, state health departments, colleges, and health professions schools should provide public awareness campaigns to encourage underrepresented minorities to pursue a career in one of the health professions. Such a campaign should have a significant budget, comparable to other major public health campaigns.
- 4.3 For underrepresented minorities who decide to pursue a health profession as a second career, health professions schools should provide opportunities through innovative programs.
- 4.4 Baccalaureate colleges and health professions schools should provide and support “bridging programs” that enable graduates of two-year colleges to succeed in the transition to four-year colleges. Graduates of two-year community college nursing programs should be encouraged (and supported) to enroll in baccalaureate degree-granting nursing programs.
- 4.5 Key stakeholders in the health system should work to increase leadership development opportunities in nursing in order to prepare minority nurses with graduate degrees for roles as scholars, faculty, and leaders in the profession.
- 4.6 Key stakeholders in the health system should work to increase leadership training and opportunities for underrepresented minority physicians and dentists.
- 4.7 Colleges, universities, and health professions schools should support socio-economically disadvantaged college students who express an interest in the health professions, and provide these students with an array of support services, including mentoring, test-taking skills, counseling on application procedures, and interviewing skills.
- 4.8 The Association of American Medical Colleges, the American Association of Colleges of Nursing, the American Dental Education Association, and the Association of

Academic Health Centers should promote the review and enhancement of health professions schools admissions policies and procedures to: a) enable more holistic, individualized screening processes; b) ensure a diverse student body with enhanced language competency and cultural competency for all students; and c) develop strategies to enhance and increase the pool of minority applicants.

- 4.9 Dental and medical schools should reduce their dependence upon standardized tests in the admissions process, the Dental Admissions Test and the Medical College Admissions Test should be utilized, along with other criteria in the admissions process as diagnostic tools to identify areas where qualified health professions applicants may need academic enrichment and support.
- 4.10 Diversity should be a core value in the health professions. Health professions schools should ensure that their mission statements reflect a social contract with the community and a commitment to diversity among their students, faculty, staff, and administration.
- 4.11 Health systems and health professions schools should use departmental evaluations as opportunities for measuring success in achieving diversity, including appropriate incentives.
- 4.12 Health systems and health professions schools should have senior program managers who oversee: a) diversity policies and practices; b) assist in the design, implementation, and evaluation of recruitment, admissions, retention, and professional development programs and initiatives; c) assess the institutional environment for diversity; and d) provide regular training for students, faculty, and staff on key principles of diversity and cultural competence.
- 4.13 Health professions schools should increase the representation of minority faculty on major institutional committees, including governance boards and advisory councils. Institutional leaders should regularly assess committee/board composition to ensure the participation of underrepresented minority professionals.

Chapter 5: Financing Education in the Health Professions

The burden of financing an education in the health professions has put the dream of becoming a health professional beyond the reach of far too many qualified, underrepresented minority students. Many of these students come from families with significantly lower incomes and fewer financial assets than their white counterparts. In 2001, the median income for white families was 40 percent higher than that of blacks and 39 percent higher than that of Hispanics. Even the most talented students from these minority families tend to view the cost of professional educa-

tion as overwhelming and insurmountable. Financial realities mean many low-income students who do graduate from high school do not plan to attend a four-year college or take the necessary qualifying exams and apply to a health professions school. Those who do pursue their dream for a health professions education experience high unmet financial needs, coupled with excessive loan and work burdens.

The situation demands creative responses to increase funding to support diversity programs and eliminate the financial barriers that discourage so many minority students. Failure to address the cost problem increases the growing diversity gap between the health professions and the populations they serve.

The Commission recommends:

- 5.1 Congress should substantially increase funding to support diversity programs within the National Health Service Corps, and Titles VII and VIII of the Public Health Service Act. Such funding should also provide for collection of data on diversity.
- 5.2 To reduce the debt burden of underrepresented minority students, public and private funding organizations for health professions students should provide scholarships, loan forgiveness programs, and tuition reimbursement strategies to students and institutions, in preference to loans.
- 5.3 Public and private entities should significantly increase their support to those health professions schools with a sustained commitment to educating and training underrepresented minority students.
- 5.4 Businesses, foundations, and other private organizations should be encouraged to support health professions schools and programs to increase financial resources needed to implement the recommendations of the Sullivan Commission.
- 5.5 The President and Congress should increase the funding for the National Institutes of Health's National Center for Minority Health and Health Disparities Loan Repayment Programs, with a special emphasis on programs for underrepresented minority students.
- 5.6 The National Institutes of Health should develop a Centers of Excellence program for schools of nursing.

Chapter 6: Accountability

From field hearings and witnesses, the commission learned the essential value of leadership. Often, the commitment of a university president, chancellor, or dean has been instrumental in developing and implementing new policies and procedures and, at the same time, has changed the cultures and attitudes that blocked diversity.

Strong leadership is required to ensure that goals and commitments to achieve diversity are met. That, in turn, demands accountability. For health professions schools, that accountability must address four key principles: quality care, measurement of progress, benefit to the community, and institutional commitment.

Leadership beyond the institutional level is essential. Professional organizations, and federal and state agencies need to promulgate guidelines, set standards and regulations, and develop other devices for promoting cultural competence and diversity within the health professions. To ensure success, federal and state legislation is needed to strengthen the institutions that serve underrepresented populations, and a Presidential interagency task force should develop and implement a comprehensive strategy to improve diversity in the health workforce.

- 6.1 Health systems and health professions schools should gather data to assess institutional progress in achieving racial and ethnic diversity among students, faculty, administration, and health services providers, as well as monitor the career patterns of graduates.
- 6.2 Health professions schools and health systems should have strategic plans that outline specific goals, standards, policies, and accountability mechanisms to ensure institutional diversity and cultural competence.
- 6.3 Health professions organizations and accrediting bodies for health professions education and health care programs should promote the development and adoption of measurable standards for cultural competency for health professions faculty and health care providers.
- 6.4 Accrediting bodies for programs in medicine and the other health professions should embrace diversity and cultural competence as requirements for accreditation.
- 6.5 State licensure boards for nurses, physicians, and dentists should determine the value of having continuing education in cultural competence as a condition of licensure.
- 6.6 Community and civil rights organizations should collaborate with health care organizations and health professions schools to advance institutional diversity and cultural competence goals, including community needs assessment and evaluation.

- 6.7 Federal and state regulatory agencies should monitor and enforce health care institutions' fulfillment of community-benefit obligations pertaining to diversity and cultural competence. Data collected should be readily available to the public.
- 6.8 The Department of Health and Human Services should establish and report national standards and measurements for diversity and cultural competence in the health workforce and health professions schools in the Agency for Healthcare Research and Quality's National Health Care Disparities Report.
- 6.9 The Department of Education should work with the appropriate accrediting bodies to ensure that health professions education institutions promulgate, monitor, and implement standards for diversity and cultural competence for students, faculty, staff, and administration.
- 6.10 The Department of Labor and the Department of Health and Human Services should ensure that the appropriate accrediting bodies hold medical residency and health professional training programs accountable for promulgating and implementing standards for diversity and cultural competence.
- 6.11 The Commission recommends the passage and funding of comprehensive state and federal legislation that will: 1) ensure the development of a diverse and culturally competent workforce; and 2) strengthen health care institutions that serve minority and underserved populations.
- 6.12 The President should appoint an advisory council or interagency task force on health workforce diversity to develop and implement a more effective national response to the shortage of minorities in the health professions.

The Commission believes its vision for American health care can be achieved within the next two decades. In that time, a new generation of physicians, dentists, nurses, and other health professionals will have been trained to care for a population where the terms “majority” and “minority” have become obsolete.

The health professions have reached a crossroads, a point where dramatic change is required and wise decisions must be made. Either health professions training will remain entrenched in the status quo and become increasingly out of touch with the demographic realities and health needs of the nation, or the professions can choose to change, and lead to a new era of excellence in health care.

From the streets of Harlem to the barrios of East Los Angeles, the Commission saw shining examples of young students and professionals who can lead to this new era. Many share a dream of returning to their communities as physicians, dentists, and nurses to provide care for friends, neighbors, and relatives. They face huge financial obstacles, but new financing mechanisms can put a health professions education within their reach. Further reducing the debt burden will broaden access to a health professions education.

“I had incredible support that allowed me to pursue my dreams and fight to get my education,” testified Claribel Sanchez, a University of California, Berkeley, student born and raised in East Los Angeles, a neighborhood that has seen more than its share of crime and violence. “Even if I’m here on loans, I’m not letting money become an issue. It’s the only way I can get through and I’m not going to give up.”

With change, new role models will provide hope to medically underserved communities which currently see health care as a luxury, not a reality. New ways for providing quality care to those who now receive little will be discovered.

Tracy Brewington, a nursing student at Howard University, told the Commission: “I’m looking forward to going back home to Philadelphia, to the inner city, where I will have the opportunity to give back to my community. I feel like even if just one person could do something to try to eliminate these health disparities, it could be me. I’m here to make a difference.”

The goal of the Commission is to increase diversity in the health professions. By its very nature, diversity allows more people from different backgrounds to look at the same problem and to explore different approaches and different solutions. To the goal of diversity, the Commission added the goal of excellence in order to achieve a health care system where no American would feel excluded and all would experience the same high level of quality care. The Commission believes the task of transforming the health system to achieve that level of excellence requires a strong commitment from all in our society, with particular leadership from the generation that was born into the post-Civil Rights Era, and is committed to seeing the “dream” truly fulfilled. In the ever-cogent words of the Rev. Dr. Martin Luther King, Jr., “The time is always right to do what is right.”

Chapter 1

Rationale for Increasing Diversity in Today's Health Workforce

What are the critical concerns regarding the lack of racial and ethnic diversity in the health professions? How does workforce diversity affect health care access, delivery, and quality? In fulfilling its charge to address the persistent shortage of racial and ethnic minorities in the health care workforce, the Sullivan Commission on Diversity in the Healthcare Workforce examined these questions through national hearings and working group sessions. The Commission listened attentively to public officials, students, faculty, and administrators at health professions education institutions; health professionals at the hearings; and supplemented their testimony with research information. This chapter represents the Commission's rationale behind the national mandate to increase diversity in the health care workforce.

The Commission has concluded that racial and ethnic diversity in the health care workforce has profound implications for the U.S. health care system. Increasing diversity in the health care professions will improve health care access and quality for minority patients and assure a sound health care system for all of our nation's citizens. It will also strengthen health care delivery systems at multiple levels, enhance educational experiences for all health professions students, promote relevant research and needed changes in health policy, and prepare our nation for the emerging and culturally dynamic health care challenges of tomorrow. From an economic point of view, increasing diversity makes good business sense. From an ethical standpoint, it serves the cause of social justice.

"Any economist will tell you that diversification is the key to a secure portfolio. Any geneticist will tell you that diversification is key to maintaining hardy species of plants and animals. But somehow, when it comes to racial politics, the virtues of diversity are lost. Diversity in health care is not about fair representation - it is about saving lives."

– Commissioner George Strait, Associate Vice Chancellor for Public Affairs,
University of California, Berkeley

Understanding Diversity

The Commission's definition of racial and ethnic diversity in the health care workforce encompasses several characteristics including: (1) the representation of all racial and ethnic groups from the community served within a given health care agency, institution, or system; (2) the system-wide incorporation of diverse skills, talents, and ideas from those racial and ethnic groups; and (3) the sharing of professional-development opportunities and resources, as well as

responsibilities and power among all racial and ethnic groups and at all levels of a given agency, institution, or system.

In defining diversity and assessing its gravity, the Commission considered several key factors. First, throughout the twenty-first century, the number of racial and ethnic minorities is expected to steadily increase and, by mid-century, they will constitute a new U.S. majority. According to the 2004 U.S. Census, by 2050 the Hispanic population will nearly triple from today's level of about 36 million to 103 million. Asian-American populations will triple from 11 million to more than 33 million. The African-American population is expected to almost double from 36 million to 61 million. As today's minorities become a larger percentage of the total population, meeting the health needs for this emerging majority will become increasingly vital. However, the current growth rate of minorities in the health care workforce indicates that tomorrow's health care professionals will not be representative of minority populations. Moreover, minority shortfalls are hardly limited to providers of direct care (e.g., nurses, physicians, and dentists), but also exist in non-clinical areas including health professions educational institution faculty and administration, hospital administration, research centers, and public policy.

Second, in defining diversity, the Commission noted that throughout the hearings a number of presenters expressed the concern that diversity might be viewed too narrowly as a student recruitment issue. Instead, many would want it addressed more broadly as it pertains to students, faculty, staff, and all areas that permeate the educational, clinical, research, and public policy missions of institutions. The Commission concurs with the premise that diversity must ultimately be considered in this broader context. Indeed, minority health professionals play unique and indispensable roles at multiple levels of the nation's health system. For example, a 1985 United States Department of Health and Human Services report, which identified minority shortages in the fields of health care research and education, noted: "An insufficient number of role models and teachers who are sensitive to the training needs of minorities has a negative effect upon the training of future minority health professionals" (pp. 191-192). The Commission heard repeatedly throughout the hearings that minority health professions educational institution students benefit greatly from mentoring by minority faculty. Minority faculty can also serve as mentors for non-minority students by helping these students deal with their cultural biases and the processes of self-discovery wherein biases are self-identified, understood, and eliminated.

Minority health professionals also play a unique role in public policy. At the hearings in Atlanta, Dr. Christopher Leggett, testifying on behalf of Mayor Shirley Franklin, told the Commission that health professionals from minority communities are more likely to keep the issues of health inequity "on the front burner of the policy landscape and focus on the importance of prevention and community empowerment than those who are from other communities."

Despite their short supply, minority health professionals serve in distinctively valued roles as educators, mentors, administrators, researchers, policymakers, and health care providers.

Lastly, while constructing a broader working definition of diversity to acknowledge the different levels and many positions that suffer shortages of minority representation, the Commission has centered its focus on provider diversity and its implications for improving health care delivery. *Care* is the essence of health care; it is the preserving and restoring of human health through disease prevention, health promotion, diagnosis, and treatment. At a broader level, caring for the health of all individuals also involves the stewardship of policies, programs, and systems that ensure the delivery of high-quality care. The Commission's paramount concern is the link between racial and ethnic disparities in care delivery and significant disparities in health outcomes, including higher levels of sickness, disability, and premature death (IOM, 2003). Accompanying this causal link between unequal treatment and unequal health status is the shortage of underrepresented minority providers.

Providers' behavior and their clinical decisions directly contribute to stark disparities in health care for minority patients (IOM, 2003). The provider-patient interaction is a complex encounter where the characteristics and actions of the provider, patient, and the system interact to produce the diagnosis, treatment, and care. For example, patient characteristics that influence the provider-patient interaction include patient preferences, cultural beliefs, mistrust of the health care system, and past experiences of discrimination. Provider factors that influence clinical decisions and care delivery include uncertainty, time pressures, and both conscious and unconscious bias and stereotyping about minority patients (IOM, 2003). Health system factors include language barriers, availability and access to services (such as the availability of high-tech procedures), the degree of clinical bureaucracy, referral patterns and access to specialty care, and fragmentation of care due to restrictions imposed by managed-care organizations.

Despite the complexity of the interaction, studies suggest that increasing the diversity of the health workforce can improve patient access, patient satisfaction, and improve quality of care for all patients. Cultural competence is a principle dynamic underlying the interaction between patient, provider, and system. Increasing diversity has profound implications for enhancing the cultural competence of the health care system at multiple levels.

Diversity Improves the Cultural Competence in Health Care Delivery

At the hearing in Los Angeles, Ms. Karin Wang, Vice President, Asian Pacific American Legal Center (APALC), put forth the premise that a key dimension of health care workforce diversity is cultural and linguistic competence. The Commission understands cultural competence as that

set of behaviors, attitudes, customs, policies, and resources that come together in a system, agency, or among professionals to enable that system, agency, or those professionals to work effectively in cross-cultural situations. The Commission believes that improving health care quality and eliminating health disparities for minorities requires ensuring diversity and cultural competence among frontline clinicians and at all levels of the health system.

In today's modern health care facilities, people from diverse cultures and social experiences cross paths. Understanding the unique and indispensable role that minority health providers play in health care delivery requires a fundamental appreciation of the powerful impact of culture on beliefs, behaviors, practices, and language related to health. Culture is an integrated pattern of commonly shared beliefs and behaviors, including styles of communicating; ways of interacting; views on roles and relationships; and normative values, practices, and customs (Robins et al., 1998 and Donini-Lenhoff & Hedrick, 2000).

Throughout the hearings, presenters often spoke passionately about the vital and dynamic role of culture in health care delivery. At the hearing in Houston, Carlos A. Moreno, Chair, Department of Family Practice and Community Medicine at the University of Texas Health Science Center, shared that his being Latino and ability to speak Spanish is a primary reason Hispanic patients seek him out. Among Latinos, it is very important to have a physician who speaks Spanish and fully understands Latino cultural values (Flores, 2000). At the hearing in Chicago, Ms. Micael Clarke, Director, Center for Faith and Missions at Loyola Marymount, shared how a Vietnamese woman abiding by her faith tradition might feel guilty or responsible for her child's illness.

Ms. Clarke explained that health care professionals who understand this are better able to work with this child's mother. At the Denver hearing, Ms. Phyllis Bigpond, Executive Director, Denver Indian Family Resource Center, noted the importance of "Native healing" and the incorporation of alternative healing systems in health care, which carry "more respect" within Native-American communities.

In health care, dominant Anglo-American cultural values (Leininger, 2002), such as individualism, competition, and dependence on technology and Western science, can often collide with cultural values that embrace collectivism; spirituality; and countervailing concepts of disease causation, illness, and treatment. Dr. Lori Alvord, the first woman Navajo surgeon, practiced medicine on a reservation alongside mostly white physicians and administrators who found the non-Western beliefs and practices of their Navajo patients "both confusing and compelling" (Alvord & Van Pelt, 2000).

“I live between two worlds. In one of them, I am a dispenser of a very technologically advanced Western style of medicine. In the other, people are healed by songs, herbs, sand paintings, and ceremonies held by firelight in the deep of winter.”

– Navajo surgeon Lori Alvord, M.D., Associate Dean for Student and Minority Affairs, Dartmouth School of Medicine

Public testimonies strongly supported the premise that there is a deep and inseparable relationship between cultural competence and the quality of health care. At the hearing in Atlanta, Ms. Vanessa Spearman, third-year student at the Medical College of Georgia, put forth the concern that the prevailing paradigm of cultural competency is inherently flawed. Ms. Spearman noted that cultural competency is more than just recognizing that there are cultural differences, but includes the capacity to incorporate these differences into models of health professions education and treatment in a manner that is beneficial to the student, the patient, and the health professional. The Commission believes that enhancing cultural competence directly supports the goal of ensuring that health care institutions deliver the highest quality of care to patients regardless of racial, ethnic, or linguistic background. Closing the healthcare gap in the 21st century involves reconfiguring the cultural relationship between diverse communities and health-care institutions. Increasing diversity and cultural competence are at the heart of this reconfiguration.

Cultural competence operates at three levels: system, organization, and provider (Betancourt et al., 2002). Testimony supports the Commission’s belief that today, cultural competence is systemically inadequate, compromising the delivery of high-quality care and necessitating the robust and steady infusion of underrepresented minority health professionals at each of the three levels.

Diversity Improves Cultural Competence at the System Level

Every system is designed, by intent or flaw, to yield exactly the results that it produces. The Commission believes that the advancement of cultural competence in the nation’s health care system is, in large part, a function of the system’s tools and approaches used to ensure cultural competent health care delivery. At the *system level*, cultural competence refers to the culturally appropriate design, development, maintenance, and evaluation of policies, programs, and processes that directly or indirectly serve racial and ethnic minority groups. Such policies, programs, and processes include the education and training of health professionals; community needs assessments; programs for community and patient feedback on system access and quality; systems for data collection of patient race, ethnicity, and language; policies and procedures for measuring health care access, delivery and quality; and processes for ensuring culturally and linguistically appropriate services, health education materials, and health promotion and disease prevention programs.

The Commission believes that when a health care organization is not racially and ethnically diverse, the cultural competence of its policies, programs, and processes are inherently and systematically compromised. Minority health professionals play a key role as trusted community members who partner with the community to hold the system accountable. They do this by bringing a unique sense of community-based cultural affinity and shared social experience to the organizational processes of system design, policy and procedure development, research, and other activities that support the effective cross-cultural operation of a health care system.

Diversity Improves Cultural Competence at the Organizational Level

Health care systems are created and sustained by people operating within organizations. At the *organizational level*, cultural competence necessitates having adequate numbers of individuals, particularly underrepresented minorities, who embrace the organization's commitment to operating a culturally competent system and are capable of providing culturally appropriate care. These individuals include frontline clinicians, faculty, administrators, directors, advisory council members, and health care policymakers. These individuals effectuate systemic cultural competence across a broad spectrum of organizational functions, including the facilitation of clinical services, research, departmental management, staff development, policymaking, and organizational oversight and leadership.

The Commission believes that a critical aspect of an organization's ability to deliver culturally competent services is that organization's commitment to maximizing racial and ethnic diversity at every operational level of the organization. The increased presence of underrepresented minority health care professionals can play a critical role in improving organizational cultural competence. For example, underrepresented minority health care professionals can enhance an organization's efforts to ensure staff and other service providers have the requisite attitudes, knowledge, and skills for delivering culturally competent care. Minority health care professionals can enhance the organization's goal-setting, policymaking, and other oversight vehicles in ways that promote cultural competence. Organizations can also benefit from including local minority community leaders and representatives in the organization's programmatic efforts to improve community care delivery. One example of this is the Metro Denver Black Church Initiative, which deploys three African-American parish nurses who serve as "cultural navigators" guiding community members through health service delivery.

Diversity Improves Cultural Competence at the Provider Level

As mentioned, the key focus of the Commission is provider diversity and its implications for significantly improving quality of care. At the *provider level*, cultural competence refers to the ability of providers to effectively identify, understand, and navigate cross-cultural challenges to

ensure the delivery of high-quality patient care. Culture significantly determines how patients communicate symptoms, cope with sickness, utilize family and community supports during illness, and demonstrate willingness to seek treatment (Betancourt et al., 2002 & DHHS, 1999). Similarly, the provider’s cultural competence profoundly influences how he or she will carry out the processes of diagnosis, treatment, and other aspects of care delivery.

Throughout the hearings, presenters underscored a number of concerns pertaining to the systemically low availability of culturally competent care and the exceptional ability of underrepresented minority providers to provide this quality of care. At the Atlanta hearing, Dean E. Nigel Harris, M.D., Morehouse School of Medicine, noted that patients often seek out providers “who can communicate with them, who understand and share their traditions and beliefs, and who treat them with respect.” Dean Harris noted that a provider’s successful delivery of health care services to a patient is substantially a function of the ability to interact effectively with the patient. He said that increasing the number of minority health care providers increases the likelihood that minority patients will seek medical care and advice at a stage when complications can be prevented.

In New York, Dr. June Osborn, President, Josiah Macy Foundation, told the Commission that a pervasive reason for the shortfall in quality of care for minorities “arises from unfamiliarity and a sense of estrangement between patient and health care provider, and in both directions.” Dr. Gary VanderArk, Chairman, Colorado Coalition for the Medically Underserved, said that in his work with Cambodian Americans, community members are often intimidated by the health system and consequently choose not to seek care. At the hearing in Chicago, Dr. John Nelson, President-elect, American Medical Association, testified that he understood why a physician of color might be more effective in a community of color than a white physician who did not understand some of the concerns of these communities.

“Latinos are constantly seeking to have access to health care, to be able to go to a place where they can be, where they feel at home, feel understood, feel unthreatened.”

– Dr. Juan Romagoza, Executive Director, La Clinica del Pueblo, Sullivan Commission
Townhall meeting, February 2004

In Los Angeles, Dr. Alberto Manetta, University of California, Irvine, College of Medicine, Program in Medical Education for the Latino Community, testified to the Commission that in order to deliver effective medical care to the Latino community, all physicians need to have specialized training to be able to provide “culturally effective care to Latinos.” Dr. Manetta added that health care organizations, independent practitioners, and physician groups that can offer culturally effective medical care will most likely attract the greatest number of clients.

At the Denver hearing, Mr. Grant Jones, Executive Director, Metro Denver Black Church Initiative, said that “cultural connection” or “cultural affinity” is an essential aspect of health care delivery for African American communities. The Commission believes that a unique level of connection is achieved when a provider has an inherent cultural affinity, shared social experiences, and perceived trustworthiness with a patient. Minority providers may identify with the understandings, experiences, and perceived barriers of patients of the same race or ethnicity. In Atlanta, Dr. Leggett testified that minority health care providers are more likely to serve minority communities and are more likely to see themselves as a part of those communities. Dr. Leggett said that it is long believed that health professionals that do not come from minority communities “may not be as committed to them as those who come from similar groups and neighborhoods.” At the hearing in New York, Dr. John Herbert, Senior Associate Dean for the Harlem Affiliation, Columbia University College of Physicians and Surgeons, said minority providers can “smooth out the problems” posed by minority patients who feel “cheated and angry” toward the health system.

In Denver, Commissioner Ben Muneta, past-President, Association of American Indian Physicians, voiced the concern that a provider’s perception of the value of a patient’s life determines whether or not the provider will “go the extra mile.” Commissioner Muneta expressed the concern that if providers “don’t see the value of your life if you’re a poor Indian,” then they may steer you away from receiving the otherwise appropriate care. These providers might ask, “Why waste all these resources?” The Commissioner explained that health economics and disparate valuations of human life can distort the provider’s role as a facilitator of care and yield disparate outcomes. Indeed, it is unpleasant but necessary to contemplate why severe health care disparities for racial and ethnic minorities continue to exist. The most generous theory is that unequal treatment is unintentional. The harshest is that minority patients are less valued and less worthy of the higher standard of care enjoyed by white Americans. The Commission believes that to achieve cultural competence providers must first recognize the intrinsic value of all humans and of health beliefs and practices that may not align with the dominant Western model. Cultural competence must also include the provider’s appreciation of the historical dynamic of racism in the health care system, including its documented manifestation of racial and ethnic disparities in clinical decisions and health status. The Commission believes that unless providers are aware of their own deeply held biases, they may unconsciously make clinical decisions based on stereotypes.

“Navajo patients simply didn’t respond well to the brusque and distanced style of Western doctors. To them, it is not acceptable to walk into a room, quickly open someone’s shirt and listen to their heart with a stethoscope, or stick something in their mouth or ear. Nor is it acceptable to ask probing questions.”

– Lori Alvord, M.D., Associate Dean for Student and Minority Affairs,
Dartmouth School of Medicine

Increasing diversity holds great promise for improving patient-provider communication. At least two major U.S. studies (Collins et al., 2002 & Malat, 2001) have reported that minority patients perceive more respect and better communications in race-concordant patient-provider relationships. Although all groups report problems in patient-physician communication, such difficulties are most pronounced for minority patients, especially Asian Americans (Collins et al., 2002). Other studies show that concordant relationships strengthen patient adherence to treatment (Cooper-Patrick et al., 1999). Research on physician patterns of information-giving during medical encounters has found that physicians provide more information to white patients than they do to black and Hispanic patients (Hall et al., 1988 & Tuckett et al., 1985 as cited by Sleath et al., 2001). Similarly, research on physician question-asking patterns has shown that physicians demonstrate better question-asking skills with non-Hispanic white patients compared to Hispanic patients (Hooper et al., 1982 as cited by Sleath et al., 2001).

Ms. Barr-Davenport, CEO, Atlanta Business League, offered a disquieting personal story of impaired patient-provider communication. She observed over the years that her mother “just did not feel comfortable asking questions of the doctor. She would go. They would tell her...what they wanted to tell her, and she’d walk away no better for that.” Dr. Kathleen Toomey, State Health Director, Georgia Division of Public Health, cautioned that the dramatic shifts in public health concerns since September 11, 2001—namely the emerging issues of bioterrorism and homeland security—make it even more critical that health professionals relate effectively to diverse communities.

“My own parents are immigrants, and my mother speaks some English, but she is fairly limited; and I know that if she gets stressed, and if she was in a hospital and she were sick or I were sick, that English that she knows is just going to go right out the window.”

– Karin Wang, Esq., Vice President, Asian Pacific American Legal Center

Language. America is a chorus of many voices. U.S. residents speak over 300 languages, with 32 million people, nearly 20 percent of Americans, speaking a language other than English at home. The percentage of Americans age 5 and older who speak a language other than English at home increased nearly 30 percent between 1990 and 2000. Spanish-speaking households increased 43 percent, to nearly 1 out of 10 American households (Andrulis et al., 2003). Nearly 25 percent of Asians/Pacific Islanders live in households where no one over the age of 14 speaks English (APALC, 2004). While it is true that more people are learning English than ever before, today there are more non-English-speaking immigrants than ever before. The Commission heard compelling testimony that the systemic lack of language competence in health care “results in impaired exchange of information, loss of language cues that aid in diagnosis, incomplete patient education, lack of informed consent, less access to services, and a lower level of preventative care” (APALC, 2004).

At the hearing in New York, Dr. Anne Beal, Senior Program Officer, The Commonwealth Fund, said that health care experiences of minorities are often marked by “problems communicating with their providers.” Dr. Beal noted that 16 percent of white patients report a communication problem with their providers while 23 percent of African American and 33 percent of Hispanic patients have difficulties with communication. Among those who speak Spanish at home, 43 percent report one or more problems communicating with their physicians. Among Latinos, physician linguistic and cultural effectiveness influences care access and outcomes (Flores, 2000).

Ms. Karin Wang told the Commission about the health care plight of a Vietnamese patient who paid a neighbor to serve as interpreter for every doctor’s visit. Consequently, the patient only went to see a doctor when he had money to pay for an interpreter. In Chicago, Ms. Ruth Rothstein, Chief, Cook County Bureau of Health Service, shared a situation involving a young physician, who spoke “some Spanish,” and who prescribed an oral antibiotic for a Mexican-American child suffering a middle ear infection. A linguistic misunderstanding resulted in the mother administering the drug into the child’s ear.

Ms. Carmen Rojas Rafter of the Latin American Association testified that while the use of an interpreter in the clinical encounter can improve the quality of patient-provider communication, language discrepancies will still exist. Ms. Rafter said one in three Hispanics have trouble communicating with physicians who use interpreters and as a result, these patients are less likely to comply with treatment.

One researcher has noted that even the usage of “black English,” a distinctive, stylized dialect that reflects African-American heritage and social experience, may lead to misunderstandings in the health care setting and to insensitive modes of care (Leininger & McFarland, 2002). In her study of a Hmong patient with epilepsy, medical writer Anne Fadiman noted that almost all of the notes in the patient’s five volumes of medical records contained the phrase “language barrier.” She observed that for the patient’s non-English-speaking parents, their child’s drug regimen “became so complicated and underwent so many revisions that keeping track of it” proved “utterly confounding” (1997, p. 45). When Fadiman queried doctors about what they do in cases of a language barrier, one physician replied, “Practice veterinary medicine” (p. 40).

Trust. The ability of the patient to trust his or her provider is integral to the development of a good patient-provider relationship. Trust strongly influences key aspects of care delivery, including communication, patient adherence to treatment, and patient satisfaction. Evidence shows that minority patients are more trusting of minority practitioners and may tend to be less trusting of white providers. Distrust can worsen a patient’s care by impairing the therapeutic relationship between patient and provider (Stone, 2002). Dr. Alvord observed in her own surgical

practice a pattern wherein patients who were more distrustful of Western medicine seemed to have more operative and post-operative complications (Alvord & Van Pelt, 2000).

Ms. Rojas Rafter explained that it is very difficult for providers to engender a trust relationship with their patients through interpreters, or to communicate effectively with patients regarding diagnosis, treatment instructions, and follow-up procedures. At the Denver hearing, Dr. Michael Trujillo, Liaison, Center for Native American Health, University of New Mexico, said in his medical practice he has encountered Native-American patients who disclosed information to him that they would not have shared with non-Native health care providers. Dr Trujillo explained, “There’s the continuity, the sensitivity. I think there’s the feeling of oneness and the ability to reach out.”

Research indicates disquieting levels of medical distrust among all patient populations, but especially among African Americans (PHR, 2003). The beliefs among many African Americans that their lives are devalued by white society carry over to their relationships with the health care system (Gamble, 1997). Findings of mistrust (among blacks) are consistent across all educational and income levels. Distrust is often traced back to the Tuskegee experiment, but Gamble argues that the root of black distrust is a deeper historical experience which dates back to the antebellum period when the slaves and freed blacks were used for dissection and medical experimentation. Contemporary health crises are also plagued by this mistrust. A 1990 survey conducted by the Southern Christian Leadership Conference found that 35 percent of the 1,056 black church members who responded believed that AIDS was a form of genocide (Thomas and Quinn, 1991). Many blacks, including prominent African Americans, believe that the disease comes from a man-made virus intended for use against minorities and other unwanted populations (Semmes, 1996). Mistrust can interact with cultural beliefs, rendering alternative theories of disease causation credible (PHR, 2003).

Increasing Patient Satisfaction and Access to Care

“I’m looking forward to going back home to Philadelphia, to the inner city, where I will have the opportunity to give back to my community. I feel like even if just one person could do something to try to eliminate these health disparities, it could be me. I’m here to make a difference.”

– Tracy Brewington, Howard University Nursing Student, Sullivan Commission townhall meeting, February 2004

The Commission heard compelling testimony to support the premise that increasing diversity in the health care workforce is an essential approach to providing high-quality care to Americans who are not receiving it because of their race or ethnicity. The Commission concurs with the

concept that health care providers who understand and hold a greater or inherent affinity to the culture, language, and social experiences of a given racial or ethnic group are more likely to provide effective care to that community. Major studies addressing minority health disparities, most notably the Institute of Medicine's report, *Unequal Treatment*, explicitly call for an increase in the number of racial and ethnic minorities in the health care workforce, as one of a number of strategies for addressing racial and ethnic health disparities. Today, a relatively small percentage of racial and ethnic minorities are likely to have access to health professionals of the same race or ethnicity: 23 percent of African Americans, 26 percent of Hispanics, and 39 percent of Asian Americans have a physician that shares their respective race or ethnicity. In contrast, 82 percent of white Americans have a white physician (Collins et al., 2002). Clearly, the ability to have a health care provider of one's own racial or ethnic background is a privilege enjoyed disproportionately by white Americans.

“Every health care organization should embrace, articulate, and commit to the concept that access to health care is an essential first step to achieving quality and that erasing disparity in care and outcomes between genders and across ethnic groups is the second essential step to achieving quality, health care.”

– Commissioner Patricia Gabow, M.D., CEO, Denver Health

Research supports testimony heard by the Commission that patients prefer physicians who share their racial or ethnic background (Gray & Stoddard, 1997; Saha et al., 1999; Garcia et al., 2003). Studies also show that minority patients have higher levels of satisfaction in race/ethnicity-concordant settings (LaVeist & Nuru-Jeter, 2002; LaVeist & Carroll, 2002; Saha et al., 1999). Patients tend to rate their physicians' communication style, which is correlated with patient satisfaction, higher in race/ethnicity-concordant relationships (Cooper-Patrick et al., 1999).

In addition, several studies show strong evidence that minority practitioners are significantly more likely than their white counterparts to serve in minority and medically underserved communities (Solomon et al., 2001; Stinson & Thurston, 2002; Cantor et al., 1996; Komaromy et al., 1996; Porterfield et al., 2003; Rabinowitz et al., 2000; Xu et al., 1997; and Moy & Bartman, 1995). The exceptional commitment of minority practitioners to provide care to underserved groups is evident even during their educational years. For example, a 2002 survey of dental school seniors found that approximately 69 percent of blacks/African Americans, 45 percent of Hispanics/Latinos, and 35 percent of Asians/Pacific Islanders planned to provide dental care to underserved populations after graduation. In contrast, only 20 percent of white seniors indicated these practice intentions (Weaver et al., 2002).

Literature and testimony from health care leaders confirmed that minority health care professionals are a unique and essential resource. As discussed earlier, this is not only true for patient care, but also for the design, implementation, and evaluation of cultural competence policies, programs, and curricula. The Commission anticipates substantial improvements in both health care access and quality for minorities when the full range of minority health professionals, including physicians, nurses, dentists, and other care providers, are represented in their professions at least in proportion to their numbers in the general population. Ultimately, minority patients should have the same opportunity to choose a provider of the same race or ethnicity as do white Americans.

Diversity is Good Business

The 2003 Supreme Court rulings on University of Michigan's affirmative action policies upheld the use of race and ethnicity-conscious admissions. During the cases, an unprecedented number of *amicus curiae*, or "friend of the court," briefs were filed. Included were briefs filed in support of University of Michigan by the business community, including dozens of Fortune 500 companies, discussing the value to business of ensuring a diverse workforce.

In the briefs, the business community emphasized that workforce diversity is imperative for business success and maintaining competitiveness in the increasingly diverse and interconnected American and global marketplaces. Having a diverse workforce is "smart business" and provides a key competitive advantage. The amicus briefs submitted by businesses for the Michigan cases demonstrate that the leading American corporations have accepted the value statement that workforce diversity is a business and economic imperative in the increasingly diverse U.S. and global economies. In particular, diversity in higher education was seen as critical for the development of skills necessary to participate and compete in the global economy, in order to foster such skills as the ability to understand, learn from, and work and build consensus with individuals from different backgrounds and cultures.

While the major benefits from diversity in the health care workforce accrue to minority patients, there are economic benefits to providers and health care systems. Mr. Mark Jaffe, Director, Greater New York Chamber of Commerce put forth the concept that diversity is consistent with the "smart business model." Increasing consumer (patient) satisfaction and consumer choice is good business. Mr. Jaffe told the Commission that people want to do business with and receive care from those with whom they can identify. Cultural competence should be viewed not only as a vehicle to increase minority patient access to high-quality care, but also as a business strategy to increase institutional access to the minority patient market (Betancourt et al., 2002).

The Commission heard testimony that supports the premise that there are valuable business benefits to derive from diversity, including improving organizational communication; maximizing the human resource pool; improving access to and the quality of services; and, ultimately, improving patient satisfaction. From a human resources vantage point, diversity maximizes an institution's talent pool by bringing skilled and diverse people together with different viewpoints, creating cross-cultural synergies, and fostering new modes of creative thinking and problem-solving. The Commission believes that businesses that are flexible in adapting to demographic change can capitalize on the benefits of racial and ethnic diversity and gain a competitive edge marked by superior quality in service delivery.

Large, successful companies recognize the need for a highly skilled diverse workforce. For insurance companies, managed care organizations, and employers who provide insurance benefits, there is likely a substantial, though largely unmeasured, price tag associated with the lack of diversity in the health care workforce. As previously discussed, the lack of a diverse health care workforce is a key factor that contributes to negative health outcomes for minorities. In the workforce, this translates into loss of productivity, higher absenteeism, and greater employee health care costs. Increasing healthcare workforce diversity along with promoting diversity in the general workforce is recognized by the business community as a necessary step to improving the business environment.

Not surprisingly, major corporations, such as Pfizer, Inc; Aetna; Johnson & Johnson; and other Fortune 500 companies, are using their influence to close racial and ethnic gaps in health care in the hope of not only improving medical treatment of minorities, but also minimizing the high costs associated with inadequate care. An example is the Bridge to Employment initiative, a partnership between Johnson & Johnson and the Academy for Educational Development aimed to introduce health care careers to at-risk students from all social, ethnic, and economic backgrounds.

Despite having adequate health coverage through their employers, racial and ethnic minorities often lack the same quality of care whites enjoy. According to the National Business Group on Health, these treatment gaps, over time, can result in millions of dollars lost to companies as the result of chronic conditions left untreated. When purchasing employee health plans, these companies are asking insurers about the diversity of their provider panels and medical staff to ensure that issues of cultural competence are effectively addressed.

For hospitals and clinics, language barriers may result in higher costs because of less efficient utilization of institutional resources. For example, an incomplete medical history truncated by a language barrier may lead a physician to compensate for possible deficiencies in the patient interview by obtaining more laboratory tests and other diagnostic evaluations. One study found the mean cost of lab testing to be higher (\$145 vs. \$104) and the length of time spent in the

emergency room to be longer (165 minutes vs. 137 minutes) in language-discordant vs. non-discordant situations, respectively (Hampers et al., 1999).

Social Justice

“Health care is a value that is worthy of fundamental protection for all Americans.”
 – U.S. Congressman Jesse Jackson, Jr., Chicago Hearing, October 20, 2003

In the broadest sense, social justice means that each person, regardless of race or ethnicity, or other factors such as gender, sexual orientation, or class, should be afforded the same benefits of society and opportunities for advancement. Two historically familiar social justice challenges are intrinsically tied to the persistent shortage of minority health professionals:

(1) unequal access to educational opportunities for minorities, and (2) unequal access to professional and economic opportunities. As a result, patients are denied equal access to culturally competent care. A question was raised in the hearings about the relationship between health and human rights. The Commission unequivocally concurs with the fundamental principle that all of our nation’s citizens have a human right to health care of equally high quality regardless of racial or ethnic background.

In addition, the Commission believes that the human right to high-quality health care also applies to the swelling number of incarcerated people in the nation’s jails and prisons. This group, comprising over two million Americans—disproportionately African Americans and Hispanics—poses a growing challenge to ensuring the delivery of culturally competent health care to this population. At the hearing in Chicago, Ms. Lydia Watts, Health Policy Director for the Rainbow Push Coalition, explained that there is a higher prevalence of many health problems within the correctional setting, and that the correctional health care system faces the same challenges confronting the larger system, including insufficient representation of minority health care providers.

Summary

The principles underlying a compelling rationale for increasing diversity in the health care workforce are: (1) diversity is critical to increasing cultural competence and thereby improving health care delivery; (2) increasing diversity in the workforce improves patient satisfaction; (3) underrepresented minority providers tend to practice in underserved areas thus improving access for the most vulnerable; (4) diversity in the health care workforce has valuable economic benefits; and (5) social justice is served. Health care institutions should view diversity not only

as a provider issue but also as a *core value* that applies to student, faculty, research, leadership, and provider populations.

Diversity is a critical part of the mission of health care and the national challenge of preparing our nation's future workforce. America's success in improving health status and advancing the health sciences is wholly dependent on the contributions of people from a myriad of diverse backgrounds and cultures, including Latinos, Native Americans, African Americans, European Americans, and Asian Americans. The lack of diversity is a key barrier to ensuring a culturally competent health care system at the provider, organizational, and system levels. It diminishes our nation's capacity to eliminate racial and ethnic health disparities and compromises our national capacity to advance the health sciences.

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Chapter 2

The Historical Roots of Today's Disparities

Today's racial and ethnic health disparities and chronic underrepresentation of minorities in the health care workforce are intersecting realities best understood in the context of the history common to minority health and minority health professionals in America. During the course of its public hearings, the Commission heard overarching themes of health care inequality and systemic lack of inclusion of minorities from the health care professions. This chapter provides a historical context for the inequitable patterns of access to health care and careers in the health care professions for racial and ethnic minorities. The chapter also provides a basic overview of minority health care today, a brief discussion of the range of public and professional perceptions of health care disparity, and a basic framework for understanding the complexity of racism in today's health care delivery system and the implications for workforce diversity.

The Importance of Looking Back

Racial and ethnic minorities, especially African Americans, Latinos, Native Americans, and some Asian/Pacific Islander subpopulations typically experience higher rates of illness, disability, and premature deaths than whites. These groups also clearly receive inferior health care (IOM, 2003). Concurrently, these same groups are, and historically have been, severely underrepresented in the health care workforce. Today's national mandate to eliminate racial and ethnic health disparities by 2010 and to rectify our longstanding and growing shortage of minority health care providers is best understood in light of our nation's peculiar social history.

Unequal Health Care Services Founded in Segregation and Exclusion

"Dr. Bailey on Main Street in Greenville was our family physician. There was a separate waiting room for blacks and you had to wait 'til all the white patients were seen before he'd see the blacks. As long as white patients kept coming in, you kept being pushed further and further back."

– An African American woman recalls her childhood in the 1950s in Greenville, South Carolina. (Smith, 1999)

Although health disparities and minority shortages in the health care professions span a broad spectrum of racial and ethnic groups, this history is best documented for African Americans.¹ A brief overview of this group's history clearly informs the overarching themes of health system inequality and exclusion that apply in various ways to all of today's underrepresented minority populations.² For African Americans, the earliest encounter with white health care providers occurred in the early 1600s when maritime surgeons performed physical inspections

and rendered medical treatment to enslaved Africans prior to their journey across the Atlantic to the New World (Byrd & Clayton, 2000). Once put to forced labor, black slaves were regarded as property and medical care was only delivered as needed to keep them at work under the most harsh and inhumane conditions. Emerging from this social reality, the nascent health care system in the United States was forged by doctrines of racial inferiority, white economic interests, and human valuations prescribed by whites. This system was rigidly segregated, cultivated during Slavery and perpetuated throughout the post-reconstruction period. Robustly supported by state and local laws and social custom, the health system that emerged in the nineteenth century was governed by the same “Jim Crow” laws that proscribed the separation of “inferior” blacks from whites.

The U.S. health care delivery system was conceived within a Eurocentric model that originally excluded non-white patients or providers. Moreover, the nation’s early history of medicine is replete with unscientific principles espousing the racial inferiority of non-white people. These doctrines entered the American medical school curricula by the early 19th century, became widely disseminated in medical textbooks and prestigious peer-reviewed medical journals, and ultimately gave rise and sanction to the medical mistreatment, abuse, and neglect of early non-white populations, particularly Native Americans and African Americans (Byrd, 2000).

At the turn of the twentieth century, the forerunner of today’s health care delivery system comprised two separate and unequal systems, one for whites, and an inferior one for non-whites. Most blacks were customarily denied access to any health facility not specifically designated for “negroes.” Hospitals that did serve blacks strictly limited their numbers, required them to use the back door for entry, and provided them treatment in outbuildings, attics, basements, and “colored” wards. In these substandard clinical care settings, the bed sheets, gowns, and even thermometers were labeled “colored.” During this era, white physicians generally refused to consult with black physicians. Most white physicians would not treat African-American patients and many thought it was a wasteful use of health care resources to do so (Byrd, 2002). At the same time, hospital policies routinely banned black health care providers from practicing, including nurses, physicians, and dentists.

Disparities in Opportunities for Health Professionals

The early periods of the U.S. health care system set a tone, which resonates even today, that America’s health care professions were to be dominated almost exclusively by white, middle- or upper-class citizens. Banned from most of the nation’s health professions schools, black health care professionals, including nurses, physicians, and dentists, primarily received their education from all-black schools. Historically, health professions associations reinforced the convention of systematic discrimination. For example, all-white national and state medical

societies banned “negroes” even though membership was a prerequisite to obtaining hospital privileges. By the early 1900s, led by the American Medical Association (AMA), the medical profession had consolidated its control over medical licensing, education, postgraduate training, the hospital industry, and the biomedical research infrastructure (Byrd, 2002). Founded in 1847, the AMA did not welcome black doctors until 1968, two years after racial segregation in medical schools legally ended in 1966 (Byrd, 2002; Semmes, 1996).

Early African-American dentists faced the same systemic patterns of overt discrimination. Excluded from the American Dental Association (ADA) and its predecessor organizations,³ black dentists joined ranks with black physicians and pharmacists to organize the National Medical Association (NMA)⁴ in 1895. Forced to segregate themselves into professional enclaves, African-American healers formed other multi-professional associations at state and local levels across the country. Black dentists, like other black health professionals of the era, faced both professional exclusion and the deplorable overall health for black patients. A commentary from the 1926 William J. Gies Report, which contributed to early dental education reform efforts, noted with the concern “the general indifference of the white population to the welfare of the colored citizens.” In 1932, “colored” dentists reorganized the multiregional Interstate Dental Association thereby establishing the National Dental Association (NDA). It was not until 1965 that the white-controlled ADA House of Delegates nullified the sanctioning of racial discrimination in the dental profession, removing the racial barrier to ADA membership for non-white dentists.

As with the early medical and dental professions, African Americans also faced overt racial barriers to entry into the nursing profession (Hine, 1989). Early northern nursing schools maintained quota limits for “colored” students, while southern schools barred them completely. When national registration for nurses started in 1903, southern states routinely banned black nurses from licensing exams. Black graduate nurses, despite their formal and specialized training, were routinely paid lower salaries than their white counterparts. White graduate nurses were often hostile to African-American graduate nurses and generally subscribed to the prevailing social custom of black subordination during this pre-Civil Rights Era (Hine, 1989).

In 1916, the American Nurses’ Association (ANA) instituted a formal policy of only accepting nurses through their state associations. Consequently, in states whose associations excluded blacks, as they did in 16 southern states and the District of Columbia, blacks could not become members of the national association. As a result, black nurses began organizing their own societies. In 1908, black nurses founded the National Association of Colored Graduate Nurses (NACGN) in New York City; in 1932, the national Chi Eta Phi sorority of registered nurses; and in 1971, the National Black Nurses Association.

In 1949, African-American nurses became the first health profession in the United States to desegregate when the ANA's House of Delegates passed a resolution calling for the admission of all qualified nurses regardless of race, creed, or national origin. However, because of persistent systemic exclusion, black nurses did not enter hospital staff duty in any significant numbers until the 1960s (Hine, 1989). Whether practicing medicine, dentistry, or nursing African-American health care professionals—regardless of their preparation, talent, and commitment, shared the common problem of exclusion from the health care system well into the second half of the twentieth century.

A New Era...with Unfinished Business

In the decade preceding the Civil Rights Era, barriers against black health professionals were still systemic (Byrd, 2002). A 1950 survey of hospitals in Los Angeles County found that discriminatory hospital practices fell into two categories: discrimination against minority patients and discrimination against minority health care providers, including physicians, nurses, and technicians. A survey of 2,400 Southern hospital administrators revealed that as late as 1956—two years after the *Brown vs. Board of Education* decision that called for desegregation of the public school system, 7 out of 10 hospital administrators were opposed to integrating hospitals. A 1959 cross-sectional study, conducted in 60 cities, on the racial integration of medical schools, medical societies, Blue Cross-Blue Shield plans, hospitals, and health agencies revealed that discrimination in minority patient access to hospital care and minority appointments to medical staffs was widespread throughout the United States. In 1965, barely 2 percent of all medical students were African Americans, and more than 75 percent of them attended one of *two* all-black institutions, Howard University and Meharry Medical (Bowen & Bok, 1998).

The Civil Rights Era brought about one of the most profound structural changes in the U.S. health system in the twentieth century while also leaving considerable unfinished business. In 1963, the United States Commission on Civil Rights (Byrd, 2002) found that the federal government, by statute and administration, supported racial discrimination in the provision of health facilities. On March 2, 1964—six months after the 1963 March on Washington, a federal court decision in *Simkins v. Moses H. Cone Memorial Hospital* struck at the very heart of government-sanctioned and government-funded health care segregation and discrimination based upon race. The U.S. Court of Appeals in Richmond, Virginia, guided by the arguments of Thurgood Marshall and the NAACP Legal Defense and Education Fund, held unconstitutional the separate-but-equal provision of the Hill-Burton Act of 1946,⁵ which had permitted the expenditure of over \$2 billion in federal monies for hospital reconstruction using a racial segregation formula (Byrd, 2002). Less than half a year later, in the face of strong opposition from

the still segregated American Medical Association, the American Dental Association, and the American Hospital Association (Byrd, 2002), President Lyndon B. Johnson signed into law the Medicare Bill, which mandated that the anti-discrimination protections of Title VI of the Civil Rights Act of 1964 apply to hospitals receiving public funds.

Still, throughout the second half of the twentieth century, minorities would continue to be severely underrepresented in health professions schools and the health care workforce. To advocate for the concerns of minority health care professionals and students, new minority associations continued to emerge in the post-Civil Rights Era, including the National Association of Hispanic Nurses (1975), the Association of Native American Medical Students (1975), the Hispanic Dental Association (1990), the Society of American Indian Dentists (1990), and the National Hispanic Medical Association (1993). These organizations and others like them provide an organized voice for minority health care professionals and students, strive to address the persistent shortage of minority health care professionals, as well as advocate for the elimination of health care inequality for minority populations.

Minority Health Today

“Before this day is ended, over 200 African Americans and other people of color will become new casualties in the unacknowledged war against the health of people of color. A war which this country has waged for over 400 years — by commission or omission.”

– U.S. Delegate Donna M. Christensen, M.D., (D-V.I.), Chair, Congressional Black Caucus Health Braintrust, Chicago hearing, October 20, 2003

Over the past few decades, significant progress has been made in improving minority access to the health care system. Still, here in the twenty-first century, in comparison to whites, racial and ethnic minorities continue to have low representation in the health profession, receive second-rate health care, and die younger from treatable diseases. The legislation and political action in the 1960s did *not* eliminate either of these chronic problems. Today, while African Americans, Hispanics, and Native Americans represent 25 percent of the U.S. population, they constitute less than 9 percent of nurses, 6 percent of physicians, and 5 percent of dentists. The 1985 Report of the Secretary’s Task Force on Black and Minority Health, the most comprehensive examination of minority health of its time, underscored “the longstanding disparity in the health status of blacks, Hispanics, Asian/Pacific Islanders, and Native Americans compared to whites” (Byrd, 2002).

The last few decades have witnessed the publication of literally hundreds of peer-reviewed research studies, marked by increasingly detailed data on variables such as health insurance, income, age, sex, education, stage and severity of disease, and co-morbidity. The findings are

consistently the same: racial and ethnic minority groups receive inferior care. Racial and ethnic disparities in care have been documented across the three major health disciplines—medicine, nursing, and dentistry. At least eight major studies and independent reviews have affirmed these findings (PHR, 2003). Most notably, the 2003 publication by the Institute of Medicine, *Unequal Treatment*, identified widespread treatment disparities across the full spectrum of disease categories and medical and surgical procedures. While recognizing multiple patient, provider, and system factors, the report concluded that bias and stereotyping by providers significantly and directly contribute to minority health disparities.

Thus, despite technological and scientific gains in addressing severe health problems such as heart disease, diabetes, kidney failure, and cancer, not all segments of the U.S. population have benefited to the fullest extent from these advances. For example, today more than 8 of 10 children with acute lymphoblastic leukemia are cured (Carroll, 2003); however, African American, Hispanic, and American Indian/Alaskan Native children continue to have the nation's worst survival rates for this disease throughout both the early and contemporary eras of treatment (Kadan-Lottick et al., 2003). For infants with Down Syndrome, the overall survival is now over 90 percent and the median age at death for Down Syndrome patients in 1997 was 49 years. However, for African Americans with Down Syndrome, the median age at death is only 25 years (CDC, 2001).

Racial and ethnic health disparities are not limited to one or two disease types. They apply to a broad array of diseases including but not limited to infant mortality, heart disease, cancer, stroke, diabetes, end-stage kidney disease, and HIV. Disparities cross an expansive array of such life-saving interventions as angioplasty, coronary artery bypass grafting, cancer chemotherapy, kidney transplantation, advanced treatment for HIV/AIDS, glaucoma surgery, and diagnostic and therapeutic procedures for stroke and peripheral arterial disease. Disparities also exist for basic medical and surgical procedures, and the treatment of diabetes, congestive heart failure, asthma, and pneumonia. Racial and ethnic disparities in care have been found even for such routine clinical procedures as history-taking, physical examination, lab x-ray procedures, and pain management. The evidence is clear, consistent, and robust: if you are a racial or ethnic minority in America, there is a concrete and historically familiar risk that you will be subject to substandard diagnosis and treatment which may result in poor health outcome, including death.

The Dynamics of Race in Today's Health Care System

History has shown that societal inequalities and injustices can deeply short-change our national supply of minority health care providers, severely compromise the quantity and quality of health care delivery to minorities, and contribute directly to racial and ethnic health disparities.

A growing number of researchers have put forth the argument that racism is a fundamental cause of racial and ethnic health disparities (Semmes, 1996; Jones, 2000 and 2001; Krieger, 2001 and 2003; Acevedo-Garcia et al., 2003; Feagin & McKinney, 2003; James, 2003; Rich & Ro, 2003; Williams et al., 2003; and Nazroo, 2003). In her article, “Race and Health,” Jane Perkins observes, “Racism infects all aspects of society, but has had a particularly negative effect on this most personal of issues—who provides and receives health care and from whom.” Throughout the hearings, testimony often identified racism, most notably the institutionalized form, as a key determinant of health care inequality and the shortage of minorities in the health care workforce.

At the hearing in Chicago, U.S. Congresswoman Donna M. Christensen (D-V.I.), chair of the Congressional Black Caucus Health Braintrust, told the Commission that, in today’s health system, “institutionalized and systemic racism” poses a barrier to achieving parity in the health professions. At the Atlanta hearing, Dr. Paul Wiesner, Director, DeKalb County Board of Health, said that efforts to reverse health status disparities must include a “major effort to reverse the still-pervasive institutional racism that exists throughout our society. In Los Angeles, Ms. Lurelean Gaines, Chair, Department of Nursing, East Los Angeles College said, “racism continues to be a barrier in changing the face of health care.” Mr. Robert Klaus, President, Oral Health America, told the Commission that the shortage of minorities in today’s health care workforce reflects the “checkered history of race in America.”

Indeed, there is no magical boundary between historical and contemporary inequalities in health care. The Commission concurs with former Surgeon General David Satcher (2004) that racism still exists in health care, but today it is more subtle and requires careful and authentic identification and recognition. An essential starting point for understanding the complexity of racism in today’s health care delivery system is to first recognize the existence of marked racial and ethnic health care disparities and to then identify how racism operates in the health care system.

Recognizing the Blind Spot

A mounting body of evidence, including such governmental reports as the Malone-Heckler report, the IOM report, the Department of Health and Human Services *Healthy People 2000* and *Healthy People 2010*, have alerted the public to the “longstanding” health gaps that have existed “ever since accurate federal record keeping began.” Still, many Americans today do not recognize these persistent inequities. Unsurprisingly, minorities do have an acute and accurate awareness of unequal treatment in the health care system (Kaiser, 1999). It seems hard to imagine, here at the outset of the twenty-first century, that one could be unaware of the persistence of severe racial and ethnic inequalities in our nation’s health care delivery system, but mis-

perceptions do exist, most notably among white health care providers. For example, the 2001 National Survey of Physicians conducted by the Kaiser Family Foundation showed striking differences in disparity perceptions between white and minority physicians. Almost 8 of 10 white practitioners believed that disparities in how people are treated within the health care system “rarely” or “never” happen based on factors such as fluency in English or racial and ethnic background. White physicians were also significantly less likely than the general public to recognize that unfair medical treatment on the basis of race or ethnicity occurs at least “somewhat often”—only 29 percent of white physicians believed or acknowledged this versus nearly half (47 percent) of the general public. In contrast, 8 of 10 black physicians reported that the health care system at least “somewhat often” treats people unfairly based on such characteristics as race and ethnicity. These sentiments are in keeping with a 1999 survey which found that 80 percent of blacks believe that they receive different medical treatment and have different care options due to race and ethnicity (Kaiser, 1999).

A Framework for Understanding Racism in Today’s Health Care System

“There are many historical hurdles yet to overcome. The ghosts of segregation and discrimination, inside and outside the health professions, still influence the quality of, and the access to, an education in the health professions for minorities.”

– Louis W. Sullivan, M.D., Chair, The Sullivan Commission, Atlanta hearing, June 26, 2003

Socioeconomic status, which commonly includes such factors as education, income, and occupational status, exerts a powerful influence on a group’s health status (Williams & Collins, 2002) and access to both higher education and careers in the health care professions. For example, regardless of race or ethnicity, socioeconomic factors, such as family income and parental education, substantially influence how well and how far a student progresses academically from kindergarten through high school into higher education (Cooper, 2003). Family income is the strongest determinant of whether a high school senior will be “very highly qualified” (as measured by class rank, grade point average, and standardized test scores) (Cooper, 2003). However, socioeconomic status does not act alone in shaping access to opportunity. Racism, through its constrictive and entrenched affect on education, income, and employment opportunities, exerts its own profound influence on the ability of vulnerable groups to improve their socioeconomic status (Williams et al., 1994).

The Commission believes that “there is clear, demonstrable, undeniable evidence of discrimination and racism in our health care system” (Sullivan, 1991). This is unacceptable and it must be addressed. In order to eliminate racism from the health care system, we must first take it into account (Rich and Ro, 2003; Jones, 2004). How do we recognize it? How does it operate in

the health care system? Most importantly, what challenges does it pose for building a diverse health care workforce? Racism is not limited in expression to individuals, but can also be a system of structures, ideologies, policies, practices, and customs that generate or perpetuate unduly disparate patterns of exclusion and unequal treatment based on race or ethnicity. While there are various ways to define the phenomenon, the Commission believes that racism in the health care system exists:

- whenever one race or ethnic group neglects to share system governance or institutional power with certain other groups;
- whenever opportunities and resources for health professions education, training, or practice unduly favor a certain racial or ethnic group;
- whenever opportunities and resources for faculty appointment, leadership, and research unduly favor a certain racial or ethnic group;
- whenever health care providers unduly deliver diagnostic and treatment services disparately to certain racial and ethnic groups;
- whenever health care institutions or health professions schools maintain unresponsive and inflexible policies, procedures, and practices that perpetuate the exclusion of certain racial and ethnic groups from health care education or practice; and
- whenever health care institutions or health professions schools impose ethnocentric culture on any other race or ethnic group to that group's detriment.

The above conditions can be either intentional or unintentional and can occur as the result of omission or commission (Jones, 2000 and 2004). Regardless, the outcome pattern will be the same: unjustifiable racial and ethnic disparities in health care delivery or unwarranted racial and ethnic disparities in access to health care professions education and health careers.

There is a common tendency for analysis around racial matters in the U.S. to limit the concept of racism to individual acts of prejudice or stereotypes (Feagin & McKinney, 2003). However, given our growing knowledge of the more subtle and complex nature of this social phenomenon, racism can be best understood by considering three basic levels in which it exerts its influence in the health system. These levels are institutional, personally mediated, and internalized (Jones, 2000).

Institutional Level: Racial inequity in health care delivery and in minority access to the health professions has lasted for centuries in no small part due to systemic, or institutional, racism. Today, the common rejection of racism as an ideology does not by itself neutralize or eliminate its effect. At the institutional level, racism still determines the quantity and quality of health

care received by minority patients (William et al., 1994). The Commission believes that it also can still determine whether or not minorities gain access to the health care professions.

Drawing from previous work on understanding the racial dynamic of health system inequality (Jones, 2000 and 2004), the Commission defines institutionalized racism in health care as that system of structures, policies, practices, and customs that together result in health care disparities or unduly constricted access to health care professions education and the health care careers for racial and ethnic minorities. Institutional racism becomes normative because of its codification within institutional policies, practices, customs, and organizational structures.

For example, during the hearings, the Commission often heard the concern that health professions schools recruit and maintain an inadequate number of minority faculty who might serve as mentors to minority students or in positions of institutional leadership. The number of underrepresented minority faculty has been historically quite low and has increased only in recent decades. Many of today's health professions schools not only inherit these historic patterns of low minority representation but also effectively *sustain* these patterns through existing policies, practices, and customs. Thus, the historic trend of minority exclusion from faculty, while not necessarily endorsed or advanced by any institutional leader, is kept alive and even reinforced by contemporary institutional frameworks.

At the institutional level, racism not only permeates health professions education, but also systems of patient care. For example, the Institute of Medicine (2003) identified clear systemic patterns of racial and ethnic bias by providers resulting in persistently disparate levels of health care quality for minority patients. As discussed in Chapter 1, the Commission heard copious testimony upholding the concern that health care institutions routinely fail to maintain culturally competent patient care systems and resources that would adequately address the health care needs of racial and ethnic minority patients.

Personally Mediated Level:

“I was told by my ‘trusted’ high school guidance counselor that there was no such thing as a black woman doctor, despite my being a member of the National Honor Society, president of my high school class, and a national YWCA youth leader. I was told that I should choose a profession more suited to my race.”

– Kimberlydawn Wisdom, M.D., M.P.H., Michigan Surgeon General

Nurses, physicians, dentists, and other health care professionals are not immune from the societal and cultural biases and attitudes of our larger society. At the personally mediated level, racism in health care can operate in the personalized form of prejudice, stereotype, or bias and

can result in discriminatory actions (or inactions). This form of racism can occur in any health system setting, including patient-provider, faculty-student, student-student, and faculty-faculty encounters. Like its institutional form, personally mediated racism can be intentional or unintentional. It is conceivable—as history is our guide—that racism in its worse manifestation can engender highly distorted conceptions and attitudes about human value, which can result in the delivery of substandard care.

Historically, in predominantly white health professions schools, minority students have often faced harsh, unsupportive, and unwelcoming institutional climates (McBride, 1989). During the pre-Civil Rights Era of medical training, white patients refused treatment at the hands of black interns (McBride, 1989). Today, minority health professions students and trainees continue to report experiences of personally mediated racism and socially unwelcoming learning environments. At the Atlanta hearing, Shereitte Stokes, a public health intern at the Centers for Disease Prevention and Control, told the Commission that her colleagues “see me as a person of color aspiring to do well, and they look at me saying, ‘Okay, you don’t deserve to be here.’” Sidney Hankerson, a fourth-year medical student at Emory University School of Medicine, told the Commission that there is an unspoken assumption “that black physicians may not be as competent or do as well as white physicians.” These experiences and perceptions of institutional climate are not likely unique to minorities in the health care professions schools and training programs. In her personal reflections on her previous work as provost of Stanford University, Dr. Condoleeza Rice, National Security Advisor, suggests a broader pattern: “I have watched with some of my very best students—even at a place like Stanford—faculty sort of think, well, that student is black so I should expect less of that student” (Williams, 2004).

Internalized Level: Internalized racism is largely a psychological phenomenon that the Commission defines as the acceptance, by stigmatized minorities, of external negative messages about their own abilities, potential, and intrinsic human worth. These messages may be transmitted in many ways, through media, peers, and teachers or parents with low expectations. Because of the stigma and diminished sense of self-worth generated by these messages (Neighbors & Williams, 2001), too many minority students may fail to ever see themselves as college students, physicians, nurses, or dentists. One medical historian (McBride, 1989) reported that in the pre-Civil Rights Era black medical students “suffered from a widespread belief among whites that blacks lacked the educational ability to complete the rigorous study of medicine” and thereby questioned their own capacity as health care leaders. Claribel Sanchez, a Mexican-American undergraduate student interviewed for the Commission’s town hall meeting said she felt that the non-Latino students around her were “naturally smart.” Aguirre-Molina and others (2001) recommended that institutional racism (and sexism) be addressed because

it not only deprives Latino communities of socioeconomic opportunities, but it also produces low self-esteem.

Internalized racism also holds cautionary implications for health status and patient care, as it may have a health-negating impact on minority patients' self-worth, health choices, and risk behaviors. It may also influence patient-provider relationships (Gamble, 1997), as well as impact an individual's decision to seek care (Wisdom, 1998). LaVeist and others (2000) found that African-American patients were more likely to perceive racism in health care and express mistrust of the medical care system. This perception and mistrust leads to less satisfaction with care. Among 1,794 black cardiac patients surveyed, only 61.2 percent believed that African Americans can receive the care they want as equally as white patients. The study found that in contrast to white patients, African-American patients were nearly twice as likely to believe that hospitals sometimes engage in harmful experiments on patients without their knowledge.

Summary

The U.S. health care system was originally conceived within an ethnocentric model that devalued non-white patients and excluded non-white health care providers. While the Civil Rights Era eventually eradicated the more visible racial and ethnic barriers of this system, it did not eliminate deeply entrenched patterns of health care inequality and unequal access to health care careers. Today, race and ethnicity still determine whether or not a patient receives appropriate health care and whether or not a talented student can successfully pursue a career in the health care professions. The Commission believes that racism still exists in health care, but today it is more subtle and requires careful and authentic identification and recognition. An essential starting point for appreciating the complexity of racism and discrimination in today's health care system is to first recognize the existence of severe inequities in health care delivery, and then identify how racism operates in the health care system. National efforts to eliminate racial and ethnic health disparities by 2010 and increase the number of underrepresented minority health care providers necessitates a fundamental shift in awareness, attitudes, and values, as well as the systematic examination and reform of institutional structures that sustain persistent patterns of unequal treatment and exclusion. In subsequent chapters, this report will put forth recommendations that address problematic structures that perpetuate unequal access and inequality.

Recommendations

- 2.1 The complementary strategies of increasing diversity and ensuring cultural competence at all levels of the health workforce should be endorsed by all in our society, with leadership from the key stakeholders in the health care system.
- 2.2 There should be increased recognition of underrepresented minority health professionals as a unique resource for the design, implementation, and evaluation of cultural competence programs, curriculums, and initiatives.
- 2.3 Public and private funding entities, including U.S. Public Health Service agencies, foundations, and corporations, should increase funding for research about racial disparities in health care and health status, including, but not limited to: research on culturally competent care, how to measure and eliminate racial bias and stereotyping, and strategies for increasing positive health behaviors among racial and ethnic groups.
- 2.4 Health systems should set measurable goals for having multilingual staff and should provide incentives for improving the language skills of all health care providers.
- 2.5 Health professions schools should work to increase the number of multilingual students, and health care systems should provide language training to health professionals.
- 2.6 Key stakeholders in the health system should promote training in diversity and cultural competence for health professions students, faculty, and providers.

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Chapter 3

State of Diversity in Today's Health Professions Schools and Workforce

The health professions are composed of nurses, dentists, physicians, public health workers, pharmacists, social workers, psychologists, nutritionists, physical therapists, and many others. Collectively, these professionals are essential to the delivery of health services. The Commission's charge, was to focus on three professions: nursing, medicine, and dentistry. This targeted focus does not mean that the state of diversity in other health professions is less problematic or less important. In fact, the Commission believes that the diversity themes apparent in medicine, nursing, and dentistry are overarching themes shared by all health professions.

The basic concept of "diversity" among human beings encompasses numerous characteristics and combinations of characteristics, such as gender, race, ethnicity, social class, religion, and sexual orientation. The specific focus of the Commission's charge was to address the problematic state of racial and ethnic diversity in the health care workforce and to benchmark practices that could facilitate expansion of diversity within this workforce. To this end, the Commission assessed the representation of racial and ethnic minorities among the nation's health professions schools, workforce, and leadership. Quantitatively, the Commission defined diversity as the numeric representation of all racial and ethnic populations. This section of the report presents a quantitative summation of the state of diversity in today's health professions schools and workforce.

African Americans, Hispanics, and American Indians are underrepresented in medicine, nursing, and dentistry (IOM, 2004; IOM, 2001). In the U.S. health care system, there are approximately 2.2 million employed nurses; 600,000 physicians; and 153,000 dentists. While African Americans, Hispanic Americans, and American Indians represent more than 25 percent of the U.S. population, less than 9 percent of nurses, 6 percent of physicians, and 5 percent of dentists are from these populations.

Although Asians are overrepresented in the medical and dental student populations, they are considered an underrepresented group in nursing. However, during the hearings held by the Commission, several individuals noted the complex characteristics and internal diversity of the Asian population and urged attention to the array of ethnic subgroups represented within this population. For instance, data regarding the representation of Asian/Pacific Islanders in the health care workforce often do not reflect the shortages that exist for several Asian/Pacific Islander subgroups. At the Los Angeles hearing, Ms. Karin Wang, Vice President, Asian Pacific American Legal Center (APALC), voiced concern regarding a common misperception that

Asian/Pacific Islanders are overrepresented in the health professions. Since 1970, the Asian/Pacific Islander population has grown from 1.5 million to 10 million, and today includes some of the most underrepresented communities in the health professions (APALC, 2004). For example, non-Hispanic whites have 251 physicians per 100,000 persons while the physician-patient ratios for Laotians, Cambodians, and Samoans are 16, 23, and 34 per 100,000 respectively (APALC, 2004). The APALC has recommended that health professions schools and health care institutions use disaggregated data on Asian/Pacific Islanders so that the diversity within the population can be fully understood. The Commission, while primarily focusing on the workforce representation of African Americans, Hispanics, and Native Americans, broadly defines underrepresented minorities as any racial and ethnic population whose representation in the health care workforce is lower than their representation in the general population.

Physicians

African Americans, Hispanics, and Native Americans/Alaska Natives are severely underrepresented in the physician workforce. In 2000, the AMA reported that African Americans represented only 2.6 percent, Hispanics 3.5 percent, and American Natives/Alaska Natives 0.001 percent of the physician workforce. While Asian and Pacific Islanders represented 8.9 percent of physicians in the U.S., this statistic tends to mask the shortage of many Asian/Pacific Islander subgroups, such as Hmong, Laotian, Cambodian, Malaysian, and all Native Hawaiian and Pacific Islander populations (Tran, 2004). The 2004 data from AMA showed lower percentages for African Americans (2.2 percent) and Hispanics (3.3 percent), demonstrating the need for robust efforts to diversify the medical student population to address this trend. (See Table 3-1.)

Table 3-1 Total Physicians by Race/Ethnicity, 2002

Source: AMA, 2004

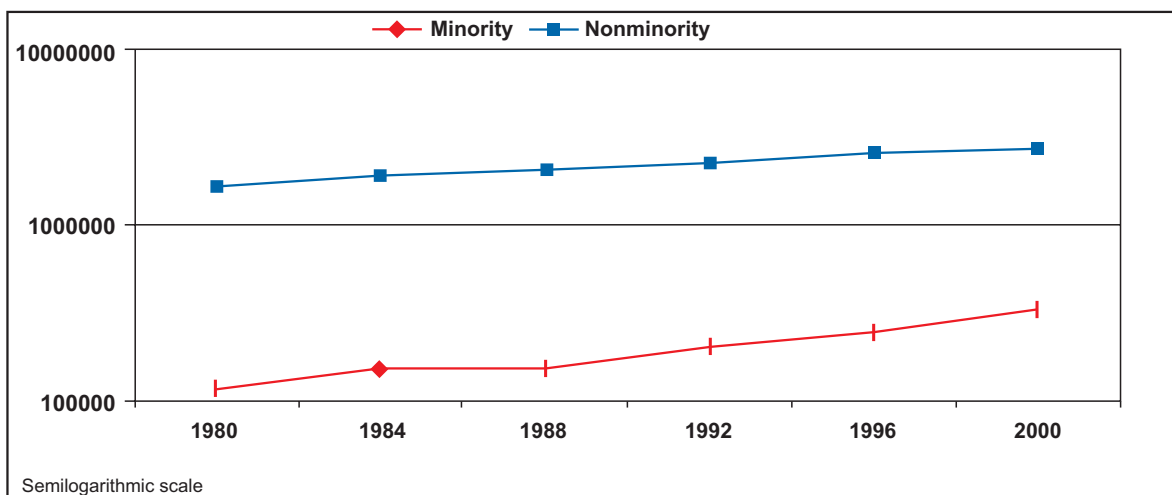
Race/Ethnicity	Number	Percentage
White	432,054	51.0
Black	20,876	2.4
Hispanic	28,536	3.3
Asian	73,702	8.6
American Native/Alaska Native	503	0.05
Other	20,161	2.4
Unknown	277,355	33.0

Nurses

In recent years, the nursing workforce has experienced growth in the number of underrepresented minority practitioners with slightly more than 12 percent of nurses coming from underrepresented minorities. However, while the number of minority nurses has increased, the proportion of nurses from underrepresented groups remains far below the percentage of those minorities in the U.S. population. The number of registered nurses from minority populations tripled from 1980-2000. (See Figure 3-1.)

Figure 3-1 Number of Racial/Ethnic Minority and Non-Minority RNs, 1980-2000

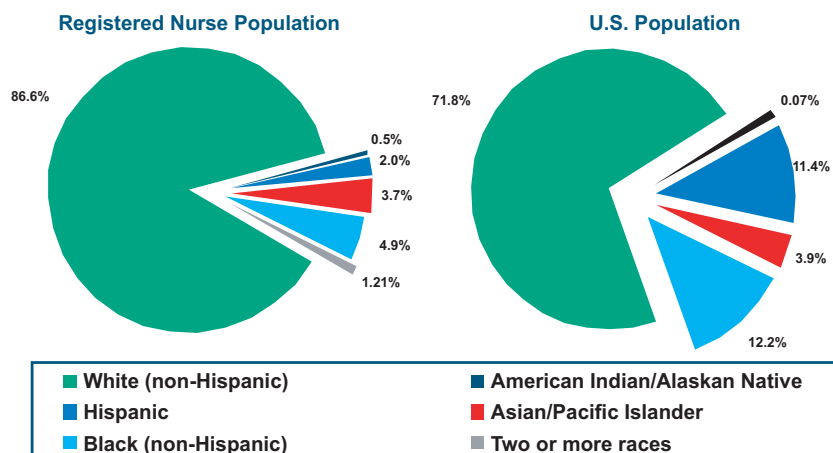
Source: <ftp://ftp.hrsa.gov/bhpr/rnsurvey2000/rnsurvey00-1.pdf>, accessed April 17, 2004



As impressive as this gain is, the percentages remain low. Data from the Health Resources and Services Administration (HRSA, 2001) show that in 2000, African-American registered nurses comprised 4.9 percent of all registered nurses, Hispanics, 2.0 percent, and American Indian/Alaskan Natives 0.5 percent. Asian/Pacific Islanders were slightly underrepresented in nursing. (See Figure 3-2.)

Figure 3-2 Distribution of Registered Nurses by Race/Ethnic Background, March 2000

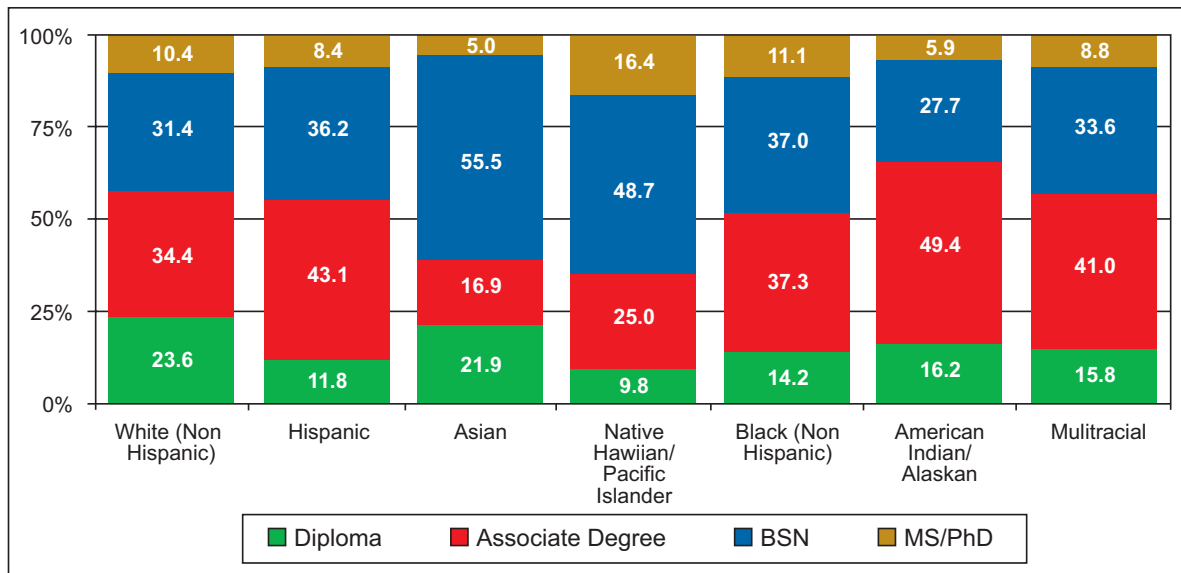
Source: *National Sample Survey of Registered Nurses, Division of Nursing, BHP, HRSA.*



An increase of more than 20,000 minority nurses is needed to increase the proportion of minority nurses by just 1 percent (HRSA, 2001). However, as reported in the latest National Sample Survey of Registered Nurses (HRSA, 2001), registered nurses from minority backgrounds are much more likely than their white counterparts to pursue baccalaureate and higher degrees in nursing. (See Figure 3-3.)

Figure 3-3 Distribution of Registered Nurses in Each Racial/Ethnic Group by Highest Educational Preparation, March 2000

Source: <ftp://ftp.hrsa.gov/bhpr/rnsurvey2000/rnsurvey00-1.pdf>, accessed April 17, 2004



Data show that while 41.8 percent of white nurses hold baccalaureate or graduate degrees in nursing, the percentage of URM nurses that have acquired these degrees is significantly higher for African American (48.1 percent), Hispanic (44.6 percent), Asian (60.5 percent), Native Hawaiian/Pacific Islander (65.1 percent), and multiracial nurses (42.4 percent). (Figure 3-3.)

These data provide evidence that minority nurses place a high value on advancing their education and have a strong interest in moving into upper-level roles. Moreover, this provides some indication that enhanced access to graduate education and support for career development can be attractive mechanisms for increasing diversity in nursing. This is an important goal given the reality that despite the impressive trend toward graduate education by URM nurses, the actual number of URM nurses in this nation is small and those individuals prepared for senior leadership and scholarly roles are similarly a small group which must be expanded. The Commission encourages federal legislators and foundations to place a high priority on programs that support graduate education and leadership development for minority nurses.

Dentists

Like medicine and nursing, the proportion of minority dentists is not reflective of the proportion of minorities in the overall population (See Table 3-2).

Table 3-2 U.S. Dentist to Population Ratio by Race/Ethnicity of the Dentist, 1996

Source: HRSA 1999

	Total	Black	Hispanic	Asian/ Pacific Islander	Native American	White
U.S. Population	265,189,000	31,933,000	28,092,000	9,181,000	1,954,000	194,029,000
Active Dentists	154,900	5,201	5,178	10,693	194	133,634
Dentist to People Ratio	1:1,712	1:6,140	1:5,425	1:859	1:10,072	1:1,452

The dentist to population ratio is 1:1,452 for the white population; 1:6,140 for blacks; 1:5,425 for Hispanics and 1:10,072 for Native Americans. Nearly 62 percent of black patients are seen by black dentists and only 10.5 percent of black patients receive their care from white dentists (ADA, 2002 and Solomon et al., 2001).

In addition to the practice characteristics of dentists as reported by the ADA, the distribution of dentists throughout the U.S. presents a major problem for access to oral health care for many Americans. The Bureau of Primary Health Care Health Resources and Services Administration (HRSA) reports a steady increase in the number of Dental Health Professions Shortage Areas (DHPSAs). In fact, the number of DHPSAs has increased from 1,098 in 1998 to 1,853 in 2001 (HRSA, 2001). The population in these areas is 38,538,542, and includes those who reside mainly in densely populated cities, rural, and border communities throughout the U.S.

Student Matriculation in Medical, Nursing, and Dental Schools

How well are minorities represented in the student bodies of the nation's medical, nursing, and dental schools? The trends in applicants, matriculants, and graduates who are racial and ethnic minorities differ across the health professions. Overall, the data indicate that their low representation is severe and persistent. Although some increases have occurred in enrollments of underrepresented minorities in nursing and dental schools, the percentages of minority students enrolled does not reflect the characteristics of the current U.S. population.

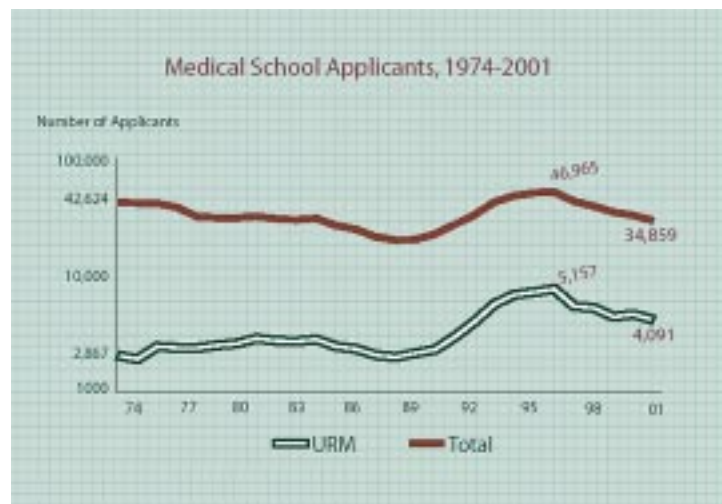
Medical Schools

The trend for matriculants of underrepresented minorities in osteopathic medical schools rose from 8.8 percent in 1989 to 10 percent in 1995, and then fell to 8.0 percent in 1998 (Grumbach et al., 2001). In allopathic medical schools, matriculation reached a high of 12.4 percent in 1994, and then fell to 10.7 percent in 2000 (AAMC, 2000).

Between 1974 (when the AAMC began collecting data on applicant race/ethnicity) and 1996, the number of medical school applicants from underrepresented minority communities increased by 80 percent, from 2,867 to 5,157 applicants. (See Figure 3-4.)

Figure 3-4 Medical School Applicants, 1974-2001

Source: AAMC Data Warehouse March 25, 2002

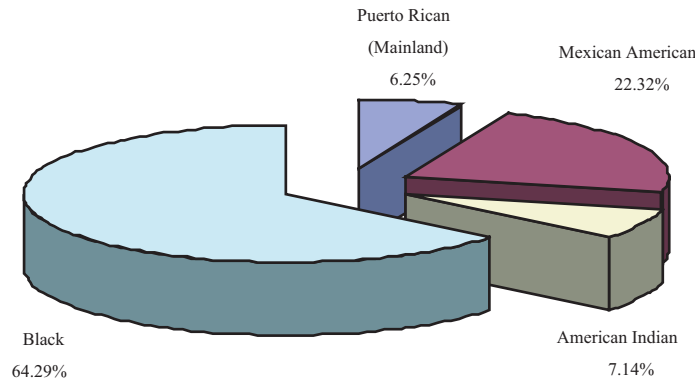


This increase could be attributed to several factors, including the positive impact of affirmative action, the doubling of the number of medical schools in the U.S. from 1965 to 1980, and the enhanced perception among undergraduate minority students that medicine was a realistic career option.

Between 1996 and 2001, a period of legal and institutional assaults on affirmative action, the percentage of underrepresented minority applicants fell by nearly 21 percent, and during that same period the total number of minority students enrolled in medical school declined from a high of 8,254 to a low of 7,394 (Dinan et al., 2004). Figure 3-5 shows the racial and ethnic distribution of underrepresented minority students enrolled in U.S. medical schools in 2002.

Figure 3-5 Underrepresented Minorities in Medical Schools, Total Enrollment 2002

Source: AAMC 2002 *Minority Students in Medical Education: Facts and Figures XII*. (Available online: <http://www.aamc.org>. Accessed April 17, 2004.)



The graduation of underrepresented minorities from U.S. medical schools followed a similar pattern between 1992 and 2002 with the numbers of graduates showing an initial increase from 1,233 in 1992 to 1,857 in 1998 followed by a 7 percent decline to 1,724 in 2002. (See Table 3-3.)

Table 3-3 Underrepresented Minority Graduates of U.S. Medical Schools 1992-2002

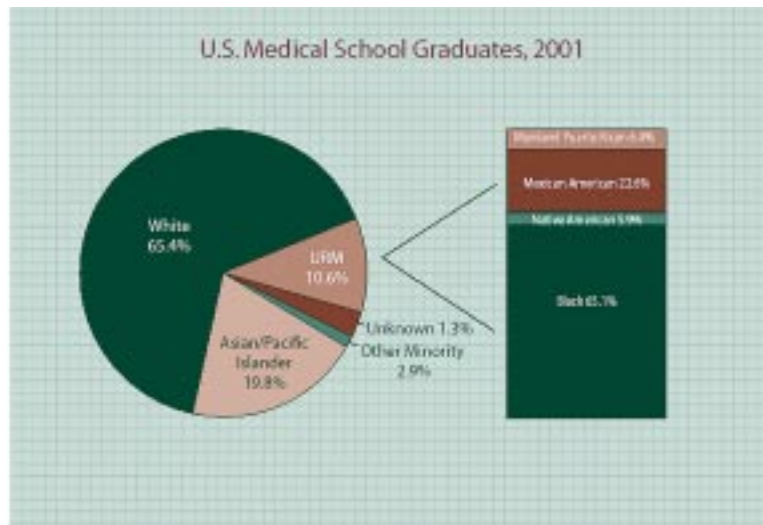
Source: AAMC (www.aamc.org/data/facts/archive/famg92002.htm)

	1992	1994	1996	1998	2000	2002
Number URM Graduates	1,233	1,346	1,598	1,857	1,796	1,724
Percent URM Graduates	8%	8.7%	10.1%	11.6%	11.4%	11.0%

As indicated in Figure 3-6, while one-third of all medical school graduates in 2001 were of racial and ethnic minority populations, less than 11 percent were underrepresented minorities.

Figure 3-6 U.S. Medical School Graduates, 2001

Source: AAMC Student Record System, April 2002

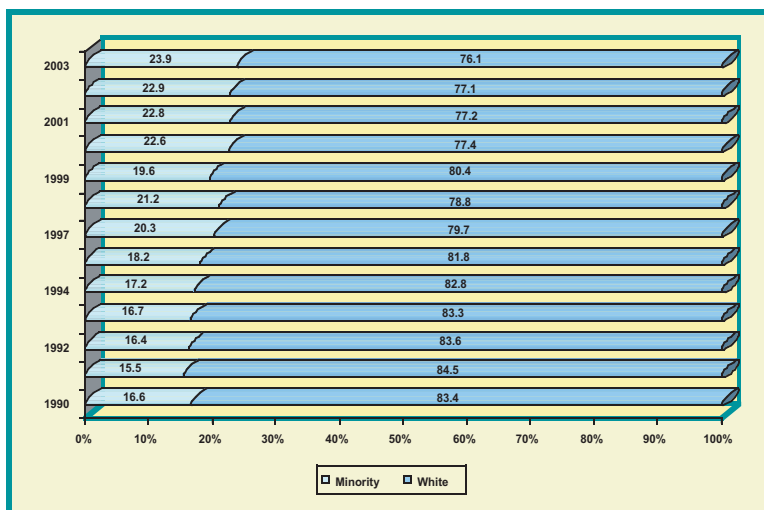


Underrepresented Minority Nursing Student Enrollments and Graduations

Enrollments of underrepresented minority students in baccalaureate and graduate nursing programs have seen sustained rise over the last 13 years. This encouraging trend is central to increasing minority representation in the nursing workforce (AACN, 2004a). Nursing schools currently have the highest proportion of underrepresented minority enrollees of any health profession except public health (Grumbach et al., 2001). Between 1991 and 2003, the number of students from underrepresented minority populations enrolled in baccalaureate nursing programs rose 44 percent. (See Figure 3-7.)

Figure 3-7 Race/Ethnicity Characteristics of Baccalaureate Nursing Students, 1990–2003

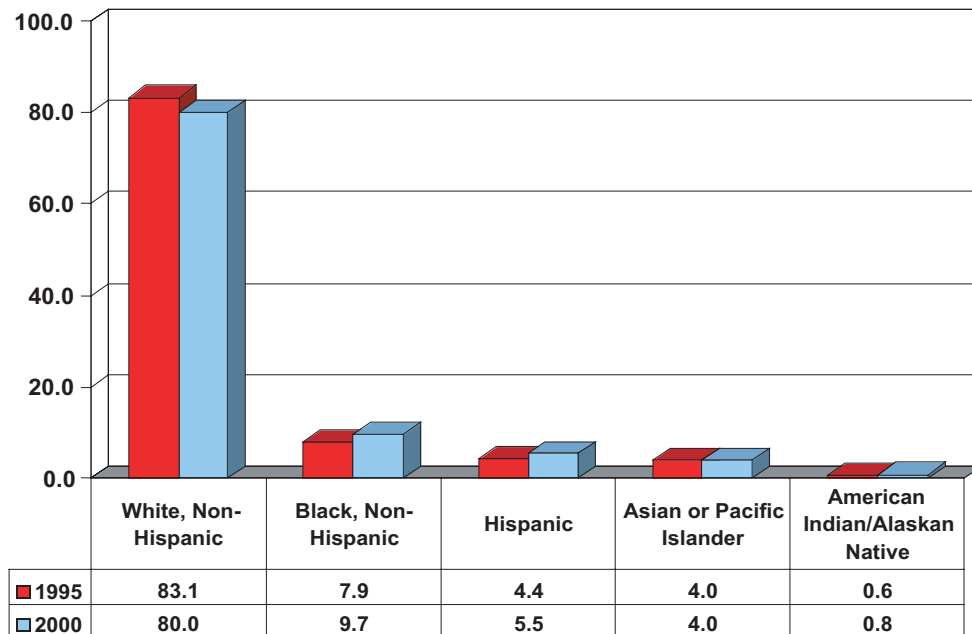
Source: American Association of Colleges of Nursing, Institutional Data Systems, 1990–2003. American Association of Colleges of Nursing © 2004



Nevertheless, shortages of underrepresented minority nursing students clearly remain. One report from the state of California, which has open enrollment for community college associate degree programs, assessed completion rates of entry level nursing students enrolled in all types of programs in California—associate degree, diploma, and baccalaureate—and found that minority nursing students were less likely to graduate from nursing programs than their non-Hispanic white counterparts (Sechrist, Lewis & Rutledge, 1999). However, U.S. Department of Education data on completion rates for minority nursing students in baccalaureate nursing programs indicate that completion rates increased for baccalaureate nursing students over the years 1995 – 2000. (See Figure 3-8.)

Figure 3-8 Race/Ethnicity of Baccalaureate Degree Completions in Nursing (RN Training), 1995 and 2000

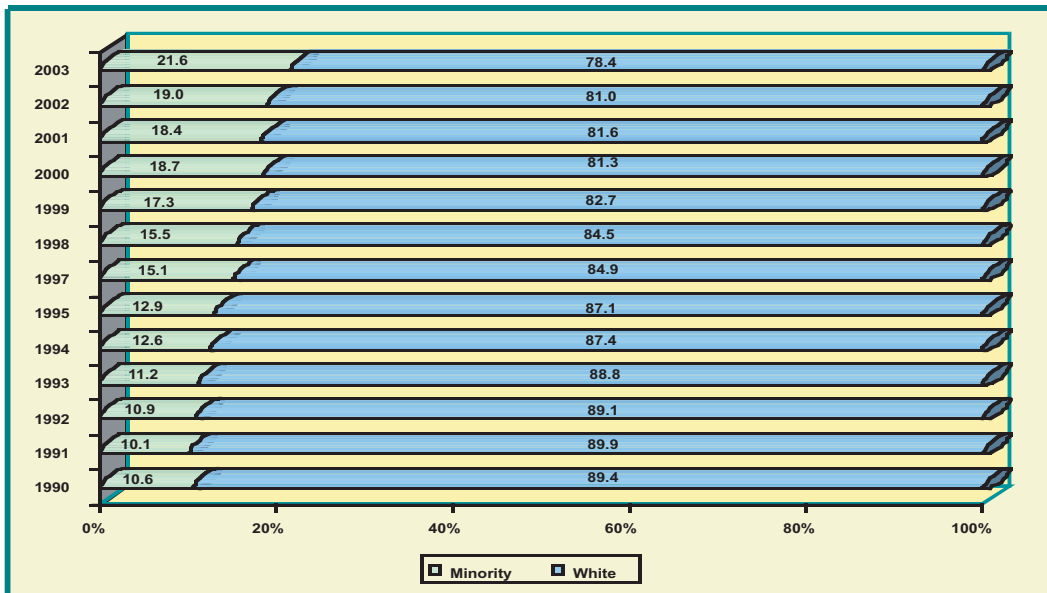
Source: U.S. Department of Education, NCES. *Integrated Postsecondary Education Data System (IPEDS), 1995 and 2000 Completions Survey.*



Minority representation has increased across all underrepresented student groups in nursing, with African Americans accounting for the largest share of this growth. In baccalaureate nursing programs, the percentage of African-American students increased from 9.3 percent in 1993 to 12.4 percent in 2003. A corresponding increase was seen in the graduate student population where the percentage of African Americans enrolled in master’s degree programs nearly doubled from 5.8 to 10.5 percent from 1993 to 2003, and enrollments in doctoral nursing programs increased from 6.1 to 9.7 percent in that same time period.

Figure 3-9 Minority Status of Students with Master’s Degrees in Nursing, 1990-2003

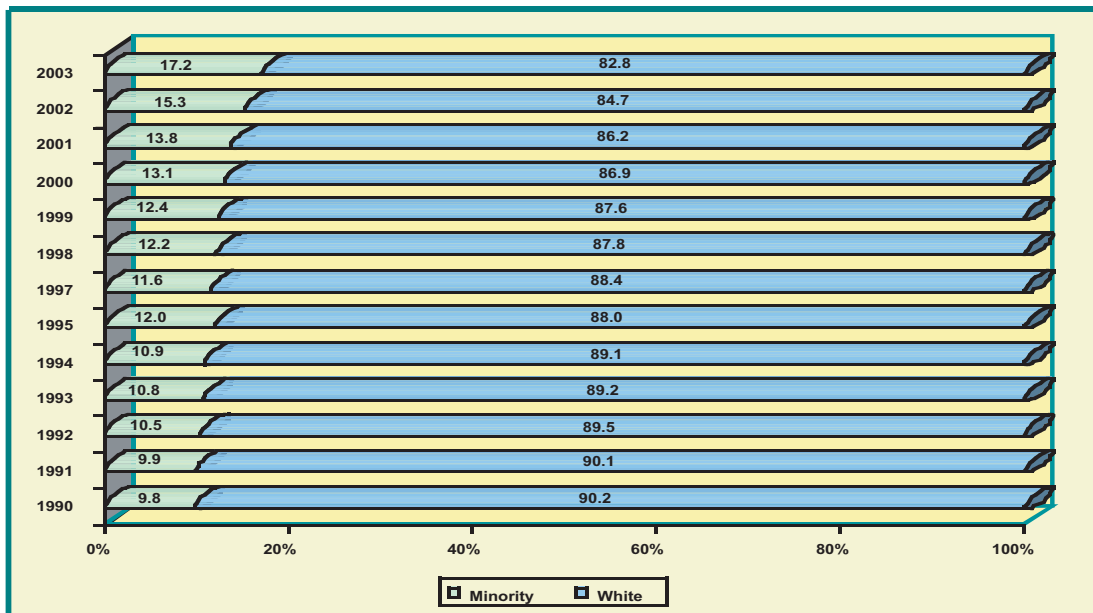
Source: American Association of Colleges of Nursing, Institutional Data Systems, 1990-2003.
 American Association of Colleges of Nursing © 2004.



Note: Race/ethnicity data were not collected in 1996. The categories of "race/ethnicity unknown" and "non-resident alien" (foreign) were excluded from analysis.

Figure 3-10 Minority Status of Doctoral Students in Nursing, 1990-2003

Source: American Association of Colleges of Nursing, Institutional Data Systems, 1990-2003.
 American Association of Colleges of Nursing © 2004.



Note: Race/ethnicity data were not collected in 1996. The categories of "race/ethnicity unknown" and "non-resident alien" (foreign) were excluded from analysis.

The representation of American Indians in the nursing student population has changed little over the past 10 years with an increase of only 0.1 percent in baccalaureate, masters and doctoral programs. In 2003, African Americans accounted for 10.7 percent of nursing graduates while

Hispanics (5.3 percent), Asian (4.6 percent), and American Indian (0.9 percent) nurses accounted for almost 11 percent of all baccalaureate nursing graduates (AACN, 2004a).

The increase in the number of underrepresented minorities in nursing programs may be attributed to many factors, including the targeted efforts of nursing schools to reach out to specific populations, strong advocacy on the part of minority nursing organizations, and increased federal funding for grant programs aimed at diversifying the nursing workforce. Clearly, efforts must be enhanced to identify obstacles to nursing careers and to facilitate access to nursing education for underrepresented students. Studies point to many reasons why URM group members do not pursue nursing, including role stereotypes, economic barriers, a lack of mentors, gender bias, lack of direction from early authority figures, misunderstanding about the practice of nursing, and increased opportunities in other fields (AACN, 2001).

Dental Schools

There has been no increase in the size of the dental underrepresented minority applicant pool in the last five years, following a slow but sustained growth during the early to mid-1990s. While the number of underrepresented enrollees has increased since 1998, they have only reached a number similar to that of the early 1990s.

To increase the number of underrepresented enrollees, it will be necessary to increase the pool of qualified underrepresented minority applicants to careers in dentistry.

Recently released dental school enrollment figures show a slight increase in total enrollment for underrepresented minority dental students. In the mid-1980s enrollment of blacks and Hispanics rose to over 1,000 students for each of these groups. While black/African American enrollment began to decline in the late 1980s, the number of Hispanic students enrolled in dental school continued to increase until the early 1990s. During the 1998-1999 academic year, the enrollment for blacks and Hispanics reached a 15-year low. The data for 1999-2000 showed an increase in Hispanic enrollment from 823 to 913. In 2000-2001, black/African American enrollment began to rebound from a low of 810 (1999-2000) to 832. The enrollment data on black/African Americans and Hispanics has increased steadily since the academic year 2000-2001. During the same year, Native American dental student enrollment peaked at a total enrollment percentage (0.65 percent) almost proportionate to their representation in the U.S. population. (See Table 3-4.)

Table 3-4 Total Pre-Doctoral Minority Enrollment in U.S. Dental Schools 1984-2003*Source: ADA Surveys of Pre-Doctoral Dental Educational Institutions*

Year	Black/ African American	Hispanic	Native American	Asian	% Total	% URM*
1984-85	1037	955	60	1592	17.61	9.88
1985-86	1019	1027	50	1672	19.27	10.72
1986-87	1032	1094	56	1805	20.64	10.97
1987-88	994	1201	60	2099	24.34	12.62
1988-89	984	1276	63	2326	27.20	13.59
1989-90	983	1278	57	2393	28.70	14.12
1990-91	940	1254	53	2519	29.88	14.08
1991-92	907	1187	51	2585	29.78	13.50
1992-93	944	1152	48	2650	30.00	13.40
1993-94	972	1141	50	2846	30.82	13.31
1994-95	973	1045	56	3107	31.68	12.68
1995-96	951	966	73	3433	32.76	11.42
1996-97	891	824	83	3672	33.01	10.85
1997-98	883	825	96	3876	33.56	10.66
1998-99	841	823	97	4035	34.03	10.33
1999-2000	810	913	99	4325	35.54	10.53
2000-2001	832	925	112	4295	35.52	10.77
2001-2002	854	1030	74	4118	34.74	11.19
2002-2003	904	1066	80	4041	34.47	11.59
2003-2004	972	1058	77	4082	34.41	11.72

*URM = Underrepresented minorities—black, Hispanic and Native American

The total 2003-2004 underrepresented minority dental student enrollment data reveal that the black/African American and Hispanic student enrollment numbers are the highest in almost eight years. For 2003-2004, enrollment for black/African Americans was 5.41 percent; 5.88 percent for Hispanic/Latino; and 0.43 percent for Native American/Alaska Natives. In spite of the recent increases, the percentages of underrepresented minority dental student enrollments from each group remains significantly lower than the percentage of each group in the U.S. population. (See Table 3-5.) In 2003-2004, 40 percent of African Americans were at Howard and Meharry. Twenty-five percent of Hispanics were at five schools: New York University, University of Texas Health Science Center-San Antonio, Nova Southeastern, Tufts University, and the University of Florida; and 40 percent of Native American students were at the University of Oklahoma.

Table 3-5 Comparison of Percentage of Minorities in the U.S. Population to the Percentage of Minorities Enrolled in Dental Schools

Source: U.S. Census Bureau 2000 and ADEA 2004

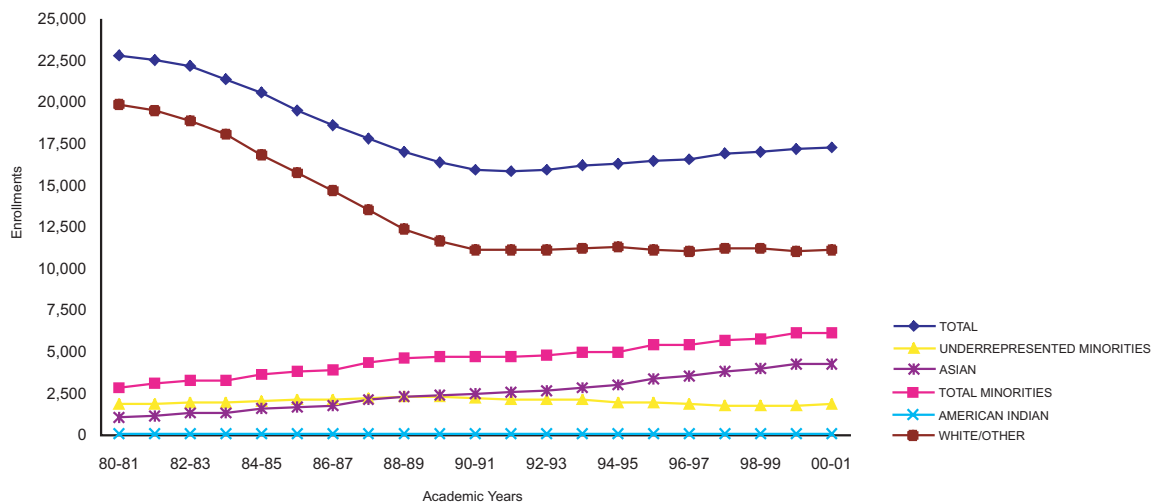
	Black	Hispanic	Native American	Asian
Minority Percentage of U.S. Population in 2000 (U.S. Census, 2000) White=75.1 percent	12.3%	12.5%	0.9%	3.6%
Minority Percentage of Total Dental Enrollment as of 2003	5.41%	5.88%	0.43%	22.7%

The current percentages of the U.S. population for underrepresented minorities are estimated to be 12.3 percent black/African American, 12.5 percent Hispanic/Latino, and 0.9 percent Native American/Alaska Native. These data are especially significant when documented reports have found that minority dentists practice in minority communities and those underrepresented senior dental students expect to serve in the inner cities and in densely populated communities at higher rates than other dental students (Solomon et al., 2001; Weaver et al., 2004).

After a decade of decline in the 1980s, the trend for total dental school enrollment showed a gradual but steady rise through the 1990s. In contrast, throughout the 1990s underrepresented minority student enrollments declined.

Figure 3-11 Total Enrollments in Dental Schools by Race and Ethnicity, Academic Years: 1980-81 to 2000-2001

Source: ADA 2002



There are nine advanced educational (specialty) programs in dentistry: Endodontics, Oral and Maxillofacial Pathology, Oral and Maxillofacial Radiology, Oral and Maxillofacial Surgery, Orthodontic and Dentofacial Orthopedics, Pediatric Dentistry, Periodontics, Prosthodontics, and Dental Public Health. In addition to the specialty programs, there are two general practice post-doctoral programs: General Practice Residencies (GPR) and Advanced Education in General Dentistry (AEGD). In 2002-03, 5,257 dentists were enrolled in advanced dental education programs (black 5.13 percent; Hispanic 6.65 percent; American Indian 0.44 percent). (See Table 3-6.)

Table 3-6 Percent Minority Enrollment in Advanced Dental Education Programs/U.S. Dental Schools 1994-2002

Source: American Dental Association Survey Center

Year	Total	Black/ African American	Hispanic	Native American	Asian	URM
1994-95	25.8	4.6	7.0	0.2	14.0	11.8
1995-96	27.2	4.6	7.2	0.2	15.2	12.0
1996-97	28.3	4.9	7.3	0.2	15.9	12.4
1997-98	29.0	4.6	7.4	0.2	16.8	12.2
1998-99	30.5	5.0	7.5	0.2	17.8	12.7
1999-2000	31.4	4.68	6.98	0.30	19.5	11.96
2000-2001	30.9	5.02	6.85	0.18	18.9	12.05
2001-2002	33.7	5.27	6.87	0.20	21.4	12.34
2002-2003	33.2	5.13	6.65	0.44	20.94	12.22

Enrollment in advanced dental education programs mirrors that of predoctoral programs with regard to underrepresented minority students.

There are approximately 200 black and 200 Hispanic dental school graduates each year. Native American dental graduates constitute less than one percent of total dental graduates annually. Dental graduate trends have reflected the pre-doctoral dental enrollment trends over the past 20 years. Thus, there are hardly enough black and Hispanic dentists to replace those that are dying or retiring. Graduation rates for dentists are not in synch with growth of the U.S. population especially for black and Hispanic groups. (See Table 3-7.)

Table 3-7 Minority Graduates of U.S. Dental Schools, 1976-2003*Source: American Dental Association Survey Center*

Year	Black	Hispanic	Native American	Asian	Total Graduates
1976-77	215	105	15	162	5,177
1978	203	135	12	189	5,324
1979	182	133	18	208	5,424
1980	190	182	14	197	5,156
1981	214	145	14	246	5,550
1982	227	177	12	265	5,278
1983	200	210	12	215	5,756
1984	219	192	9	304	5,337
1985	223	213	17	378	5,353
1986	195	208	10	382	4,957
1987	211	231	11	396	4,717
1988	227	221	14	459	4,581
1989	193	296	14	521	4,312
1990	216	320	8	524	4,233
1991	204	348	12	577	3,995
1992	174	296	12	640	3,918
1993	171	288	12	607	3,778
1994	194	292	13	603	3,875
1995	201	300	8	660	3,908
1996	205	209	9	693	3,810
1997	201	210	18	767	3,930
1998	196	196	17	888	4,041
1999	174	204	27	999	4,095
2000	239	220	31	1,034	4,171
2001	215	214	27	1,159	4,367
2002	176	232	23	1,091	4,349
2003	196	270	24	1,095	4,443

Faculty and Leadership of the Nation's Health Professions Schools

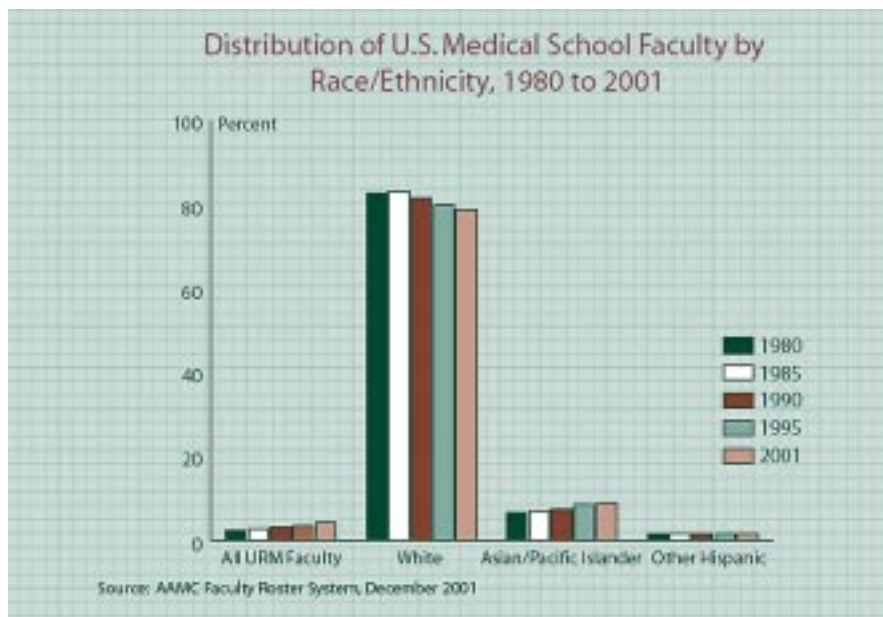
Diversity in the faculty and administration of health professions schools is central to creating a welcoming environment for all students. The Commission heard a consistent theme from potential applicants to health professions schools, and from students in those schools, that they desired a welcoming environment that was reflected in the racial, ethnic, and gender composition among those who would serve as their educators, mentors, and role models. Examination of the data on race and ethnicity of the faculty and individuals serving in leadership roles in our nation's medical, nursing, and dental schools makes evident a critical need to focus on this concern. The Commission agrees that development of minority leaders to serve as scholars, researchers, faculty, and senior administrators is a key element in enhancing the diversity of the health professions' student population and should be a major consideration in achieving the goal of increased diversity in the health professions.

Medical School Faculty and Leadership

Although faculty members from underrepresented minority groups tripled between 1981 and 2001, today they account for only 4.2 percent of the total U.S. medical school faculty. (See Figure 3-12.)

Figure 3-12 Distribution of U.S. Medical School Faculty by Race/Ethnicity, 1980-2001

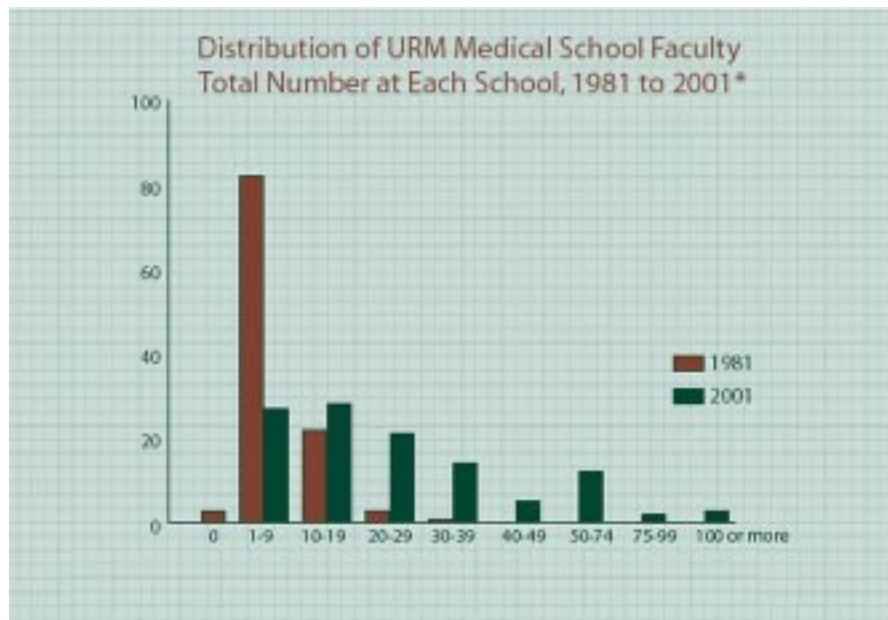
Source: AAMC Faculty Roster System, December 2001



Of the approximately 4,900 underrepresented minority faculty in 2003, 20 percent of these faculty are located at six (of 126) medical schools. These six medical schools, which have a tradition of preparing minority students for the healthcare workforce, include Howard University School of Medicine, Meharry Medical College, Morehouse School of Medicine, and three schools in Puerto Rico—Universidad Central del Caribe School of Medicine, Ponce School of Medicine, and the University of Puerto Rico School of Medicine. A review of medical school faculty distribution, excluding these six schools above, shows that between 1981 and 2001 there was a decrease in the percentage of schools with 1-9 underrepresented minority faculty and a corresponding increase in the percentage of schools with greater than 30 underrepresented minority faculty. (See Figure 3-13.)

Figure 3-13 Distribution of URM Medical School Faculty Total Number at Each School, 1981 to 2001

Source: AAMC Faculty Roster System, December 2001

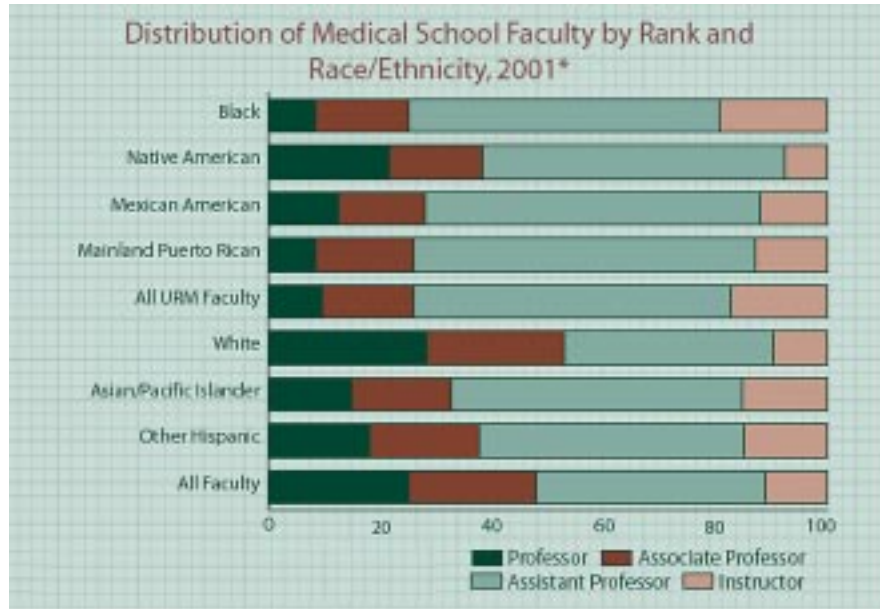


*Excludes Howard, Meharry, Morehouse, Caribe, and University of Puerto Rico. Data for 1981 are based on 111 schools and 2001 are based on 112 schools. Schools with unknown race/ethnicity data greater than or equal to 15 percent are excluded.

In addition, underrepresented minority faculty lag behind their white counterparts in achieving appointments to associate and full professorships. (See Figure 3-14.)

Figure 3-14 Distribution of U.S. Medical School Faculty by Race/Ethnicity and Rank, 1980-2001

Source: AAMC Faculty Roster System, December 2001



*Excludes historically Black and Puerto Rican medical schools.

To a large extent, medical school leadership determines institutional policies that are aligned with its mission; sets the direction of medical education and curricular reform; and oversees student and faculty recruitment, retention, and promotion. A review of the senior leadership, including deans and department chairs in U.S. medical schools, reveals a low representation of African Americans, Hispanics, and Native Americans, particularly when the six medical schools mentioned above are omitted. The representation of Asians at these senior levels is also shown to be much lower than their representation among the faculty in general. (See Figure 3-15.) A separate study found that 57 percent of medical schools have faculty development programs and 50 percent had funding earmarked for minority faculty retention (Dinan, et al., 2004).

Figure 3-15 Distribution of U.S. Medical School Deans and Department Chairs by Race and Ethnicity 2002

Source: AAMC Faculty Roster System, January 2002

All U.S. Medical Schools						
	White	Asian	URM	Other Hispanics	Unknown	Total
Deans	112 (89.6%)	0	10 (8%)	0	3 (1.6%)	125
Department Chairs	2,303 (87.4%)	96 (3.6%)	112 (4.2%)	39 (1.5%)	84 (3.2%)	2,634

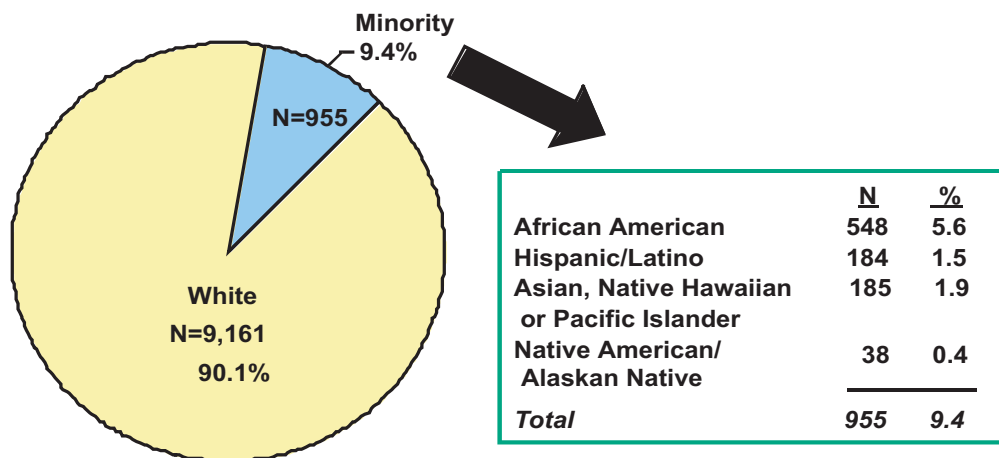
All U.S. Medical Schools—Excluding Howard, Meharry, Morehouse, and Schools in Puerto Rico						
	White	Asian	URM	Other Hispanics	Unknown	Total
Deans	112 (94.1%)	0	4 (3.4%)	0	3 (2.5%)	119
Department Chairs	2,288 (90%)	92 (3.6%)	48 (1.9%)	34 (1.3%)	84 (3.3%)	2,546

Nursing School Faculty and Leadership

In striking contrast to the relatively diverse student body in nursing schools, the faculties of the nation’s nursing schools fall considerably short of reflecting the nation’s racial and ethnic diversity (IOM, 2004). Nationally, AACN reports that fewer than 10 percent of faculty in baccalaureate and graduate nursing programs are members of underrepresented minority groups. In 2003, minority representation among nursing faculty at senior colleges and universities included 5.6 percent African Americans, 1.5 percent Hispanics, 1.9 percent Asian, and less than 1 percent American Indian/Alaskan Native (AACN, 2004b). There is clearly a strong need to expand the pool of URM nurses available to serve in faculty roles and as mentors for students from diverse backgrounds. (See Figure 3-16.)

Figure 3-16 Minority Status of All Full-Time Nurse Faculty, 2003

Source: Berlin, L.E., Stennett, J., & Bednash, G.D. (2004)

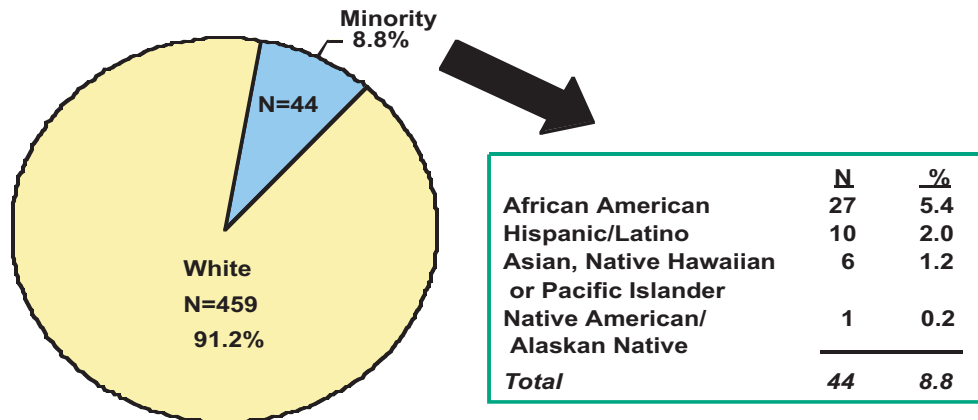


Note: Includes full-time instructional, administrative, and interim/acting deans. Excludes deans or other institutionally determined titles for chief executive officers of the nursing academic unit.

In addition, individuals in key leadership positions in schools of nursing provide further evidence of the need to place a strong emphasis on development of underrepresented minority nurses to serve in these roles. Less than 9 percent of individuals in the chief academic leadership roles in baccalaureate and graduate nursing programs come from an underrepresented minority group. (See Figure 3-17.) Moreover, only 8.4 percent of those individuals in other leadership roles in these schools are members of an underrepresented minority group. (See Figure 3-18.) Minority faculty development at nursing schools also lags behind that of medical and dental schools. Only 20 percent of surveyed schools indicated that they had an established minority faculty development program and only 40 percent had funds (Dinan et al., 2004).

Figure 3-17 Minority Status of Deans, 2003 (N=503)

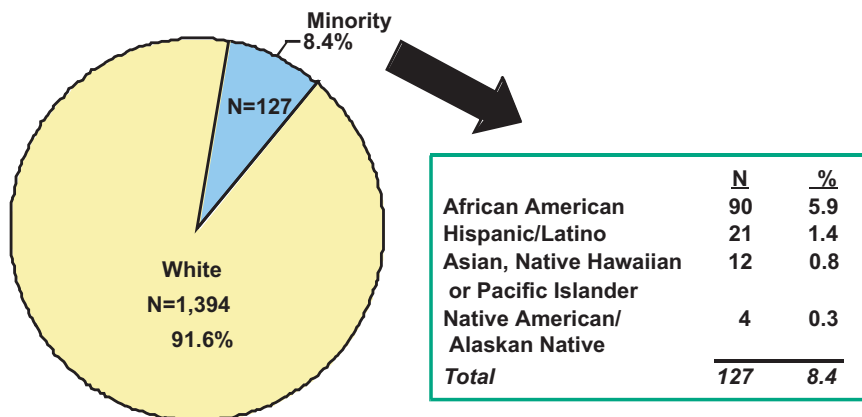
Source: Berlin, L.E., Stennett, J., & Bednash, G.D. (2004)



Note: The term dean refers to the chief executive officer of a school of nursing. It encompasses institutionally determined titles such as director, chair, head, and coordinator. Excludes interim/acting deans.

Figure 3-18 Minority Status of All Full-Time Administrative Nurse Faculty, 2003 (Valid N=1,521 Faculty; N=127 Minority Faculty)

Source: Berlin, L.E., Stennett, J., & Bednash, G.D. (2004)



Note: Includes interim/acting deans; excludes deans or other institutionally determined titles for chief executive officers of the nursing academic unit.

Dental School Faculty and Leadership

Underrepresented minority faculty in dentistry reflects the underrepresented minority student enrollments for 2002-2003. The percentage of full-time minority faculty in dental schools was low and relatively stable throughout the 1990s (IOM 2004). Between 1990 and 1998, the percentage of African-American and Hispanic faculty members remained at approximately 5 percent and 3 percent, respectively. During this period, the percentage of Native American faculty doubled from 0.3 percent to 0.6 percent but remained quite low in comparison to overall faculty (IOM 2004).

Of the 4,805 full-time dental faculty in 2002-03, 267 were black/African American (5.5 percent), 233 were Hispanic/Latino (4.84 percent) and 16 were Native American (0.33 percent). (See Table 3-8.)

Table 3-8: Dental School Faculty 2002-03 by Race/Ethnicity and Employment Status

Source: American Dental Education Association Survey of Dental Educators 2002-2003

Race/Ethnicity	Total	Full-Time	Part-Time	Volunteers	Status Not Reported
Native American	37	16	20	1	0
Asian/Pacific Islander	1086	443	474	156	13
Black/African American	459	267	168	22	2
Hispanic/Latino	524	233	252	35	4
White	8676	3724	3975	930	47
Other	151	74	65	12	0
Not Reported	388	48	208	100	32

The gender difference in minority dental faculty reflects the gender difference in the total dental faculty. (See Table 3-9.)

Table 3-9 Dental School Faculty 2002-2003 by Gender and Race/Ethnicity

Source: American Dental Education Association Survey of Dental Educators 2002-2003

Race/Ethnicity	Total	Female	Male	Gender Not Reported
Native American	37	9	28	0
Asian/Pacific Islander	1086	337	745	4
Black/African American	459	178	281	0
Hispanic/Latino	524	216	308	0
White	8676	1900	6769	7
Other	151	56	95	0
Not Reported	388	121	233	34

There continues to be a national shortage of full-time dental faculty that has not been met by the increased number of women and minorities among its ranks. There is a need to increase the number of minorities and women entering advanced dental educational programs to assure an adequate workforce to meet the academic, research, and patient care needs projected for the future.

Only 30 percent (17 out of the 56 U.S. dental schools) have underrepresented minority deans, associate or assistant deans. This includes Howard and Meharry dental schools.

There is a paucity of financial support for leadership training and development in dental education. Even at “best practice” dental schools, only 40 percent included career counseling in their minority faculty development programs (Dinan et al., 2004). In addition, the more than 250 funded, vacant faculty positions in dentistry are of major concern to dental educators. A recent survey of dental school deans cited leadership training as a priority (Valachovic et al., 2000).

Summary

These data are further supported by a commissioned study, *Diversity of Students and Faculty: An Assessment of Health Professions Schools* (Dinan et al., 2004), conducted during the course of the Commission’s work. Using surveys and informant interviews, student and faculty data were disaggregated by race and ethnicity for the 1998 and 2003 graduating classes for the nation’s medical, dental, and nursing schools. Data were also gathered to ascertain the types of programs offered to attract minority students and faculty. The study’s findings undergird what is already known about the decline in the numbers of minority students in health professions education institutions and the modest success programmatic activities have had in addressing this issue.

The data for medicine, nursing, and dentistry at the student, provider, faculty, and leadership levels demonstrate the failure of these professions to keep pace with the changing demographics of the nation. If unchanged, these data draw a roadmap to a health care system that remains inherently unequal, bearing little resemblance to the nation at large, and directly contributory to the health disparities faced by minority populations. This report examines the problematic nature of these shortages, their causes, and rationale for diversity in all levels of the health professions, with recommendations for action.

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Chapter 4

The Pipeline to the Health Care Professions

Equal access to high-quality education provides the means for an individual to pursue a career in the health professions. In theory, a pipeline from primary to secondary to postsecondary education, and finally to professional training, channels the flow of a diverse and talented stream of individuals into the nation's health care workforce. However, in reality, not all Americans flow equally through the pipeline to the health care professions. Instead, race and ethnicity often substantially influence an individual's forward motion at every stage of the pipeline. This chapter provides a discussion of multiple obstructions found at three key segments of the pipeline: (1) primary and secondary education (K-12), (2) post-secondary education (the college years), and (3) health professions education.

Primary and Secondary Education

“The barriers present in the education system for minorities from K-12 as well as in the undergraduate and graduate levels must be assessed. Since 50 percent of medical students may have decided to become a physician by junior high level, it is important to provide the professional exposure programs and standardized testing support necessary to matriculate into medical school and be successful once there.”

– Kara L. Odom, President, Student National Medical Association, Los Angeles hearing, November 20, 2003

Concurrent with the broader demographic shifts in the United States, the nation's student population is also undergoing an unprecedented transformation. The U.S. Census Bureau projects that racial and ethnic minority students will become the majority in K-12 classrooms by the middle of this century, increasing to 44 percent by 2020 and 54 percent by 2050. Already, 40 percent of elementary and secondary school children are of racial and ethnic minorities. Despite this shift, about 90 percent of classroom teachers, at all levels, are white (IHEP, 2000).

During the course of the Commission's hearings, there was a striking unanimity of concern among educators, university administrators, health care practitioners, public officials, and others regarding the chronic failure of the nation's educational system to produce an adequate pool of talented minority candidates for the health professions schools. The single most consistent recommendation of the hearings was for interventions that begin at the earliest possible grades and continue through the scholastic pipeline.

An obstructed pipeline poses significant challenges for transporting a critical mass of minority students to the schools of the health professions. Multiple obstructions are evident throughout the primary, secondary, and postsecondary segments of the pipeline, posing a grave threat to the future diversity of the nation's health care workforce. Minority students lag behind white students at every educational level, trailing in nearly all key scholastic indicators, such as reading and math skills, high school completion rates, college enrollment rates, and graduation rates. The gap between the primary and secondary educational experience of whites versus that of Hispanics, African Americans, Native Americans, and some Asian subgroups is wide, deep, and persistent.

Presenter after presenter expressed the concern that the educational system posed the greatest barrier to achieving diversity in the health care workforce. At the public hearing in Chicago, Congresswoman Donna M. Christensen told the Commission that although other interventions are important, "the only real fix is the kind of investment that creates systemic change in our public education system." At the Atlanta hearing, Dr. Valerie Hepburn, Director, Division of Health Planning, Department of Community Health, said that increasing diversity "doesn't really happen at the admissions process for pharmacy or medicine or nursing. It happens when a child is in elementary school." Dr. Randall Maxey, President of the National Medical Association told the Commission in Chicago, that unless students are prepared to attend college and consider careers in the health professions by ninth grade, they typically will not be competitors for admission into the health professions schools. In Atlanta, Dean Ann Jobe, M.D., Mercer University School of Medicine, said that even second grade may be too late.

Key obstructions in the primary and secondary segments of the pipeline include stark inequalities in educational resources; disparities in learning outcomes, especially reading and math deficits; disparities in high school completion rates; perceptions among minority youth that education is of little value; low aspirations; diminished expectations among teachers; and the need for more role-modeling and youth mentoring. Too many minority youth float hazardously through the nation's pipeline, and fail to realize their true potential. A few falter in ways that lead to unemployment, underemployment, crime, and incarceration.

The achievement disparities in reading begin in elementary school. According to the National Center for Education Statistics (NCES, 2003), 61 percent of black, 57 percent of Hispanic, and 53 percent of Native American fourth-graders read below basic reading level, compared with 26 percent of white fourth-graders. Math testing shows similar achievement gaps. The NCES found that 46 percent of black, 38 percent of Hispanic, and 35 percent of Native American

fourth-graders scored below basic math skills, compared with 13 percent of white students. Likewise, among eighth-graders, 61 percent of black, 53 percent of Hispanic, and 46 percent of Native American youths showed below basic math skills. Only 25 percent of white students scored that low. In 24 states and the District of Columbia, at least 60 percent of black eighth-graders scored below basic skills in math. In six states and the District of Columbia, 70 percent of black eighth-graders were under par. While there has been some progress in test scores, the National Assessment of Educational Progress tests reveal a widening achievement gap between white and minority students.

The Commission held public hearings in New York City, where the school system faces alarmingly high dropout rates among minority youths. In the city's preponderantly African-American and Latino schools, 36 percent of ninth graders and 43 percent of tenth graders must repeat their grade for a second year. Only 61 percent of Hispanic children and 65 percent of African-American students, but 94 percent of white children, who started high school in 1999 reached their senior year on time (Rankin, 2003). Obviously, completion of high school is a prerequisite for college admission and subsequent entry into schools of the health professions. In New York, Mr. Ronald Ross, Distinguished Fellow for Urban Education Reform, National Urban League, told the Commission that students who do not take physics and calculus in high school will not be prepared to enter a career program in the health professions. Mr. Marc Nivet, Associate Executive Editor, Associated Medical Schools of New York, said students who have not taken algebra by the eighth grade are already lost to the pipeline. Throughout its public hearings, the Commission heard ample testimony to support its belief that guiding young students to the health professions requires the successful completion of a high school curriculum that includes strong preparation in the sciences.

The Commission also heard testimony about many other systemic challenges facing predominantly minority schools, including fewer students in advanced placement courses, limited curricula, less-qualified teachers, and poor academic counseling. In New York, Mr. Ross testified that public school students are "guided away" from taking math and science, and those that are poorly prepared in middle school are already tracked for failure by the time they arrive at high school. He also put forth the concern that many public school students, particularly urban minorities, are "at risk of being taught science and/or math by a teacher unlicensed in either field of study." Interestingly, the Rankin study found that the effect of teacher certification is greatest in high schools where the majority of students entered school with the basic skills to succeed.

"I was amazed to learn that if a student doesn't take algebra by the 8th grade, he will not likely choose a health career. By then, the student has chosen a different pathway and is very unlikely

to go back and take algebra and calculus later, thus assuring a career other than medicine, pharmacy or dentistry. That is why it is so important to reach students and their parents early enough to keep their options open."

– Commissioner Regina Benjamin, M.D., M.B.A., Founder & CEO,
Bayou La Batre Rural Health Clinic

Many people testified that there is a need for communities and schools of the health professions to collaborate and give greater support to youth. Such collaborations provide students with the chance to see how what they learn in school is being applied to actual health problems. One presenter spoke about the need for parents to understand how important it is for them to support their child's education and share his or her learning experiences. In Atlanta, Dr. Gregory Strayhorn of Morehouse School of Medicine expressed the concern that in some minority communities, there is a need to change the "whole cultural view as far as academic excellence and [to] find ways to make that part of the fabric of the community." Dr. Strayhorn said that such a cultural transformation must make minority students "feel that academics are as important as sports and entertainment."

Several presenters expressed the concern that insufficient effort is made at the primary and secondary levels to direct minority students to the health care professions. Ms. Elbra Wedgeworth, President, Denver City Council, recollected that although she was encouraged to pursue higher education and to use that education to serve the community, mentors did not guide her toward the health professions. Dr. Hilda Hutchinson, Associate Dean for Minority Affairs, Columbia University College of Physicians and Surgeons, said other industries, such as engineering and computer technology, draw some talented minority students away from the health professions. Dr. Hutchinson said that some recruiters tell students that these other disciplines allow them to make more money, avoid the worry of malpractice, and finish their education in less time.

"I was told by my mother: 'You're going to be a doctor.'"

– Louis W. Sullivan, M.D., Chair, The Sullivan Commission

Ultimately, the nation must invest dramatically more resources in ensuring that all public school children receive a solid educational foundation before they reach high school. Presenters consistently called for increased resources for rebuilding the pipeline at the elementary, middle school, and high school levels. Although the landmark Michigan decision in 2003 affirmed the compelling state interest of diversity in higher education, it is painfully clear that the Brown decision 50 years earlier never unclogged the pipeline. This is the ongoing tragedy of American education: the nation still has not figured out how to educate all of its children.

The College Years

Pipeline obstructions for racial and ethnic minorities are not limited to primary and secondary education. Successful minority high school graduates continue to face barriers in their college years. One presenter noted that there are low aspirations among racial and ethnic minority students in colleges and universities. More than one presenter expressed concern that faculties have lower expectations for minority students.

At the Los Angeles hearing, Dr. Robert Montoya testified to the Commission that of the over 3,000 Latino, black, and American Indian students in California who began college with the specific goal of becoming a physician, only 450 actually applied to medical school and only 250 were accepted. Dr. Montoya said that “the 80 percent that drop out of the pre-medicine pathway” usually do so because of lack of information about the medical school application process.

First-generation college students often face unique adaptation and retention needs. Dean Mecca Cranley, School of Nursing, State University of New York at Buffalo, told the Commission that the academic needs of first-generation college students are different from the needs of students accustomed to hearing stories from parents and grandparents about navigating college life. Dean Cranley said that without the advantage of these early familial exposures, first-generation students typically require more adaptive support. Mr. Marc Nivet, Associate Executive Director, Associated Medical Schools of New York, expressed the view that student support programs too often focus mainly on enrichment not remedial support.

In the past 20 years, the college enrollment gap for high school graduates has widened between whites, blacks, and Hispanics (Harvey, 2003). Furthermore, 30 percent of whites, but only 17 percent of African Americans and 11 percent of Hispanics graduate with a four-year degree (U.S. Census Bureau, 2003). The good news is that the number of minorities pursuing degrees in science is increasing: between 1991 and 1997, the number of bachelor’s degrees in the biological and physical sciences awarded to African Americans, Hispanics, and American Indians nearly doubled, from 5,906 to 10,259. This increase is significant for diversity in the health care workforce because most graduates who pursue a health profession, including three-fourths of all medical school graduates, have degrees in the sciences (Butler, 1999).

Two-year college programs play a vital role in preparing students for allied health and nursing careers, or enabling them to develop their academic readiness for four-year colleges, universities, and health professions education. However, two-year students face systemic barriers that can discourage them from applying to health professions schools. Competitive medical school admissions offices prefer applicants who obtained their college degree in four years or less. At

the Denver hearing, Commissioner Geraldine Bednash, Ph.D., Executive Director, American Association of Colleges of Nursing, put forth the concern that talented Native Americans are guided only to two-year college programs because of “diminished expectations” that are “societal and maybe even cultural.”

At the public hearing in Chicago, Dr. Jean Bartels, President-elect, American Association of Colleges of Nursing, said the percentage of individuals who enter nursing with an associate degree (ADN) may be as high as 60 percent, and very few graduates of these programs are encouraged to go on to pursue baccalaureate or advanced degrees. This premise minimizes the benefit that higher levels of nursing education brings to health care delivery and patient outcomes. Currently, only 17 percent of registered nurses who enter the profession with an associate degree go on to complete baccalaureate or higher programs. However, leading nursing associations, including the National Black Nurses Association, the National Association of Hispanic Nurses, the American Association of Colleges of Nursing, and other leading nursing organizations are committed to increasing the number of minority nurses with baccalaureate and advanced degrees. Many health professions education institutions use two-year education programs as a bridge to higher levels of education. At the Denver hearing, Dr. Spero Manson noted that “bridging” has been a successful strategy at the University of Colorado, Health Sciences Center, particularly between the School of Nursing and the Ogalala Lakota College’s nursing program in Pine Ridge, South Dakota. Nationwide, hundreds of articulation agreements between two-year and four-year institutions create pathways for two-year students to advance to baccalaureate and graduate degrees in nursing. In addition, there are 433 RN to baccalaureate degree programs and 137 RN to master’s degree programs. Several presenters noted the need to increase support for “bridging” programs. The Commission believes that community colleges represent a valuable resource for recruiting minority students to four-year colleges and ultimately to nursing, medical, and dental schools. To maximize this resource, increased funding should be directed toward bridging programs that increase student capacity in baccalaureate and higher degree programs.

Presenters also called for greater support for pre-admissions programs that provide comprehensive, residential experience in which students can receive a range of support services including academic enrichment courses in the sciences, guidance in study skills, mock-interview sessions, and standardized admissions test preparation and practice exams.

Health Professions Education

One of the most striking and historically persistent phenomena of the pipeline is that talented minority students who succeed at the primary, secondary, and college levels, and who are committed to pursuing health professions careers, still face barriers in gaining access to health professions education. Throughout its hearings, the Commission heard compelling testimony corroborating the concern that from admissions to graduation, underrepresented minority students encounter persistent hindrances at virtually every stage of the journey to obtaining a health professions education and securing a health care career.

Standardized Testing

Although admissions policies and procedures vary by institution and health professions discipline, gaining admittance to these schools is typically a highly competitive process with many talented applicants competing for a limited number of positions. Conventionally, to streamline the applicant pool and identify the “best” applicants, many admissions offices rely heavily—in some cases predominantly—on quantitative factors, such as an applicant’s undergraduate grade point average (GPA) and standardized admissions test scores.

Standardized test scores are generally useful, though limited, predictors of academic performance. For example, at the public hearing in Chicago, Dr. Laura Neumann, Associate Executive Director, Division of Education, American Dental Association, said that the Dental Admissions Test (DAT) is equally effective in predicting the potential academic success of both minority and majority applicants. However, standardized test scores do not fully measure the wider range of abilities and personal attributes required to succeed in higher education (IOM, 2004). As a result, admissions test scores are imprecise and incomplete approximations of an applicant’s potential academic performance. In addition, and perhaps most importantly, these tests do not measure or predict a student’s future clinical competency as a practitioner. At the public hearing in Atlanta, Dean Nigel Harris, Morehouse School of Medicine, told the Commission that despite their entering with lower average MCAT scores, Morehouse medical students pass their board exams with scores comparable to other groups. He added that the apparent success of Morehouse medical students is directly attributable to the school’s historic mission to train minority health care providers and to its robust and well-regarded student support system.

Still, despite the known limitations of standardized tests, many admissions offices rely quite heavily on test scores to determine an applicant’s overall merit and suitability, often to the detriment of underrepresented minority applicants. Consequently, the heavy use of standardized test scores often serves as a mechanism of exclusion for underrepresented minority students who

typically score lower than their white or Asian American counterparts on standardized admissions tests, including the DAT and MCAT (IOM, 2004). As discussed earlier in this chapter, minority students are more likely to receive an inferior education at the primary and secondary levels. When admissions officers heavily weigh quantitative factors such as standardized test scores, it follows that many underrepresented minority applicants are less successful in gaining admittance than their peers because they have had limited opportunities for strong scholastic preparation (IOM, 2004). For example, a three-year evaluation (1991-1993) by Meharry Medical College found that most students performed in the 30th to 45th percentiles of the MCAT. A subsequent evaluation found that more than 90 percent of the students had not previously taken requisite courses (e.g., advanced biology, organic chemistry, physics, and calculus) that were needed to do well on MCAT (Wilson & Murphy 1999).

In addition to an applicant's standardized test score and GPA, there are many different student attributes that help to determine an applicant's suitability for health professions education. These attributes include active community service, leadership, compassion, perseverance, intention to serve underserved communities, experience with diverse populations, as well as letters of recommendation. The admissions committee at the Morehouse School of Medicine uses many of these factors along with a numeric scale to screen applicants using the following additional factors: motivation/goals; maturity/emotional stability/social support structure; educational readiness/self-discipline; leadership experience; and honesty/ethical dimensions.

Indeed, there is a growing appreciation in the health professions that professional and humanistic qualities must receive greater attention in the admissions process in order to promote professional quality, to ensure that future health professional can fulfill societal needs, and to support public trust in the health professions (IOM, 2004). The Commission believes that standardized test scores are outmoded barometers of applicant suitability. At best, standardized test scores provide a single, convenient measure for admissions officers. Their utility is clearly vulnerable to systemic overuse. Standardized tests serve most usefully as diagnostic tools—not passports—that enable admissions officers to only partly identify applicants' potential strengths and weaknesses. If standardized tests reveal gaps in an otherwise qualified student's preparation, these gaps can be addressed through academic support to ensure success in the first two years of medical or dental school.

Affirmative Action

Direct consideration of an applicant's race and ethnicity yields the greatest diversity benefits. A 2003 study (NACAC, 2003) of approximately 1,500 four-year institutions of higher education found that only 33 percent of colleges and universities consider race or ethnicity as a factor in

the admissions decision. Among those institutions that used race or ethnicity as a factor, more than 8 of 10 schools credited this policy with boosting the number of underrepresented minorities in the student body.

Contrary to some public misconceptions, the use of race as one factor in the admissions process does not yield unqualified students or translate into a “race-based” program. If an institution conducts a special search for qualified applicants that can also throw a football 60 yards or play an oboe, such a recruitment effort would not constitute a “football-based” or “oboe-based” admissions program that admits unqualified applicants. In the *Grutter v. Bollinger* decision that resolved over five years of litigation, the U.S. Supreme Court ruled that the University of Michigan Law School’s consideration of race and ethnicity as one of many factors in the admissions process was lawful, because it was “narrowly tailored” and did not infringe upon the constitutional rights of non-minority applicants. In addition, the court stood behind the overarching principle that achieving a “critical mass” of racial and ethnic student diversity in higher education is a compelling interest of education institutions and the nation.

The landmark Michigan decision lifted the legal cloud over affirmative action. In so doing, the U.S. Supreme Court validated affirmative action as a meaningful and justifiable strategy for increasing racial and ethnic diversity in higher education. The Commission believes that to build a critical mass of underrepresented minority students in the health professions schools, admissions offices should assertively move forward in developing and activating admissions programs that explicitly account for race and ethnicity in the context of a holistic admissions program. The key to a “narrowly tailored” admissions program is the use of individualized, holistic consideration of the complete applicant. Admissions officers should duly consider the many relevant factors pertaining to applicant background that determine an applicant’s potential suitability, including race, ethnicity, history of community service, intention to serve underserved communities, and other germane factors.

Admissions Committees

Race-conscious admissions policies and procedures are only one aspect of the institutional efforts required to address the persistent shortage of underrepresented minority students in the health professions schools. Admissions committees play an important role in identifying and developing meaningful policies, procedures, and strategies for increasing minority representation in the student body. Although there is little research that assesses the racial and ethnic composition of admissions committees for health professions schools, anecdotal evidence often suggests that the vast majority of these committees are composed of whites (IOM, 2004). One of the few studies of admission committee make-up found that among 85 medical schools sur-

veyed, only 16 percent of admissions committee members were from underrepresented minority groups, and over half of the surveyed schools reported that their committees had no or only one underrepresented minority physician (IOM, 2004). Also, less than one of ten admissions committees required their members to participate on a compulsory (non-volunteer) basis.

These patterns suggest that admissions committees need to improve their capacity to integrate the talents, skills, and perspectives of professional colleagues from underrepresented minority groups. The Commission believes that admissions committee composition should reflect the robust diversity commitment of the institution. In addition, institutions that provide diversity training for its admissions committee members, special incentives for participation, and compel compulsory participation demonstrate a higher level of institutional commitment to diversity that could yield desirable results.

Institutional Leadership

The Commission believes that in order to improve the institutional climate for minority students and faculty, institutions must vigorously affirm the value of diversity, promulgate the institutional commitment to diversity, and demonstrate this commitment with action. Institutional leaders—including chairs of the boards of trustees, university presidents, deans, department chairs, and other administrators—must lay out clear expectations for students, faculty, and staff regarding the fulfillment of the institution’s commitment to racial and ethnic diversity. Through the public hearings, many presenters put forth the premise that institutional commitment is highly dependent on school leadership. In Denver, Dean Howard Landesman, University of Colorado School of Dentistry, put it candidly: “If it doesn’t come from the top down, it will never happen.”

An institution’s mission statement plays a vital role in promulgating institutional commitment and vision. In designing the mission statement, broad organizational input from the student body to senior institutional leaders can help ensure buy-in across organizational levels and greatly enhance organizational buy-in. The Commission believes that mission statements should capture an authentic appreciation and valuation—not simply tolerance—of racial and ethnic diversity and a multicultural environment. The mission statement must recognize diversity as a key institutional value and an organizational asset that positions the institution as a national leader in diversity and a model of academic excellence for a talent-based, research-driven, multicultural learning environment. The mission statement sets the tone for institutional policies, programs, or procedures undertaken to build and maintain a diverse student body and faculty.

In addition, a strategic plan for building diversity and enhancing institutional climate can serve as a crucial yardstick for determining action and measuring progress. A strategic plan that vigorously actualizes the mission statement—meaningfully incorporating the conveyed needs and ideas of minority students, faculty, and staff—is a potent tool of institutional accountability and a tangible manifestation of institutional commitment. The development of the strategic plan should identify and address barriers to matriculation and academic success for students of color. The plan’s development should also incorporate strategies to evaluate and enhance the cultural competence components of curriculum and instruction. Ultimately, the plan must provide specific goals, timeline for action, measurable outcomes, and accountability. The plan should also incorporate diverse representation at all leadership levels, including senior faculty and administration.

Institutional commitment to diversity planning requires an adequate staffing commitment. At the Denver hearing, Dean Richard Krugman, University of Colorado School of Medicine, told the Commission that although the school’s faculty participates in diversity-related activities, there are significant constraints placed on faculty time, commitment, and prioritization. As a result, a core group of faculty largely shoulders the institution’s responsibility for pushing forward its diversity agenda. The Commission believes that institutions should put the full weight of their commitment behind ensuring the adequate staffing, development, and management of diversity programs.

Lastly, like the mission statement, the admissions policy statement must also put forth unequivocal language that the institution’s senior executives and board of directors expect the institution to become a leader in diversity and a model of academic excellence for a dynamic, multicultural learning environment. Given the clarity of the U.S. Supreme Court decision in *Grutter v. Bollinger*, admissions policy statements should provide a clear and bold promulgation of the institution’s recognition of the higher court’s positive ruling on affirmative action.

Institutional Climate

Diversity among health professions students may improve the cross-cultural learning experiences and cultural competencies of all students (IOM, 2004). The dynamic interaction among students from diverse backgrounds may help students challenge assumptions and expand perspectives regarding race, ethnicity, and culture (IOM, 2004). Undoubtedly, the quality of the institutional environment plays no small part in enhancing the learning experiences for all students. Scholars and university administrators often speak of the special importance of building a “critical mass” of minority students to create and maintain a supportive institutional climate for these students. While it is intuitive that maintaining a “critical mass” of underrepresented minority students and faculty can itself promote an atmosphere of inclusion, institutional lead-

ers must also be aware of many untended aspects of institutional climate. Broadly speaking, institutional climate refers to the collective social, cultural, and psychological attitudes and values that prevail within an institution and which demonstrate—particularly as seen from the viewpoint of minority students and faculty—whether the institution truly welcomes minorities. In essence, institutional climate is the real or perceived manifestations of an institution’s commitment to diversity.

For minority students, institutional climate exerts a profound effect on the quality of the educational experience and directly influences a student’s sense of comfort and security. Institutional climate also directly affects a student’s academic persistence and scholastic success. Several institutional elements help shape the institutional environment and student perceptions of the environment, including the degree of organizational diversity and organizational cultural competence; the historical legacy of exclusion or inclusion of racial and ethnic minority students, faculty, and administrators; and perceptions of the degree of cross-cultural receptivity, and racial and ethnic tension and discrimination on campus.

The Commission believes that the absence of overt hostility, harassment, and unfriendliness does not alone constitute a welcoming climate for racial and ethnic minorities. One study noted, for example, the institutional phenomenon of “benign neglect” wherein a campus feels friendly, but the faculty and staff do not respond to the needs of minority students (McGlenn et al., 1999). A truly welcoming climate demonstrates that minority students are valued equally with majority students by meaningfully addressing the needs and concerns of all students. A welcoming climate requires the authentic campus-wide acceptance of students and faculty from diverse racial and ethnic backgrounds. Achieving a genuinely welcoming climate may require that institutions promote a campus-wide appreciation for diversity. At the public hearing in Denver, Dr. Jesus Trevino, Associate Provost for Multicultural Affairs, University of Denver, described the common but harmful misconception that affirmative action translates into the admittance of unqualified minority students. Dr. Trevino called for “massive training” for faculty, staff, and students to dispel this misconception. Dean Patricia Moritz, University of Colorado, School of Nursing, told the Commission that the school’s competency-based curriculum addresses racism directly. Dean Moritz said students must be able to “understand and recognize racism when it occurs and the equivalent of unconscious bias.”

Promoting Student Success

The educational mission of all health professions schools is to provide the opportunity for all students to succeed. An essential aspect of institutional climate is the provision of accessible, well-developed minority support services that promote a welcoming atmosphere and enhance

opportunities for minority student success. To this end, institutions must make meaningful investments in a broad spectrum of essential programming, including academic enrichment and mentoring, and ensure that these services are available to all students. Institutions should undertake activities geared toward the development and strengthening of a diverse and welcoming institutional climate such as campus-wide diversity training. As mentioned, the overall educational experience, as shaped by the institutional climate, substantially influences a student's persistence and success. Several institutional elements significantly determine the quality of the educational experience, including academic program and advisement; faculty/student relationships; administrative practices and policies; the availability of support services; and co-curricular resources and activities.

With an incredulous lack of foresight, Ben Carson's medical school advisor told him that he was not "cut out for medical school" (Smiley, 2004). Yet today, Dr. Ben Carson, a black male who grew up in a low-income single-parent household, is a world-renowned neurosurgeon and Director of the Division of Pediatric Neurosurgery at Johns Hopkins. Still, despite tenacity and resourcefulness, many underrepresented minority students require support services, such as academic enrichment, to ensure their academic persistence and scholastic success. As mentioned, students of color often receive their education in poor schools. Not unlike Dr. Carson's inappropriate medical school advisement, minorities often receive poor academic guidance during the crucial development years. Unsurprisingly, this inferior educational experience can lead to a range of support needs during health professions schooling. In contrast to their white peers, minority health professions students are more likely to demonstrate lower reading levels and problem solving skills, resulting in higher attrition rates (Taylor & Rust, 1999). According to the AAMC, black and Hispanic medical students are more likely to repeat their first year or drop out (IOM, 1994). A 1994 study in JAMA showed that, in 1988, over half (51 percent) of black medical students failed Part 1 of the National Medical Board Exam (Dawson et al., 1994).

The presence of pre-admissions programs that provide opportunities for academic enrichment and acclimation is positively associated with the enrollment of under represented minority students (Strayhorn & Demby, 1999) and is indicative of an institution's commitment to student success. In addition, the early linkage of a student with an advisor or faculty mentor can make the difference between academic failure and success. Culturally competent advisors and mentors can serve as guideposts for students, enabling them to navigate each twist and turn of the student's academic pathway. Mentors also serve as student advocates and sounding boards for difficult issues (e.g., acclimation challenges, personal difficulties, harassment, personally mediated racism, etc.).

Mirroring the teacher demographics of the public education system, more than 90 percent of health professions schools faculty are white. Learning involves a dynamic psychosocial relationship between teacher, student, and educational setting. Enhancing the diversity of faculty can provide needed resources for support for mentoring and role models for underrepresented minority students. Interactions with minority faculty may enable minority students to envision themselves as faculty, researchers, and clinicians and to overcome feelings of isolation. At the Atlanta hearing, Mr. Paul Young, a second-year medical student at Mercer University School of Medicine, described the profound sense of isolation he faced as a lone African American medical student: "...I somehow feel I share similarities with Jackie Robinson in the sense that currently, at my medical school, I'm the only black male at the school." Ms. Vanessa Spearman, a third-year student at the Medical College of Georgia put forth a related frustration: "We don't want to have to always look outside to find support and motivation to go on. We want to have it within our school."

Ms. Carrie Broadus, a consumer advocate and member of the Board of Governors of LA Care Health Plan, told the Commission that a minority student may oftentimes feel isolated even from his or her own family because of the student's different sense of vision. Theron Jones, a senior dental student at the Medical College of Georgia and past-president of the Student National Dental Association, testified that the "visible presence of minority mentors and students can create a sense of belonging and encouragement to current students and to younger students considering dentistry as a career." Dr. Eric Whitaker, Director, Illinois Department of Public Health told the Commission that he credits his scholastic success at the University of Chicago School of Medicine (where he was the only African-American in his entering class) to the mentorship he received from two African-American internal medicine residents.

The paucity of minority faculty means fewer minority students will enjoy the privilege and benefits of race-concordant mentorship, teaching, and role modeling enjoyed by white students. In addition, given the low numbers of minority faculty, mentorship responsibilities with minority students may place a heavier administrative burden or "color tax" on minority faculty (Gonzalez & Stoll, 2002). Schools should regularly evaluate and, as needed, enhance the quality and impact of its minority mentoring program. Students are the primary beneficiaries of a diverse faculty. The Commission believes that health professions schools have an obligation to build and maintain a critical mass of minority faculty and to ensure effective mechanisms are in place for faculty recruitment, development, and retention.

Institutions also have an obligation to maintain an environment that is safe and free of racial and ethnic harassment. Freedom from racial and ethnic stigma enhances the institutional atmosphere for all individuals and improves the sense of comfort and security for minority

students. All students and faculty should expect prompt attention to and resolution of reported instances of harassment or bias. The Commission believes that institutional leaders must forcefully put forth a zero-tolerance policy toward such incidents. In addition, institutions should periodically evaluate the efficacy of their incident reporting and resolution systems.

Health professions schools often centralize support services for underrepresented minority students within a designated office (e.g., the Office of Minority Affairs or the Office of Multicultural Affairs). These offices often provide an array support services such as scholarship information, academic support, co-curricular support services, and other resources directed toward minority students. As with race-concordant mentors, minority students often find respite in these offices. At the Denver hearing, Dr. Trevino noted the importance of selecting positive language in naming and operating an institution’s minority affairs office. Dr. Trevino noted with concern that some programs use deficit model language such as, “at-risk” or “socially disadvantaged.” The Commission believes that it is incumbent upon institutional leaders to ensure that centralized URM support programs do not substitute the broader imperative for an active, institution-wide commitment to URM development. Institutional leaders should regularly evaluate the financial and operational alignment of these offices with the institution’s diversity mission to ensure program efficacy and adequate staffing and programmatic resources.

Health Professions Leadership Development

“In order to cultivate a set of leaders with legitimacy in the eyes of the citizenry, it is necessary that the path to leadership be visibly open to talented and qualified individuals of every race and ethnicity. All members of our heterogeneous society must have confidence in the openness and integrity of the educational institutions that provide this training.”

– Sandra Day O’Connor, U.S. Supreme Court Justice⁶

In Atlanta, Dr. Christopher Leggett told the Commission that minority health professionals in leadership and policy positions are more likely to keep the issues of diversity, and racial and ethnic health disparities on the “front burner of the policy landscape.” They are more likely to focus on the crucial issues of prevention and community empowerment than are majority professionals. However, talented underrepresented minorities who successfully navigate obstructions along the pipeline to the health professions can expect to encounter further barriers along the path to leadership. Across the nation, African Americans, Hispanics, Native Americans, and several Asian subgroups are chronically underrepresented in leadership positions in nursing, medicine, and dentistry. As discussed previously, minority health professionals serve a unique role as faculty mentors and role models. They also enhance organizational and systemic cultural competency at all levels of the health system.

With the exception of minority-serving health professions education institutions,⁷ only 4 out of 119 deans (3.4 percent) are underrepresented minorities. Of the 2,546 medical departments, only 48 (1.9 percent) are chaired by an underrepresented minority (AAMC, 2002).

At the Denver hearing, Dr. Spero Manson of the University of Colorado, Health Sciences Center, voiced the concern that Native Americans are severely underrepresented in research projects designed to address the health concerns of this community. Dr. Manson reported to the Commission that only one-tenth of one percent of total faculty in major U.S. universities is American Indian/Alaska Native. Dr. Gregory Strayhorn of Morehouse School of Medicine told the Commission that minority faculty tend to be at the lower ranks. Dr. William Casarella, Executive Assistant Dean for Clinical Affairs, Emory University School of Medicine, noted that while the medical school nearly doubled its black faculty over the past decade (from 59 to 111), only 2 of the school's 111 black faculty members are tenured. In some health professions schools there is no systematic plan for minority leadership development. Dr. Jean Bartels of the AACN called for increased support for nursing leadership-development programs. The Commission believes that medical, nursing, and dental schools should evaluate their minority leadership-development programming, establish a formal system for mentorship and leadership development, assess program activities during regular minority career-development meetings, and provide greater opportunities for junior minority faculty to obtain research skills and experience.

Institutions should also evaluate their faculty search procedures. For example, the search committee procedure at the University of Colorado, School of Medicine includes a mandatory consultation with the Office of Diversity and special training for search committee chairs and members. The University of Denver has hired an assistant provost whose full-time job is to ensure faculty diversity. The Colorado Department of Public Health and Environment extends the posting time for open positions when there is an inadequate number of applicants of color to allow time for a more expanded search.

Summary

The nation's pipeline to the health care professions has significant obstructions that limit the likelihood that a critical mass of talented minority health professions students and health professionals will emerge. The social markers of race and ethnicity often substantially influence an individual's access and forward motion at each of three key stages of the pipeline: (1) primary and secondary education, (2) college years, and (3) health professions education and leadership development. On average, racial and ethnic minority students score lower on standardized tests, are less likely to complete high school or college, and overall receive a substantially lower quality of education than white students. However, even talented minority youths who

successfully complete high school and college still face disparate barriers to gaining admission to the nation's health professions schools. Even still, minorities who successfully gain admission to the health professions schools continue to encounter multiple barriers to academic success, as well as impediments to professional development.

Recommendations

- 4.1 Health professions schools, hospitals, and other organizations should partner with businesses, communities, and public school systems to: a) provide students with classroom and other learning opportunities for academic enrichment in the sciences; and b) promote opportunities for parents and families to increase their participation in the education and learning experiences of their children.
- 4.2 The U.S. Public Health Service, state health departments, colleges, and health professions schools should provide public awareness campaigns to encourage underrepresented minorities to pursue a career in one of the health professions. Such a campaign should have a significant budget comparable to other major public health campaigns.
- 4.3 For underrepresented minorities who decide to pursue a health profession as a second career, health professions schools should provide opportunities through innovative programs.
- 4.4 Baccalaureate colleges and health professions schools should provide and support "bridging programs" that enable graduates of two-year colleges to succeed in the transition to four-year colleges. Graduates of two-year community college nursing programs should be encouraged (and supported) to enroll in baccalaureate degree-granting nursing programs.
- 4.5 Key stakeholders in the health system should work to increase leadership development opportunities in nursing in order to prepare minority nurses with graduate degrees for roles as scholars, faculty, and leaders in the profession.
- 4.6 Key stakeholders in the health system should work to increase leadership training and opportunities for underrepresented minority physicians and dentists.
- 4.7 Colleges, universities, and health professions schools should support socio-economically disadvantaged college students who express an interest in the health professions, and

provide these students with an array of support services, including mentoring, test-taking skills, counseling on application procedures, and interviewing skills.

- 4.8 The Association of American Medical Colleges, the American Association of Colleges of Nursing, the American Dental Education Association, and the Association of Academic Health Centers should promote the review and enhancement of health professions schools admissions policies and procedures to: a) enable more holistic, individualized screening processes; b) ensure a diverse student body with enhanced language competency and cultural competency for all students; and c) develop strategies to enhance and increase the pool of minority applicants.
- 4.9 Dental and medical schools should reduce their dependence upon standardized tests in the admissions process. The Dental Admissions Test and the Medical College Admissions Test should be utilized, along with other criteria in the admissions process, as diagnostic tools to identify areas where qualified health professions applicants may need academic enrichment and support.
- 4.10 Diversity should be a core value in the health professions. Health professions schools should ensure that their mission statements reflect a social contract with the community and a commitment to diversity among their students, faculty, staff, and administration.
- 4.11 Health systems and health professions schools should use departmental evaluations as opportunities for measuring success in achieving diversity, including appropriate incentives.
- 4.12 Health systems and health professions schools should have senior program managers who oversee: a) diversity policies and practices; b) assist in the design, implementation, and evaluation of recruitment, admissions, retention, and professional-development programs and initiatives; c) assess the institutional environment for diversity; and d) provide regular training for students, faculty, and staff on key principles of diversity and cultural competence.
- 4.13 Health professions schools should increase the representation of minority faculty on major institutional committees, including governance boards, and advisory councils. Institutional leaders should regularly assess committee/board composition to ensure the participation of underrepresented minority professionals.

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Chapter 5

Financing Education in the Health Professions

Throughout the hearings, many people mentioned the cost of an education in the health professions as a major barrier to increasing diversity in medical, dental, and nursing schools. The high and rising costs of both an undergraduate education and an education in the health professions pose a formidable barrier for students of underrepresented minorities, who are more likely to come from low-income groups.

This chapter provides an overview of the costs of financing an education in the health professions and the attendant debt burden. Additionally, this chapter assesses the impact of high educational costs on academic persistence, career choices, and career planning. Finally, a review of financial assistance resources for undergraduate and health professions education is made, and a rationale is given for emphasizing scholarships, tuition reimbursement, and loan repayment over conventional loan instruments.

The Costs and the Ability to Pay

“I had incredible support that allowed me to pursue my dreams and fight to get my education. Even if I’m here on loans, I’m not letting money become an issue. It’s the only way I can get through and I’m not going to give up.”

– Claribel Sanchez, a University of California, Berkeley, student born and raised in East Los Angeles, Los Angeles hearing, November 14, 2003

A family’s ability to finance the costs associated with postsecondary schooling is a factor for all students as they prepare for higher education. However, underrepresented minority students come disproportionately from families with lower income and lower wealth than whites and are more likely to perceive the cost of an education as a deterrent or an unmanageable burden. According to the Census Bureau, there is sizeable disparity in family income across racial and ethnic groups, with families headed by blacks or Hispanics earning considerably less than families headed by white non-Hispanics or Asians and Pacific Islanders (U.S. Census Bureau, 2002a). In 2001, the median income for white families was 40 percent above that of blacks and 39 percent above Hispanics. For Asian/Pacific Islanders the numbers were even higher, with these families earning levels 43 percent above those earned by blacks and 42 percent above Hispanic family earning levels (U.S. Census Bureau, 2002a). Over the three-year period from 1999-2001 the average income for American Indian and Alaskan Native families was on par with that of Hispanic families (U.S. Census Bureau, 2002b). Additionally, black and Hispanic families have less overall wealth than white families (Choudhury, 2002).

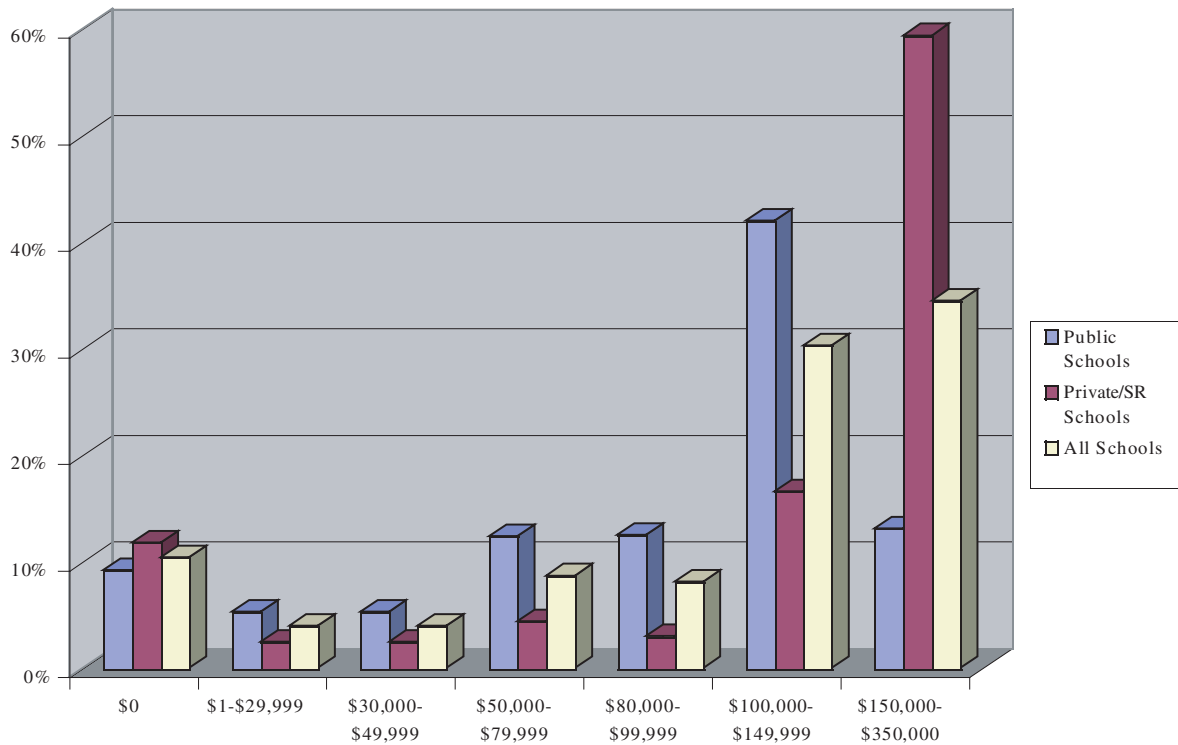
An unfortunate circumstance for all low-income students is that the costs of college education have climbed steadily at a time when sources of student aid, especially need-based grant aid, have declined sharply. In the 1975-1976 academic year the maximum Pell grant awarded by the federal government covered 84 percent of public four-year costs; by 1999-2000 the maximum need-based award fell to 39 percent of costs (College Board, 2000 and U.S. Department of Education, 2000b, as cited in Advisory Committee on Student Financial Assistance, 2001). The decreased ability of these grants to cover college costs is particularly disheartening in light of evidence, suggesting that the type of aid received may influence college attendance for students in the lowest income quartile. Grants were shown to greatly influence enrollment for low-income students; however, loans were not linked with increased rates of enrollment for this group (Grumbach et al., 2002).

The Advisory Committee on Student Financial Assistance reports that even the most qualified of low-income students face inordinately high unmet financial need⁸ and excessive levels of work and loan burden are required to meet the expenses (Advisory Committee on Student Financial Assistance, 2002 and 2001). Because of the high levels of unmet need, graduating low-income high school students are less likely than high-income students to plan to attend four-year institutions; take qualifying exams; and apply, enroll, and persist to graduation (Advisory Committee on Student Financial Assistance, 2002). In fact, the Advisory Committee estimates that 48 percent of academically qualified low-income students do not attend four-year colleges because of the financial barriers.

Data on the 1999-2000 academic school year, collected by the National Center for Education Statistics, indicate that most underrepresented minority undergraduates are from low-income families (U.S. Department of Education, 2003b). Upon graduating from a four-year college, many students have debts of \$10,000 or more. Faced with paying off the debt, low-income students may not even consider incurring more debt in order to pursue an education in the health professions. Similar to undergraduate colleges and universities, tuitions have increased substantially in dental, medical, and nursing schools. Tuition and fees at dental schools increased by 84.6 percent between 1991-1992 and 1997-1998, with the largest increase happening in public schools, at a rate of 94.5 percent (Valachovic et al., 2001). Rising fees are accompanied by rising debt. At the public hearing in New York, Dean Richard Buchanan, at the School of Dental Medicine, State University of New York at Buffalo, put forth the concern that debt burden for dental education poses a serious obstacle for students from disadvantaged backgrounds. More than 60 percent of students graduating from dental schools in 2003 owed upwards of \$100,000 in dental school debt for their dental education (see Figure 5-1) (Weaver et al., 2004).

Figure 5-1 Percentage distribution of Educational Debt of Dental Students Upon Graduation from Dental School 2003 by Level of Debt

Source: American Dental Education Association, 2004



“The average educational debt of graduating dental students in 2003 was \$118,748, ranging from \$93,622 for public schools to \$147,967 for private/state related schools. Rising dental student educational debt and faculty vacancies are two major challenges for the dental profession. There is a critical need for the influx of funds estimated at \$1 billion to assure a viable pipeline of candidates for careers in dental practice, education, and research for the future.”

– Commissioner Jeanne C. Sinkford, D.D.S., Ph.D., American Dental Education Association and Dean Emeritus, Howard University College of Dentistry

Similarly, the costs and debt associated with medical education are considerable. Over the last 20 years, the debt levels have increased six-fold for graduates of medical school (IOM, 2004). The majority of medical students will acquire substantial debt during the course of their training. About 50 percent of 2001 graduates owed more than \$100,000 (AAMC, 2002). Student debt loads are similar for all medical students; however, students from underrepresented minorities are two to three times more likely to have an existing debt burden from their undergraduate education. At public institutions, 16.8 percent of non-minority students graduated debt-free in 2001, whereas only 8.4 percent of underrepresented minority students did so. For private medical schools in the same year, the numbers were 20.3 percent and 8.1 percent, respectively (AAMC, 2002).

“An important step to diversifying the student population is to remove the financial barriers to a nursing education. Moreover, students interested in pursuing a graduate degree, often point to a lack of funding as a primary reason for not pursuing additional education. Scholarships, grants, loan repayment plans, fellowships, and other funding streams are needed to attract more underrepresented minority students to nursing and to provide incentives for current underrepresented minority nurses to advance their education and move into leadership roles.”

– Commissioner Geraldine Bednash, Ph.D., R.N., F.A.A.N., Executive Director,
American Association of Colleges of Nursing

Data on costs and debts related to nursing education are not routinely gathered. However, preliminary data from the National League for Nursing indicate that between 1990-1991 and 2000-2001 the tuition for public and private R.N. programs nearly doubled (IOM, 2004). Anecdotal evidence suggests that nursing students also encounter serious debt burdens (IOM, 2004).

The Impact

Educational costs and debt in the health professions exert influence on students from underrepresented minorities in myriad ways, from the initial decision to pursue a health degree to persistence, career choice, job satisfaction, and even lifestyle.

First, promising secondary students who might consider medicine, nursing, or dentistry as a career are deterred by the high educational costs. The Commission heard this familiar concern expressed by a student from the Francisco Bravo Medical Magnet High School in Los Angeles, California. The Commission is deeply concerned that even students attending such a prestigious secondary public school as Bravo are dissuaded from pursuing careers in the health professions because of the high costs. That deterrent would surely be compounded by other deterrents, such as the lack of adequate guidance and direction toward financial aid resources.

Second, the high costs of a medical education cause some students who begin their education to drop out if they encounter unanticipated costs or debts along the way. Studies suggest that there may be some correlation between perceptions of debt burden and a person’s racial and socioeconomic background. Minority and low-income students associate greater hardship than their counterparts when faced with similar debt and income levels (Baum & O’Malley, 2003 as cited by IOM, 2004). Other studies indicate that semester-to-semester persistence is significantly compromised by debt. Dental students were 5.76 percentage points less likely to persist to the next semester with every \$1,000 increase in debt (DeAngelis, 2000).

Third, a number of studies in the medical literature indicate that the need to repay school debts influences the careers choices of medical school students (Baker & Barker, 1997; Colquitt et al.,

1996; Rosenthal et al., 1996). Graduates with debts may be reluctant to go into primary care fields where incomes are lower than in specialty areas. As noted in the Institute of Medicine report (2004), there is evidence that levels of debt may exert a greater influence on students of color with regard to career choice. Students from underrepresented minority populations were less likely to choose primary care fields when they had debt over \$75,000; however, when carrying a debt under \$75,000 they were equally likely to choose primary care fields (Rico and Stagnaro-Green, 1997 as cited in IOM, 2004).

Finally, debt influences career satisfaction and lifestyle. Overall, debt levels from undergraduate and professional education seem to affect the quality of life that graduates have once they enter practice. An examination of the characteristics of physicians expressing dissatisfaction with their choice of medicine as a career reveals that Hispanics, African Americans, and Caucasian women are least satisfied, and debt was one of the contributing reasons (Hadley et al., 1992 as cited in IOM, 2004). Debt management is a serious issue for health professionals. While debt levels have outpaced economic growth, resident salaries and the income of dental practitioners have not grown at the same rate (Myers & Zwemer, 1998 and Johnson, 2002b, as cited in IOM, 2004). Great debt burden affects how graduates feel about their work, affects the quality of their work, and may influence them to leave a health care delivery field for an administrative position.

Addressing the Need for Financial Assistance

Throughout its deliberations, the Commission heard about the importance of federal programs such as the federal Health Careers Opportunities Program (HCOP) and the National Health Service Corps (NHSC) in helping to alleviate the debt burden of minority students. Several presenters testified that without these crucial programs many minority students would not have been able to make it through their professional education. There are several programs that provide financial assistance to students in the health professions. For example, the National Center on Minority Health and Health Disparities (NCMHD) provides two major educational loan repayment programs⁹ which support over 300 individuals. In the Loan Repayment Program for Health Disparity Research (HDR-LRP), eligible participants receive up to \$35,000 each year for the two-year program; participants are obligated to conduct a minimum of two years of basic, clinical, or behavioral research directly related to health disparities. Half of the loans are made to individuals from populations with health disparities. In the Extramural Clinical Research Loan Repayment Program for Individuals from Disadvantaged Backgrounds (ECR-LRP), eligible participants must come from a family with a low income below a prescribed threshold determined annually. Centers of Excellence (COE) provide federal grants to health

professions schools to support minority students in programs of allopathic and osteopathic medicine, dentistry, and pharmacy, as well as graduate programs in behavioral science and mental health. However, despite financial hardships faced by minority nursing students, COE does not provide grants to schools of nursing.

Presenters often noted with concern, that the assistance strategy of providing loans does not adequately address the debt burden of low-income, underrepresented minority students. As noted, low-income students confronted by the formidable debt burden of an education in the health professions—and who already face significant debt from their undergraduate education—may be discouraged from pursuing, or continuing with, that education. Mr. Marc Nivet of the Associated Medical Schools of New York told the Commission that attaching extracurricular student obligations to loans and scholarships poses an added performance challenge to students receiving this aid. For example, one study (Whitten, 1999) showed that the poor performance of some low-income students were attributable, in part, to the lack of study time caused by the need to work in order to finance their education. One presenter cited the example of the Regents Healthcare Scholarship Program, which gives students \$10,000 per academic year. Although 100 of these scholarships (80 for medical students and 20 for dental students) are available in New York State, there have been no more than 50 program applicants in the past five years because the amount does not make a sufficient dent in student debt and students are asked to take on extra-curriculum responsibilities to qualify. Dean Buchanan expressed opposition to the federal practice of taxing loan redemption payments to students. The Commission noted the repeated call for a better evaluation of the effectiveness of student aid programs. There is a strong consensus in the Commission that unattached scholarships—not loans—should be a major mechanism for financing education for students of color and a major strategy to increasing diversity among health professionals.

Federal and state loan forgiveness programs should be broadly implemented, with special consideration given to low-income students who are dedicated to professionally serving underrepresented minorities or conducting research on racial and ethnic health disparities. Dean Buchanan cited the effectiveness of New York State's public health program, which in the last six years increased loan redemption efforts from 39 to 82 programs leading to the creation of 1,700 public health positions. Dean Buchanan noted that progressive loan redemption programs increase the percentage of loan reduction annually and serve as "powerful tools" for long-term professional placement of underrepresented minority health professionals.

In addition to governmental sources of student financial aid, there are some private foundation sources of funding for health careers education. However, cuts in federal and state resources for health-related programs have placed an increased burden on these foundations to fill the gaps.

Given the resource limitations and various missions of private foundations, there is an unmet need for greater federal commitment to financial aid programs that bolster the mission of increasing diversity in the health professions. The benefits that diversity brings to the business sector, especially health care businesses, should compel the private sector to higher commitments of support for financing educational opportunities for underrepresented minority students. Health care institutions, many of which are struggling to fill health care provider vacancies, particularly for nurses, should also provide financing support for education, including tuition-relief incentives, to underrepresented minority students.

The Commission believes strongly that the education finance issue requires a renewed focus that recognizes and decreases the financial barriers faced by low-income, underrepresented minority students. Within this group, however, there is also a need to direct the financial support to the poorest students, giving them priority consideration over underrepresented minority students from middle-class backgrounds.

The Commission also heard from administrators, faculty, and students at predominantly minority institutions that represent an exceptional and longstanding legacy of commitment to training students of color. There was strong and consistent recognition that these schools play a particularly important role in producing talented, culturally competent health professionals who not only increase the diversity of the workforce but who also tend to practice in underserved communities. The Commission supports a robust and reinvigorated federal commitment to financial aid capacity of these institutions.

Recommendations

- 5.1 Congress should substantially increase funding to support diversity programs within the National Health Service Corps, and Titles VII and VIII of the Public Health Service Act. Such funding should also provide for collection of data on diversity.
- 5.2 To reduce the debt burden of underrepresented minority students, public and private funding organizations for health professions students should provide scholarships, loan forgiveness programs, and tuition reimbursement strategies to students and institutions, in preference to loans.
- 5.3 Public and private entities should significantly increase their support to those health professions schools with a sustained commitment to educating and training underrepresented minority students.

- 5.4 Businesses, foundations, and other private organizations should be encouraged to support health professions schools and programs to increase financial resources needed to implement the recommendations of the Sullivan Commission.
- 5.5 The President and Congress should increase the funding for the National Institutes of Health's National Center for Minority Health and Health Disparities Loan Repayment Programs, with a special emphasis on programs for underrepresented minority students.
- 5.6 The National Institutes of Health should develop a Centers of Excellence program for schools of nursing.

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Chapter 6

Accountability

Principles of Accountability

The mandate to increase diversity and cultural competence in the health care workforce will not be fulfilled unless institutions and systems hold themselves accountable—and are held accountable—to achieve those goals. During the course of its public hearings, the Commission identified two questions fundamental to accountability: (1) How should institutions hold themselves accountable for meeting diversity goals? (2) What roles do external entities—accreditation bodies, government, community, and others—play in ensuring an institution’s commitment to diversity and cultural competence? In considering these questions, we identified four imperatives that shaped our operational definition of accountability: quality care mandate, measurement, community benefit, and institutional commitment.

Quality Care Mandate

The Commission believes that because diversity is important to the delivery of high-quality health care to all Americans, institutions that deliver health care are intrinsically obligated to demonstrate a robust commitment to diversity and cultural competency and to uphold an efficient and transparent system of accountability. Agencies that grant accreditation to health care institutions or licensure to health care professionals share this same commitment, and should monitor and promote institutional and professional accountability. Similarly, health professions schools hold the weighty responsibility of preparing a diverse and culturally competent health care workforce that can deliver high-quality care and manage the health care system. Health professions organizations involved in education and training should share the commitment of accountability to the quality care mandate.

Accountability Measurement

At the public hearing in Chicago, the Vice President, Division of Community and Minority Programs, Association of American Medical Colleges, put forth the premise that achieving diversity “requires elevating diversity to a widely accepted measure of health care quality that is comparable to other quality measures,” such as student test scores, mortality rates, and customer service. The Commission believes that diversity and cultural competence are measurable¹⁰ attributes of health system quality. These measurements enable institutions, and their governing agencies, to monitor and evaluate accountability—that is, to gauge where they are in achieving diversity and where they should be. The Commission believes that

each institution should have a transparent process to collect and monitor data collection systems to provide these assessments across all levels, for example, students, faculty, staff, and governing boards.

Measuring health system diversity and cultural competency raises a twofold question: What is the unit measured? What is the appropriate standard to measure against? First, there are two basic units or levels¹¹ of measurements: national and institutional. A national measurement provides the data to calculate the overall level of diversity and cultural competency in the nation's health professions schools and in the health care workforce.¹² The national standard for diversity should be set at a value that approximates the demographic representation of minorities nationally. The national standard for cultural competence should be set at 100 percent of the health care workforce. The Department of Health and Human Services should set the national diversity and cultural competency standard and should publicly report national measurements and standards for diversity and cultural competency in the nation's health care workforce.

Similarly, an institutional measurement provides the data with which to evaluate diversity in a given school or health care organization. While federal laws do not allow schools or employers to set numeric goals for admissions or hiring based upon race and ethnicity, it is, nonetheless, both practical and lawful for institutions to measure their diversity level. For example, health care institutions, in carrying out community benefits program activities, may conduct needs assessments to measure or appraise the health care needs of a target community or health care market. Needs assessments that capture community demographics, including race and ethnicity variables, are valuable instruments in enabling an institution to approximate a community's health care workforce needs and ensure a critical mass of underrepresented minority providers.

Major health care school associations, such as the American Association of Colleges of Nursing, the American Dental Education Association, and the American Association of Medical Colleges already collect comprehensive data on diversity. Data collection is a prerequisite of measurement. To ensure accountability to diversity and cultural competency, health care schools and institutions, and their respective governing associations, must develop and maintain data collection systems that facilitate diversity and cultural competency measurement. For example, the New York City Health and Hospital Corporation utilizes a detailed report that monitors workforce diversity at its affiliated contract hospitals. The Department of Health and Human Services (HHS) has the authority under Title VI of the Civil Rights Act of 1964 to require healthcare providers and states to collect data on patient race, ethnicity, and language preference. In January 2001, OCR and the Surgeon General sent letters to over 30 prominent health care organizations underscoring the importance of data collection and affirming its legality. HHS has also funded numerous projects on data collection. Even still, HHS has only exer-

cised its discretion to invoke this authority in a piecemeal fashion. Overall, the nation's current data collection system is patchwork at best. The Commission believes that HHS must fully invoke its authority under the Title VI regulation and promulgate mandatory data collection requirements for hospitals and states.

The adage “knowledge is power” holds true for institutions and their governing agencies—and it also holds true for the general public. Access to diversity and cultural competency data can empower affected communities by enabling them to participate meaningfully in the mandate to improve health care quality. To this end, it is important that federal, state, and institutional data collection systems include provisions for public reporting.

Community Benefit¹³

As part of their federal tax-exempt status, hospitals must promote the health of the community. Schools for the health professions, teaching hospitals, universities in the governmental and not-for-profit organization forum all derive significant advantages from their tax-exempt status. A requirement for tax-exempt status for nonprofit health care delivery organizations is that these institutions provide benefit to the communities that they serve. The Commission believes that a community benefits principle applies to educational organizations and those providing training as well, and that diversity and cultural competence are easily identifiable community benefits because they fulfill essential community goals. Health professions schools and health care institutions that hold a tax-exempt status should be accountable to provide communities with the benefits of institutional diversity and cultural competency. While many organizations may recognize the community benefit obligation in principle, they may not recognize it with regard to diversity and cultural competence. One key strategy for not-for-profit hospitals in increasing workforce diversity is to strengthen links between health professions education and training programs and community benefit programs. Barnett and Hattis (2004) found that when community benefit programs are well designed, comprehensive, and fully integrated into local communities, these programs¹⁴ enrich the learning environment for health professions trainees.

Some organizations that do recognize the community benefit mandate of diversity and cultural competency may not be held accountable for its fulfillment. State governments can play an important role in ensuring accountability. Some state agencies have actively requested that hospitals report annually their compliance with the community benefit obligation. For example, after area health institutions in Massachusetts articulated expectations of community benefits, the state's Attorney General's office responded by requiring regular reporting of institutional efforts through the Hospital Community Benefit report form for nonprofit hospitals. In addition,

concerted community efforts led by Health Care for All¹⁵ yielded inclusion of annual reporting of physician diversity efforts to the state's reporting guidelines.

Institutional Commitment

“The commitment of a university president or chancellor or dean can not only institute new policies and procedures, but can provide a change in culture, change in attitudes, changes that will remove roadblocks that have been there on the path to diversity.”

– Dr. Sullivan, Chicago hearing, October 20, 2004

As discussed in Chapter 4, increasing diversity and cultural competency requires leadership, vision, political will, and a clear institutional mandate. The institutional changes and major cultural shift required to fulfill the diversity mandate are not likely to occur in the absence of strong leadership. Mission statements, admissions policy statements, and a strategic plan can go a long way in actualizing institutional commitment. Nonetheless, the persistent institutional barriers faced by underrepresented minorities strongly suggest that not every institution fully recognizes or appreciates the value and importance of diversity and cultural competency. Some institutions may express a commitment to diversity and cultural competence, and may even undertake efforts to address the shortage of minorities, while their internal efforts of accountability still fall short. Institutions may fail to generate a vertically proportionate commitment at all organizational levels—from providers, faculty, administrators, deans, and board members. At the public hearing in Chicago, the Vice President of the AAMC expressed the view that while sanctions for noncompliance can be useful, “publicly acknowledging and rewarding those who significantly contribute to diversity concretely demonstrates that an institution appreciates the benefits that diversity brings.” Another strategy for accountability might be to tie a department chair's performance evaluation to the department's success in increasing diversity.

Institutional commitment and incentives are necessary but insufficient vehicles for increasing diversity and cultural competency. Increasing institutional compliance may require considerable outside influence and pressure. The Commission believes that institutions that demonstrate ineffectiveness at ensuring diversity and cultural competency must be identified and brought to greater scrutiny and corrective action. The Commission considered several realms of external accountability, including school/program accreditation bodies; professional licensure agencies; health care governance bodies; associations of health professions schools; and societies of health professionals, government, and community. We heard testimony calling for a robust, internal/external, multi-sector paradigm of accountability. The Commission concluded that many private and public agencies and organizations can play effective roles as stewards and change agents in ensuring institutional accountability to diversity and cultural competence.

Strategic Change Agents for Accountability

“It is, therefore, an imperative that we increase access to the profession for minority students by removing both the academic and financial barriers. This can be achieved through leadership at all levels of the profession and by minority programs that build on community and academic resources throughout the U.S.” (Solomon et al., 2001)

Accrediting Organizations

Governance organizations that oversee and accredit schools of the health professions can take a vanguard role in promulgating standards and ensuring that institutions meet those standards for diversity and cultural competence. For example, as the organization responsible for the national oversight and accreditation of medical education, the Liaison Committee on Medical Education should hold medical schools accountable for diversity of these institutions’ student bodies, residency and fellowship programs, faculties, and advisory and governance boards. To improve institutional awareness and understanding of the important value of diversity and cultural competence, accrediting organizations should strongly encourage deans to receive diversity training as well as technical training that enables institutions to design and manage effective diversity programs. As monitors of quality in education responsible for pushing institutions to higher levels of performance, accrediting bodies should make explicit the connection between preparing a workforce that is culturally competent and diverse, and meeting the health care needs of our diverse population. To that end, health professions schools should be held accountable for expanding diversity and the cultural competence of their graduates. In keeping with the quality measurement imperative, we believe that accrediting agencies should monitor the diversity and cultural competence indicators for schools of the health professions.

Dr. Charles Terrell of the AAMC cautioned that accreditation should not be viewed as a primary vehicle for moving a “massive institutional culture” toward greater diversity. Dr. Jean Bartels of the AACN cautioned that accreditation should not be prescriptive in terms of setting quotas.

Health Care Delivery Institutions

Health care accrediting bodies, such as the Joint Commission on the Accreditation of Healthcare Organizations, provide critical oversight of hospitals and other health care delivery institutions, and therefore play a significant role in ensuring that these health care institutions adopt and maintain the highest standards of health care delivery, including standards for diversity and cultural competence. The Commission believes that accrediting or oversight bodies for health care delivery organizations should recognize the considerable achievements of those institutions that maintain high standards. Conversely, accrediting or oversight bodies should,

as needed, apply strong sanctions to those health care institutions that fail to meet standards. Dr. Anne Beal of the Commonwealth Fund suggested that the Joint Commission might leverage its influence as health care regulators to monitor institutional accountability for cultural competence standards.

Similarly in the educational context within health care delivery organizations, the Commission believes there should be high standards advancing cultural competency goals. For major teaching hospitals, responsibilities may include providing leadership in this arena, as it is often these institutions' trainees who go on to take leadership roles in these organizations. This doesn't preclude the responsibility of all hospitals to address this issue. A recent study (Barnett & Hattis, 2004) of the diversity efforts of hospital-based health professions education and training (HPET) programs highlighted the untapped opportunities for accountability and advancing cultural competency goals. One respondent indicated that their hospital's quality assurance department has never examined issues of race and ethnicity. The researchers found that most HPET programs covered in their study had limited processes in place to address issues related to diversity, health disparities, or cultural competency. An example of hospital-based strategies the study identified includes:

- Giving added weight to language skills and cultural competency in the selection process for health professions trainees.
- Appointing an underrepresented minority faculty as Director of the HPET program.
- Offering rotational clerkships with a focus on health disparities.
- Identifying diversity as a key goal in the HPET program literature and the recruitment process.
- Establishing articulated links between HPET training process and community benefit program activities in diverse racial and ethnic communities.
- Offering special programs to support health professional trainees who may not meet standard application criteria.

In some states, state health departments oversee health care institutional quality and respond to concerns or complaints about quality of care. These departments could also require that health care institutions meet the standards for diversity and cultural competence. For example, state agencies could help ensure that minority health professionals are at least proportionately represented, that health care staff members are properly certified in cultural competence, and that

culture-relevant resources, such as language interpreters and cultural competence trainers, are readily available.

In addition, state and local health departments often contract with health care institutions and local health departments to provide certain types of care or to operate community health programs. Conditions for contract eligibility often include requirements for training or hiring (for example, criminal background checks). State and local agencies could require similar training or monitoring as a condition for contract award.

Associations of Health Care Professionals

A number of organizations and societies represent nursing, medical, and dental professionals. Delegates from across the country represent their memberships at national meetings in addressing issues of the professions, including the development and monitoring of professional standards. Those organizations could play an important role in sensitizing their members to the need for cultural competency and diversity, and in endorsing measures to achieve those goals. For example, the American Medical Association could propose strong recommendations that call for mandatory training in cultural competency for all licensed physicians. The Commission applauds the American Medical Association leadership's decision to focus a national campaign on eliminating racial and ethnic health disparities. In addition, the American Association of Colleges of Nursing, the American Nurses Association, and more than 60 national nursing organizations, have established a goal for their collaborative and individual efforts to enhance diversity and cultural competence as a primary objective in the collaborative. The Nursing's Agenda for the Future (NAF) initiative outlines the desired future state of the nursing profession and was developed as a mechanism for achieving specific goals for the profession. The work of the NAF coalition includes specific initiatives by each organization in the coalition to enhance diversity in the profession. In its strategic plan, the AACN will focus on instituting innovative strategies to recruit a highly qualified and diverse nursing workforce, including faculty, sufficient to meet societal needs. This builds upon and expands a longstanding commitment to enhancing diversity established between AACN, the Hispanic Association of Colleges and Universities, and the National Association of Hispanic Nurses to expand leadership-development opportunities for Hispanic nurses. At the Chicago hearing, Dr. Hilda Richards, President, National Black Nurses Association (NBNA), discussed the valuable role that the association fulfills in providing "hands on" recruitment and mentorship programming to increase diversity in the nursing workforce. NBNA supports minority mentoring programs from primary to postsecondary levels.

The Commission believes that as leaders, associations representing health care institutions and health professionals (such as the Association of American Medical Colleges, the American Association of Colleges of Nursing, and the American Dental Education Association) can help to set and propel a robust agenda for cultural competence and diversity. It is important for professional associations to recognize the need for diversity and cultural competence across the spectrum of health professionals, including students, residents, fellows, faculty, and care providers. Because of their national influence, these associations can play a critical role in building a national alliance of opinion leaders who can make the case for diversity. Such an alliance would encourage rigorous accountability in data collection, focus energy and resources into major education and awareness campaigns, and enable a cultural shift to occur on multiple levels.

The Community

“Health care inequality is the forgotten frontier of the Civil Rights Movement.”

– Commissioner Tom Perez, former Director Office of Civil Rights,
U.S. Department of Health and Human Services

The community itself has a role in addressing the disparities in health care services and professions, but more critical reflection is needed to describe that role. Community awareness and action to hold the system accountable are often overlooked in debates about health care disparities. As consumers, recipients of health care services are potentially the greatest untapped resource for improving the status of diversity and cultural competence in health care delivery. The bureaucratic insularity of the health care system suggests that the drive for meaningful change must come from outside a system that is so clearly a product of closed culture (Gonzalez & Stoll, 2002). Fundamental change will require new allies and new organizing opportunities (Gonzalez & Stoll, 2002). The legacy of the Civil Rights Era of the 1960s is the lesson that grassroots social movements, and greater accountability in the use of public funds, can catalyze changes in the health care system and make a real difference (Smith, 1999). Dr. Charles Terrell of the AAMC told the Commission in Chicago that the challenge of diversity requires an infusion of civil rights groups in order to keep the issue relevant in the public arena and “keep it on the streets.” The AAMC is currently engaging groups such as the NAACP, Urban League, and the Leadership Coalition on Civil Rights around the issue of increasing diversity in the health professions.

Improving community-based health literacy and health disparity awareness is an important step toward galvanizing communities. The Commission was particularly struck by the testimony of one presenter who noted that many racial and ethnic minority patients are not even aware that they are receiving unequal and inappropriate treatment. At the public hearing in Los Angeles,

Dr. Michael Drake, Vice President, Health Affairs, University of California, told the Commission that there exists a need to raise public knowledge about the impact of unequal health care for underserved populations. Dr. Drake also raised the concern that the basic concept of health disparities can offend minorities because they may misconstrue this idea as an expression of innate defect. Ms. Maxine Golub, Project Director, New York State Metropolitan Area Health Education Center System (AHEC), told the Commission that most of the people in the community served by her AHEC “don’t know they’re getting bad care. They think if their doctor is nice to them that means it’s good care.” Dr. Ruth Browne, Co-Chair, Community Coalition to Increase Diversity in the Health Professions,¹⁶ said that the planning and implementation of any intervention designed to address diversity in the health care workforce must involve community-based organizations.

The Commission finds that there is an absence of outcry from minority communities and organizations, including civil rights, grassroots, faith-based, minority media, and other community-based institutions. In recent decades, civil rights groups have expended significant resources on defending minority communities against assaults on affirmative action, racial profiling in law enforcement, discrimination in housing, and other social justice issues facing the nation. Unfortunately, the shortage of minorities in the health care professions and its implications for racial and ethnic health disparities are not prominently on the radar of today’s civil rights agenda. Racial and ethnic profiling in health care is well documented in the health science literature. The Commission urges and joins the call for greater community-based awareness, education, mobilization, and activism—at local and national levels—around the intersecting issues of diversity, cultural competence, and health care disparities. We believe it is essential that minority communities develop a robust, organized, well-informed response to health care inequality and the poorly tended need for greater diversity and cultural competence in the health care workforce. One strategy is for community leaders to call upon health care schools and institutions regularly publish “diversity and cultural competence report cards” that would inform communities about these issues. Another accountability strategy is for community leaders to form meaningful partnerships with health care leaders to assist institutions in ensuring that students in the health professions receive meaningful community-based orientations and exposures. Community educators could also support health care institutions by offering to be resources for workshops in cultural competence, anti-racism education, and community health advocacy.

“It’s part of everyone’s role to help individuals understand that there is a tremendous growing need for diversity in the health care professions. I personally believe this is very important, especially as we look at how various disease states affect different minority groups. We want to be part of the solution and not part of the problem.”

– Commissioner William Weldon, Chairman and CEO, Johnson & Johnson

The Commission heard testimony about the need for communities and health care leaders to form more effective partnerships that empower communities. Unbalanced power relationships can hinder the success of collaborations between communities and health care institutions. We believe that vulnerable minority communities need active and meaningful representation at all levels of health care institutions and agencies that decide how to address minority health disparities and the shortage of minority health care providers. Health care leaders must include minority community representation in making decisions about what community interventions to initiate, what community-based research is needed, and how to evaluate intervention efficacy. At the New York hearing, Mr. Moises Perez, Executive Director, Alianza Dominicana, described the organization's community-provider partnership model¹⁷ that provides basic power-sharing principles of an effective partnership. These community principles require that:

- (1) partners mutually agree on mission, values, goals, and measurable outcomes;
- (2) the relationship is based on mutual trust, respect, genuineness, and commitment;
- (3) the partnership builds on identified strengths and assets while also addressing areas for improvement;
- (4) the partnership balances power between the health care institution and the community; and
- (5) the roles, norms, and processes for the partnership are created with the input and agreement of all partners.

Health Professions Licensure Agencies

Licensure agencies help to ensure that health care professionals receive and maintain the appropriate knowledge and skills they will need to provide quality health care. Licensure is designed to protect the public by ensuring that health care professionals have attained an adequate and verifiable level of competence prior to offering and delivering their services. The Commission believes that understanding diversity and cultural competence is a key aspect of patient care. As such, licensure agencies for nursing, medicine, and dentistry should require that diversity and cultural competence training be successfully completed. For example, cultural competency is a topic that should be part of the curricula in schools for the health professions, and required knowledge-based standardized tests should have questions on the topic. One presenter proposed that ongoing cultural competence training be a part of licensure requirements.

Licensure agencies should recommend continuing education programs that include provisions for cultural competence. There is precedent for this. In Massachusetts, in order to renew one's

license as a physician, one must have completed a certain number of hours of training in risk management. Testimony from the president of the Federal of State Medical Boards indicated that it would be reasonable to require continuing education of physicians on the topic of cultural competency. A concurrent requirement across the health professions would help ensure that all health professionals are well-prepared to address the health care needs of the increasingly diverse U.S. population.

The Role of Government

“The tremendous potential of Title VI to address racial and ethnic disparities in health care remains untapped.”

– Physicians for Human Rights, 2003

“No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.”

– Title VI of the Civil Rights Act of 1964

The Commission believes that the nation, through its government agencies, has an ethical and legal responsibility to ensure diversity and cultural competence in the health care professions, and to hold institutions accountable for their obligations in that regard. We believe that the failure, decade after decade, of federally supported health care institutions to produce ample numbers of minority health care professionals seriously compromises the “equal access” protections of Title VI of the Civil Rights Act of 1964. We believe that a person who receives lower quality health care because of conscious or unconscious provider attitudes based on race or ethnicity is, without a doubt, covered by Title VI. Moreover, we believe that the law applies not only to individual and group cases of unequal treatment but also to systemic patterns of discrimination and exclusion in the health professions.

The persistence of racial and ethnic inequality in health care delivery and health career participation requires a forceful, long overdue response from a government committed to the protection of civil and human rights. One of the profound responsibilities of any government is to provide for and protect its most vulnerable citizens. The Office of Civil Rights (OCR) of the U.S. Department of Health and Human Services is an important participant in the nation’s effort to eliminate racial and ethnic disparities in health status. OCR is charged with enforcing several applicable federal statutes and regulations that prohibit discrimination in health care. Historically, OCR has focused its efforts on the patient population not the health care workforce. The Commission believes that OCR should exercise its authority under Title VI to ensure that institutional recipients of federal financial assistance (which includes hospitals) have

a sufficiently diverse workforce to meet the unique health care needs of the community they serve. Tragically, the agency has historically suffered from inadequate resources to investigate possible violations and does not have a tradition of proactive monitoring and intervention (Smith 1999). In 1999, the U.S. Commission on Civil Rights found that the OCR suffered inadequate staffing and training, lacked appropriate technical medical staff for assisting in the investigation of possible violations, and failed to collect and monitor data germane to its mandate (PHR, 2003).

The U.S. Department of Education could also play a key role within the scope of its responsibility to provide oversight of accrediting bodies. Specifically, the Department of Education could develop standards for accrediting agencies of schools for health professions and hold these agencies accountable for diversity and cultural competency standards. The Department of Education could also require that these accrediting bodies demand a remediation plan from institutions that fail to have a plan in place or that fail to comply with standards. At the Chicago hearing, Representative Jesse Jackson, Jr. expressed concern that the DHHS 2004 budget proposal had eliminated substantial funding for vital federal initiatives authorized under Health Resources and Services Administration (HRSA). Rep. Jackson said key health professions education initiatives, such as Centers for Excellence and Health Careers Opportunities Programs, make the most significant contributions to increasing diversity and closing the health care gap.

The Commission believes that a number of federal agencies—including Department of Health and Human Services, the Department of Education, and the Department of Justice—play an important role in ensuring equal access for all Americans to health care education and the health professions. However, too often these agencies pursue this common mission without adequate interagency collaboration, planning, and action. An interagency task force on health care workforce diversity could provide a vehicle through which to galvanize and orchestrate a more efficacious federal response to the shortage of minorities in the health care professions.

As mentioned previously, states also play an important role in ensuring accountability for the community benefit obligation that organizations incur through their tax-exempt status. State agencies could require that grant applicants meet satisfactory diversity standards and cultural competency certification or training requirements as a condition for contract award. For example, Ned Calonge, M.D., Chief Medical Officer, Colorado Department of Public Health and Environment, testified in Denver that many of Colorado's public health services are federally funded through CDC grants, which stipulate that services be culturally competent.

Finally, legislation plays a role in accountability for diversity and cultural competence in the health care workforce. Legislative initiatives at the state and municipal level can also be developed to support diversity and cultural competence. For example, the public can hold legislators accountable for introducing and advancing bills that require cultural competence as a condition of education, licensure, and practice.

Recommendations

- 6.1 Health systems and health professions schools should gather data to assess institutional progress in achieving racial and ethnic diversity among students, faculty, administration, and health services providers, as well as monitor the career patterns of graduates.
- 6.2 Health professions schools and health systems should have strategic plans that outline specific goals, standards, policies, and accountability mechanisms to ensure institutional diversity and cultural competence.
- 6.3 Health professions organizations and accrediting bodies for health professions education and health care programs should promote the development and adoption of measurable standards for cultural competency for health professions faculty and health care providers.
- 6.4 Accrediting bodies for programs in medicine and the other health professions should embrace diversity and cultural competence as requirements for accreditation.
- 6.5 State licensure boards for nurses, physicians, and dentists should determine the value of having continuing education in cultural competence as a condition of licensure.
- 6.6 Community and civil rights organizations should collaborate with health care organizations and health professions schools to advance institutional diversity and cultural competence goals, including community needs assessment and evaluation.
- 6.7 Federal and state regulatory agencies should monitor and enforce health care institutions' fulfillment of community benefit obligations pertaining to diversity and cultural competence. Data collected should be readily available to the public.
- 6.8 The Department of Health and Human Services should establish and report national standards and measurements for diversity and cultural competence in the health workforce and health professions schools in the Agency for Healthcare Research and Quality's National Health Care Disparities Report.

- 6.9 The Department of Education should work with the appropriate accrediting bodies to ensure that health professions education institutions promulgate, monitor, and implement standards for diversity and cultural competence for students, faculty, staff, and administration.
- 6.10 The Department of Labor and the Department of Health and Human Services should ensure that the appropriate accrediting bodies hold medical residency and health professional training programs accountable for promulgating and implementing standards for diversity and cultural competence.
- 6.11 The Commission recommends the passage and funding of comprehensive state and federal legislation that will: 1) ensure the development of a diverse and culturally competent workforce; and 2) strengthen health care institutions that serve minority and underserved populations.
- 6.12 The President should appoint an advisory council or interagency task force on health workforce diversity to develop and implement a more effective national response to the shortage of minorities in the health professions.

Chapter 6 References

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CONCLUSION

Racial and ethnic minorities are conspicuously missing from our nation's health professions workforce. In the future, if current trends continue, this workforce will have even less resemblance to the nation's dynamically changing demographic composition. There is a direct link between poorer health outcomes for minorities and the shortage of minority health care providers. The evidence that the Commission reviewed and the testimony it heard led its members to conclude that the condition of the healthcare workforce is "critical" and demands swift, large-scale change. To increase diversity the culture of health professions must change; new and traditional paths to the health professions must be explored; and commitments must be at the highest levels of our government and private sectors. The Sullivan Commission calls upon the leaders in the public and private sectors to act on the report's recommendations.

END NOTES

¹ A preponderance of health sciences literature, including most major studies such as the IOM's landmark report, *Unequal Treatment* (2003), focuses primarily on black-white health differentials. Moreover, national health data collection and historical health policy analyses prior to the Civil Rights Era conventionally focused on black-white health status. Still, a significant and growing body of evidence does clearly identify substantial disparities for other minority groups and may represent the tip of the iceberg of the true magnitude of racial and ethnic health disparities.

² In this report, “underrepresented minorities” refers to racial and ethnic groups who suffer health disparities and whose respective population is underrepresented in the health professions workforce.

³ It is estimated that there were 200 African-American dentists in 1897 when the American and Southern Dental Associations merged to form the (first) National Dental Association for white dentists. Following an internal reorganization in 1913, the association was renamed the American Dental Association (Dummett, 2000).

⁴ The organization was originally named the National Negro Medical Association (NNMA) and later renamed the National Medical Association (NMA).

⁵ The Hill-Burton Act (Hospital Survey and Construction Act of 1946) was the first federal health planning legislation targeting African Americans since the Freedmen's Bureau Act of 1865.

⁶ *Grutter v. Bollinger, et al.*, 123 S.Ct. 2325, 2341 (2003).

⁷ Minority-serving institutions referred to here are Howard University College of Medicine, Meharry Medical School, Morehouse School of Medicine, Ponce School of Medicine, Universidad Central del Caribe School of Medicine, and University of Puerto Rico School of Medicine.

⁸ Unmet financial need is the total cost of education minus expected family contribution and aid (U.S. Department of Education, 2003a).

⁹ More information on the two NCMHD educational loan repayment programs is available online at http://ncmhd.nih.gov/our_programs/loan/index.asp.

¹⁰ Diversity is readily adaptable to quantitative measures (e.g., the number of racial and ethnic minority health care students or professionals, or the institutional proportions of these respective groups). Similarly, the number and proportion of cultural competence-certified providers are attainable measures. Institutions can also appraise diversity and cultural competence using qualitative methods. For example, ethnographic studies can be used to evaluate the institutional climate for racial and ethnic minority students or health care professionals, as well as assess the clinical experiences of minority patients.

¹¹ This certainly does not rule out the feasibility or necessity of measuring diversity and cultural competence within other geographic units (e.g., by region, state, county, municipality, etc.).

¹² The number of health professionals should include residents, fellows, and interns.

¹³ Community benefit, according to the operational test for hospital tax exemption under IRS ruling 69-545 (1969), is defined as the requirement that hospitals must promote health in a manner which is beneficial to the community in order to be federally tax exempt.

¹⁴ Barnett and Hattis (2004) developed a set of 18 hospital-based guidelines to help Health Professions Education and Training program leaders define areas of focus for action and build stronger links with hospital community benefits programs.

¹⁵ Health Care for All is a nonprofit organization in Massachusetts committed to making quality health care available to all, especially the most vulnerable members of society—the uninsured, low-income elders, children, people with disabilities, and immigrants. It is one of two pilot sites for the Kellogg Foundation/Community Catalyst Physician Diversity Project.

¹⁶ The “Community Coalition to Increase Diversity in the Health Professions,” based in New York City was formed in the spring of 2003 to increase diversity in the health care workforce. It is part of the Kellogg Foundation/Community Catalyst Physician Diversity Project.

¹⁷ The Principles of Good Community-Campus Partnerships, adopted by Alianza Dominicana, were developed by the Community-Campus Partnership for Health (CCPH), Center for Health Professions, University of California San Francisco.

GLOSSARY

AACN	American Association of Colleges of Nursing
AACOM	American Association of Colleges of Osteopathic Medicine
AAIP	Association of American Indian Physicians
AAMC	Association of American Medical Colleges
ACGME	Accreditation Council for Graduate Medical Education
ADA	American Dental Association
AED	Academy for Educational Development
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
ANA	American Nurses Association
APALC	Asian Pacific American Legal Center
ASACB	Advancing the State of the Art in Community Benefit
CDC	Centers for Disease Control and Prevention
DAT	Dental Admissions Test
GME	Graduate Medical Education
HDA	Hispanic Dental Association
HHS	U.S. Department of Health and Human Services
HPEIs	Health Professions Education Institutions
HPEPPs	Health Professions Educational Practice Partnerships
IOM	Institute of Medicine
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
KFF	Kaiser Family Foundation
MCAT	Medical College Admissions Test
NACAC	National Association for College Admission Counseling
NACGN	National Association of Colored Graduate Nurses
NAEP	National Assessment of Educational Progress
NAHN	National Association of Hispanic Nurses
NAS	National Academies of Sciences
NBNA	National Black Nurses Association
NCES	National Center for Educational Statistics
NDA	National Dental Association
NHMA	National Hispanic Medical Association
NHSC	National Health Service Corps
NMA	National Medical Association
OCR	Office of Civil Rights, U.S. Department of Health and Human Services
PHR	Physicians for Human Rights
RWJF	Robert Wood Johnson Foundation
SAID	Society for American Indian Dentists
WKKF	W. K. Kellogg Foundation

Appendix A

Increasing Workforce Diversity and Addressing Health Disparities: Strategies for Hospitals in Health Professions Educational Practice Partnerships

*Final Report
March 27, 2004*

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Appendix A Contents

Acknowledgements	121
Executive Summary	122
I. Introduction	125
II. Background/Justification	126
III. Methods	128
A. Survey Development / Implementation	
B. Guidelines Development / Review	
C. Exemplary Practices	
IV. Survey Findings	130
V. Discussion	146
Appendix A-1: Final Guidelines	
Appendix A-2: Exemplary Practices	

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Finally, we would like to thank the health professions education and training leaders of the hospitals and health systems participating in this inquiry for their time and thoughtful input at multiple stages during this inquiry.

EXECUTIVE SUMMARY

This report summarizes the findings of a six-month inquiry into the practices of a group of hospitals in a four-state demonstration project that are engaged in health professions educational practice partnerships (HPEPPs) with academic institutions. The primary objectives of the inquiry were to: a) identify current efforts in a defined cohort of hospitals in HPEPPs to increase health care workforce diversity and address health disparities in local communities, and b) develop guidelines aimed at encouraging definitive action by hospitals and their academic affiliates to help advance these objectives. The inquiry is funded by the W.K. Kellogg Foundation, and is part of a larger national initiative to address the need for increased diversity in the health care workforce.

The identification and dissemination of current efforts is intended to provide practical examples that can serve as reference points for HPEPP leaders who seek to enhance existing programs and build stronger links with hospital community benefit programs. Similarly, the development and dissemination of guidelines is intended to provide a framework for educational and training leaders to address relevant facets of HPEPP program planning and implementation that can concomitantly advance efforts surrounding health care workforce diversity and health disparities reduction.

Participants in the inquiry are affiliated with four health systems and three independent hospitals (a total of 76 facilities) that are participants in the first phase of a demonstration project entitled “Advancing the State of the Art in Community Benefit” (ASACB). Partners in the ASACB demonstration made a commitment to develop and implement a series of institutional systems reforms that will enhance the use of charitable resources to address unmet health needs in low-income, ethnically and culturally diverse communities. Given the central theme for the ASACB demonstration, a third objective for this inquiry was to identify current links between HPEPP programs and community benefit operations, and explore potential advantages of increased coordination in efforts to reduce disparities.

Twenty-one of the 76 ASACB partner hospitals provide some form of health professions education and residency training through affiliations with regional academic institutions. Three facilities are major academic medical centers and members of the Council on Teaching Hospitals. Thirteen of the 21 facilities serve as training sites for physicians, and 12 facilities provide and/or sponsor some form of training for nursing students. Most of the study participants were connected to one of these 21 hospitals.

Focusing on diversity and health disparity issues in HPEPP programs and exploring synergistic links with community benefit and related staff from the hospital to advance common goals is an important area of exploration. A lack of attention to these societal concerns represents a missed opportunity to advance the community benefit goals of not-for-profit hospitals, which represent the vast majority of hospitals engaged in health professions education and training.

There were two stages in the inquiry. The first stage involved the development and implementation of a semi-structured telephone survey to solicit information from HPEPP leaders on existing programs and priorities. The second stage involved a series of conference calls with participants in the stage one survey to solicit their input on a set of draft guidelines.

The findings in this study illustrate the potential benefits of definitive action by HPEPP leaders and teaching hospitals to increase health care workforce diversity and address health disparities. These benefits accrue not only to current and future URM trainees, but to the other participants in programs who benefit from a more rich learning environment; to the hospital, in terms of increased cultural competency and quality of care; and of course, to the communities served by the hospitals. Moreover, the diversity in the size of the hospital, location, population dynamics, and type of training provided by participants in this study highlights the fact that deliberate effort can yield many forms of excellence under different circumstances.

Participants in this inquiry highlighted the array of obstacles faced by different kinds of hospital-based HPEPP programs in efforts to increase health care workforce diversity. In the recruitment process, participants cited challenges associated with efforts to influence academic affiliates, expand and/or enhance selection criteria, and provide the resources and environment that would attract URM applicants to HPEPP programs outside of larger, urban-based teaching hospitals. Participants also cited scarce resources, time constraints associated with the volume of required components, and a lack of teaching tools in efforts to enhance formal curricula. Finally, participants cited challenges both in the recruitment of URM HPEPP faculty and ensuring that existing HPEPP faculty (URM and otherwise) have the tools to deal with issues of race, ethnicity, and culture in their mentorship and education of trainees. Despite these challenges, many participants cited significant progress, and numerous examples are provided in the text and in the summary of exemplary practices in Appendix A-2.

Our findings from these discussions suggest that properly conceived and focused guidelines may be quite helpful in defining areas of focus for action by HPEPP leaders and their institutions. An initial draft set of guideline statements were developed and have evolved based on comments from focus group participants drawn from the initial surveyed group of HPEPP leaders. The final working draft set contains 18 guideline statements under the following six subject headings: A) Pipeline Support/Expansion, B) Recruitment/Admissions, C) Curriculum Content, D) Training Environment, E) Retention/Advancement, and F) Resource Commitment/Policy Advocacy.

In looking at the ability of hospitals to use these guidelines as a tool to increase workforce diversity and reduce health disparities, we are mindful that there are differences between major teaching hospitals and smaller or less educationally intensive institutions that sponsor HPEPP programs in their abilities to successfully implement efforts that respond to these guideline statements. Nevertheless, we think that both kinds of hospitals have important roles to play.

Major teaching hospitals may have greater responsibility to provide leadership in this arena, as it is often that such program's trainees go on to take leadership roles in the health professions. These hospitals also often have great ability to influence the directions of their affiliated schools in many ways—including admissions as well as educational content of programs. However, such programs with broad agendas often find that they are already pulled in many different directions with respect to how best to dedicate training time and diversity, and cultural competency of trainees have to compete with attention for research and technical competency.

For minor teaching hospitals, often filling their programs with graduates of American schools is a key priority. They may also be located in geographic areas where it may be more difficult to attract URM trainees to their programs. With those realities and concerns, such hospitals may be more inclined to hew to traditional criteria in the selection process as a means of demonstrating commitment to excellence. It will be important to clearly address this perception and interpretation of excellence for minor teaching hospitals that are considering the importance of these issues and their priorities. At the same time, the smaller sized programs in these institutions may provide increased flexibility to institute cutting-edge reforms that would be more difficult to implement in large teaching hospitals.

There may be a need for some sort of system that provides either carrots (e.g., financial or other resources) or sticks (e.g., loss of accreditation) to accompany efforts aimed at guideline implementation. And for all hospitals—at least nonprofit ones—issues surrounding the relevance of these goals to other institutional prerogatives tied to community benefit may be of great interest. Given increased public scrutiny into the charitable obligations of nonprofit hospitals, this represents an opportunity for these institutions to provide leadership on an issue of considerable social importance.

We believe that further testing of the guidelines in a range of institutions is an important next step to address these issues. Testing could be supplemented by further discussions with representatives from HPEPPs, accrediting bodies, trade associations, and policymakers about what has been learned from, as well as a general discussion about how best to further common goals. One of the products of field testing should be a list of specific steps that can be taken by teaching hospitals in the implementation of individual guidelines.

Teaching hospitals can play an important role in efforts to increase health care workforce diversity and ensure that the next generation of providers has the skills necessary to provide quality care to our increasingly diverse communities. Definitive action is also needed, however, by academic affiliates. The recent study completed by the Institute of Medicine entitled “In the Nation’s Compelling Interest” outlines both the issues to be addressed and specific steps that could be taken by health professions education institutions. Both definitive action and ongoing coordination is needed by teaching hospitals, academic affiliates, policymakers, and the public at large in order to make progress in addressing this important social imperative.

I. Introduction

This report summarizes the findings of a six-month inquiry into the practices of hospitals engaged in health professions educational practice partnerships (HPEPPs) with academic institutions. There were two primary objectives in the inquiry:

- Identify current efforts in hospitals engaged in HPEPPs to increase health care workforce diversity and address health disparities in local communities.
- Develop guidelines for broad dissemination to provide insights and encourage definitive action by hospitals and their academic affiliates.

The identification and dissemination of exemplary practices is intended to provide practical examples that provide a point of reference for HPEPP leaders in hospitals who seek to enhance existing programs and build stronger links with hospital community benefit programs. Similarly, the development and dissemination of guidelines is intended to provide a framework for leaders to address different facets of HPEPP program planning and implementation in their efforts to increase health care workforce diversity and reduce health disparities.

Participants in the inquiry are affiliated with four health systems and three independent hospitals (a total of 76 facilities). These organizations were participants in the first phase of a four-state demonstration project entitled “Advancing the State of the Art in Community Benefit” (ASACB). The demonstration is being administered by the Public Health Institute, a private, nonprofit national research center based in Oakland, CA. Partners in the ASACB demonstration have made a commitment to develop and implement a series of institutional systems reforms that will enhance the use of charitable resources to address unmet health needs in low-income, ethnically and culturally diverse communities. Given the central theme for the ASACB demonstration, a third objective for this inquiry was to identify current links between HPEPP programs and community benefit operations, and explore potential advantages of increased coordination in efforts to reduce disparities.

Health system partners in the ASACB demonstration include Catholic Healthcare West, with 41 hospitals in California, Arizona, and Nevada; St. Joseph Health System, with 14 hospitals in California and Texas; Texas Health Resources, with 13 hospitals in Northern Texas; and Scripps Health, with 5 hospitals in metropolitan San Diego. Independent hospital partners include Hoag Memorial Hospital Presbyterian in Newport Beach, CA; Lucile Packard Children’s Hospital at Stanford in Palo Alto, CA; and Presbyterian Intercommunity Hospital in Whittier, CA.

Twenty-one of the 76 ASACB partner hospitals provide some form of health professions education and residency training through affiliations with regional academic institutions. Three facilities are major academic medical centers and members of the Council on Teaching Hospitals (COTH). Thirteen of the 21 facilities serve as training sites for physicians, and 12

facilities provide and/or sponsor some form of training for nursing students. Most of the study participants were connected to one of these 21 hospitals.

This component of the demonstration is funded by the W.K. Kellogg Foundation, and is part of a larger national initiative to address the need for increased diversity in the health care workforce.

II. Background/Justification

Hospitals have important roles to play in working to increase the diversity of the workforce and in efforts to reduce health disparities among racial and ethnic minorities. Hospitals with formal educational missions tied to the training of health professionals can use formal programs as mechanisms to advance important societal goals tied to diversity and health disparities. Moreover, as community institutions with charitable missions, not-for-profit hospitals are in a unique position to engage their academic affiliates and make the case that these societal goals require ongoing dialogue and coordinated effort.

A key strategy for not-for-profit hospitals in increasing workforce diversity and reducing health disparities is to strengthen links between health professions training and community benefit programs. When community benefit programs are well-designed, comprehensive, and fully integrated into local communities, they provide a rich learning environment for trainees. This is particularly the case for programs that focus on addressing disproportionate unmet health needs in ethnically and culturally diverse communities. Involvement of health professions trainees provides valuable knowledge and experience and, at the same time, helps to advance the charitable mission of the hospital.

Using physician training as the paradigm for discussion (though comments here are relevant to varying degrees for other health professional training programs in fields such as nursing, dentistry, and psychology), a few background comments are in order with respect to the opportunities of hospitals to advance community benefit goals in this area.

First, underrepresented minorities (URMs)¹, while comprising over 25 percent of the US population, represent a mere 6 percent of the physician workforce.² Though hospitals do not control the entry way into medicine (medical schools have that responsibility) and the resultant racial/ethnic make-up of medical school graduates (at present about 70 percent white, 16 percent Asian, 6 percent Hispanic, 6 percent African American, and 2 percent other), they can exert some influence over medical school admissions decisions by the way they rank for selection, create a supportive and culturally sensitive and competent training environment, and

¹ Initially defined by the AAMC to include people who are African Americans, Mexican Americans, Mainland Puerto Ricans, and Native Americans. In June, 2003, the AAMC broadened its definition of URM to the following: “those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population.”

² American Association of Medical Colleges, “Minority Graduates of U.S. Medical Schools: Trends 1995-1998,” Washington, DC (September 2000).

advocate for selection criteria that lead to greater numbers of persons of color to be admitted to medical schools.

Recently published data from 2000-2001 indicates that throughout the United States, and primarily in hospitals, there are nearly 100,000 resident physicians enrolled in Accreditation Council for Graduate Medical Education (ACGME)-accredited and combined specialty graduate medical education (GME) programs.³ Those residents are trained in nearly 8,000 active ACGME-accredited and combined programs, primarily located in hospitals in the United States.⁴ While about three-quarters of these residents are trained in the 400 or so largest, major teaching hospitals⁵ (three of which are part of the current field demonstration), over 25,000 residents learn their specialty areas in smaller, community teaching hospitals.

Both the larger teaching hospitals and smaller community hospitals have important roles to play with their residency programs (many of which also provide training for medical students through one or more of the nation's 126 schools of medicine) in advancing workforce diversity and in addressing health disparities.

Increasing the diversity of the health care workforce is important not only because of its moral implications. There is a growing volume of data to show that there are substantial health effects associated with a lack of diversity among health care providers. For example, studies have found that African American and Hispanic physicians cared for a larger percentage of minority patients than did their white counterparts. In addition, they were more likely to enter primary care, practice in communities with insufficient numbers of primary care practitioners, and care for Medicaid patients and uninsured patients.⁶ Research has also shown that minority patients prefer to receive their medical care from racially concordant physicians;⁷ and that there is better patient compliance with treatment regimens when there is racially-concordant physician-patient relationships.⁸

There is also evidence that if more clinicians of color are trained, they are more likely to be available to care for disadvantaged URM patients. A 1993 report from the American Association of Medical Colleges noted that 39.8 percent of medical school graduates from underrepresented minorities reported that they intended to practice in underserved areas, compared with only 9 percent of other graduates.⁹ There are numerous other studies that

³ Brotherton, Sarah E. PhD; Simon, Frank A. MD; Etzel, Sylvia I., "U.S. Graduate Medical Education, 2000-2001." *Journal of the American Medical Association*, Volume 286(9), 5 September 2001, pp 1056-1060.

⁴ Ibid

⁵ <http://www.aamc.org/teachinghospitals.htm>--See AAMC Website [accessed March 28, 2003].

⁶ Komaromy M. Grumbach K. Drake M. et al. The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations. *New England Journal of Medicine*. 1996; 334:1305-1310.

⁷ Saha S., et. al, "Patient-Physician Racial Concordance and the Perceived Quality and Use of Health Care," *Archives of Internal Medicine* 1999; 159(9):997-1004.

⁸ Cooper-Patrick, et. al. "Race, Gender, and Partnership in the Patient-Physician Relationship," *Journal of the American Medical Association* 1999; 282:583-9

⁹ Steinbrook R. Diversity in Medicine. *New England Journal of Medicine*. 1996; 334:1327-1328.

document inferior care received by minorities as compared to their white counterparts—in our current system where most caregivers are not members of racial and ethnic minorities.

Notwithstanding the health effects from having a physician workforce which is less diverse than the overall population, there doesn't seem to be much concern about the issue among residency program directors. One recent study of internal medicine program directors found that training minorities and women was not an important factor to their notion of what defines quality in residency education.¹⁰ There is also evidence that there is insufficient attention given to issues of health disparities in residency training.¹¹

Accordingly, it is our view that focusing on diversity and health disparity issues at the level of the hospital and its formal training programs, along with exploring how such programs can find synergistic opportunities working with community benefit and related staff from the hospital to advance common goals is an important area of exploration. A lack of attention to these societal concerns represents a missed opportunity to advance the community benefit goals of not-for-profit hospitals, which represent the vast majority of hospitals engaged in health professions education and training.

III. Methods

There were two stages in the inquiry. The first stage involved the development and implementation of a semi-structured telephone survey to solicit information on existing HPEPPs and priorities. The second stage involved a series of conference calls with participants in the stage one survey to solicit their input on a set of draft guidelines.

A. *Survey Development/Implementation*

The survey instrument developed for this inquiry included 28 questions in five sections, including: A) Basic Program Information, B) Recruitment of Under-Represented Minorities (URMs), C) Support Systems, D) Curriculum and Training Experiences, and E) Health Professions Education, and Training and Community Benefit. Prospective participants in the inquiry were identified, contacted, and encouraged to participate by the Chief Medical Officer or their equivalent among health system and hospital partners in the ASACB demonstration.

After preliminary contact was made, a cover letter and the survey instrument were mailed to HPEPP hospital leaders. Individual telephone interviews were scheduled with each HPEPP representative to complete the surveys. In some cases, multiple interviews were needed with

¹⁰ Klessig, J.M. et al. "A Pilot Survey Study to Define Quality in Residency Education," *Academic Medicine*, Vol 75 (1): pp. 71-3, January 2000.

¹¹ Tervalon M. Community-Physician Education Partnerships: One Strategy to Eliminate Racial/Ethnic Health Disparities. Commentary on "Teaching Physicians-in-Training to Address Racial Disparities in Health: A Hospital-Community Partnership." [comment]. *Public Health Reports*. 118(4):357, 2003 Jul-Aug.

different HPEPP representatives to fill in missing information. In a few cases, information requested was not available.

A total of 25 telephone interviews were conducted by the study co-investigators with HPEPP representatives of 17 hospitals during September and October 2003. Interviewees represented 31 training programs, including 18 physician residency programs, 10 nursing programs, and 3 other medical professional training programs. Among the medical residencies, 9 are Family Practice, 3 are Internal Medicine, 3 are Pediatrics, and one each are Orthopedics, OB/GYN, and Dentistry. Nursing programs include 5 Associate Degree, 3 Bachelor Degree, and 2 Nurse Practitioner. Other medical training programs include Physical Therapy, Medical Social Worker, and Dental Hygiene. Responses were compiled with three purposes in mind: a) to provide a general profile of current efforts to increase workforce diversity and address health disparities, b) to extract and summarize exemplary practices, and c) to inform the development of a set of guidelines for broad dissemination in the field.

B. Guidelines Development/Review

The initial draft of the guidelines was drawn from information collected in the telephone interviews with health professions education and training leaders from ASACB hospitals, field observations, and a review of current literature.

The initial draft set contained 21 different statements organized under six subject headings: A) Pipeline Support/Expansion, B) Admissions, C) Curriculum Content, D) Training Environment, E) Retention/Advancement, and F) Funding/Policy Advocacy. These guideline statements were drafted by Drs. Barnett and Hattis and were reflective of the suggestions and ideas that grew out of the information gleaned in the telephone surveys with individual HPEPP leaders (plus a few other hospital leaders from the community benefits arena as well).

A series of six focus group conference calls were conducted in December 2003 with a subset of the initial interviewees. In those discussions, we reviewed each of the 21 guideline statements and asked the focus group members to first provide input on the clarity of each statement. After providing input, each person was then asked to rank each one as having either: high, medium or low importance with respect to helping their HPEPP program achieve the overall stated goals tied to workforce diversity and health disparities reduction. Finally, we asked the focus group members to make specific comments to help explain their rankings and share any other thoughts about the guideline statement or related issues raised by the statement.

In addition to Drs. Barnett and Hattis, the external evaluator for the project, Arthur Himmelman was present for all conference call discussions. At the conclusion of each discussion, project staff discussed strategies for the integration of input and the accommodation of diverse perspectives in the development of the final guidelines. The final draft of the guidelines was disseminated electronically to HPEPP leaders in January to secure

additional input prior to completion and dissemination. Integration of final input was completed and a final version was disseminated to participants on January 29, 2004. (Appendix A-1)

C. Exemplary Practices

The survey of HPEPP leaders yielded information on a number of programs and practices that demonstrated a commitment to increase health care workforce diversity and/or address health disparities as part of the health professions educational process. Seven examples were selected for documentation, and draft summaries were developed for review and comment by HPEPP leaders based upon information provided in the initial survey. Final edits of the summaries were completed and forwarded to HPEPP leaders in February 2004.

It is our view that documentation and dissemination of these exemplary practices may provide insights for other HPEPP leaders who seek to enhance programs and practices. At a minimum, the exemplary practices documented in this inquiry demonstrate that institutional leadership and commitment can yield meaningful results. A summary of exemplary practices is included as Appendix A-2.

IV. Survey Findings

Given the diversity in the type and size of HPEPP programs participating in this inquiry, as well as the inability to secure complete or reliable information in some cases, aggregate numbers are not reported in the findings. The intent is provide an overview of the level and different strategies to increase health care workforce diversity and address health disparities as part of the HPEPP process under a variety of local circumstances. Findings will provide insights into opportunities for HPEPP programs seeking to enhance efforts to date, as well as challenges that must be addressed in order to achieve intended results.

1. Basic Program Information

In our efforts to collect data on the number of URMs participating in programs, we discovered that many HPEPP programs did not formally compile this information, and were only able to offer rough estimates. Moreover, we began the inquiry with the draft AAMC definition of URMs (i.e., African Americans, Mexican Americans, Mainland Puerto Ricans, and Native Americans), but found that many programs included substantial representation from other racial and ethnic minorities (e.g., Southeast Asian, Pacific Islander) that met criteria consistent with the revised AAMC definition of URMs released in June 2003.

In general terms, however, we found that the percentages of URM students and faculty in most HPEPP programs are broadly consistent with current figures reported at the national level. Two of the medical residencies (Scripps Chula Vista, Mercy Methodist) and two of the

nursing training programs (Santa Rosa Memorial Hospital, Texas Health Resources) reported proportions of trainees and/or faculty that were significantly higher than national averages.

One respondent in California noted that there has been a substantial decrease in URM applicants since the implementation of California's Proposition 209 in 1996.¹² This has resulted in a smaller pool of URM graduates available to take residency positions. One respondent cited a 50 percent decrease in the URM applicant pool since 1998. A number of respondents also indicated that they had little influence over the school selection process, noting that their graduate training program generally takes all qualified applicants. Others noted that having affiliations with multiple academic institutions and matching processes complicates any effort to exert influence over the application process.

2. Strategies for Recruitment of URM

Opportunities—Respondents identified a number of strategies that have yielded success in their efforts to increase the pool of URM applicants. Examples of current community strategies include the following:

- Conducting targeted outreach in local communities to increase awareness of health care career opportunities.
- Mentoring of high school students by medical residents.
- Partnering with other hospitals to enhance the exposure of HPEPP trainees to diverse populations and coordinate community outreach.

In general, most respondents identified investment in pipeline initiatives as an important resource that has helped to build stronger links with community resources and helped to expand the pool of URM HPEPP applicants. One respondent described an initiative that involves the engagement of all providers and academic affiliates in the region to coordinate community outreach and increase the pool of URM applicants (See Appendix A-2, Site #5). Another respondent noted that their hospital is exploring a partnership with a medical center in an urban area with a high percentage of URM medical residents that had recently lost their accreditation, both to help address the immediate crisis and to build internal competency and a reputation for supporting URM trainees.

Examples of current strategies to increase URM in the application process include:

¹² A 1996 California Constitutional Amendment which prohibits the state, local governments, districts, public universities, colleges and schools, and other government instrumentalities from discriminating against or giving preferential treatment to any individual or group in public employment, public education, or public contracting on the basis of race, sex, color, ethnicity, or national origin.

- Giving added weight to language skills and evidence of cultural competency in selection process.
- Appointing a URM faculty as director of HPEPP program (sends an important message to academic affiliates and URM applicants).
- Offering clerkships with a focus on health disparities (one month to six week rotations).
- Identifying diversity as a key goal in HPEPP literature and recruitment process.
- Establishing explicit links between the HPEPP training process and community benefit program activities in diverse ethnic and racial communities.
- Offering special programs to support health professional trainees who may not meet standard application criteria.

One hospital cited an informal program entitled “Diamond in the Rough” to identify students who show promise but have had some problems in medical school. If the problem is academically related, a “coach” is assigned to provide support. If the problem is economic, the student is provided with assistance to facilitate access to all available resources. If the problem is related to substance abuse, they are put into a group program and closely monitored. There is a high proportion of URM in this program. Another program cited is a nurse re-entry program for nurse trainees who were initially unable to pass their boards.

Challenges—A key obstacle to URM recruitment for teaching hospitals outside of major urban areas is that the demographics of the service area may not give URM the exposure to diverse populations they may desire as part of the training process. A natural corollary to this situation is a concomitant lack of a peer and faculty social support that may be desired by prospective URM applicants to these programs. The net result is a “catch 22” for teaching hospitals with these dynamics that seek to increase URM representation in their HPEPP programs.

Given the focus of this inquiry on teaching hospitals in California, Texas, and Arizona, many respondents cited specific challenges in the recruitment of Hispanic trainees and HPEPP faculty. Hospitals with few Hispanic faculty members and current trainees find it difficult to compete with the few major teaching hospitals located in Hispanic population high-density areas. While recruitment of Hispanic trainees is a priority, efforts by these hospitals to recruit Hispanics and other URM are further complicated by the fact that medical schools often have multiple hospital affiliations, and students may not be able to have rotations or learn enough information about residency programs at hospitals where they have had more limited contact.

A number of respondents acknowledged that gaps in overall objective test performance for URM applicants presents a problem for committees that use specific cut-offs to guide whom they will even invite for an interview for their program. At least one respondent acknowledged that they rely heavily upon test scores, with the idea that this measure will yield the best candidates. Another respondent noted that having a URM faculty member on their residency selection committee has helped to broaden the discussion to include consideration of the mix of characteristics that ought to be weighed in ranking applicants.

A number of respondents for nursing training programs indicated that given the critical shortage of nurses, their focus is simply to secure as many new employees as possible. One respondent noted that their hospital had just completed a process to recruit 50 Filipino nurses who were trained overseas. Two respondents cited a perceived cultural bias against the nursing profession among Hispanic populations as a barrier to recruitment. Finally, at least one respondent indicated that increasing URM representation among health professionals is the responsibility of the academic affiliates, rather than teaching hospitals.

3. Engaging Academic Affiliates

A number of respondents indicated that they serve on academic affiliate advisory boards, and acknowledged that they could do a better job of raising issues such as leadership, race, and ethnicity. One HPEPP program representative indicated that they meet monthly with academic affiliate representatives, and would like to recruit more students with an interest in primary care. They have a departmental representative who sits on the academic affiliate research committee, but they don't feel they have a practical means to affect the academic affiliate's selection process of students entering the school. Another respondent noted that they participate on an academic affiliate admissions committee, and have regular meetings and network across residency programs at other institutions in the region. It was suggested by one respondent that both hospital administration and public relations could play a role in advocating for a larger pool of URM applicants.

A number of HPEPP program leaders acknowledged that they had not yet initiated dialogue with their academic affiliates regarding their interest in URM applicants; a number of them noted that this would be a good starting point to raise awareness and explore options. Many also acknowledged that they did not know a lot about the process employed by their academic affiliates to cultivate a diverse applicant pool. At least one respondent noted that their program has a Graduate Medical Affairs Committee that meets monthly, and that it was the respondent's plan to bring this issue to their attention with the hope that the committee might try to more formally influence the admissions process of the affiliated medical school.

One respondent noted that their academic affiliate offers financial support for URM students, and that additional support may increase the pool of URM medical students. Another indicated that financial support is needed all the way through the educational process, and it is important to address it at the beginning of the college years so as to minimize its impact upon the future planning of URM students who may want to consider health care careers. One institution indicated that they had sent HPEPP faculty members to Howard University to increase their awareness and understanding of dynamics among applicants, and in part, because they had not received any residency applications from Howard University medical students in a number of years. They also noted that it is important to highlight the racial and ethnic diversity among a program's current students and faculty (even if it is proportionately less than desired levels) as a means of encouraging future applicants to consider training opportunities there.

4. Increasing URM faculty

Respondents expressed an ongoing interest in URM faculty, and indicated some progress among individual programs, but acknowledged this as a significant challenge. One respondent indicated that there is a lack of URM practitioners in the geographic region that would be candidates for faculty. Another noted that they do not recruit very often, and that specialty expertise tends to outweigh racial and ethnic diversity or gender in hiring decisions. A number of respondents identified program need as a central criteria, followed by personal characteristics for faculty such as communication skills, time-management and organization skills, and collegiality.

Other HPEPP leaders indicated that they had achieved some success with URM faculty recruitment. One respondent noted successful recruitment of bilingual providers through use of National Health Services Corp scholarships. Others cited the recruitment of minority physicians in private practice to serve as part-time faculty, which has also helped in establishing relationships for outreach efforts for future health professionals. One respondent noted that they had increased their URM faculty through attrition; replacing three departing Caucasians with one African American, one Mexican American, and one Japanese American faculty member. At one institution, internal communication with the medical staff about the need for greater URM presence has contributed to active recruitment of URM trainees for clinical positions; as a result, the respondent estimated that approximately 50 percent of recent URM trainees have become employed by their hospital in clinical and teaching roles.

Another important factor in facilitating URM faculty recruitment is the relative efficiency of the review and selection process. One respondent indicated that streamlining their process had enabled them to recruit a new URM faculty member that may have otherwise gone to another institution.

5. Support Systems

Trainee Mentoring—Most respondents indicated that specific “targeted” supports for URM are not provided. In a variety of ways, interviewees noted that students from all backgrounds need assistance of some form or another at different times. Most make efforts to match trainees with faculty mentors, but the primary criteria appears to be medical specialty interest, rather than personal and/or race and ethnicity criteria. A number of respondents indicated that it is important not to assume that trainees want to be linked with faculty of the same race and ethnicity. In some cases, variations in ancestry and life experience within larger racial and ethnic groupings may be a source of conflict, rather than comity. It was also noted that it is important in programs with limited numbers of URM faculty who may already carry a disproportionate burden of representation on committees not to assume that they will also take on the responsibility to mentor all URM trainees. Finally, it was noted that mentorship across racial and ethnic lines provides an important source of learning for both participants.

A number of respondents identified more informal approaches to mentorship and support, most often in group settings. For example, one respondent noted that they hold monthly conferences with residents to discuss a full range of issues to facilitate proactive problem solving of personal problems and group dynamics. Another indicated that they hold periodic meetings for trainees tied to exploring career issues and options; often issues of race and ethnicity have come up as factors in the discussion. Still another program has multicultural dinners where trainees take turns selecting a restaurant connected to their culture and lead a discussion to share experiences about their backgrounds. A number of respondents indicated that having small programs enables them to give individual attention to all residents. At the same time, it was noted that it is important to be careful about confidentiality in a small program when specific problems arise for individual trainees.

Orientation—Most respondents indicated that their HPEPP trainees participated in an orientation, but it did not include a specific focus on issues of race and ethnicity. Some respondents indicated that their hospital has an orientation for all employees that includes a component on diversity, but only one program indicated that it includes trainees in that orientation. One hospital indicated that it is currently providing copies of a book on culture and nursing care to all departments, and acknowledged that it should also be provided for its trainees.

One respondent indicated that during orientation and throughout the year, medical residents are challenged to link educational process to “core values,” as well as issues associated with care for special populations (e.g., disease prevention among women, care of seniors, changing roles in society, post-assault sequelae, community health resources). Another respondent indicated that their program partners with a local federally qualified health center (FQHC) to increase cultural competence in both the orientation program as well as throughout the training experience.

6. Curriculum

Didactic Component—Five of the respondents from medical residency programs indicated that they have integrated elements of race, ethnicity, and culture into their formal curriculum; another five indicated that they have regular conferences and discussion groups on cultural issues and on ethical and professional approaches to patient care issues where race, culture, or language are issues. One respondent indicated that their program held an ethics forum every other month, and a broad spectrum of practitioners are invited to the discussions which often delved into cultural matters. A number of HPEPP programs have secured funding to support Spanish-language and cultural training for residents and hospital staff. Others indicated that formal curricula and/or special conferences are under development, or indicated that cultural issues are covered well in the applied curriculum (i.e., in the context of patient care).

One respondent cited trainee participation in a cultural competency curriculum developed with a local FQHC that had secured a grant for this purpose, but noted that the relationship with the clinic had been curtailed by the hospital administration due to budget pressures. Constraints

on the relationship now deprive trainees of exposure to these issues and the patient population served by the FQHC. Another institution has developed a course in medical Spanish and related cultural competency issues for second-year residents, and faculty make a special effort to raise race and ethnic disparity issues during grand rounds presentations. One hospital indicated that cultural competency is an important part of its training curriculum, and uses a number of videotaped lectures and scenarios for discussion purposes. One respondent indicated that their hospital was engaged in a major effort to increase cultural competency that included the development of a formal curriculum for all employees and trainees. A central goal of the initiative is to implement the 14 National Standards for Culturally and Linguistically Appropriate Services;¹³ seven hospital-wide committees have been established to guide the implementation process.

In a number of the interviews, respondents indicated that the most effective means for educating trainees in cultural competency is through the patient-care process, and emphasized the importance of both supervision and follow-up dialogue with trainees focusing on cultural issues which came up in the clinical context. Along these lines, one respondent noted that their hospital's quality assurance department has never examined issues associated with race and ethnicity, and indicated that this should be an important area of focus for the future.

Applied Component—Most of the respondents indicated that HPEPP trainees benefit from hospital affiliations with FQHCs. In addition, a number referenced links with school-based health centers, migrant farmworker clinics, Indian Health Service settings, and Area Health Education Center (AHEC) sites. One respondent described a partnership with a community-based organization that serves the Southeast Asian community (see Appendix A-2, Site #7). One of the respondents with links to an FQHC described a community medicine rotation framed as a “cultural clinic.” While the program was initially funded by a foundation grant, the hospital has made a financial commitment to continue the rotation. Another program brings speakers in from the community to discuss a variety of issues such as border health (see Appendix A-2, Site #6). Residents do work on both sides of the border to gain a better understanding of community needs and dynamics.

Many of the hospitals participating in this demonstration are engaged in efforts to increase access for Limited English Proficient (LEP) populations. One example described by an interviewee includes a focus on methods to make optimal use of language interpreters. An evaluation form is under development for use by interpreters to assess the work of residents. Another evaluation form currently being used that focuses on continuing care clinic patients asks them to assess the interpersonal and communications skills of all clinicians. One respondent indicated that their institution was engaged in a major effort around language access, and it has galvanized faculty and residents to play a leadership role for the hospital in this area of interest.

¹³ Fourteen standards outlined in a report entitled “National Standards for Culturally and Linguistically Appropriate Services in Health Care,” DHHS, OPHS, Office of Minority Health, published March 2001.

7. **Diversity Issues Arise in Discussion**

One question in the survey asked HPEPP leaders to describe situations where diversity issues had arisen in discussions with HPEPP trainees. Most respondents cited discussions around race, ethnicity, and culture that had come up in relation to the patient care process, rather than issues related to the experiences of trainees. Examples cited by interviewees include, but are not limited to the following:

- A pregnant woman with mild lead toxicity who wanted to eat from a particular clay pot from Mexico.
- A Hmong patient with lead toxicity from ceremonial liquor brewed at a home still.
- The tendency for Cambodian patients to share their medical history through storytelling, rather than through question and answer.
- Reluctance by Cambodian patients to be cared for by Vietnamese physicians.
- Misunderstandings between Central American patients and Mexican physicians.
- Biased views of African-American patients that involved depiction of their manifesting non-compliant attitudes.
- Communication issues around a do-not-resuscitate (DNR) request for a Southeast Asian woman and her husband's reluctance to order without permission from her parents.
- Discussion of care issues, payment, and involvement of family members of an undocumented Mexican immigrant with HIV.

A number of respondents indicated that faculty and trainees deal with issues of race and ethnicity every day in patient and family interactions; at least one respondent posited that this is the best way to build understanding.

Only a few interviewees referenced situations where diversity issues unrelated to patient care came up in discussions with HPEPP trainees. In two cases, respondents identified language and cultural problems experienced by Asian HPEPP trainees. In one case, the respondent cited a tendency for Asian residents to internalize problems, and noted that in some cases, problems can be traced back to familial pressures to pursue a medical career against the wishes of the trainee.

8. Preparation of Faculty

In most HPEPP programs covered in this inquiry, there has been no formal process to prepare faculty to deal with issues associated with diversity, health disparities, or cultural competency. Most respondents indicated that this form of knowledge development is an ongoing process associated with patient care for diverse populations. In some cases, specific developmental efforts have been undertaken in the last few years in acknowledgment of the need to support similar educational processes with residents. One respondent cited the hosting of conferences on cultural awareness, including a regional meeting of the American College of Physicians entitled “Racial and Ethnic Differences in Medical Care,” and lamented that there was a need for more time for faculty to interact with academic affiliate research institutes to delve deeper into these topical areas. Another cited participation in a faculty development program in underserved medicine run by an academic affiliate. Still another respondent indicated that their academic affiliate provides information to assist faculty in dealing with a range of issues, including race, ethnicity, and culture.

Finally, one respondent noted that their hospital has a graduate medical education committee that brings together department heads and medical school faculty on a monthly basis, and acknowledged that while there has not been focused discussion on these issues to date, this group would be an excellent forum for such a dialogue.

9. Links to Community Advocates

A number of residents cited ongoing links with local FQHCs cited previously as a key resource to provide trainees with exposure to community advocates. One respondent cited periodic meetings with community and tribal leaders has contributed to both increased access and better understanding of cultural issues among trainees. Another indicated that in their program there is limited exposure to community advocates for most trainees, with time being the most limiting factor.

However, there were examples of such interactions cited by multiple respondents, including dialogue between residents and interpreters, meetings with cultural and ethnic community leaders, and trainee volunteer work at local high schools and family resource centers. One respondent indicated that medical residents are encouraged to use electives to address their particular interests or needs, but there is no organized effort to give them exposure to community issues and advocates. At one hospital, residents participate in “Meet the Doc” programs at a local shopping mall, where they present on a variety of topics and engage community members as a means of discussing health issues in a non-technical manner.

The most formal and extensive effort among hospitals cited is a community advocacy rotation for pediatric residents. First- and second-year residents in this program learn a variety of skills, ranging from community assessments and population health planning to engagement of diverse community stakeholders and policy advocacy (Appendix A-2, Site #4).

10. HPEPP Training and Community Benefit

In this section of the survey, interviewees were first asked to describe how their HPEPP programs support the charitable mission of their hospital. Most respondents identified the fact that trainees play a major role in efforts to serve medically indigent, racial and ethnically diverse populations. In some cases, however, respondents described their contribution to the community as: “training the next generation of health care providers.”

Interviewees were then asked a series of questions regarding their links and coordination with community benefit staff at their hospital. The majority of respondents indicated that there were ongoing links with community benefit staff. In most cases, however, it was a one-way process, where residents were recruited to participate in periodic events such as health fairs. In most situations where HPEPP programs had partnerships with FQHCs and other community-based service settings, they were a result of internal leadership, rather than coordination with community benefit staff. A number of respondents indicated that there were no links between the two functional units.

A number of interviewees expressed interest in greater coordination and proactive planning with community benefit staff, particularly given current constraints on resources. This theme was further amplified in subsequent focus group discussions of the draft guidelines.

HPEPP GUIDELINES – FOCUS GROUP DISCUSSION AND REDRAFTING

As noted previously, an initial draft set of guidelines was developed from the information collected in the telephone interviews with health professions education and training leaders from ASACB hospitals, field observations, and a review of current literature. The initial draft guidelines contained 21 different statements organized under six subject headings: A) Pipeline Support/Expansion, B) Admissions, C) Curriculum Content, D) Training Environment, E) Retention/Advancement, and F) Funding/Policy Advocacy.

Using the process of review and editing that is outlined in the Methods Section III B, a final working set of guidelines (Appendix A-1) was developed. The final version has 18 guideline statements under the original six subject headings (slight edits in the heading titles for Sections B and F). Key aspects in the evolution of the guidelines are summarized with key excerpts from each of the six subject headings below.

A. Pipeline Support/Expansion

The first section of the guidelines included the following language:

Efforts to increase health care workforce diversity should include an investment in local and regional strategies to increase the pool of URM youth who are interested in health care careers. These strategies are long-term efforts to expand the “pipeline” of future applicants to health professional education and training programs.

Focus group members generally ranked these “pipeline” initiatives as an area of high importance for HPEPP program activity. In our discussions, it was noted that since a key function of HPEPP participation in these efforts includes providing mentor and role models to URM youth who may want to consider health careers and working with diverse groups in the community to support similar outreach efforts, it is helpful to have a diverse racial and ethnic mix among HPEPP personnel. Accordingly, it seemed fitting for this content area to include a guideline statement that asks HPEPP programs to assess their own staff racial and ethnic composition, as follows:

1. *Hospitals with health professions educational practice partnership (HPEPP) programs assess the racial and ethnic composition of their contract and staff providers in comparison with the representation of racial and ethnic populations in their region.*

Other focus group comments led us to combine the second and third draft guideline statements into a single one with two parts (2 a. and b.). As now written, the second guideline encourages hospitals with HPEPP programs to make an affirmative effort to connect with current pipeline initiatives in the area as well as to mobilize and catalyze other similar and related efforts:

2. *Hospitals with HPEPP programs participate with health care providers, academic affiliates, local schools (k-12), business, and community leaders to develop a local or regional outreach and recruitment strategy for URMs. Areas of focus for this strategy include the following:*
 - a. *Connecting hospital-based health professions education and training programs to local or regional pipeline initiatives that focus on increasing the pool of URMs interested in health care careers.*
 - b. *Engaging and mobilizing existing community assets (e.g., community-based organizations, chambers of commerce, advocacy groups) to implement outreach strategies in URM communities.*

Additional comments in this content area focused on the need for more collaborative work in this area, even though it may be difficult (competition, geographic barriers, lack of external interest).

B. Recruitment and Admissions

The first guideline statement in this content area calls for HPEPP programs to maintain statistics about racial/ethnic composition of applicant interviewees and matriculates, as follows:

1. *Within legal parameters, HPEPP leaders maintain statistics about the race/ethnicity of applicants, interviewees, and program matriculants.*

Most participants in our inquiry do not collect and maintain data for the first two groups. That having been said, most of the focus group participants supported this as a worthwhile endeavor—though a few noted their concerns about whether it could be done legally and that “purely counting” does not reveal much sometimes about effort and having the right perspective.

The second guideline in this section calls for increased communication between hospitals engaged in HPEPPs and their academic affiliates:

2. *Hospitals and HPEPP leaders communicate with academic affiliates on how to both select and educate students in areas such as language competency, cultural competency, working effectively with diverse ethnic/cultural groups, and population health.*

Focus group participants expressed significant support for increased communication, and there was general agreement to encourage integration of cultural competence into the academic curriculum. Focus group participants also agreed that HPEPP programs and faculty should be more active in the admission committees of health professional schools and/or to at least provide feedback to schools about trying to select a more diverse group of applicants. At the request of a few participants, we removed the initial reference to “encouraging interest in primary care practice.” Interestingly, to some, encouraging the selection of persons interested in primary care was actually thought to be a barrier for admitting URM medical residents who allegedly (we are unsure of the data about this) are increasingly considering other non-primary care specialties for their careers.

The third guideline in this section focused on student clerkships:

3. *HPEPP leaders work with health professional training schools to sponsor student clerkships that will attract individuals with demonstrated interest in health issues affecting URM populations.*

The initial draft of this guideline focused on clerkships for URM trainees. Focus group participants expressed support for the general concept of clerkships, but expressed concern about limiting the scope to URM trainees. Participants suggested that all trainees with commitment and expertise in these areas should have the opportunity benefit from such clerkships. We agreed to broaden the language accordingly.

The fourth and final guideline in this section focuses on recruitment of URM local residents:

4. *HPEPP leaders make an affirmative effort to recruit, as program trainees, URM students who grew-up in or have other significant personal connections to the local area.*

There was broad agreement with the fourth guideline among focus group participants. A number of participants cited examples where local (personal) connections have facilitated recruitment processes.

C. Curriculum Content

The initial draft guidelines had five statements in this area; the final working draft was reduced to four. (A statement asking hospitals engaged in HPEPPs to make efforts to connect to organized academic or community efforts to reduce health disparities and improve cultural diversity training was combined with another statement that also includes community-based health education.) The first three guidelines focus on the establishment and/or deepening of working relationships between HPEPP leaders and staff in the hospital with community-related functions in order to facilitate increased integration of didactic and applied curriculum elements related to care for diverse populations. As a first step in this process, guideline C.1 calls for regular meetings of HPEPP leaders and hospital community benefit staff:

1. *HPEPP leaders meet periodically with people in the hospital who are responsible for community benefit and related functions to share emerging priorities, program initiatives, and explore opportunities for mutual benefit.*

Focus group participants strongly supported the need to do this while recognizing that at present, this happens only in a minority of teaching hospitals. Both HPEPP program leaders as well as community benefit staff felt that such meetings, if substantive, proactive, and properly focused, would be mutually beneficial to both constituencies as well as to the communities they serve.

The second guideline statement calls for establishing relationships with other health care facilities (e.g. FQHS, Indian Health Services centers, homeless shelters, etc.) to provide trainees with the opportunity to care for people from diverse racial, ethnic, and socioeconomic backgrounds; and the third guideline statement builds on this to include a range of community programs that focus on improving cultural competency and/or reducing health disparities:

2. *HPEPP leaders work with community benefit and/or other appropriate hospital staff to establish affiliations/relationships with one or more community-based health center/clinics or facilities to enhance the diversity of the training environment for health professional trainees.*
3. *HPEPP leaders work with community benefit and/or other appropriate hospital staff to provide opportunities for trainees to participate in community-based*

health education and other efforts aimed at reducing health disparities and improving cultural competence of trainees.

Focus group participants viewed both of these guideline statements as important. Discussion in this area stimulated overarching questions regarding what community-based activities should emerge from HPEPP program leadership versus community benefit program leadership. The net result of this discussion is that for the two guideline statements (C.2 and 3) that focus on establishing or nurturing external relationships (which, concomitantly can have multiple purposes; training, community benefit, ambulatory care expansion, marketing and communications), the source of leadership in any particular hospital may vary. In some hospitals, the leadership to build and maintain an external relationship comes out of the health professions training program; in other hospitals, it comes out of the community benefits department (or a related functional unit). Participants, did, however, acknowledge inherent tensions about learning versus service delivery in some of these efforts, and the practical challenge of adding more experiences for health professions trainees who already have very full schedules. The fourth and final guideline statement focused on the integration of special learning modules on how diverse populations deal with health issues:

4. *HPEPPs integrate programs and learning modules for trainees that provide education on how various religious or cultural groups are affected by certain health and health care issues (e.g., access to care for different ethnic groups, diabetes in ethnic populations, death and dying, post-traumatic stress disorder, etc.).*

This statement gathered many comments as to its importance, yet acknowledgment that these areas are poorly addressed in the current environment. Participants indicated a clear need for both up-to-date and content-rich materials and teachers of the variety of subjects noted in the guideline. Also, it was noted that there is a similar need for such programs and training modules for attending staff and even clinicians at non-teaching hospitals. Finally, participants expressed a strong desire for web-based and/or CD-ROMs to help provide on-demand training.

D. Training Environment

The guideline statements in this content area stimulated the greatest amount of push back for language change. Initially, the first guideline statement read:

“Develop component of trainee orientation that specifically addresses issues of race, ethnicity, and culture in the training experience and, as appropriate, provide special support options for URM trainees (including safe and private options for resolution of interpersonal issues).”

There were a number of focus group participants who questioned whether this is something that needs to be done in the trainee orientation. We agreed to eliminate the first clause. In addition, while a number of people supported the thrust of a focus on the needs of URM

trainees, there was about an equal number of people who strongly objected to the focus on such a targeted group. Many felt that this special treatment was divisive and stigmatizing—and while acknowledging trainee support is important—urged us to make the guideline respond to the needs of all trainees, and not only URM trainees. The final version of D. 1 represented an effort to strike a compromise between the two groups:

1. *HPEPP programs provide support options for trainees who may need assistance with interpersonal challenges—especially for those challenges that grow out of their life experiences tied to race, ethnicity, and culture.*

Participants also expressed concern over the second guideline statement in this content area, which focused on linking URM trainees with mentors. While there was general agreement about support for mentoring, it was felt that the trainee is the best person to decide who should play that special role. Accordingly, the guideline statement language evolved to respect the right of the trainee to decide what characteristics of “similar background” are important, as follows:

2. *HPEPP leaders assist URM trainees in identifying clinician mentors from similar backgrounds for periodic consultation.*

Finally, the third guideline statement in this area called for HPEPP programs to support faculty development training to deepen understanding of issues related to race, ethnicity, and culture:

3. *HPEPP programs support faculty development of core competencies to deepen understanding of issues related to race, ethnicity, and culture in the education and training process.*

Our initial draft guideline had called on HPEPP programs to sponsor this type of training. In our focus group discussions, participants acknowledged the importance of support, but suggested that the guideline should avoid prescribing where and how faculty obtain such training and support. The final version of the guideline reflects this change.

E. Retention/Advancement

The initial draft of guidelines included four statements. Based on preliminary discussions with some members, the fourth guideline was dropped. While worthy in its direction, it focused on developing relationships between physician residencies and fellowship training sites. The intent was to assist URM residents in obtaining fellowships that will better launch them toward academic careers—as written, the guideline is somewhat unclear and elusive for a group of community teaching hospital program directors.

The other three initial draft guidelines aimed at:

- Recruiting a more diverse faculty;
- Supporting career advancement for URM employees; and
- Rewarding faculty who develop skills and provide leadership around efforts to care for diverse populations.

The remaining three guideline statements were maintained with minor revisions:

1. *Hospitals and their HPEPP programs make an affirmative effort to recruit URM health professionals to the faculty and staff of health professions training programs to better reflect the ethnic and racial makeup of the regional population.*
2. *Hospitals sponsor continuing education training programs to support the career development and advancement of current URM employees (e.g., nursing aides, RNs, BSNs, and MSNs) in cooperation with academic affiliates and other organizations.*
3. *Hospitals and their HPEPP programs encourage and reward faculty and staff who develop specialized skills and provide leadership in efforts to care for diverse populations.*

There was some discussion from our focus group participants with respect to guideline E.1. While all supported the need to recruit more diverse faculty and staffs, they reiterated concerns shared in the survey process, that—especially in some of the rural areas—it is often difficult to recruit persons of color to their programs or geographic areas.

F. Resource Commitment/Policy Advocacy

The last section of guidelines focused on the development of overarching strategies to increase workforce diversity and reduce health disparities:

1. *Hospitals and their HPEPP programs develop measurable objectives, allocate specific resources, and implement plans to increase workforce diversity and reduce health disparities.*
2. *Hospitals and their HPEPP programs identify, mobilize, and support leaders to advocate for improvements in workforce diversity and reductions in health disparities.*

As initially drafted, the two statements focused on obtaining external support for URM-related enhancements to HPEPP programs. After discussion, we became more secure in the belief that the proper focus for these guidelines was not about where and how to obtain funding; rather, it should be about developing plans and objectives, and allocating resources accordingly. While for many hospitals and/or training programs, securing the funds for such URM-related efforts remains an important issue; we leave it to the institution to find out how best to finance such efforts—including using its own resources.

In addition, asking HPEPP programs and their leaders to advocate for the overarching aims of workforce diversity and health disparity reduction was missing from the initial draft set of guidelines. With the encouragement of our focus group participants, we added it with a focus on leaders—conceivably both internal and external to the hospital or HPEPP program—to advocate for policy improvements that would support greater workforce diversity and health disparity reduction.

EXEMPLARY PRACTICES

The following seven exemplary practices were documented as part of this inquiry:

Hoag Memorial Hospital Presbyterian (Newport Beach, CA) – Sponsorship of Professors at Regional Nursing Schools

Mission Hospital (Orange County, CA) St. Joseph Health System – Orthopedic Residency Program to Support Community Clinic

Texas Health Resources (Northern TX) – Job-Based Nursing Career Development

Lucile Packard Children’s Hospital at Stanford (Palo Alto, CA) – Pediatric Advocacy Program

Santa Rosa Memorial Hospital (Sonoma County, CA) St. Joseph Health System – Healthcare Workforce Development Roundtable

Scripps Chula Vista Hospital (San Diego, CA) Scripps Health – Family Practice Community Immersion Program

St. Mary Medical Center (Long Beach, CA) Catholic Healthcare West – Internal Medicine Links with Local Cultural Organizations

Summaries of each exemplary practice are included as Appendix A-2.

V. Discussion

The information shared by participants in this study clearly illustrates the potential benefits of definitive action by HPEPP leaders and teaching hospitals to increase health care workforce diversity and address health disparities. These benefits accrue not only to current and future URM trainees, but to the other participants in programs who benefit from a more rich learning environment, to the hospital in terms of increased cultural competency and quality of care, and of course, to the communities served by the hospitals. Moreover, the diversity in the size of

the hospital, location, population dynamics, and type of HPEPP training provided by participants in this study highlights the fact that deliberate effort can yield many forms of excellence.

At the same time, participants in this inquiry highlighted the array of obstacles faced by different kinds of hospitals engaged in HPEPPs in their efforts to increase health care workforce diversity. In the recruitment process, participants cited a number of challenges associated with efforts to influence academic affiliates, expand and/or enhance selection criteria, and provide the resources and environment that would attract URM applicants to HPEPP programs outside of larger, urban-based teaching hospitals. Participants also cited a number of challenges associated with efforts to increase attention to issues related to race, ethnicity, and culture in HPEPP curricula. A combination of scarce resources, time constraints associated with the volume of required components, and a lack of teaching tools were among the issues cited in our discussions. Finally, participants cited challenges both in the recruitment of URM HPEPP faculty and ensuring that existing HPEPP faculty (URM and otherwise) have the tools to deal with issues of race, ethnicity, and culture in their mentorship and education of trainees. Despite these challenges, many of the participants in this inquiry have made significant progress, and numerous examples are provided in the text and in the summary of exemplary practices in Appendix A-2.

The core issue is how to achieve and encourage a deliberate effort to increase program diversity and create a training environment that emphasizes a collaborative, culturally competent approach to improve health status in our increasingly diverse communities. We think that articulating key goals and specific steps towards this end would be useful so long as any written expectations are not overly prescriptive. Findings from our survey and input during the conference calls suggest that properly conceived and focused guidelines may be quite helpful in defining areas of focus for action by HPEPP leaders and their institutions. We think this is especially so if a set of guidelines are both framed and grounded in principle, yet flexible enough to respect institutional and program differences while encouraging innovation. In addition, such guidelines should be: (1) understandable; (2) acceptable to the health professions education and training field; (3) add value; and (4) require appropriate levels of both leadership commitment and resources for their implementation.

We are also mindful that there are differences between major teaching hospitals and smaller or less educationally intensive institutions that are engaged in HPEPPs. These differences result in both opportunities and challenges for each group. For major teaching hospitals, there may well be both greater responsibilities to take a leadership role in this arena, as it is often that such program's trainees go on to take leadership roles in the health professions. These hospitals also often have great ability to influence the directions of their academic affiliates in many ways—including admissions as well as educational content of programs. However, such programs with broad agendas often find that they are already pulled in many different directions with respect to how best to dedicate training time and diversity, and cultural competency of trainees have to compete with attention for research and technical competency.

For minor teaching hospitals, often filling their programs with graduates of American schools is a key priority. They may sometimes be located in geographic areas where it may be more difficult to attract URM trainees to their programs. With those realities and concerns, such hospitals may be more inclined to hew to traditional criteria in the selection process as a means of demonstrating commitment to excellence. It will be important to clearly address this perception and interpretation of excellence for minor teaching hospitals that are considering the importance of these issues and their priorities. At the same time, the smaller size of programs in these institutions may provide increased flexibility to institute reforms that would be more difficult to implement in large teaching hospitals.

With respect to all hospitals engaged in HPEPPs, surrounding the issue of any set of guidelines is a question regarding their usefulness and how best to offer review and guidance to their efforts. Even when guidelines may be robust, there is often a need for some sort of system that provides either carrots (e.g., financial or other resources) or sticks (e.g., loss of accreditation) to accompany efforts aimed at guideline implementation. And for all hospitals—at least nonprofit ones—issues surrounding the relevance of these goals to other institutional prerogatives tied to community benefit may be of great interest. Increased emphasis on proactive planning and coordination between HPEPP leaders and community benefit staff may yield substantial returns for hospitals and the communities they serve. Given increased public scrutiny into the charitable obligations of nonprofit hospitals, this represents an opportunity for these institutions to provide leadership on an issue of considerable social importance.

We believe that further testing of the guidelines in a range of different sorts of institutions is an important next step to address these and other questions. Accompanying that testing could well be some additional discussions with HPEPP representatives, accrediting bodies, trade associations, and policymakers about what has been learned from such a testing effort, as well as a general discussion about how best to further common goals. One of the products of additional field testing of the guidelines should be a list of specific steps that can be taken by teaching hospitals in the implementation of individual guidelines. For example, a list of specific options and alternatives are needed for guideline B.2, which calls for communication with academic affiliates on how to select and educate students in areas such as cultural competency. Focused inquiry is needed into specific strategies, as well as an examination of possible incentives and/or disincentives for definitive action.

Teaching hospitals can play an important role in efforts to increase health care workforce diversity and ensure that the next generation of providers has the skills necessary to provide quality care to our increasingly diverse communities. Definitive action is also needed, however, by academic affiliates. The recent study completed by the Institute of Medicine entitled “In the Nation’s Compelling Interest” outlines both the issues to be addressed and specific steps that could be taken by health professions education institutions. Both definitive action and ongoing coordination is needed by teaching hospitals, academic affiliates, policymakers, and the public at large in order to make progress in addressing this important social imperative.

APPENDIX A-1 FINAL GUIDELINES



Increasing Workforce Diversity and Addressing Health Disparities: Guidelines for Educational Practice Partnerships in Health Professions Education and Training

January 31, 2003

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The following draft guidelines are intended for use by hospitals engaged in health professions educational partnerships (HPEPPs) with academic affiliates as a tool to increase workforce diversity and provide trainees with the skills necessary to deliver quality care in an increasingly diverse society.

Often, an array of educational and health care organizations come together to help provide the educational experiences that are necessary to train a variety of health professionals in this increasingly complex world of health and health care. For physician, nursing and allied health professionals, the hospital remains a central partner in such educational efforts. Other community health provider settings have also taken on key roles as sites for health professional training.

In most communities, this vast array of affiliated health care providers are in the not-for-profit organizational form, and with a charitable mission, these organizations are in a special position to engage academic affiliates and make the case that health care workforce diversity is an important societal imperative that requires ongoing dialogue and coordinated effort. These efforts include, but are not limited to, outreach, mentorship, and career development support in diverse communities, revising criteria for admissions into training programs that they sponsor or are in partnership with, expanding the scope of curricula to provide increased exposure on how best to care for diverse populations, and creating incentives for retention and advancement of trainees and staff that share these important goals.

Not-for-profit hospitals represent an important and significant educational practice partner for a variety of health professional training programs. In particular for physician training, such institutions form an essential part of both the undergraduate and graduate educational

experience for trainees. For such institutions which operate with community benefit responsibilities, it can be argued that their accountable obligations should include efforts to increase workforce diversity and reduce health disparities while concomitantly strengthening links between health professions education and training and their community benefit programs. When community benefit programs are well designed, comprehensive, and fully integrated into local communities, they provide a rich learning environment for trainees. This is particularly the case with programs that focus on addressing disproportionate unmet health needs in ethnically and culturally diverse communities. Involvement of health professions trainees provides valuable knowledge and experience and helps to advance the charitable mission of the hospital.

The guidelines were developed as a component of the Advancing the State of the Art in Community Benefit (ASACB) demonstration, a four-state initiative involving 71 hospitals, including three health systems and three independent hospitals. This component of the demonstration is funded by the W.K. Kellogg Foundation, and is part of a larger national initiative to address the need for increased diversity in the health care workforce. Ideas for the guidelines were drawn from information collected in interviews with health professions education and training leaders from ASACB hospitals, field observations, and a review of current literature.

In the dissemination of the guidelines, it is important to acknowledge that hospitals have varying degrees of influence with academic affiliates given variations in the scale, focus, and design of particular programs. Moreover, some guidelines may not be relevant to the particular environment or circumstances of the hospital or its health professions training programs. Legal statutes and regional demographics may present further obstacles to definitive action. While it is our hope that hospitals will make a substantial effort to meet the overall aim of each of the specific draft guidelines, individual hospitals may well find that it is not of value for them to focus on all of them, and will allocate their efforts accordingly. Despite these complicating factors, there is much that can be done to improve upon efforts to date.

The guidelines are divided into six major groups; A) Pipeline Support / Expansion, B) Admissions, C) Curriculum Content, D) Training Environment, E) Retention / Advancement, and F) Resource Commitment/ Policy Advocacy. As drafted, the guidelines primarily address specific actions or activities of hospital-based health professional training programs and their leaders; however, in some instances the guidelines place expectations on a broader set of hospital staff and leaders. We leave it to individual institutions as to how best to manage these suggested actions and activities in a way that is value adding for the communities served by the institution as well as for the hospital and its HPEPP programs.

A. Pipeline Support / Expansion

Efforts to increase health care workforce diversity should include an investment in local and regional strategies to increase the pool of URM** youth who are interested in health care careers. These strategies are long-term efforts to expand the “pipeline” of future applicants to health professional education and training programs.

1. Hospitals with health professions education and training (HPEPP) programs assess the racial and ethnic composition of their contract and staff providers in comparison with the representation of racial and ethnic populations in their region.
2. Hospitals with HPEPP programs participate with health care providers, academic affiliates, local schools (k-12), business, and community leaders to develop a local or regional outreach and recruitment strategy for URMs. Areas of focus for this strategy include the following:
 - a. Connecting hospital-based health professions education and training programs to local or regional pipeline initiatives that focus on increasing the pool of URMs interested in health care careers.
 - b. Engaging and mobilizing existing community assets (e.g., community-based organizations, chambers of commerce, advocacy groups) to implement outreach strategies in URM communities.

B. Recruitment and Admissions

1. Within legal parameters, HPEPP leaders maintain statistics about the race/ethnicity of applicants, interviewees and program matriculants as well as assess the racial and ethnic composition of their contract and staff providers in comparison with the representation of racial and ethnic populations in their region.
2. Hospitals and HPEPP leaders communicate with academic affiliates on how to both select and educate students in areas such as language competency, cultural competency, working effectively with diverse ethnic/cultural groups, and population health.
3. HPEPP leaders work with health professional training schools to sponsor student clerkships that will attract individuals with demonstrated interest in health issues affecting URM populations.

* *New language adopted June 23, 2003 by the Association for American Medical Colleges for URMs is the following: "Underrepresented in medicine means those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population."*

4. HPEPP leaders make an affirmative effort to recruit, as program trainees, URM students who grew-up in or have other significant personal connections to the local area.

C. Curriculum Content

1. HPEPP leaders meet periodically with people in the hospital who are responsible for community benefit and related functions to share emerging priorities, program initiatives, and explore opportunities for mutual benefit.
2. HPEPP leaders work with community benefit and/or other appropriate hospital staff to establish affiliations/relationships with one or more community-based health center/clinics or facilities to enhance the diversity of the training environment for health professional trainees.
3. HPEPP leaders work with community benefit and/or other appropriate hospital staff to provide opportunities for trainees to participate in community based health education and other efforts aimed at reducing health disparities and improving cultural competence of trainees.
4. HPEPP programs integrate programs and learning modules for trainees that provide education on how various religious, or cultural groups are affected by certain health and health care issues (e.g., access to care for different ethnic groups, diabetes in ethnic populations, death and dying, PTSD, etc.).

D. Training Environment

1. HPEPP programs provide support options for trainees who may need assistance with interpersonal challenges--especially for those challenges that grow out of their life experiences tied to race, ethnicity and culture.
2. HPEPP leaders assist URM trainees in identifying clinician mentors from similar backgrounds for periodic consultation.
3. HPEPP programs support faculty development of core competencies to deepen understanding of issues related to race, ethnicity, and culture in the education and training process.

E. Retention / Advancement

1. Hospitals and their HPEPP programs make an affirmative effort to recruit URM health professionals to the faculty and staff of health professions training programs to better reflect the ethnic and racial make-up of the regional population.

2. Hospitals sponsor continuing education training programs to support the career development and advancement of current URM employees (e.g., nursing aides, RNs, BSNs, and MSNs) in cooperation with academic affiliates and other organizations.
3. Hospitals and their HPEPP programs encourage and reward faculty and staff who develop specialized skills and provide leadership in efforts to care for diverse populations.

F. Resource Commitment/ Policy Advocacy

1. Hospitals and their HPEPP programs develop measurable objectives, allocate specific resources, and implement plans to increase workforce diversity and reduce health disparities.
2. Hospitals and their HPEPP programs identify, mobilize, and support leaders to advocate for improvements in workforce diversity and reductions in health disparities.

APPENDIX A-2 EXEMPLARY PRACTICES



Advancing the State of the Art in Community Benefit Demonstration Health Professions Education and Training Programs Exemplary Practices

Site #1

Hoag Memorial Hospital Presbyterian

Sponsorship of Professors at Regional Nursing Schools

Hoag Memorial Hospital Presbyterian in Newport Beach, CA funds three professors at local colleges; each professor enables the schools to bring in 12 additional students (Currently in negotiations with another college in an area with a larger percentage of Latinos to fund another professor). Hoag Hospital also provides field training experiences for the students through linkages with their community benefit programs. The community benefit program provides in-depth exposure to health-related issues and challenges faced by low-income, ethnic and culturally diverse populations.

Site #2

Mission Hospital – St. Joseph Health System

Orthopedic Residency Program to Support Community Clinic

Mission Hospital (St. Joseph Health System) in Southern Orange County signed an Affiliation Agreement with UCI Medical Center to become a participating institution in UCI's post-graduate medical education program for orthopedic physicians. A primary consideration of Mission Hospital for beginning this residency rotation was to respond to a need for orthopedic services for the underserved population that receives services at a community based clinic that is solely sponsored by Mission Hospital. Almost 100% of the patients served by the clinic are Latino, and the majority are limited English proficient. The Medical Director of the residency program came to Mission Hospital from San Francisco, and is an advocate for community benefit and who wanted to make sure trainees are exposed to these issues.

Site #3

Texas Health Resources

Job-Based Nursing Career Development

Texas Health Resources (THR) has developed a program to provide nursing career opportunities primarily for its existing employees. The goal is to increase the pool of nursing professionals to meet growing demands and to increase workforce diversity. The program is a partnership with El Centro Community College, which has seven campuses in North Texas. THR just invested 1.2 million to establish an on-line distance learning network that enables employees to access educational instruction through the workplace.

Interested employees apply directly to El Centro for the program once they have completed the first four of eight prerequisites and have maintained at least a 2.5 GPA. After acceptance by El Centro, students are then accepted into the THR program and the internal criteria include longevity with THR and work performance. Full-time employees may have the option to change their work schedules in order to have focused time for academic study. There were 15 students in the initial cohort who successfully completed the first semester of study. THR added 40 additional students in Spring 2004 and will add another 40 in Fall 2004.

In addition to the Associate Degree in Nursing program to pursue the RN licensure, THR employees also have the option of pursuing an RN to BSN degree or a BSN to MSN degree. These programs are done in partnership with the University of Texas at Arlington.

Site #4

Lucile Packard Children's Hospital at Stanford

Pediatric Advocacy Program

Lucile Packard Children's Hospital (LPCH), in collaboration with Stanford University School of Medicine initiated a pediatric advocacy training program for pediatric residents in July 2000. The main component of the program is a two-week Pediatric Community and Child Advocacy Rotation for first year residents and a month long Adolescent Medicine and Advocacy rotation. These rotations provide residents with the opportunity to develop a variety of skills, ranging from community assessments and population health planning to engagement of diverse community stakeholders and policy advocacy.

A major group project over the last year has been the development of an asthma prevention and management initiative in East Palo Alto, a predominantly low-income, racially and ethnically diverse urban area near the university. The program is currently being replicated at the University of California, San Francisco and the University of Miami, Florida. The head of the program, Lisa Chamberlain, M.D., M.P.H., also lectures at the Stanford Medical School where she gives child advocacy seminars to medical students (February 2002- 2003) and has participated in the development and helps lead "Physicians in Society", a course required for all first year medical students (2003 to present). These course offerings are an effort to provide a broader perspective earlier in the medical education process.

Site #5

Santa Rosa Memorial Hospital / Petaluma Valley Hospital – St. Joseph Health System
Healthcare Workforce Development Roundtable

Santa Rosa Memorial Hospital and Petaluma Valley Hospital (St. Joseph Health System) formed a partnership with other local hospitals, community clinics, community colleges and universities, local schools, and the local chamber of commerce to promote interest in the health professions and enhance opportunities for diverse residents. Core strategies include:

- Outreach and early entry programs for youth and adults
- Enhanced economic support for training and education
- A health professions media campaign
- Career development programs within health organizations
- Capacity-building within health care organizations for recruitment, training, and retention.

Accomplishments to date include the development of an inventory of local health care training programs and resources; a formal projection of health care workforce needs in the region, and a social marketing program that focuses on the Latino community. The collaborative environment of the roundtable has provided a valuable forum for strategic planning and joint problem solving among provider organizations, educational institutions, and local community leaders.

Each health care organization in the partnership is engaged in individual efforts to support the objectives of the Roundtable. At Santa Rosa Memorial Hospital and Petaluma Valley Hospital, a two-track process is underway. The first is a cultural competency initiative that is tied to the 14 Federal Standards for Cultural and Linguistically Appropriate Services; they have formed seven committees to guide the process. Efforts to date include a self-assessment and strategic planning process, two-day training on cultural wisdom to familiarize clinicians and administrative staff, translation of patient information, the development of a series of classes, video forums and discussions on cultural competency issues, and the development and application of an internal audit tool based on the 14 standards to track their progress. The process is being facilitated by Community Benefit staff and is being championed by the SRM Hospital Executive Management Team.

The second effort is a health “promotores” initiative in partnership with the city of Santa Rosa. The promotores conduct outreach to the Latino community to encourage and link interested community members to health professions opportunities. In addition to outreach directly in the community through health fairs and other local events, a key targets for outreach are Latino students at local junior colleges and immigrants who were health professionals in their own country. A parallel program that has just started is called “promotoritos,” and involves the education of children on health issues, and the introduction of a potential future career in the health professions.

Site #6

Scripps Chula Vista Hospital – Scripps Health
Family Practice Community Immersion Program

The family practice residency program at Scripps Chula Vista Hospital in San Diego, CA makes a strong effort to both enhance the medical educational process and advance the community benefit goals of the hospital. Through a partnership of both the residency and the hospital's director of community benefit programs, family practice residents participate in a "Meet the Doc" program. At a local shopping mall site, family practice residents conduct health education sessions on a range of topics. The sessions enable them to talk about health issues in 'non-medicalized' ways, learn about community belief systems, and build trusting relationships with community members.

The residency program has also provided leadership for the establishment of a formal relationship with a local high school that involves sponsorship of a school-based health center and a career mentoring program. The mentoring program provides the opportunity for 30 local high school students each year to accompany family practice residents in some aspects of their training experience. During weekly 90 minute visits, high school students join the family practice residents in grand rounds, participate in patient care rounds, and learn about the application of medical technologies. The weekly visits also provide informal opportunities for doctors in training to talk with students about college and future health professions training.

Site #7

St. Mary Medical Center – Catholic Healthcare West
Internal Medicine Links with Local Cultural Organizations

St. Mary Medical Center in Long Beach, CA is located in an area that has the largest population of Cambodians outside of Southeast Asia. The hospital is a sponsor of Families in Good Health (FIGH), a health promotion organization that works to improve the life and health of SE Asian immigrants who reside in the Long Beach area. In the process, a relationship has developed between the agency and the St. Mary internal medicine training program that has benefited both partners.

Through its relationship with FIGH, St. Mary trainees have gained considerable knowledge from meetings with community elders who have helped to explain a variety of cultural issues and practices. As internal medicine residents have become involved in health education and outreach efforts of FIGH tied to diabetes and other chronic illnesses, it has benefited the people that FIGH aims to serve in its health and well being improvement efforts.

APPENDIX B
Diversity of Students and Faculty:
An Assessment of Health Profession Schools

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EXECUTIVE SUMMARY

Introduction

The Sullivan Commission on Diversity in the Health care Workforce, chaired by former U.S. Secretary of Health and Human Services, Louis W. Sullivan, M.D., was established in response to a 2002 report by the Institute of Medicine that cited increased diversity in the health professions as critical to reducing alarming racial health disparities. The Sullivan Commission will make policy recommendations to bring about systemic change at America's health profession schools and, ultimately, help eliminate unequal access to health services.

Despite an overall improvement in the health status of the U.S. population over the past ten years, health disparities in minority populations continue to plague the nation. Differences in culture have been shown to affect many aspects of health care (Ferguson et al., 2003). Many studies suggest that an increase in cultural-sensitive care would result in positive health outcomes for minority populations (Crandall et al., 2003).

The Institute of Medicine has recommended that increasing the amount of minority health care providers would help significantly reduce health disparities among minority populations. With this in mind, the Association of American Medical Colleges (AAMC), the American Dental Education Association (ADEA), the American Association of Colleges of Nursing (AACN), and other associations continue to encourage medical, nursing, and dental institutions to increase outreach and matriculation programs targeted at minority students with the goal of increasing the number of minority health care providers to better represent the race/ethnic population distribution of the United States.

This study consisted of two main objectives. The first was to quantify and compare student, financial aid, and faculty data broken down by race/ethnicity for the 1998 and 2003 graduating classes of all U.S. medical, dental, and nursing institutions. The second objective was to gather detailed information about the types of formal programs to attract minority students and faculty that medical, dental, and nursing institutions offer.

Methods

The study consisted of two parts. First, a Diversity Assessment Card was sent to all members of four member associations, representing the medical, dental, and nursing professions [Association of American Medical Colleges (AAMC, n=126), the American Association of Colleges of Osteopathic Medicine (AACOM, n=20), the American Dental Education Association (ADEA, n=56), and the American Association of Colleges of Nursing (AACN, n=563)]. A total of 765 schools were asked to participate in the survey.

The Diversity Assessment Card asked for quantitative data about the student body, financial aid, and faculty/administration for the 1998 and 2003 graduating classes of each health

profession institution. Student and faculty data provided by the AAMC, ADEA, and AACN was used to supplement the Diversity Assessment Card data.

The second part of the study consisted of Key Informant Interviews asking for detailed qualitative information about formal programs to attract minority students implemented at medical, dental, and nursing institutions. The Key Informant Interview was administered to 24 “best practice” health profession institutions. These “best practice” institutions were chosen non-randomly and consisted of 14 medical schools, five dental schools, and five nursing schools.

Results

Diversity Assessment Card responses were received from 51 of 126 (40.5 percent) medical schools, 38 of 56 (67.9 percent) dental schools, 42 of 573 (7.3 percent) nursing schools, and 7 of 20 (35 percent) osteopath schools. Most cards were only partially completed, particularly the fields concerning financial aid data.

“Best practice” institutions had multiple programs in place to attract minority students. However, “best practice” schools, while more diverse than competitor schools, had still not achieved parity in student or faculty demographics with the general population. Analysis of the Key Informant Interview showed that 92.9 percent of the “best practice” medical schools and 100 percent of the “best practice” dental and nursing schools had pipeline programs aimed at increasing minority enrollment. All “best practice” institutions interviewed reported that cultural competency was integrated in the curriculum. Approximately 57 percent of medical, 40 percent of dental, and 20 percent of nursing “best practice” institutions reported having a minority faculty development program.

Minorities continue to hold low percentages of faculty and administrative positions in the U.S. health profession schools. Interestingly, relatively low percentages of “best practice” institutions (57 percent medical, 40 percent dental, 20 percent nursing) reported having a minority faculty development program at all.

Discussion

Analysis of the Diversity Assessment Card data supplemented with data provided by the AAMC, ADEA, and AACN supports existing data that overall minority enrollment in health profession schools has decreased over the past four years.

Financial information was largely reported as unavailable for questions on both the Diversity Assessment Card and questions in the Key Informant Interview. The fact that this information was not more closely tracked was interesting in itself as financial issues are more likely to present a larger concern for minorities in a health profession school than for white students.

The findings in this study support what is already known about the decreasing numbers of minority students in health professions institutions. In 2001, for the fifth year in a row, the total number of minorities enrolled in medical school declined, going from a high of 8,254 in 1996 to a low of 7,394 (AAMC, 2002). This study also documented the types of programs to attract minority students and faculty implemented at 24 “best practice” medical, dental, and nursing institutions in the United States. However, given the scope of some of these programs and their modest success suggests that much more aggressive programs may be required to achieve equal representation for minority populations.

Introduction

The Sullivan Commission on Diversity in the Health care Workforce, chaired by former U.S. Secretary of Health and Human Services, Louis W. Sullivan, M.D., was established in response to a 2002 report by the Institute of Medicine that cited increased diversity in the health professions as critical to reducing alarming racial health disparities. The Sullivan Commission will make policy recommendations to bring about systemic change at America's health profession schools and, ultimately, help eliminate unequal access to health services.

Despite an overall improvement in the health status of the U.S. population over the past ten years, health disparities in minority populations continue to plague the nation (Ferguson et al., 2003). Differences in culture have been shown to affect many aspects of health care including access issues, health status, continuity of care, preventative treatments, patient-doctor communication, immunization rates, and prescription practices according to a study conducted by Flores et al. in 2000. Many studies suggest that an increase in cultural-sensitive care would result in positive health outcomes for minority populations (Crandall et al., 2003).

Many studies suggest that concordance of racial/ethnic backgrounds with one's physician results in increased patient satisfaction. The Institute of Medicine has recommended that increasing the amount of minority health care providers would help significantly reduce health disparities among minority populations. In addition to providing more cultural competent care, health care professionals from minority groups are more successful in recruiting minority patients to participate in clinical trials (Institute of Medicine, 2003). With this in mind, the Association of American Medical Colleges (AAMC), the American Dental Education Association (ADEA), the American Association of Colleges of Nursing (AACN), and other associations continue to encourage medical, nursing, and dental institutions to increase outreach and matriculation programs targeted at minority students with the goal of increasing the number of minority health care providers to better represent the race/ethnic population distribution of the United States.

This study consisted of two main objectives. The first was to quantify and compare student, financial aid, and faculty data broken down by race/ethnicity for the 1998 and 2003 graduating classes of all U.S. medical, dental, and nursing institutions. The second objective was to gather detailed information about the types of programs to attract minority students and faculty that medical, dental, and nursing institutions offer. Using the information collected, the goal of this study was to determine the current state of race/ethnic distribution of faculty and students at U.S. health care profession institutions and determine the effectiveness of recent initiatives aimed at increasing the number of minorities in the health care field.

Methods

Diversity Assessment Card

Subjects

Surveys were sent to all members of four member associations, representing the medical, dental, and nursing professions [(AAMC, n=126), (AACOM, n=20), (ADEA, n=56), and (AACN, n=563)]. A total of 765 schools were asked to participate in our study.

Survey Development

Survey items were developed through literature reviews and modified from the annual surveys that the membership organizations distribute. These candidate items were reviewed by members of the medical, dental, and nursing communities. The final survey instrument was revised based on the comments received.

All aspects of the study were exempted by the Duke University Institutional Review Board.

Survey Contents

The Diversity Assessment Card asked for data for both the 1998 and 2003 graduating classes in order to establish a basis for comparison. The survey domains consisted of the following three areas: 1. student body (e.g., applicants, enrollees, graduates, etc.) 2. financial aid information (e.g., loan, scholarships, debt, etc.) and 3. faculty and administration data (tenure, part-time, deans, etc.).

Survey Administration

Letters requesting participation and the surveys were sent to both the Dean and the Registrar's office for each school (excluding the nursing schools) in Q4 2003. Non-responders received a phone call and a reminder letter one month after the survey was distributed (excluding nursing schools). Respondents had an option of either completing the survey on-line or faxing the form to the study team. All responses were entered into an ACCESS database

Analysis

Simple statistics were used to describe the results.

Methods

Key Informant Interviews

Subjects

Using a non-random sample, we conducted phone interviews with schools that report “best practices” in providing cultural competency programs, and in the recruitment and retention of minority students and faculty. Specifically, we interviewed 14 medical, 5 dental, and 5 nursing programs. Senior staff at the Sullivan Commission identified an initial individual to contact at each school, and was usually the Director of Admissions. In almost all cases, we needed to speak with multiple people at the institution in order to complete the questionnaire

Survey Development

Survey items were developed through a review of the literature. Candidate survey items were reviewed by members of the medical, dental, and nursing communities. The final survey instrument was revised based on the comments received.

All aspects of the study were exempted by the Duke University Institutional Review Board.

Survey Contents

Survey domains focused on the following four areas: 1. pipeline and matriculation programs offered by the institution, 2. contained questions about cultural competency programs and their implementation at the institution 3. questions about minority faculty development and retention programs, and 4. any additional innovative programs aimed at increasing diversity that the institution offered.

Survey Administration

Interviews were scheduled and conducted within a two-week time period of February/March of 2004.

Analysis

Simple statistics were used to describe the results.

Results

Diversity Assessment Card

Of the institutions asked to participate, responses were received from 51 of 126 (40.5 percent) medical schools, 38 of 56 (67.9 percent) dental schools, 42 of 573 (7.3 percent) nursing schools, and 7 of 20 (35 percent) osteopath schools. Most cards were only partially completed, especially the fields concerning financial aid data. The sample of the respondents was not entirely representative of the public vs. private institution dynamic as slightly more responses were received from public institutions as compared to private institutions. Approximately 45 percent of medical responses were received from public institutions and approximately 40.1 percent of U.S. medical schools are public institutions. Approximately 57.9 percent of dental school responses and 45.2 percent of nursing school responses were received from public institutions whereas 50 percent of U.S. dental schools are public and 27 percent of U.S. nursing schools are public.

On average, 7.3 percent of first year medical school enrollees for the graduating class of 2003 were black, 0.5 percent were Native American, and 5.7 percent were Hispanic.¹⁴ For dental schools, an average of 4.7 percent of first-year enrollees for the 2003 graduating class were black, 0.9 percent were Native American, and 3.8 percent were Hispanic. The nursing school student body averages were 8.6 percent black, 1.4 percent Native American, and 2.9 percent Hispanic. None of this data yielded statistically significant results when compared to numbers of minority enrollees from the 1998 graduating class. Table 1 compares the enrollment data received from the Diversity Assessment Cards to the data provided by the AAMC, ADEA, and AACN. Most students of the graduating class of 2003 would have enrolled in 1999. Where 1999 enrollment data was unavailable, the next closest enrollment year data was provided.

¹⁴ The U.S. Census Bureau reports that in 2000, 27.8 percent of the population was comprised of minorities. By the year 2030, the U.S. Census Bureau projects that 38.1 percent of the population will be made up of minorities.

Table 1: Percent of Minority Enrollees and Graduates from Diversity Assessment Card Data Compared to Member Associations Data

Diversity Assessment Card Data Enrollees	Year	Black	Native American	Hispanic	Member Association Data	Black	Native American	Hispanic
Medical Institutions On Admission	1999	7.3%	0.5%	5.7%	AAMC 2000	7.4%	0.8%	6.1%
Dental Institutions On Admission	1999	4.7%	0.9%	3.8%	ADEA 1999	4.9%	0.6%	4.8%
Nursing Institutions On Admission	1999	8.6%	1.4%	2.9%	AACN 1997	10.5%	0.7%	4.0%
Diversity Assessment Card Data Graduates	Year	Black	Native American	Hispanic	Member Association Data	Black	Native American	Hispanic
Medical Institutions On Graduation	2003	7.2%	0.9%	5.7%	AAMC 2002	7.0%	0.9%	6.2%
Dental Institutions On Graduation	2003	3.8%	1.3%	3.8%	ADEA 2002	4.1%	0.5%	5.3%
Nursing Institutions On Graduation 2003	2003	9.6%	1.9%	1.9%	AACN 2002	9.3%	0.7%	5.6%

Data collected from the medical institutions for the graduating class of 2003 found an average of 7.2 percent of graduates were black, 0.9 percent Native American, and 5.7 percent were Hispanic. Dental graduates of the class of 2003 were made up of an average of 3.8 percent blacks, 1.3 percent Native Americans, and 3.8 percent Hispanics. Data from the nursing schools 2003 graduating class showed 9.6 percent of graduates were black, 1.9 percent Native American and 1.9 percent were Hispanic 2003. Comparisons with data collected from the 1998 graduated class did not yield statistically significant results. Table 1 also compares graduate data received from the Diversity Card with data provided by the AAMC, ADEA, and AACN. Data for 2003 graduates was unavailable so 2002 graduate data was used in its place.

Due to the lack of responses on the financial aid portion of the Diversity Assessment Card, analysis of financial aid data was not possible. Data provided by the AAMC listed the average indebtedness of 2002 medical school graduates as \$103,855. This data, however, was not broken down by race/ethnicity. Financial aid data provided by ADEA reported that 70.4 percent of black dental students who graduated in 2002 had accumulated \$100,000 to \$150,000 in educational debt as compared to only 57.2 percent of whites who had accumulated the same amount (Weaver et al., 2002). 48.7 percent of black and 37.9 percent of Hispanic dental students also reported having either “much” or “very much” concern with financing their dental education as compared to only 27.5 percent of white dental students who reported the same level of concern (Weaver et al., 2002). No additional financial aid data was reported by the AACN.

Faculty data collected from the Diversity Assessment Card found that for the 2002-2003 academic year an average of 2.1 percent of medical school tenured faculty were black, 0.2 percent was Native American, and 3.5 percent were Hispanic. Faculty data collected for dental schools for the 2002-2003 academic year found that an average of 4.5 percent of tenured faculty

were black and 3.0 percent were Hispanic. No Native American faculty were reported. Nursing faculty data was not captured on the Diversity Assessment Card. AACN data on faculty for nursing institutions reported that in 2002, 5.5 percent of tenured faculty members were black, 0.4 percent were Native American, and 1.3 percent were Hispanic. Table 2 provides a comparison of faculty data from the Diversity Assessment Card to faculty data provided by the AAMC, ADEA, and AACN.

Table 2: Percent of Minority Faculty from Diversity Assessment Card Data Compared to Member Associations Data

Diversity Assessment Card Data	Year	Black	Native American	Hispanic	Member Association Data	Black	Native American	Hispanic
Medical Institutions	2002-2003	2.1%	0.2%	3.5%	AAMC 2002	3.9%	0.1%	5.0%
Dental Institutions	2002-2003	4.5%	0%	3.9%	ADEA 2002	4.2%	0.3%	4.8%
Nursing Institutions	2002-2003	N/A	N/A	N/A	AACN 2002	5.5%	0.4%	1.3%

Diversity Assessment Card data collected for medical school administration for the 2002-2003 academic year found that a mean of 7.1 percent of deans, vice/associate deans, and assistant deans were black and zero percent were Native American or Hispanic. Data on the race/ethnic distribution of administrative positions in dental schools showed that no dental school deans, vice/associate deans, or assistant deans were black, Native American or Hispanic. The AACN provided the race/ethnic breakdown of nursing school administrative positions for 2002—including the positions of dean, associate dean, and assistant dean—as 5.7 percent blacks, 0.5 percent Native Americans, and 0.8 percent Hispanics.

Comparisons of the 2003 faculty/administration data to 1998 faculty/administration data on the Diversity Assessment Card did not produce statistically significant results except in three cases. For those medical schools which participated in the study, no medical school deans were female in either 2003 or 1998 ($P=0.0162$). Also, for the year 2003, 22.2 percent of medical schools associate/vice deans were female as opposed to 28.8 percent that were female in 1998. Finally, for dental schools that participated in the Diversity Assessment survey, an average of 25 percent of associate/vice deans were female in 2003 as compared to no female associate/female vice deans in 1998.

Key Informant Interviews

Key Informant Interviews were administered to 24 “best practice” health professions institutions which consisted of 14 medical schools, 5 dental schools, and 5 nursing institutions. “Best practice” schools were chosen non-randomly selecting for health professions universities with innovative programs aimed at increasing minority faculty and student recruitment and retention.

Pipeline/Matriculation Programs

Pipeline programs are outreach programs implemented by health profession schools which target minority youth up through high school and try to cultivate interest in the health professions and provide mentoring opportunities to help set minority students on the track to a career in health care.

When asked whether their institution had established pipeline programs, 92.9 percent of medical schools answered yes, as well as 100 percent of nursing and dental institutions (Table 3). 42.9 percent of medical schools reported having pipeline programs aimed at grades 6-8, along with 40 percent of dental institutions, and 80 percent of nursing institutions.

Table 3: Percent of “Best Practice” Institutions with Pipeline Programs

Program	Medical Institutions	Dental Institutions	Nursing Institutions
General Pipeline Programs	92.9%	100%	100%
Pipeline Programs Targeted at Grades 6-8	42.9%	40%	80%
Pipeline Programs Targeted at Grades 9-12	78.6%	40%	100%

Interview participants were asked what percentage of funding for these pipeline programs came from institutional support. Thirty-six percent of the medical schools, 80 percent of nursing schools, and 40 percent of dental institutions gave estimates of this funding. Results are shown below.

Table 4: Reported Institutional Funding of Grade 6-8 Pipeline Programs

Institutional Funding	Medical Schools	Dental Schools	Nursing Schools
Low (5% or less)	0%	0%	50%
Moderate (35-50%)	80%	100%	0%
Full (100%)	20%	0%	50%

When asked if they had pipeline programs targeted at grades 9-12, 78.6 percent of medical schools, 40 percent of dental schools, and 100 percent of nursing school answered yes. When asked about funding for these programs, 64 percent of medical, 40 percent of dental, and 100 percent of nursing schools gave estimates of institutional funding. Of medical schools providing estimates, 56 percent received 20-50 percent institutional support and 46 percent received greater than 95 percent of program funding from the institution. Results are shown below.

Table 5: Reported institutional funding of grade 9-12 pipeline programs

Institutional Funding	Medical Schools	Dental Schools	Nursing Schools
Low (1% or less)	0%	0%	40%
Moderate (20-40%)	33%	0%	20%
High (50-75%)	22%	50%	0%
Full (95% or greater)	44%	50%	40%

Interview participants were asked for the number of minority students admitted to their 2002-2003 class that were affiliated with the pipeline programs. 50 percent of medical schools, 40 percent of dental schools, and 60 percent of nursing schools responded. Seventy-one percent of responding medical schools reported the number of minority students affiliated with the pipeline programs ranged from 0-4, while the remaining 29 percent had reported the number of minority students was greater than 30. An average of 8.5 minority students were affiliated with responding dental schools. Of the responding nursing schools, 66 percent had 2 or fewer minority students affiliated with their pipeline programs and the remaining 33 percent had 10.

Sixty-four percent of medical schools, 40 percent of dental schools, and 100 percent of nursing schools reported having either pre-matriculation programs or early matriculation programs geared toward minority students.

Interviewees were asked to describe the pipeline/matriculation programs implemented by their institution. Many medical, dental, and nursing institutions described pipeline programs aimed at grade-school children which involved health care professionals visiting local minority-dominated schools and trying to cultivate interest in health sciences through special lectures or activities. Summer educational and enrichment programs for minority high school students were also commonly implemented by the “best practice” institutions. Often these programs lasted several weeks during the summer and offered courses in basic medical sciences and mentoring by local health care providers. Early matriculation programs for undergraduates were often mentioned as well. These programs were mostly geared toward minority students preparing to enroll in either a medical, dental, or nursing school and involved several weeks of training to give the students a head start. Many of these programs also offered mentoring on required entrance exams.

Cultural Competency

Cultural competency was defined as a set of behaviors, attitudes, and policies that enable an institution to work effectively in cross-cultural situations.

Interviewees were asked whether cultural competency was integrated into their curriculum. One hundred percent of all medical, dental, and nursing institutions reported that it was. Participants were asked how cultural competency was integrated into their curriculum. Their responses, broken down by institution, are presented in Table 6.

Table 6: Percent of “Best Practice” Institutions Using Different Methods to Integrate Cultural Competency into the Curriculum

Method	Medical Institutions	Dental Institutions	Nursing Institutions
A Class Devoted Entirely to Cultural Competency	42.9%	20.0%	40.0%
A Training Session During Orientation	92.9%	40.0%	0%
Language Training	40.0%	57.1%	40.0%
Special Lectures	100.0%	100.0%	60.0%

Each institution was asked to specify the aspects of cultural competency covered in their curriculum. Results are presented in Table 7. All “best practice” institutions interviewed said that race and ethnicity diversity were addressed in their curriculum. Several schools mentioned that their cultural competency program addressed gender and religion as well.

Table 7: Percent of “Best Practice” Institutions Addressing Specific Aspects of Culture in the Curriculum

Aspect of Culture	Medical Institutions	Dental Institutions	Nursing Institutions
Race/Ethnicity Diversity	100%	100%	100%
Social Class	100%	80%	80%
Disability Status	63%	100%	60%
Sexual Orientation	80%	93%	80%

When asked what teaching methods were used in the cultural competency program, medical and dental institutions were most likely to use lecture by an individual (92.9 percent), case studies (92.9 percent), community-based service learning (85.7 percent), and guest speakers (85.7 percent). Dental institutions were also most likely to use lecture by an individual (100 percent), community-based service learning (100 percent), case studies (100 percent), and guest speakers. Nursing institutions were most likely to use case studies (100 percent), guest speakers (100 percent), and videos (100 percent).

Interviewees were asked what skills were taught in the cultural competency program. Their responses, broken down by institution, are presented in Table 8.

Table 8: Percent of “Best Practice” Institutions Teaching Specific Skills in their Cultural Competency Programs

Cultural Competency Skills	Medical Institutions	Dental Institutions	Nursing Institutions
Self-Assessment - exploring how individual backgrounds affect attitudes and decision making	100%	100%	100%
History taking with a cross-cultural emphasis	100%	79%	100%
Recognizing the need for mediation for language or cultural barriers	60%	86%	100%
Soliciting the patient’s health care values and ways of understanding his or her illness	80%	93%	100%

Participants were asked what content was covered in the cultural competency program. One hundred percent of medical, dental, and nursing schools responded that general concepts of culture are covered. One hundred percent of both medical and dental schools along with 80 percent of nursing schools reported that both racism and language are covered by their cultural competency program. One hundred percent of both medical and nursing institutions and 80 percent of dental schools reported covering specific cultural content, and 100 percent of dental and nursing schools along with 92.9 percent of medical schools reported addressing access issues in their cultural competency programs.

When asked about assignments students are required to complete outside of class, 85.7 percent of medical schools and 100 percent of both dental and nursing schools reported that students are required to complete reading assignments. Sixty-four percent of medical schools, 60 percent of dental schools and 100 percent of nursing schools responded that students are required to complete writing assignments, and 28.6 percent of medical schools, 60 percent of dental schools, and 20 percent of nursing school respondents reported that students are required to volunteer outside of class.

Each “best practice” institution was asked if they had a strategy in place to measure the effectiveness of their cultural competency programs. Fifty percent of medical schools and 60 percent of dental schools reported they did. One hundred percent of nursing institutions responded that they did not have a strategy in place to measure the effectiveness of their cultural competency programs. Those medical and dental institutions that reported having a strategy in place were asked what methods were used to measure the effectiveness of their cultural competency programs. These responses are presented in Table 9.

Table 9: Percent of “Best Practice” Institutions Using Specific Methods to Measure the Effectiveness of their Cultural Competency Programs

Method	Medical Institutions	Dental Institutions	Nursing Institutions
Pre-and Post-Intervention Self-Assessment	60%	21.4%	N/A
Presentation of Clinical Cases	40%	21.4%	N/A
Video/Audiotaped Clinical Encounters with Patients	20%	14.3%	N/A
Objective Structure Clinical Exam	40%	35.7%	N/A
Interview Patients Regarding Experience with Provider	20%	28.6%	N/A

Interviewed participants were asked what educational tools they would like to have access to. Fifty-seven percent of medical schools and 80 percent of both dental and nursing schools said they would like access to more videos. Fifty-seven percent of medical schools and 60 percent of both dental and nursing schools responded that they would like to have access to more reading tools. Sixty-four percent medical schools and 80 percent of both dental and nursing institutions reported they would like access to more case studies, and 71.4 percent of medical schools, 60 percent of dental schools, and 100 percent of nursing schools responded they would like access to on-line, problem-based learning cases.

Each interviewee was asked whether their existing curriculum supported formalized opportunities for students to serve in the community. Ninety-two percent of medical schools and 100 percent of dental and nursing schools responded yes. On average, the medical schools reported 61 percent participation, dental intuitions reported 64 percent participation, and nursing schools reported 100 percent participation in these programs.

When asked about the types of community-based initiatives that their institution supports, 57.1 percent of medical schools, 20 percent of dental schools, and 20 percent of nursing schools reported that their institution supports work in a local health clinic as a patient navigator. Ninety-three percent of medical schools, 100 percent of dental school, and 60 percent of nursing schools

reported their institution supports student clerkships, and 35.7 percent of medical institutions, 20 percent of dental schools, and 40 percent of nursing institutions reported that their institution supported formalized opportunities for students to work as patient translators. Medical students reportedly spent an average of eight hours a week dedicated to community-based initiatives. Dental students spent an average of 12.8 hours, and nursing students spent an average of 8.5 hours on community-based initiatives.

Many medical, dental, and nursing interview participants related that instead of having a single class devoted entirely to cultural competency, many health profession institutions have moved toward integrating cultural competency throughout the four-year curriculum. Discussion forums in which students talk with their peers and faculty members about cultural competent care is one format in which this is done. Some institutions have their students participate in clerkships in urban areas where health care services are provided for free or at a reduced rate. Other institutions offer students the opportunity to participate in cultural immersion programs in which students study abroad, usually in Mexico.

Minority Faculty Development Programs

Minority Faculty Development Programs were defined as programs implemented by health profession institutions in order to promote minority faculty recruitment and retention.

Interview participants were asked if their institution had an established minority faculty development program. Fifty-seven percent of medical schools, 40 percent of dental schools, and 20 percent of nursing schools answered yes. Seventy-one percent of medical schools, 40 percent of dental schools, and 40 percent of nursing schools respondents reported that their institution has systematic methods for recruiting minority faculty members. When asked if their institution had funds earmarked for minority faculty recruitment, 57.1 percent of medical school participants, 80 percent of dental school participants, and 20 percent of nursing school participants said yes. Interview participants were asked what initiatives were included in their minority faculty development programs. Responses are presented below. The variation in responses between medical and dental institutions could be due to the difference in sample size.

Table 10: Percent of “Best Practice” Institutions with Specific Initiatives Included in their Minority Faculty Development Program

Initiative	Medical Institutions	Dental Institutions	Nursing Institutions
Career counseling	71%	40%	0%
Assigning of mentors	86%	60%	0%
Training in research skills	79%	80%	0%
Training in presentation skills	71%	60%	0%
Training in scientific writing skills	86%	60%	0%
Training in research grant writing skills	86%	60%	0%

When asked if their institution has systemized methods for tracking minority faculty retention, 64.3 percent of medical schools, 10 percent of dental schools, and 20 percent of nursing schools

answered yes. Approximately 64.3 percent of medical schools and 100 percent of dental schools reported that their institutions track faculty retention by quantifying promotions and appointments. Averages of 28.6 percent of medical schools, and 20 percent of dental schools reported that they track minority faculty that leave for industry. Forty-three percent of medical school interviewees, 20 percent of dental school interviewees and 20 percent of nursing school respondents reported that their institution administers exit interviews. Fifty percent of medical institutions, 60 percent of dental institutions, and 40 percent of nursing institutions reported having funds earmarked for minority faculty retention.

The final question from this section asked each participant to provide their institution's written policy or statement on diversity. Only one institution reported that they did not have one. Most of the statements provided were non-discrimination policies implemented by the parent university which stated that the university does not tolerate discrimination based on race, ethnicity, religion, heritage, gender, or sexual orientation. A few institutions provided statements by administration officials stating a commitment to diversity. A handful of statements mentioned their commitment to affirmative action.

Many of the interview participants mentioned additional initiatives being taken to increase minority faculty recruitment and retention at U.S. medical, dental, and nursing institutions. Some health profession institutions have established minority faculty organizations in order to allow opportunities for social networking. Other universities provide opportunities for minority faculty to attend and present their work at conferences as part of their minority faculty development program.

Other Innovative Diversity Programs

During the interview process, participants from “best practice” medical, dental, and nursing schools were given the opportunity to talk about innovative programs at their institution aimed at increasing diversity. Almost all of the institutions interviewed mentioned university offices that had been created to manage minority affairs. Minority student associations were also very popular among the “best practice” health professions institutions. These two organizations were often involved in the planning of conferences and career fairs geared toward minority students. The Office of Minority Affairs, or its equivalent, was also often involved in hiring recruiters to target minority students and faculty, and recruit them to the health care field.

A few “best practice” institutions mentioned collaborations with historically black universities. These affiliates help direct minority students to graduate schools in the health care professions. Another benefit of the collaboration is that faculty from the historically black universities will travel to the medical, dental, or nursing institution and teach a course on cultural competent care. These affiliations also allow a health profession institution to collaborate with a historically black university on health disparities research.

The last two questions in the Key Informant Interview asked for the median family income of minority students attending the institution and the median family income of the rest of the student

body. Seventy-one percent of medical institutions and 100 percent of nursing and dental institutions reported that they did not know this information. Of those medical schools that did respond, the average family income for a minority student was approximately \$45,000-\$55,000. The average family income for the rest of the student body was approximately \$55,000-\$65,000.

Of the 14 medical schools that participated in the Key Informant Interview, eight of these also returned the Diversity Assessment Card. Ten percent of 1999 first-year enrollees in these eight institutions were black, 1.6 percent were Native American, and 6.5 percent were Hispanic (Table 11). Comparatively, data from the AAMC for all first-year enrollees in the U.S. in 2000 reported that 7.4 percent of first-year enrollees were black, 0.8 percent were Native American, and 6.1 percent were Hispanic (AAMC Data Book, 2003). The graduate data for these eight “best practice” medical institutions shows that for the graduating class of 2003, 6.7 percent of graduates were black, 1.6 percent were Native American and 6.8 percent were Hispanic (Table 11). This again can be compared to the AAMC data which reports that of all U.S. medical school graduates in 2002, 7.0 percent of graduates were black, 0.9 percent were Native American, and 6.2 percent were Hispanic.

Table 11: Percent of Minority Enrollees and Graduates From “Best Practice” Medical Institutions as Compared to AAMC Data

Enrollment Data Source	Black	Native American	Hispanic	Graduation Data Source	Black	Native American	Hispanic
Diversity Assessment Card 1999	10.3%	1.6%	6.5%	Diversity Assessment Card 2003	6.7%	1.6%	6.8%
AAMC 2000	7.4%	0.8%	6.1%	AAMC 2002	7.0%	0.9%	6.2%

All five of the dental schools that participated in the Key Informant Interview also completed the Diversity Assessment Card. Five percent of the 1999 enrollees for these five “best practice” dental institutions were black, 1.9 percent were Native American, and 4.7 percent were Hispanic (Table 12). Data provided by ADEA for the 1999 reported that 4.9 percent of enrollees were black, 0.6 percent were Native American and 4.8 percent were Hispanic. Four percent of the graduating class of 2003 for the 5 “best practice” dental schools was black, 0.8 percent of the graduating class was Native American, and 2.4 percent was Hispanic (Table 12). ADEA data for dental school graduates report 4.1 percent of 2002 graduates were black, 5.3 percent were Hispanic, and 0.5 percent were Native American.

Table 12: Percent of Minority Enrollees and Graduates From “Best Practice” Dental Institutions as Compared to ADEA Data

Enrollment Data Source	Year	Black	Native American	Hispanic	Graduation Data Source	Year	Black	Native American	Hispanic
Diversity Assessment Card	1999	5.0%	1.9%	4.7%	Diversity Assessment Card	2003	3.8%	0.8%	2.4%
ADEA	1999	4.9%	0.6%	4.8%	ADEA	2002	4.1%	0.5%	5.3%

No Diversity Assessment Card data was received from any of the “best practice” nursing institutions that participated in the Key Informant Interview.

Discussion

The objective of this study was to quantify and compare student, financial aid, and faculty data broken down by race/ethnicity for the 1998 and 2003 graduating classes of all U.S. medical, dental, and nursing institutions. In addition, qualitative data concerning diversity and cultural competency programs being implemented at “best practice” medical, nursing, and dental institutions was collected and analyzed for trends linking these “best practices” to increased minority enrollment. The goal of this study was to determine the current state of race/ethnic distribution of faculty and students at U.S. health care profession institutions and determine the effectiveness of recent initiatives aimed at increasing the number of minorities in the health care field.

Medical student minority enrollment decreased numerically from 1999-2000 consistent with a long-term trend towards decreasing minority enrollment since 1994.

**Table 13: Percent of Minority Enrollees and Graduates in Medical Institutions–
AAMC Data**

Enrollment Year	Black	Native American	Hispanic	Graduation Year	Black	Native American	Hispanic
1994	8.9%	0.8%	6.8%	1998	7.3%	0.8%	6.7%
2000	7.4%	0.8%	6.1%	2002	7.0%	0.9%	6.2%

Likewise, the percentages of minority dental school enrollees dropped from 5.9 percent black and 6.4 percent Hispanic enrollees in 1994 to 4.9 percent black and 5.9 percent Hispanic enrollees in 1999 (ADEA, 2003). The percentage of black graduates also fell from 4.9 percent in 1998 to 4.1 percent in 2002 but Native American and Hispanic graduate percentages increased slightly as seen in Table 14.

**Table 14: Percent of Minority Enrollees and Graduates in Dental Institutions –
ADEA Data**

Enrollment Year	Black	Native American	Hispanic	Graduation Year	Black	Native American	Hispanic
1994	5.9%	0.3%	6.4%	1998	4.9%	0.4%	4.9%
1999	4.9%	0.4%	5.9%	2002	4.1%	0.5%	5.3%

According to the data provided by the AACN, percentages of minority enrollees and graduates, for the most part, rose from 1997 to 2002 except for the percentage of Native American enrollees and graduates which dropped as is seen in Table 15 (Berlin, 2002). Also notable are the low percentages of minorities completing nursing programs as compared to the percentages of minority enrollees for both 1997 and 2002.

Table 15: Percent of Minority Enrollees and Graduates in Nursing Institutions – AACN Data

Enrollment Year	Black	Native American	Hispanic	Graduation Year	Black	Native American	Hispanic
1997	10.5%	0.7%	4.0%	1997	4.9%	0.6%	1.0%
2002	11.0%	0.5%	5.5%	2002	5.5%	0.4%	1.3%

Financial data was widely unavailable for both the financial aid portion of the Diversity Assessment Card and the Key Informant Interview question asking for the mean income of minority students as compared to the rest of the student body — 71.4 percent of medical institutions and 100 percent of nursing and dental institutions reported that they did not know this information. This information is interesting in itself especially considering that financial constraints are more likely to be a concern for minorities interested in a career in health care than whites. A 2002 study by Weaver et al. found that 48.7 percent of black and 37.9 percent of Hispanic dental students reported having either “much” or “very much” concern with financing their dental education as compared to only 27.5 percent of white dental students who reported the same level of concern. Every institution has financial aid forms, but a lack of interdepartmental communication leads to difficulties in integrating this information. Perhaps, if the financial situations of minority students in medical, dental, and nursing institutions are more closely followed, new insights will become available as to why these disparities in the number of minority health care providers persist and what can be done to overcome them.

Minorities continue to hold low percentages of faculty and administrative positions in the U.S. health profession schools (Table 2). Data from the AAMC reported that in 2002, 3.9 percent of faculty at U.S. medical schools were black, 0.1 percent were Native American, and 5.0 percent were Hispanic. Interestingly, relatively low percentages of “best practice” institutions (57.1 percent medical, 40 percent dental, and 20 percent nursing) reported having a minority faculty development program at all. Widespread implementation of minority faculty development programs at health profession institutions could provide an avenue for increased minority representation in the health profession, but not if there are no candidates from the health professions schools.

Limitations of this study include a non-response bias for the data collected with the Diversity Assessment Card. For those institutions who did participate in the Diversity Assessment Card portion of the study, responses were often incomplete and data fields were often left empty. Limitations for the Key Informant Interview include a selection bias for the 24 “best practice” institutions that were chosen non-randomly to participate in the study.

The findings in this study support what is already known about the decreasing numbers of minority students in health professions institutions. In 2001, for the fifth year in a row, the total number of minorities enrolled in medical school declined, going from a high of 8,254 in 1996 to a low of 7,394 (AAMC, 2002).

“Best practice” institutions were defined in this study as health professions universities with innovative programs aimed at increasing minority faculty and student recruitment and retention. One of the key finds of the best practice interviews was that best practice institutions fared better than non-best practice sites but still did not have representative student bodies. We could not calculate success of individual programs at best practice sites on minority recruitment and retention at the student, faculty, or leadership level. However, given the scope of some of these programs and their modest success suggests that much more aggressive programs may be required to achieve equal representation for minority populations.

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APPENDIX C

The Charge to the Sullivan Commission on Diversity in the Healthcare Workforce

Robert A. DeVries
W.K. Kellogg Foundation

April 30, 2003

On behalf of the board and staff of the Kellogg Foundation thank you for accepting this opportunity to serve on the Sullivan Commission. We at Kellogg have great respect and appreciation for the many contributions of Dr. Louis Sullivan.

A word of background that led to the Foundation's commitment for the Commission may be helpful. The numbers of students from underrepresented and underserved communities who are racial and ethnic minorities available for service in health professions systems has not increased notably since the 1950s. In medicine, nursing, dentistry, and health administration, the numbers have decreased, especially in the past five years. The greatest declines have occurred in public medical schools. Prior to 1996, these institutions enrolled a greater proportion of underrepresented minority students than private students. Yet the U.S. population is increasingly diverse. A recent Institute of Medicine Report, *Unequal Treatment* (2003), reports that minorities increasingly suffer disproportionate morbidity (incidence of disease) and mortality. The report concludes that one of the reasons for the disparity is the lack of a diverse provider workforce. Therefore, increasing the numbers of physicians from these groups, and the diversity of the health care workforce overall, will help improve access to care, and ultimately, improve minority health status. Yet post-secondary institutions continue to perform poorly in identifying, admitting, and graduating racial and ethnic minorities. WKKF has supported pipeline preparation programs at many institutions, including major investments through the American Association of Medical Colleges. With few exceptions, these programs are not sustained beyond the term of the grant and have not strongly integrated identification of potential students, review of admissions and retention policy, and linkages to public policy and public financing.

Beginning two years ago, in collaboration with Dr. Sullivan, exploratory and options analyses were conducted. During the process, we developed three documents for discussion at national meetings that involved more than 150 participants. Key collaborators in this phase included: The Henry J. Kaiser Family Foundation; the American Association of Medical Colleges; The Robert Wood Johnson Foundation; the California Endowment; The Commonwealth Foundation; the Josiah Macy Foundation; the Public Welfare Foundation; the Allegheny Franciscan Foundation; the Institute of Medicine; the U.S. Public Health Service; the Internal Revenue Service; and academic health centers like Duke University, the University of

Michigan, and the Medical College of Georgia. Also involved were professional organizations, and community-based institutions that seek to improve health among underserved and underrepresented racial and ethnic populations in the health workforce. The meetings were facilitated by Community Catalyst and chaired by Dr. Sullivan. (Community Catalyst is a national advocacy organization that helps consumers and communities develop the capacity to participate in the decisions that shape their health care systems. They provide technical assistance services including policy analysis, legal support, and a focus on strategic planning and organizational development, aimed at building the capacity of health advocacy groups and strengthening the voice of consumers.)

The collaborators, at a final consultative forum at the National Press Club, endorsed the publication of *The Color of Medicine: Strategies for Increasing Diversity in the U.S. Physician Workforce*. Among its findings, the report concludes, “the U.S. medical profession is on a demographic collision course with an increasingly diverse nation.” The strategies and approaches set forth in the report include: community benefits, civil rights and equal opportunity approaches, marketplace, public engagement and permitting approaches, and philanthropic approaches. During the consultation process, key informants identified three strategic interventions. Each intervention was developed into an action step that attendees viewed as having the greatest chance of effecting sustainable change.

Given Duke’s reputation and track record in diversity, it was a logical choice for administering this Blue Ribbon Commission. Indeed, the Commission will serve as the nucleus for national efforts in health professions diversity. It will focus high-profile public attention on the crisis facing the nation’s health care system, and will clarify the historical role of universities in finding and implementing solutions to the problems at hand. Each of you have been selected for your outstanding leadership and status in a variety of sectors which include corporate, academic, entertainment, government, national association, and community advocacy.

The Commission will convene key meetings from policy at all levels. It will hold news conferences and release succinct fact sheets, convene community town hall meetings, develop op-ed pieces, examine and highlight health disparities in communities visited, and examine admission practices and outcomes experienced by students and patients. Questions to be addressed by the Commission will include: admissions criteria; local, state, and federal financing of health professions education nationally, but also in key communities; relative taxpayer burden to support education; student debt burden; placement of graduates in communities for service (e.g., public service requirement); the potential use of community benefit principles; and role of the health professions training program to gather and groom a diverse entering class. The primary audience for this process and work will be local, state, and federal policy leaders; the corporate community; academic health center leadership; and the general public. The goal is to promote revised curriculums, implement new admissions practices, introduce evidence-based medical practice, and align tax funds to ensure that community benefits and other levers be used as customary benchmarks for education practices.

In sum, what are the Foundation's expectations for the national Blue Ribbon Commission – the Sullivan Commission? As a central entity in a multi-pronged national program to increase diversity in America's health care workforce, the Sullivan Commission, after national hearings and deliberations, will publish and broadly disseminate a report of findings and recommendations including a plan of action. This will all be carried out in the public domain, for broad public use and benefit.

APPENDIX D
W.K. Kellogg Foundation Health Professions Grant Program

GRANTEE	PROGRAM DESCRIPTION	GRANT
Americans for Indian Opportunity	Help prepare American Indians for leadership roles in addressing their communities' and culture's concerns through American Indian Leaders Program	\$1,353,780
Association of American Medical Colleges	Develop students from communities to enter health professions education for careers in community-based health services by introducing youth to health careers and fostering academic achievement	\$3,118,348
Bay Mills Community College	Increase the number of American Indians in the health professions through a prehealth career program that articulates with postsecondary institutions	\$886,327
Board of Trustees of the University of Illinois	Prepare community health workers and health care professionals to link people in need of services with health care providers	\$610,369
Congressional Black Caucus Foundation, Inc.	Develop a cadre of qualified students to enter health professions education for careers in community-based health services by building partnerships between communities and health professions education programs	\$269,000
Dundalk Community College	Improve health services for Baltimore-area residents through the education of minorities in the health professions	\$332,530
Hampton University	Address underrepresentation of ethnic minorities in health professions, respond to changing criteria that will result in improved community access to health service delivery, and demonstrate a sustainable academic program	\$1,530,579

Oregon State University	Increase the number of minorities in the health professions through an enrichment program for elementary students in rural Hispanic and Native-American communities	\$445,473
Regents of the University of Michigan	Promote minority faculty development in the health professions at Michigan's research universities by creating the Kellogg Michigan Center for Minority Health and Health Disparities	\$100,000
Sigma Theta Tau International Honor Society of Nursing, Inc.	Foster development of leadership for integrated, comprehensive health services and education systems	\$50,000
Sisseton-Whapeton Community College	Develop a cadre of qualified students to enter health professions education for careers in community-based health services by building partnerships between communities and health professions education programs	\$385,800
Umoja Care, Inc.	Improve health care for the frail elderly by training community men and women as health care providers	\$35,075
University of Hawaii	Improve health care for Native Hawaiians, immigrants, and disadvantaged populations by creating a statewide, interdisciplinary health professions education program	\$292,939
University of Puerto Rico Medical Sciences Campus	Develop a group of qualified students to enter health professions education for careers in community-based health services by building partnerships between communities and health professions education programs	\$160,000
University of Texas-El Paso	Increase the number of Hispanics in the health professions and provide health education through an educational/mentoring program for youth and their families	\$940,172

APPENDIX E

SULLIVAN COMMISSION FIELD HEARINGS

The Sullivan Commission on Diversity in the Healthcare Workforce conducted field hearings in six cities across the country between June 2003 and January 2004. With compelling testimony from 140 health and education experts, community advocates, business leaders, legislators, health professionals, and students, the hearings are a significant part of the Commission's process. Witnesses provided the Commission with written and oral testimony focusing on the health manpower crisis facing the nation's health care system and the role of diversity in finding solutions. The Commission invited witnesses based on their professional expertise, personal experience, and/or affiliation.

Traveling to six of the most diverse cities in the country, the Commission chose to hold hearings in venues that reflected and resonated its objective. Every hearing focused on a different aspect of the challenge of diversifying our nation's health professions workforce.

Testimony collected from the field hearings are the pillars of the work of the Sullivan Commission. The agenda for each hearing is included here.

- June 26, 2003
Morehouse School of Medicine, Atlanta, GA
- September 5, 2003
Denver Health, Denver, CO
- October 3, 2003
Harlem Hospital Center, New York, NY
- October 20, 2003
John H. Stroger, Jr. Hospital of Cook County, Chicago, IL
- November 14, 2003
Francisco Bravo Medical Magnet High School, Los Angeles, CA
- January 16, 2004
MD Anderson Cancer Center, Houston, TX

Sullivan Commission Field Hearing: Atlanta, GA

Morehouse School of Medicine, National Center for Primary Care
720 Westview Drive, S.W., Atlanta, GA, 30310

June 26, 2003

AGENDA

Opening Remarks

- The Hon. Louis W. Sullivan, M.D., Chair, The Sullivan Commission on Diversity in the Healthcare Workforce

Panel I. Importance of a Diverse Health Care Workforce

- Christopher Leggett, M.D., Consultant, Office of the Mayor, City of Atlanta
- Gail Stennies, M.D., Director, Preventive Medicine Residency Program, Centers for Disease Control
- Valerie Hepburn, Director, Division of Health Planning, Department of Community Health
- James Couch, Chief of Health Improvement Programs, Office of Minority Health, Georgia Department of Community Health Care

Panel II. Training Diverse Medical Professionals

- E. Nigel Harris, M.D., Dean, Morehouse School of Medicine
- Gregory Strayhorn, M.D., Ph.D., Chief, Department of Family Medicine, Morehouse School of Medicine
- Ann Conner Jobe, M.D., Dean, Mercer University School of Medicine
- William Casarella, M.D., Executive Associate Dean for Clinical Affairs, Emory University School of Medicine
- David Mark Stern, M.D., Dean and Senior Vice President, Clinical Activities, Medical College of Georgia School of Medicine

Panel III. Hearing from Future Health Care Professionals

- Vanessa Spearman, Second-Year Medical Student, Medical College of Georgia School of Medicine
- Sidney Hankerson, Fourth-Year Medical Student, Emory University School of Medicine
- Shereitte Stokes IV, M.P.H., Graduate, Morehouse School of Medicine
- Paul Young, Second-Year Medical Student, Mercer University School of Medicine
- Theron Jones, Fourth-Year Dentistry Student, Medical College of Georgia School of Dentistry
- Kelly Moynes, Fourth-Year Nursing Student, Emory University, Nell Hodgson Woodruff School of Nursing

Panel IV. Training Diverse Nurses and Dentists

- Carole Hanes, D.M.D., Associate Dean, Students, Admissions and Alumni, Medical College of Georgia, School of Dentistry
- Gloria McWhirter, Asst. Professor, University of Florida College of Nursing
- Gwen Childs, Faculty, Medical College of Georgia School of Nursing

- Shelly Mishoe, Ph.D., Dean, Medical College of Georgia School of Allied Health Sciences
- Jean Bartels, Ph.D., Chair, Georgia Southern University School of Nursing
- Maggie Gilead, Ph.D., Associate Professor; and Ann Bavier, Ph.D., R.N., FAAN; Assistant Dean, Emory University, Nell Hodgson Woodruff School of Medicine
- Cece Grindell, Ph.D., Associate Director for Undergraduate Programs, Georgia State University School of Nursing
- David N. Bennett, Ph.D., R.N., Chairman, Kennesaw State University School of Nursing

Panel V. Impact of a Diverse Health Care Workforce on Consumers and the Community

- Shirley Miller, Patient Advocate
- Carmelita Jordan, American Cancer Society
- Carolyn Fraser, Georgia Partnership for Caring Foundation
- Wes McCoy, North Cobb High School Science Teacher
- Elizabeth Webster, American Kidney Fund
- Michael Bond, Programs Director, National Association for the Advancement of Colored People Atlanta Branch
- Carmen Rojas Rafter, Latin American Association
- Leona Barr-Davenport, President and CEO, Atlanta Business League
- Marie Mitchell, Director, Teen Services Program, Grady Memorial Hospital

Panel VI. Diversifying the Health Professions

- Wilma Sykes-Brown, M.A., Regional Director-Elect, National Association of Minority Medical Educators, Southern Region
- Antwan Treadway, D.M.D., Georgia Dental Association
- Eula Aiken, Georgia Nurses Association; Executive Director for Council on Collegiate Education in Nursing, Southern Regional Education Board
- Cecilia Galvis, President, Hispanic Health Coalition
- Malcolm Taylor, Association of Black Cardiologists

Panel VII. Health Professions Diversity: Policies and Implications

- George Rust, M.D., Deputy Director, National Center for Primary Care at the Morehouse School of Medicine
- Paul J. Wiesner, M.D., Director, DeKalb County Board of Health
- Kathleen E. Toomey, M.D., M.P.H., State Health Director, Georgia Division of Public Health
- James Peoples, Director, Department of Community Health Care, Office of Community Affairs; President, Georgia Rural Health Association

Sullivan Commission Field Hearing: Denver, CO

Denver Health, The Rita Bass Trauma and Education Institute
190 West Sixth Avenue, Denver, CO 80204

September 5, 2003

AGENDA

Opening Remarks

- The Hon. Louis W. Sullivan, M.D., Chair, The Sullivan Commission on Diversity in the Healthcare Workforce
- Patricia Gabow, M.D., Chief Executive Officer and Medical Director, Denver Health; and Member, Sullivan Commission

Panel I. Policies on Health Professions Diversity

- Senator Ed Jones, Colorado State Senator, District 11
- Senator Pat Pascoe, former Colorado State Senator
- Representative Terrance Carroll, Colorado State Representative, District 7
- Ned Calonge, M.D., Chief Medical Officer, Colorado Dept. of Public Health and Environment

Panel II. Education Policies and Implications

- Elbra Wedgeworth, President, Denver City Council
- Jay Gershen, M.D., Executive Vice Chancellor, University of Colorado Health Sciences Center
- Alan Tucker, Ph.D., Vice Provost for Faculty Affairs, Colorado State University
- Jesús Treviño, Ph.D., Associate Provost for Multicultural Affairs, University of Denver

Panel III. Initiatives for Underrepresented Minorities

- Grant Jones, Executive Director, Metro Denver Black Church Initiative
- Phyllis Bigpond, M.S.W., Executive Director, Denver Indian Family Resource Center
- Spero Manson, Ph.D., Head, Division of American Indian and Alaska Native Programs, University of Colorado Health Sciences Center

Panel IV. Importance of a Diverse Health Care Workforce

- Michael H. Trujillo, M.D., M.P.H., M.S., Liaison, Center for Native American Health, University of New Mexico
- Jennifer Miles, Director of Public Policy, Colorado Community Health Network
- Lorez Meinhold, Executive Director, Colorado Consumer Health Initiative
- Gary VanderArk, M.D., Chairman, Colorado Coalition for the Medically Underserved

Panel V. Training Diverse Health Professionals

- Richard D. Krugman, M.D., Dean, University of Colorado School of Medicine
- Patricia Moritz, Ph.D., RN, FAAN., Dean, University of Colorado, School of Nursing
- Howard M. Landesman, D.D.S., M.Ed., Dean, University of Colorado, School of Dentistry
- Christine Johnson, Ph.D. President, Community College of Denver

Sullivan Commission Field Hearing: New York, NY

Harlem Hospital Center

506 Lenox Avenue, Second Floor Auditorium, New York, NY 10037

October 3, 2003

AGENDA

Opening Remarks

- The Hon. Louis W. Sullivan, M.D., Chair, Sullivan Commission on Diversity in the Healthcare Workforce
- The Hon. Charles B. Rangel, U.S. Representative, New York's 15th Congressional District

Panel I. Health Care Delivery: The Community Impact of Culturally Competent Health Care

- John T. Herbert, M.D., M.B.A., Senior Associate Dean for the Harlem Affiliation and Clinical Professor of Anesthesiology, Columbia University College of Physicians and Surgeons
- Ronald Ross, Distinguished Fellow for Urban Education Reform, National Urban League
- Moises Perez, Executive Director, Alianza Dominicana

Panel III. The Workforce: Health Professions Recruitment, Retention, and Training Practices

- Mecca Cranley, Ph.D., R.N., Dean, School of Nursing, University at Buffalo, The State University of New York
- Richard Buchanan, D.D.S., Dean, School of Dental Medicine, University at Buffalo, The State University of New York
- Marc A. Nivet, M.S., Associate Executive Director, Associated Medical Schools of New York
- Hilda Hutcherson, M.D., Associate Dean for Minority Affairs, Columbia University College of Physicians and Surgeons

Panel IV: A Compelling Interest: Investment in Health Professions Education

- Benjamin Chu, M.D., President, New York City Health and Hospitals Corporation
- Charles Aswad, M.D., Chairman, Subcommittee on Minority Participation in Medical Education, New York State Council on Graduate Medical Education
- Maxine Golub, M.P.H., Project Director, New York State Metropolitan Area Health Education Center System

Panel V: The Dividends of Diversity in the Health Professions

- Anne Beal, M.D., Ph.D., Senior Program Officer for the Program on Quality of Care for Underserved Populations, Commonwealth Fund
- June Osborn, M.D., President, Josiah Macy Foundation
- Ruth C. Browne, Sc.D., and Milagros Batista, M.S.W., Co-Chairs, Community Coalition to Increase Diversity in the Healthcare Professions
- Mark Jaffe, Director, Greater New York Chamber of Commerce

Sullivan Commission Field Hearing: Chicago, IL

John H. Stroger, Jr. Hospital of Cook County
1901 W. Harrison Street, Fifth Floor, Chicago, IL 60612

October 20, 2003

AGENDA

Opening Remarks

- The Hon. Louis W. Sullivan, M.D., Chair, Sullivan Commission on Diversity in the Healthcare Workforce
- The Hon. Jesse L. Jackson, Jr., U.S. Representative, Illinois 2nd District
- The Hon. John H. Stroger, Jr., President, Cook County Board of Commissioners

Panel I. The Dividends of Diversity in the Health Professions

- The Hon. Donna Christian-Christensen, U.S. Representative, U.S. Virgin Islands; Chair, Congressional Black Caucus, Health Brain Trust
- John Ruffin, Ph.D., Director, National Center for Minority Health and Health Disparities, National Institutes of Health
- Eric E. Whitaker, M.D., M.P.H., Director, Illinois Department of Public Health

Panel II. The Community Impact of Culturally Competent Health Care

- Lydia L. Watts, Health Policy Director, Rainbow PUSH Coalition
- Ruth Rothstein, Chief, Cook County Bureau of Health Services
- Micael Clarke, Director, Center for Faith and Mission, Loyola University

Panel III. Role of Professional Associations in Ensuring a Diverse Health Care Workforce

Panel A:

- Charles Terrell, Ed.D., Vice President, Division of Community and Minority Programs, Association of American Medical Colleges
- Jean Bartels, Ph.D., President-Elect, American Association of Colleges of Nursing
- Dr. Paula K. Friedman, President, American Dental Education Association

Panel B:

- John C. Nelson, M.D., M.P.H., President-Elect, American Medical Association
- Randall W. Maxey, M.D., President, National Medical Association
- Teresa Ramos, M.D., Board Member, National Hispanic Medical Association
- Dr. Edwin Marshall, Executive Board Vice Chair, American Public Health Association

Panel C:

- Dr. Laura M. Neumann, Associate Executive Director, Division of Education, American Dental Association
- Robert Klaus, President, Oral Health America
- Dr. Romell J. Madison, President, National Dental Association
- Mary Maryland, R.N., President, Illinois Nurses Association
- Hilda Richards, Ed.D., RN, FAAN, President, National Black Nurses Association

Sullivan Commission Field Hearing: Los Angeles, CA

Francisco Bravo Medical Magnet High School
1200 N. Cornwell Street, Auditorium, Los Angeles, CA 90033

November 14, 2003

AGENDA

Welcome

- Richard Alonzo, Superintendent, Los Angeles Unified School District F
- Jennifer Garcia, Bravo High School Student Body President

Opening Remarks

- The Hon. Louis W. Sullivan, M.D., Chair, Sullivan Commission on Diversity in the Healthcare Workforce
- Michael V. Drake, M.D., Vice President, Health Affairs, University of California

Panel I: The Dividends of Diversity in the Health Professions

- Robert K. Ross, M.D., President and Chief Executive Officer, The California Endowment
- Karin Wang, Esq., Vice President, Programs, Asian Pacific American Legal Center
- Heng Lam Foong, Program Director, PALS for Health
- John T. Matsui, Ph.D., Director, The Biology Scholars Program, University of California, Berkeley

Panel II. Models for Recruitment, Admissions, and Retention of Minority Health Professional Students

- Ronald D. Garcia, Ph.D., Program Director, The Stanford Minority Center of Excellence, Stanford University School of Medicine
- Edward O'Neil, M.P.A., Ph.D., Director, Center for the Health Professions, University of California, San Francisco
- Alberto Manetta, M.D., The Program in Medical Education for the Latino Community; Sr. Associate Dean for Educational Affairs, University of California, Irvine College of Medicine
- Theodore Miller, M.D., Associate Dean for Student Affairs, Charles R. Drew University of Medicine and Science

Panel III. Pursuing a Career in the Health Professions

- Dr. Rosa Maria Hernandez, Director, Los Angeles Unified School District F; Former Principal, Bravo Medical Magnet High School
- Francisco Melero, M.D., Family Practice Physician, Roybal Comprehensive Health Center, and Member of Bravo High School's Class of 1990
- Claribel Sanchez, Freshman, University of California, Berkeley; Member of Bravo High School's Class of 2003

Open Forum Discussion with Bravo Magnet Medical High School Students, moderated by Bravo High School Alumni

Panel IV. Best Practices in Training a Diverse Health Professions Workforce

- Hector Flores, M.D., Co-Director, White Memorial Hospital Family Practice Residency Program
- Bertram Lubin, M.D., Medical Research Director, Children's Hospital, Oakland Research Institute
- Charles Goldstein, D.D.S., Chair, Section of Community Dentistry and Public Health, School of Dentistry, University of Southern California
- Kay Baker, R.N., M.N., Associate Dean of Student Affairs, School of Nursing, University of California, Los Angeles
- Priscilla Gonzalez-Leiva, R.N., Former Deputy Director of the Office of Statewide Health Planning and Development Office

Panel V. A Health Professions Career for Minorities: Fact or Fiction?

- Bob Montoya M.D., M.P.H., California Wellness Foundation's Champion of Health Professions Diversity
- Carrie Broadus, Consumer Advocate, Board of Governors, LA Care Health Plan
- Carlos Venegas, Director of Outreach and Community Programs, Keck School of Medicine of the University of Southern California
- Lurelean Gaines, Chair, Department of Nursing, East Los Angeles College
- Kara L. Odom, 5th Year MD/MPH Candidate, Jefferson Medical College and Johns Hopkins Bloomberg School of Public Health; 2003-2004 National President, Student National Medical Association

Sullivan Commission Field Hearing: Houston, TX

MD Anderson Cancer Center
Hickey Auditorium, 11th Floor
1515 Holcombe Blvd, Houston, TX 77030

January 16, 2004

AGENDA

Opening Remarks

- The Hon. Louis W. Sullivan, M.D., Chair, The Sullivan Commission on Diversity in the Healthcare Workforce
- The Hon. Chris Bell (D), U.S. Representative, Texas Congressional District 25
- John Mendelsohn, M.D., President, The University of Texas MD Anderson Cancer Center

Panel I. The Dividends of Diversity in the Health Professions

- The Hon. Ruth Jones McClendon, Member, Texas House of Representatives
- L. Natalie Carroll, M.D., Chair, NMA Health Institute
- Michael Jhin, Chief Executive Officer Emeritus, St. Luke's Episcopal Health System; Member of the Board of Directors, Greater Houston Partnership
- Regina F. Kyles, M.D., CEO/Medical Director, People 1st Healthcare Network

Panel II. Meeting the Needs of Medically Underserved Populations

- Rev. Dr. William A. Lawson, Senior Pastor, Wheeler Avenue Baptist Church
- Lovell Allan Jones, Ph.D., Director, Center for Research on Minority Health, M.D. Anderson Cancer Center
- Dorothy F. Caram, Ed.D., Director and Founding Member, The Houston Hispanic Forum
- Carlos A. Moreno, M.D., M.S.P.H., Professor and Chair, The University of Texas Health Science Center at Houston, Family Practice and Community Medicine Department

Panel III. The Culturally Competent Curriculum: Theory and Practice

- Doris Brooker, M.D., Chair-Elect, Federation of State Medical Boards
- Douglas M. Simmons, D.D.S., M.P.H., Chair, Board of Directors, Community Campus Partnerships for Health
- Mary Lou Bond, Ph.D., R.N., Co-Director, Center for Hispanic Studies in Nursing and Health, The University of Texas at Arlington School of Nursing
- Charles Whitten, M.D., Distinguished Professor and Associate Dean Emeritus, Wayne State University School of Medicine

Panel IV. Paving the Path for Minorities in the Health Professions

- Michael L. Lomax, Ph.D., President, Dillard University
- Capt. Kerry Nesseler, R.N., M.S., Health Resources and Services Administration Associate Administrator for Health Professions
- Rupert Evans, President & CEO, American Hospital Association's Institute for Diversity in Health Management
- Lawrence "Hy" Doyle, Learning Skills Specialist, University of California, Los Angeles School of Medicine, Center for Health Sciences

APPENDIX F

Diversity Resources

ADEA/W.K. Kellogg Access to Dental Careers Program

Website: www.adea.org

The American Dental Education Association/W.K. Kellogg Foundation Access to Dental Careers Program provides grants for schools to provide direct aid for underrepresented minorities, including undergraduate, postdoctoral, and fellowship scholarship and financial aid. Schools are chosen based on participation in The Robert Wood Johnson Pipeline, Profession & Practice Program: Community-Based Dental Education.

ADEA/W.K. Kellogg Minority Dental Faculty Development (MDFD) Grants

Website: <http://www.adea.org/ced>

The MDFD program will provide institutional grants to accredited U.S. dental schools (ADEA member institutions) that will be used primarily for direct educational assistance to: underrepresented minority senior predoctoral dental students, postgraduate dental students, or junior faculty that are being recruited to academic careers in dentistry.

The Algebra Project, Inc.

Website: <http://www.algebra.org/mission.html>

The Algebra Project is a national mathematics literacy effort aimed at helping low-income students and students of color—particularly African American and Latino—achieve prerequisite skills for college preparatory mathematics while in high school. Founded by Civil Rights activist and Math Educator Robert P. Moses in the 1980s, the Algebra Project has developed curricular materials, training programs, provided ongoing professional development support, and community involvement activities to schools seeking to achieve a systemic change in mathematics education.

Area Health Education Centers

Website: <http://www.nationalahec.org/main/ahec.asp>

Programs serve to enhance access to quality health care, particularly in primary and preventive care, by improving the supply and distribution of health care professionals through community/academic educational partnerships. Area Health Education Centers (AHEC) seeks to develop health careers recruitment programs in underserved rural and urban areas for underrepresented and disadvantaged populations.

American Indian Nursing Student Success Program

Website: <http://www.nursing.ouhsc.edu/americanindian.asp>

The Indian Health Service is working with the University of Oklahoma to provide assistance to Native-American nursing students interested in completing the Bachelors of Science in Nursing program. The purpose of this grant is to recruit, retain, and graduate Native-American nursing students from the baccalaureate program while preparing a cadre of culturally competent nurses who can provide health care services to the state's Native-American citizens.

Through a related initiative, a Bridge Project is also available for graduate degree candidates interested in nursing research careers.

The Biomedical Science Careers Program

Website: <http://www.bscp.org>

The Biomedical Science Careers Program, Inc. (BSCP) provides students of all races, ethnic backgrounds, gender, and financial status with encouragement, support, and guidance needed for the successful pursuit of careers in biomedical sciences. BSCP works to expand the academic and career horizons of students, particularly students of color; link educational training and mentoring opportunities for students with employment opportunities in science, academia, business and government; support the academic capability, desire to succeed, and willingness to persevere of minority and disadvantaged youth; and engage all sectors of society, regardless of race, ethnicity, gender, disability, or class in pursuit of excellence.

Bridge to Employment

Website: <http://www.aed.org/Projects/bte.cfm>

Bridge to Employment (BTE) is in an effort to reform education by communicating to at-risk students that learning can be meaningful, engaging, and relevant. The BTE program, in partnership with the Academy for Educational Development, benefits both students and the workforce of the future through the integration of school-based and work-based learning. Coordinated by Johnson & Johnson operating companies and local schools and universities, the Bridge to Employment program encourages students to pursue careers in the health care industry.

Centers of Excellence Program (Title VII)

Website: <http://bhpr.hrsa.gov/kidscareers/coe.htm>

The Centers of Excellence (COE) Program is designed to strengthen the national capacity to train underrepresented minority students in the health professions. COE supports programs at certain Historically Black Colleges and Universities, as well as Hispanic and American Indian. COEs at health professions schools (schools of medicine, osteopathic medicine, dentistry, pharmacy, and other public and nonprofit or educational entities and graduate programs in mental or behavioral health) train a significant number of the targeted minority students. COE also supports "Other" minority health professions education programs at health professions schools having enrollments of underrepresented minorities above the national average.

Community Campus Partnerships for Health

Website: <http://depts.washington.edu/ccph/index.html>

Community-Campus Partnerships for Health (CCPH) is a nonprofit organization that promotes health through partnerships between communities and higher educational institutions. Founded in 1996, CCPH is a growing network of over 1,000 communities and campuses. CCPH has members throughout the United States, and increasingly the world, who are collaborating to promote health through service-learning, community-based research, community service, and other partnership strategies. These partnerships are powerful tools for improving health professional education, civic responsibility, and the overall health of communities.

The Cross Cultural Health Care Program

Website: www.xculture.org

The Cross Cultural Health Care Program (CCHCP) has been addressing broad cultural issues that impact the health of individuals and families in ethnic minority communities in Seattle and nationwide. Through a combination of cultural competency trainings, interpreter trainings, research projects, community coalition building, and other services, the CCHCP serves as a bridge between communities and health care institutions to ensure full access to quality health care that is culturally and linguistically appropriate.

Cultural Advancement Recruitment and Enrichment (CARE) Program

Website: <http://www.udel.edu/nursing/bnahistory.html>

The University of Delaware's CARE Program was initiated by the school's Black Student Nurses Association (BSNA) in 1994. This program encourages URM nursing students to work through their local schools and churches to identify high school seniors interested in nursing. The BSNA also serves as a strong support group for minority students by encouraging leadership development and community involvement.

Department of Health and Human Services Office of Minority Health

Website: <http://www.omhrc.gov>

The mission of the Office of Minority Health (OMH) is to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities. OMH was established in 1985 by the U.S. Department of Health and Human Services (HHS). It advises the Secretary and the Office of Public Health and Science on public health program activities affecting American Indians and Alaska Natives, Asian Americans, Blacks/African Americans, Hispanics/Latinos, Native Hawaiians, and other Pacific Islanders.

Duke University Health Professions Advising Center

Website: <http://www.aas.duke.edu/trinity/prehealth>

The Health Professions Advising Center (HPAC) is part of the Trinity College academic advising system at Duke University and serves students from both Trinity College of Arts & Sciences and the Pratt School of Engineering.

Ethnic Minority Fellowship Program

Website: <http://www.nursingworld.org/emfp>

The Ethnic Minority Fellowship Program assists URM nurses in attaining advanced degrees in mental health related areas. The two-fold intent is to expand and enhance the scientific knowledge of mental health care, and to provide quality, culturally relevant care to a diverse group of individuals and families throughout the global community. Since its inception in 1974, the program has nurtured 266 Fellows, many of whom are leaders in research, clinical practice, public policy, and administration.

Gateway to Higher Education

Website: <http://www.aypf.org/RAA/07gate.pdf>

Started in 1986, Gateway to Higher Education is a comprehensive, four-year secondary school program administered through the City University of New York and operating in

five New York City high schools. It aims to prepare students for higher education and for careers in science, medicine, and technology. Gateway is aimed at students who are underrepresented in mathematics, science, and medical careers.

Harvard Medical School Minority Faculty Development Program

Website: <http://www.mfdp.med.harvard.edu>

In May of 1990, the Harvard Medical School Faculty Council unanimously approved the creation of the Minority Faculty Development Program (MFDP). MFDP is designed to support the career development of junior faculty and to address crucial pipeline issues. This includes: increasing the pool of minority students interested in careers in science and medicine; promoting medical students, graduate students, and fellows to develop the needed skills for success in the academic arena; and advancing the career development of junior faculty. MFDP is a part of the Harvard Medical School Office for Diversity and Community Partnership.

HCOP – Health Careers Opportunity Program (Title VII)

Website: <http://bhpr.hrsa.gov/kidscareers/HCOP.htm>

The Health Careers Opportunity Program (HCOP) strives to build diversity in the health professions by developing a more competitive applicant pool. The program provides students from disadvantaged backgrounds an opportunity to develop the skills needed to successfully compete for admission to and graduation from health professions schools, allied health professions schools, graduate programs in behavioral and mental health, and programs to train physician assistants.

Kids Into Health Careers

Website: <http://bhpr.hrsa.gov/kidscareers/>

Operating through the HRSA Bureau of Health Professions (BHPr), the Kids Into Health Careers initiative calls on all Bureau grantees to choose a local school or community-based organization; meet with school officials, students, and parents about the initiative; and report the results. BHPr is developing strategies to achieve a diverse, culturally competent health professions workforce. In FY 2000, all applicants were encouraged to work with school systems through the high school level, where there is a high percentage of minority and disadvantaged students. The objectives of developing this working relationship were to: (1) encourage and inform minority and disadvantaged teenage students of educational and career opportunities in health professions; and (2) assist minority and disadvantaged students in planning and preparing for postsecondary education in the health care professions.

Massachusetts General Hospital Institute for Health Policy Report: Cultural Competence in Health Care

Website: <http://www.mgh.harvard.edu/healthpolicy/culturalcompetence/introduction.htm>

Incorporating "cultural competence" into health care delivery has been hypothesized to improve health outcomes for racially/ethnically diverse populations. This new approach emphasizes the importance of providing care that is tailored to meet the needs of racially, ethnically, culturally, and linguistically diverse patients. Despite the fact that cultural competence is now being recognized by policymakers, managed care, academia,

providers, and the community as part of a solution to eliminating disparities in health care, there is an ongoing debate regarding how to further define and operationalize this critical yet broad construct. Cultural Competence in Health Care constructs a practical framework for the implementation of cultural competence at multiple levels of the health care delivery system.

Minority Access to Research Careers

Website: <http://ns2.faseb.org/marc>

The Minority Access to Research Careers (MARC) program was created by the National Institute of General Medical Sciences (NIGMS) to increase the number of biomedical and behavioral scientists from minority groups. A key objective of the MARC program is the encouragement of minority students in the pursuit of graduate training leading to the Ph.D. degree in the biomedical and behavioral sciences.

Minority Faculty Fellowship Program

Website: <http://bhpr.hrsa.gov/diversity/mffp>

This Bureau of Health Professions program provides grants to increase the number of health professions faculty who are racial and ethnic minorities underrepresented in health care. The grants enable schools to provide a stipend and a training allowance to faculty. MFFP grantees include schools of medicine, nursing, osteopathic medicine, dentistry, pharmacy, allied health, podiatric medicine, optometry, veterinary medicine, public health, and schools offering graduate programs in behavioral and mental health.

National Association of Advisors for the Health Professions

Website: <http://www.naahp.org>

The National Association of Advisors for the Health Professions serves as a resource for the professional development of health professions advisors. It is a representative voice with health professions schools and their professional associations, undergraduate institutions, and other health professions organizations. The Association promotes high standards for health professions advising at universities and colleges. It assists advisors in fostering the intellectual, personal, and humanistic development of students as they prepare for careers in health professions.

National Association of Medical Minority Educators, Inc.

Website: <http://www.namme-hpe.org>

NAMME is a national organization dedicated to improving the overall health status of racial/ ethnic populations, who, because of past laws and/or social customs, have been historically underrepresented in and/or underserved by the health professions. This is accomplished through increasing students' access to and graduation from programs for health professionals, student advocacy, policy development and legislation, networking and professional development, and related research.

The National Center for Cultural Competence

Website: <http://gucchd.georgetown.edu/nccc/index.html>

The mission of the National Center for Cultural Competence (NCCC) is to increase the capacity of health and mental health programs to design, implement, and evaluate

culturally and linguistically competent service delivery systems. NCCC activities emphasize policy development, cultural competence for organizations and practitioners, and strategic approaches to incorporate culturally and linguistically competent values, policy, and practices within organizations and systems.

National Coalition of Ethnic Minority Nurse Associations

Website: <http://www.ncemna.org>

National Coalition of Ethnic Minority Nurse Associations (NCEMNA) is a unified force advocating for equity and justice in nursing and health care for ethnic minority populations. This group is made up of five national ethnic nurse associations: Asian American/Pacific Islander Nurses Association, National Alaska Native American Indian Nurses Association, National Association of Hispanic Nurses, National Black Nurses Association, and Philippine Nurses Association of America. NCEMNA's goals include support for the development of a cadre of ethnic nurses reflecting the nation's diversity and the development of ethnic minority nurse leaders.

National Hispanic Medical Association Leadership Fellowship Program

Website: www.nhmamd.org

The NHMA Leadership Fellowship Program promotes leadership development among members of the National Hispanic Medical Association. The emphasis is on the knowledge and skills necessary to take a leadership role in health policy development and advocacy at local, state and national levels on issues of importance to the health of the Hispanic community. Major sponsors are AMGEN, Inc., the R. F. Wagner Graduate School of Public Service, New York University, and the National Hispanic Medical Association. Applications are solicited from association membership. A committee consisting of association officers, NYU Wagner faculty and the Dean selects approximately 20 Fellows each year.

National Institutes of Health National Center on Minority Health and Health Disparities

Website: <http://ncmhd.nih.gov>

The mission of the National Center on Minority Health and Health Disparities (NCMHD) is to promote minority health and to lead, coordinate, support, and assess the National Institute of Health's effort to reduce and ultimately eliminate health disparities. In this effort, NCMHD will conduct and support basic, clinical, social, and behavioral research; promote research infrastructure and training; foster emerging programs; disseminate information; and reach out to minority and other health disparity communities. The NCMHD envisions an America in which all populations will have an equal opportunity to live long, healthy, and productive lives.

National Institute of Nursing Research Diversity Programs and Resources

Website: <http://ninr.nih.gov/ninr/research/diversity.html>

National Institute of Nursing Research (NINR), a branch of the National Institutes of Health, offers funding and training opportunities specifically for nurses from underrepresented groups. These resources include research and training grants for URM nurses, a scientist-mentoring initiative, collaborations with minority-focus nursing

groups, student scholarship programs, and links with other federal agencies that support a diversified nursing workforce.

National Science Foundation Urban Systemic Program

Website: <http://www.ehr.nsf.gov/esr/programs/usp/#overview>

The Urban Systemic Program (USP) in Science, Mathematics, and Technology Education derives from the merger of two past efforts, the Urban Systemic Initiatives Program (USI) and the Comprehensive Partnerships for Mathematics and Science Achievement (CPMSA). Through the USP effort, the National Science Foundation seeks to stimulate interest, increase participation, improve achievement, and accelerate career advancement and success for all students of the participating urban school districts. The USP is a K-12-based program that promotes systemic reform of science and mathematics education for all students. The USP includes programmatic components that seek to foster partnerships between urban school districts, and two- and four-year colleges and universities.

New York State Academic Dental Centers

Website: www.adea.org

New York State Academic Dental Centers (NYSADC) is a consortium that includes: New York University, Columbia University, State University of New York at Buffalo, State University of New York at Stony Brook, and the University of Rochester Eastman Dental Center. It has received grants to create formal mentoring programs, academic partnerships, and community-based practices and projects to attract, nurture, and support the development of URM/LI academicians and researchers. Individual schools have funding to direct educational assistance to increase the number of URM students recruited to and entering dental academic careers, and to establish academic partnerships that facilitate advanced training and career development.

Nursing Workforce Diversity Grants

Website: <http://bhpr.hrsa.gov/grants/applications/03nrsdiversity.htm>

Administered by HRSA's Bureau of Health Professions, Nursing Workforce Diversity Grants are offered to increase opportunities for individuals from disadvantaged backgrounds, including racial and ethnic minorities underrepresented among registered nurses, to enter the nursing profession. Grants are awarded to schools of nursing, non-profits, local governments, and other entities to fund student scholarships or stipends, pre-entry preparation, and retention activities.

Office of Premedical Programs Xavier University

Website: <http://www.xupremed.com>

Xavier's Premedical Office provides support for students interested in obtaining careers in medicine (M.D. degrees), osteopathic medicine (D.O. degrees), dentistry, veterinary medicine, optometry, podiatry, and public health/health care administration. Support provided by the Premedical Office is designed to complement academic advising, scheduling, etc. provided by academic advisors within a student's major department. A detailed list of programs and resources are available for students and parents on the website.

Posse Foundation

Website: <http://www.possefoundation.org>

The Posse Foundation identifies, recruits, and selects student leaders from public high schools to form multicultural teams called “Posses.” These teams are then prepared, through an intensive eight-month Posse Training Program, for enrollment at top universities nationwide to pursue their academics and to help promote cross-cultural communication on campus.

Pre-Baccalaureate Program – University of California, San Francisco

Website: <http://dentistry.ucsf.edu/studentaffairs/ucsf-sodosa/ucsf-sodosa-programs.htm>

The UCSF School of Dentistry Office of Student Affairs operates a number of outreach and recruitment programs designed to increase the numbers of economically disadvantaged students and students from underserved areas. These programs augment UCSF’s involvement in local career fairs, recruiting visits to high schools and colleges, and the UCSF Dental Admissions Test preparation course. UCSF also participates fully in campus programs in pursuit of these goals.

RWJF/AAMC Health Professions Partnership Initiative

Website: www.aamc.org

The grants program, which grew out of AAMC's Project 3000 by 2000, is an example of the many AAMC initiatives to address the long-standing under-representation of blacks, Mexican Americans, mainland Puerto Ricans, and American Indians in U.S. medical schools and the medical profession. HPPI partnerships coordinate the efforts of two or more health professional schools with those of colleges, predominantly minority high schools, and community-based organizations to enhance the interest and academic preparedness of students as they progress from one stage of the health professions education "pipeline" to the next.

The HPPI partnership grants aim to stimulate high career aspirations; interest in health careers; high academic achievement; and modifications to educational programs, as needed, guided by a detailed understanding of students' needs, local resources, and the best practices of institutions known for their success.

RWJF Pipeline, Profession & Practice: Community-Based Dental Education

Website: <http://www.rwjf.org/programs> and <http://dentalpipeline.columbia.edu>

This program expands the recruitment of minority and low-income students into dental schools, increases the number of dental schools with community-based practice sites, and expands access to oral health care for vulnerable populations through dental school and community partnerships.

Society for Advancement of Chicanos and Native Americans in Science

Website: <http://www.sacnas.org/index.html>

The goal of the K-12 Education Program at SACNAS is to ensure that elementary, middle, and high school students from traditionally underrepresented minority backgrounds receive superior educational opportunities, role models, and the

encouragement needed to pursue careers in science, mathematics, engineering, and technology.

Ventures Scholars

Website: <http://www.venturescholar.org>

The Ventures Scholars program is a national membership program designed to promote equity in and access to higher education. The Ventures Scholars program identifies high achieving, historically underrepresented, and first-generation college-going students interested in pursuing math- and science-based careers, and provides academic recognition, information, and resources needed to successfully reach their career goals.

Yale-Howard Partnership Center on Health Disparities

Website: <http://www.cpnahs.howard.edu/Nursing/yalehoward>

In 2002, Yale School of Nursing and Howard University Division of Nursing launched the Partnership Center on Reducing Health Disparities. The Center works to build capacity by recruiting and developing nurse scientists to conduct culturally relevant and competent research to aid in eliminating health disparities. Goals include enhancing collaboration in key areas of research on health disparities and providing faculty development through training and mentorship to a diverse group of nurses.