Promoting Greater Diversity in the Healthcare Workforce

By Jennifer Goodwin, David Matyas, and Deepa Selvam, Epstein Becker & Green PC, Washington, DC

Despite advances in medicine over the last century, disparities in quality of—and access to—care that minorities receive in the United States continue to exist.

> Disparities remain in the quality of care received even when income, health insurance and access to care are taken into account, and patients from racial and ethnic minorities often fare far worse than their white counterparts on a range of health indicators: life expectancy, infant mortality, prevalence of chronic diseases and insurance coverage, among others.[1]

The Agency for Healthcare Research and Quality (AHRQ) continues to study and report on these issues and as of last year, African Americans continued to receive worse care than Whites for 41% of reviewed quality measures, while Hispanics received worse care than non-Hispanic Whites for 39% of these measures. Moreover, African Americans had worse access to care than Whites for 32% of access measures, while Hispanics had worse access to care than non-Hispanic Whites for 63% of these measures.[2]

Another example of the disparities in healthcare concern the fact that AIDS disproportionately affects certain racial and ethnic minorities. For example, in 2007, African Americans comprised 13% of the U.S. population, but accounted for nearly 50% of those persons living with the AIDS virus.[3]

In addition, racial/ethnic minority populations have much higher rates of being uninsured.[4] As a result, with respect to receiving primary care services, African American and Hispanic adults are less likely to rely on a private physician for their medical care than White adults (62% and 44% versus 77%).[5] This is likely to lead to missed or undiagnosed illnesses.

Infant mortality rates also differ among racial or ethnic groups.[6] Infant mortality rates among different racial or ethnic groups differ even when individuals with similar education levels are compared with one another,[7] indicating that education levels may not be the only determining factor in terms of how individuals access and take advantage of the healthcare system.

While many different factors contribute to disparities in healthcare, the lack of diversity in the healthcare workforce is routinely cited as a major contributing factor and that "[i]ncreasing the racial and ethnic diversity of the healthcare workforce is essential for the adequate provision of culturally competent care of our nation's burgeoning minority communities."[8]

This article examines a number of the provisions in the Affordable Care Act (ACA) that are designed to address the current disparities in the racial and ethnic make-up of America's healthcare workforce.

The Impact of the Lack of Racial and Ethnic Diversity in the Healthcare Workforce

While a number of factors likely contribute to the prevalence of healthcare disparities between racially and ethnically diverse populations, the lack of diversity among healthcare professionals has been shown to have a profound impact on minority communities, leading to poor health outcomes or fragmented care at best.

AHRQ's most recent *National Healthcare Disparities Report* highlighted the fact that workplace diversity is limited.[9] The report tracks workforce diversity among physicians and surgeons, registered nurses, licensed practical and licensed vocational nurses, dentists, dental hygienists, dental assistants, pharmacists, occupational therapists, physical therapists, and speech-language pathologists. Specifically, the report found that generally for these occupations, Whites and Asians are overrepresented while African Americans and Hispanics are underrepresented. Interestingly, however, African Americans were overrepresented among licensed practical and licensed vocational nurses, and Hispanics were overrepresented when it came to dental assistants. As the report pointed out, of those listed, these two occupations require the least amount of education and have the lowest median annual wages.

Although the latest census data highlights the country's ever-increasing diversity,[10] the census data confirms that the composition of the healthcare workforce is not reflective or indicative of the changing population dynamics. For example, according to the 2010 U.S. census data, the Hispanic population increased from 35.3 million in 2000 to 50.5 million in 2010, roughly 16% of the total population. However, despite this change in population demographics, Hispanics make up only about 5% of individuals practicing medicine.[11] In terms of other ethnic groups, of those practicing medicine, only 12.2% are Asian, 3.5% African American, and 0.16% American Native/Alaska Native.[12] With respect to nursing, African Americans comprise 5.4% of registered nurses (approximately 12% of the U.S. population), and Hispanics make up 3.6 % of registered nurses (while over 15% of the U.S. population).[13]

Various studies have shown "racial and ethnic minority practitioners are more likely to practice in medically underserved areas and provide healthcare to large numbers of racial and ethnic minorities who are uninsured and underinsured."[14] Thus, increasing the diversity among healthcare professionals likely would improve minority access to care in historically underserved areas. Additionally, some minority patients may believe that they will receive better care from a practitioner of their own race or ethnicity.[15] Thus, addressing the diversity issue not only

promotes cultural competency but may also encourage more individuals to seek care, including preventative care.[16]

These sensitivities emphasize the importance of, and need for, increased diversity among healthcare professionals.

The Affordable Care Act

By no means was the ACA[17] Congress' first attempt to try to tackle the issue of healthcare workforce diversity. Indeed, state and federal legislators and policymakers have long been attempting to develop and establish programs designed to combat the disparities in healthcare in the United States. According to the Robert Wood Johnson Foundation, "[m]ore than 50 years of efforts to improve diversity in the nation's healthcare workforce have not achieved their goal."[18]

While past efforts have fallen short and healthcare disparities persist, the ACA attempts to address the issue and encourage racial and ethnic diversity in the healthcare workforce.[19] Amongst its numerous provisions, the ACA established a National Health Care Workforce Commission (the Commission), which, among other things, is to "review current and projected healthcare workforce supply and demand . . . [and] make recommendations to Congress and the Administration concerning national healthcare workforce priorities, goals, and policies."[20] Among the topics to be reviewed by the Commission are the healthcare workforce needs of certain groups, including minorities, rural populations, and medically underserved populations.[21] Additionally, the Commission is to review recommendations that require low-income, minority medical students in national loan repayment and scholarship programs to serve in their home communities if they are designated medically underserved communities.[22]

The ACA also recognizes the importance of cultural competency in healthcare delivery.[23] Cultural and linguistic competence has been described as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations."[24] Cultural competency is considered to be critical in reducing health disparities and improving access to high-quality healthcare. It is important for healthcare professionals to understand and appreciate cultural and linguistic diversity so that they may better serve the unique needs of their individual patients. As such, training for health professionals should include cross-cultural curricula and practical case-based continuing education programs as these are crucial components in providing high-quality care.[25]

When cultural competence is developed and implemented within a comprehensive framework, health professionals are in a better position to understand the needs of the various groups accessing health information and healthcare services or participating in research. Cultural competence enables

While a number of factors likely contribute to the prevalence of healthcare disparities between racially and ethnically diverse populations, the lack of diversity among healthcare professionals has been shown to have a profound impact on minority communities, leading to poor health outcomes or fragmented care at best.

systems, agencies, and groups of professionals to function in an inclusive partnership where the provider and the user of the information meet on common ground. The ACA included provisions whereby the Department of Health and Human Services (HHS) Secretary

> may make awards of grants, contracts, or cooperative agreements to public and nonprofit private entities (including tribal entities) for the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs, and for other purposes determined as appropriate by the Secretary.[26]

The ACA also modifies provisions of the Public Health Service Act related to Centers of Excellence (COE), which are eligible for certain grants to assist schools in "supporting programs of excellence in health professions education for under-represented minority individuals."[27] Specifically, the ACA expanded

While past efforts have fallen short and healthcare disparities persist, the ACA attempts to address the issue and encourage racial and ethnic diversity in the healthcare workforce.

the funding allocation formula "by identifying a methodology to distribute appropriations in excess of $40M among awarded health professions schools serving underrepresented minority (URM) individuals."[28]

According to the Health Resources and Services Administration,

> [t]he COE program grantees serve as innovative resource and education centers to recruit, train, and retain URM students and faculty at health professions schools. Programs are implemented to improve information resources, clinical education, curricula, and cultural competence as they relate to minority health issues. These grantees also focus on facilitating faculty and student research on health issues particularly affecting URM groups. The ultimate goal of the program is to strengthen the national capacity to produce quality healthcare workforce whose racial and ethnic diversity is representative of the U.S. population.[29]

Additionally, the ACA increases the authorized appropriation related to educational assistance for individuals from disadvantaged backgrounds.[30] For example, with respect to workforce diversity grants for nurses, the ACA provides for additional sources of assistance, including student scholarships or stipends, stipends for diploma or associate degree nurses to enter a bridge or degree completion program, student scholarships or stipends for accelerated nursing degree programs, and advanced education preparation.[31] These grants are aimed at racial and ethnic minority individuals underrepresented in the nursing profession. The ACA also authorized $5 million for fiscal years 2010 through 2014 for continuing educational support for health professionals serving in underserved communities.[32] Under this grant, eligible entities shall use amounts awarded "to provide innovative supportive activities to enhance education through distance learning, continuing educational activities, collaborative conferences, and electronic and telelearning activities, with priority for primary care."[33]

The Office of Minority Health (OMH) was created in 1996 as a result of poor health outcomes for certain minority groups as compared to the rest of the U.S. population.[34] OMH's primary responsibility is "to improve health and healthcare outcomes for racial and ethnic minority communities by developing or advancing policies, programs, and practices that address health, social, economic, environmental and other factors which impact health."[35] The ACA reauthorized and transferred OMH to the Office of the Secretary "for the purpose of improving minority health and the quality of health care minorities receive, and eliminating racial and ethnic disparities."[36] ACA also required the establishment of OMHs within six agencies of HHS:

- AHRQ
- Centers for Disease Control and Prevention
- Centers for Medicare and Medicaid Services
- Food and Drug Administration
- Health Resources and Services Administration
- Substance Abuse and Mental Health Services Administration.[37]

Within HHS's action plan to reduce racial and ethnic health disparities (for which OMH is leading the charge), there are action items specifically related to strengthening and diversifying the nation's healthcare workforce.[38] As stated in the plan, "Diversity in the healthcare workforce is a key element of patient-centered care. The ability of the healthcare workforce to address disparities will depend on its future culture competence and diversity."[39] One of the goals identified is to strengthen the nation's health and human services infrastructure and workforce. "With growing national diversity, the disparity between the racial and ethnic composition of the healthcare workforce and that of the U.S. population widens as well."[40]

One of the strategies identified to accomplish this goal is to increase the diversity of the healthcare and public health workforces by creating a pipeline program for students to increase racial and ethnic diversity in the public health and biomedical sciences professions, increasing education and training opportunities for low-income individuals for occupations in healthcare fields through Health Professions Opportunity Grants, and increasing the diversity and cultural competency of clinicians.[41] In an effort to increase diversity and cultural competency, the plan makes a number of recommendations including developing a plan for targeted recruitment of students from underrepresented backgrounds, activities designed to encourage student interest in primary care and scholarship programs, and loan repayment programs. In addition to these national-level efforts, every state has a minority health or health equity office or entity.

Beyond the ACA Provisions

While the ACA sets forth several efforts to increase diversity among members of the healthcare workforce, organizations and the community-at-large need to work on a smaller scale to develop and implement strategies designed to increase diversity within their own institutions which would serve to improve healthcare outcomes in their own communities. For example, even without legislation, healthcare organizations should create a culture where diversity is not only valued generally but where there is also a true appreciation for cultural sensitivities and the effect they have on healthcare outcomes. To this end, it is necessary for healthcare providers to be aware of (and learn about) the community they serve and the particular needs of any specific patient groups. In addition, the leadership of existing healthcare organizations should take active steps to target recruitment of minority healthcare providers and to foster an environment in which minority healthcare professionals can be given leadership roles. C

About the Authors

Jennifer K. Goodwin (jgoodwin@ebglaw.com) is an Associate in the Health Care and Life Sciences practice of Epstein Becker Green in the firm's Washington, DC, office. Ms. Goodwin counsels clients on matters related to government investigations as well as the regulatory and due diligence aspects of healthcare transactions. Ms. Goodwin also counsels clients on federal and state healthcare fraud and abuse compliance.

David E. Matyas (dmatyas@ebglaw.com) is a Member of the Firm at Epstein Becker Green's Washington, DC, office. He is in the firm's Health Care and Life Sciences practice group. Mr. Matyas represents an array of healthcare providers including hospitals and health systems, pharmaceutical and medical device manufacturers, academic medical centers, retail and specialty pharmacies, ambulatory surgery centers, home health agencies, and physician organizations. He also advises investors and other financial institutions that invest in or support the healthcare industry. Mr. Matyas counsels his clients on matters related to government audits and investigations, compliance programs, and the regulatory and due diligence aspects of healthcare transactions.

Deepa B. Selvam (dselvam@ebglaw.com) is an Associate in the Health Care and Life Sciences practice of Epstein Becker Green in the firm's Washington, DC, office. Ms. Selvam advises clients on regulatory matters arising under third-party reimbursement programs as well as government and internal investigations relating to healthcare fraud and abuse issues. Ms. Selvam also assists clients with compliance programs as well as due diligence, licensing and other change of ownership issues.

Analysis

Endnotes

1 Robert Wood Johnson Foundation, *How Does the Affordable Care Act Address Racial and Ethnic Disparities in Health Care?*, Dec. 2011, *available at* www.rwjf.org/healthpolicy/product.jsp?id=73766.
2 Agency for Healthcare Research and Quality, *National Healthcare Disparities Report 2011*, Mar. 2012, at 4, *available at* www.ahrq.gov/qual/qrdr11.htm.
3 National Institutes of Health, Health Disparities, *available at* http://report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=124&key=H#H (last visited Sept. 4, 2012).
4 Kaiser Family Foundation, *Eliminating Racial/Ethnic Disparities in Health Care: What are the Options?*, Oct. 24, 2008, *available at* http://www.kff.org/minorityhealth/h08_7830.cfm; *see also* U.S. Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Health Care*, Apr. 2011, at 2, *available at* http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=285.
5 Kaiser Family Foundation, *Eliminating Racial/Ethnic Disparities in Health Care: What are the Options?*, Oct. 24, 2008, *available at* www.kff.org/minorityhealth/h08_7830.cfm; *see also* U.S. Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Health Care*, Apr. 2011, at 3, *available at* http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=285.
6 Kaiser Family Foundation, *Eliminating Racial/Ethnic Disparities in Health Care: What are the Options?*, Oct. 24, 2008, *available at* www.kff.org/minorityhealth/h08_7830.cfm.
7 *Id.*
8 Jordan J. Chen, Barbara A. Gabriel and Charles Terrell, *The Case for Diversity in the Health Care Workforce*, 21 Health Affairs, 90-102, 91 (2002).
9 Agency for Healthcare Research and Quality, *National Healthcare Disparities Report 2011*, Mar. 2012, at 19, *available at* www.ahrq.gov/qual/qrdr11.htm.
10 United States 2010 Census Brief, The Hispanic Population: 2010, May 2011, *available at* http://2010.census.gov/2010census/data/.
11 The American Medical Association, Total Physicians by Race/Ethnicity - 2008 (citing Physician Characteristics in Distribution in the U.S., 2010 Edition), *available at* www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/minority-affairs-section/physician-statistics/total-physicians-raceethnicity.page (last visited Sept. 13, 2012).
12 *Id.*
13 Robert Wood Johnson Foundation, *Facts about the Nursing Workforce*, July 27, 2010, *available at* www.rwjf.org/pr/product.jsp?id=66388.
14 U.S. Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Health Care*, Apr. 2011, at 21, *available at* http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=285.
15 *See* Frederick M. Chen, et al, *Patients' Beliefs About Racism, Preference for Physician Race, and Satisfaction with Care*, 3 Ann. Fam. Med.138-143 (2005); *see also* Health Resources and Services Administration, T*he Rationale for Diversity in the Health Professions: A Review of the Evidence*, Oct. 2006, *available at* http://bhpr.hrsa.gov/healthworkforce/reports/diversityreviewevidence.pdf.
16 *Id.*
17 The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 5001 et seq., 124 Stat. 119 (2010).
18 Robert Wood Johnson Foundation, *How Does the Affordable Care Act Address Racial and Ethnic Disparities in Health Care?*, Dec. 2011, *available at* www.rwjf.org/healthpolicy/product.jsp?id=73766. *See also* Institute of Medicine, *Unequal Treatment Confronting Racial and Ethnic Disparities in Health Care*, Mar. 2002, at 186 (which made recommendations to increase the proportion of underrepresented minorities among healthcare professionals), *available at* www.nap.edu/openbook.php?isbn=030908265X.
19 Robert Wood Johnson Foundation, *How Does the Affordable Care Act Address Racial and Ethnic Disparities in Health Care?*, Dec. 2011, *available at* www.rwjf.org/healthpolicy/product.jsp?id=73766.
20 42 U.S.C. § 294q(d)(2)(a-b).
21 42 U.S.C. § 294q (d)(3)(e).
22 42 U.S.C. § 294q (d)(3)(f).
23 *See* 42 U.S.C. § 293e.
24 Offices of Minority Health, U.S. Department of Health and Human Services, *What Is Cultural Competency?*, *available at* http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=11 (last visited Sept. 18, 2012).
25 Institute of Medicine, *Unequal Treatment: What Health Care System Administrators Need to Know about Racial and Ethnic Disparities in Health Care*, Mar. 2002, *available at* www.iom.edu/~/...Racial...Health-Care/DisparitiesAdmin8pg.pdf.
26 42 U.S.C. § 293e(a)(1).
27 42 U.S.C. § 293(a).
28 Health Resources and Services Administration, Funding Opportunities – Centers of Excellence Program, https://grants.hrsa.gov/webExternal/FundingOppDetails.asp?FundingCycleId=DD3D74D9-6B5E-4B00-A0AC-8A347DBBB0F1&ViewMode=EU&GoBack=&PrintMode=&OnlineAvailabilityFlag=&pageNumber=&version=&NC=&Popup (last visited Sept. 17, 2012). *See also* 42 U.S.C. § 293(h).
29 Health Resources and Services Administration, Funding Opportunities – Centers of Excellence Program, https://grants.hrsa.gov/webExternal/FundingOppDetails.asp?FundingCycleId=DD3D74D9-6B5E-4B00-A0AC-8A347DBBB0F1&ViewMode=EU&GoBack=&PrintMode=&OnlineAvailabilityFlag=&pageNumber=&version=&NC=&Popup (last visited Sept. 17, 2012).
30 42 U.S.C. § 293d(c).
31 42 U.S.C. § 296m.
32 42 U.S.C. § 294b.
33 42 U.S.C. § 294b(d).
34 Offices of Minority Health, U.S. Department of Health and Human Services, http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=1&lvlID=7 (last visited Sept. 17, 2012).
35 *Id.*
36 42 U.S.C. § 300u-6.
37 Offices of Minority Health, U.S. Department of Health and Human Services, http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=1&lvlid=45 (last visited Sept. 4, 2012).
38 U.S. Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Health Care*, Apr. 2011, *available at* http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=285.
39 *Id.* at 3.
40 *Id.* at 19.
41 *Id.* at 21-22.