

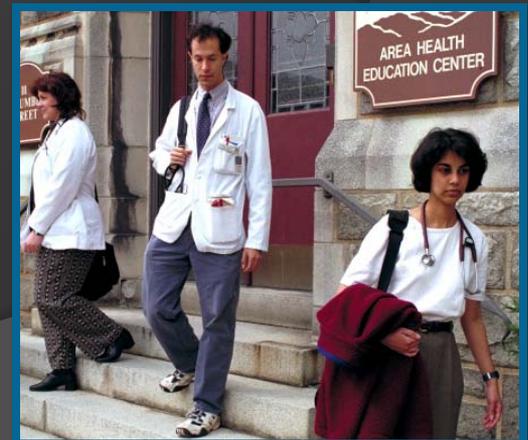
ENHANCING DIVERSITY AMONG HEALTHCARE PROFESSIONALS AND ELIMINATING DISPARITIES

**MINORITY OFFICERS LIAISON COUNCIL
20TH HEALTH DISPARITIES SYMPOSIUM**

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Health Resources and Services Administration

Healthy Communities, Healthy People



The Programs We Deliver

- ✓ Community Health Centers
- ✓ National Health Service Corps
- ✓ Workforce Training for Primary Care, Public Health, Medicine, Dentistry, Nursing, and Geriatrics
- ✓ Workforce Diversity
- ✓ Children's Hospital GME
- ✓ Practitioner Databanks
- ✓ Maternal and Child Health
- ✓ Healthy Start
- ✓ Stop Bullying Now!
- ✓ Poison Control
- ✓ Ryan White HIV/AIDS
- ✓ Rural Health Policy & Programs
- ✓ Telehealth
- ✓ Health Care for the Homeless
- ✓ Migrant Health Centers
- ✓ Native Hawaiian Health
- ✓ Vaccine Injury Compensation
- ✓ Hansen's Disease (Leprosy)
- ✓ 340B Drug Pricing
- ✓ Organ Donation & Transplantation
- ✓ And more...

The People We Serve



- HRSA-funded health centers-
 - served nearly 19 million patients,
 - 1 in 3 people with incomes below the poverty level
 - 2 in 3 people are racial ethnic minorities.
- HIV/AIDS through Ryan White services
 - Over 500,000 people living with HIV/AIDS
 - Two-thirds are members of minority groups.
- Maternal and Child Health Programs
 - 34 million women, infants, children, and adolescents
- 340B discount drug program
 - About 14,000 safety net providers participate
- National Health Service Corps
 - 6,700 clinicians working in underserved areas in exchange for loan repayment or scholarships.

Outline

- ① **Workforce diversity and health disparities- Is there a connection?**
 - The evidence for increasing diversity
- ② **Solutions? Healthcare Workforce Strategies-**
 - HRSA Programs
- ③ **Opportunities for Improvement**
 - USPHS Officers

Health Disparity Definition

- **A Difference in health outcomes that is closely linked with social or economic disadvantage.**
- **Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles.**

HEALTH IS UNEVENLY DISTRIBUTED IN POPULATIONS

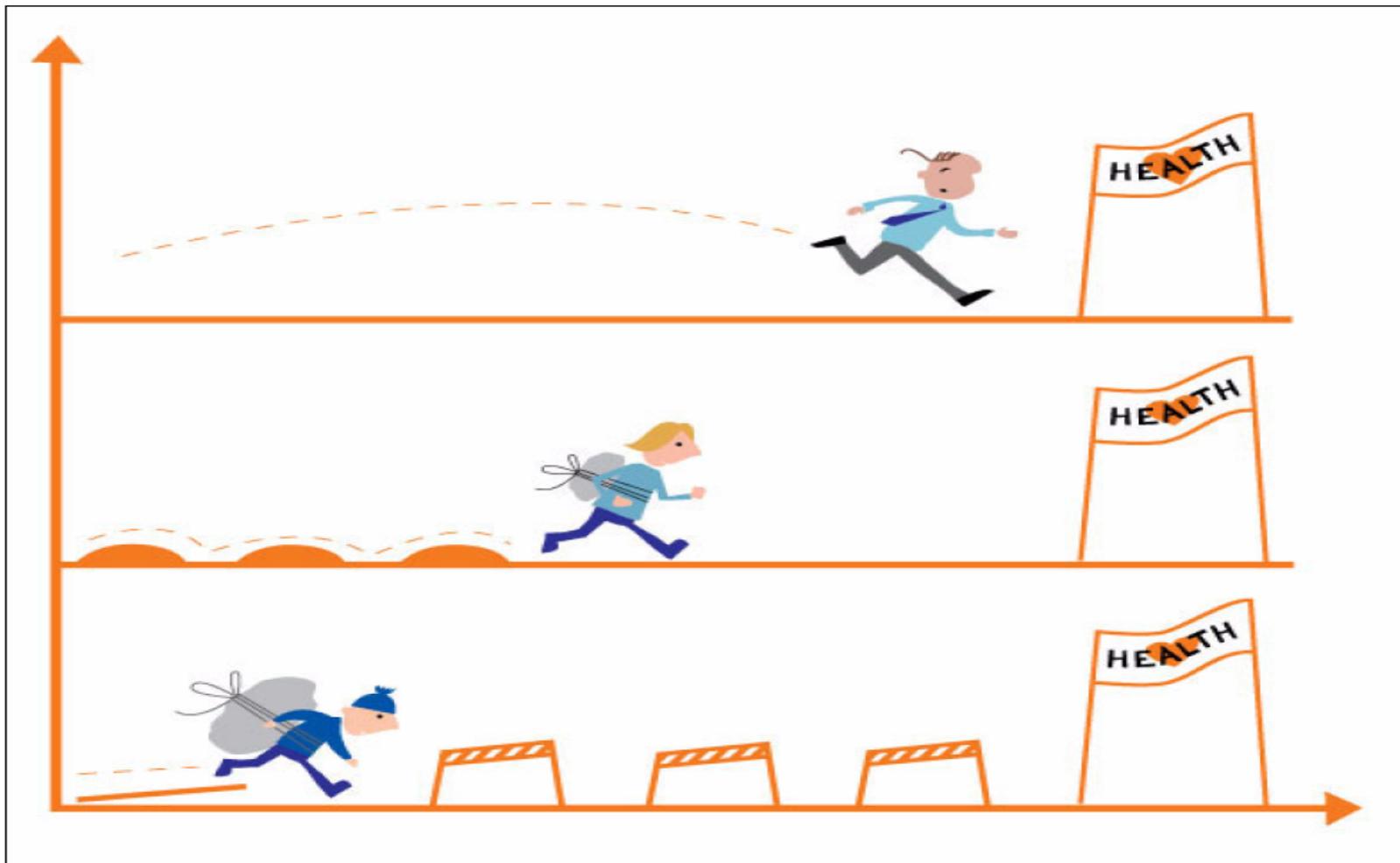
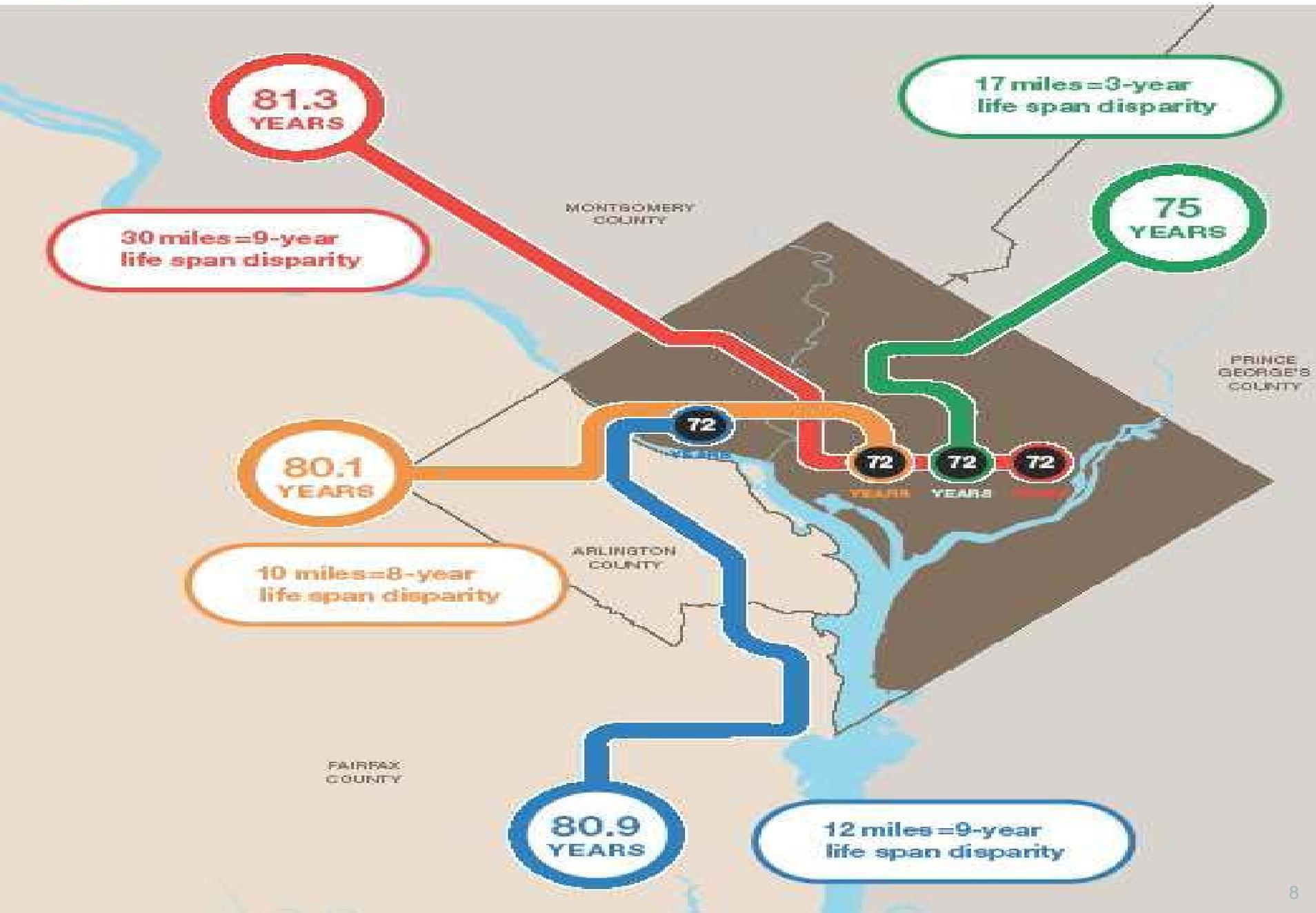


Figure 2.1 Social inequalities in health

Source: Norwegian Ministry of Health and Care Services: National strategy to reduce social inequalities in health.



Economic Burden of Health Inequities *September 2009*

Study Period 2003-2006

- Combined costs of health inequalities and premature death in the U.S.
 - \$ 1.24 trillion
- Eliminating health disparities for minorities would have reduced direct medical care expenditures
 - \$ 229.4 billion
- Direct medical care expenditures excess costs due to health inequalities for African Americans, Asians, & Hispanics
 - 30.6 %

The Health Impact of Resolving Racial Disparities: An Analysis of US Mortality Data

Steven H. Woolf, MD, MPH, Robert E. Johnson, PhD, George E. Fryer Jr, PhD, MSW, George Rust, MD, MPH, and David Satcher, MD, PhD

The US health system spends far more on the “technology” of care (e.g., drugs, devices) than on achieving equity in its delivery. For 1991 to 2000, we contrasted the number of lives saved by medical advances with the number of deaths attributable to excess mortality among African Americans. Medical advances averted 176633 deaths, but equalizing the mortality rates of Whites and African Americans would have averted 886202 deaths. Achieving equity may do more for health than perfecting the technology of care. (*Am J Public Health*. 2004;94:2078–2081)

The Evidence Base...

- Before publications and reports to congress- There was a general “awareness” about disparities in outcomes Some of the following research and publications represent the “evidence base” and created the urgency for action.

Is Access Enough?

- After gaining **access** to health care,, minorities still do not fare as well as their white counterparts;
- African Americans, and to a lesser extent Hispanics, receive fewer diagnostic and therapeutic procedures than whites, even after controlling for clinical, co-morbid, and socio-demographic factors.

Reports of Disparities Based on Race

- Blacks and Hispanics with HIV infection were found to have lower outpatient utilization and less treatment with antiretroviral medications and prophylactic medications (Andersen et al., 2000; Schwarcz, 1997; Moore et al., 1994; Easterbrook et al., 1991).
- Inadequate pain management has also been found to be significantly more likely among black nursing home patients with cancer compared with Whites (Bernabei, 1998).

“Care”

Disparities Based on Race

- Evidence to suggest significant racial differences in who receives appropriate diagnostic tests and treatment for cancer.
- Minorities are less likely to receive kidney dialysis or transplants.
- Racial differences have been reported in the provision of analgesics in the emergency room.
(Bach et al. 1999- NEJM; Todd et al., 1993- JAMA)

“Care”

Disparities Based on Race

- Black patients were found to receive lower intensity of hospital services than Whites (Yergan et al., 1987), and
- To experience higher rates of post-discharge complications for several major conditions in a national study of hospital care (Kahn et al., 1994).

“Care”

Disparities Based on Race

Minorities receive unequal care for cardiac conditions:

- Non-white patients presenting to the emergency department with angina or acute myocardial infarction reported to be hospitalized less often than white patients.

(Johnson et al., 1993- Am. Intern. Med.; Pope et al., 2000- NEJM)

- 79% of black women referred for catheterization as compared to 91% for both white men and women.

(Schulman et al., 1999- NEJM)

“Care”

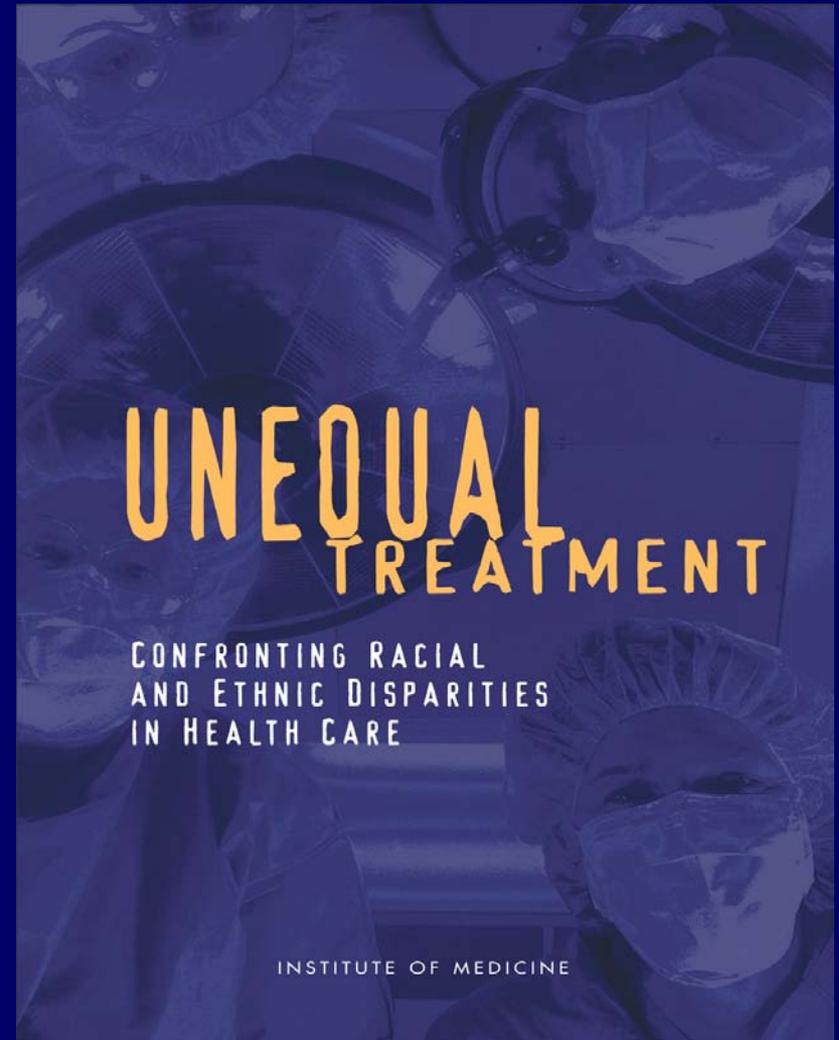
Disparities Based on Race:

- ⦿ African-Americans and Hispanics less likely to receive depression treatment during office visits with physicians (Skaer et al., 2000)
- ⦿ African-Americans less likely, even with same symptoms, to receive tx recs for depression from physicians (Sirey et al., 1999)
- ⦿ After controlling for multi factors, African-Americans less likely to receive mental health specialist services (Harman et al., 2004)

Disparities in Health Care 2002

Racial/Ethnic disparities found across a wide range of health care settings, disease areas, and clinical services, even when various confounders (SES, insurance) controlled for.

Findings: Many sources contribute to disparities—no one suspect, no one solution



The IOM – **Unequal Treatment** Recommendations (2002)

- Increase awareness of racial and ethnic disparities in health care
- Integrate cross-cultural education into the training of all current and future health care professionals
- **Increase the proportion of underrepresented U.S. racial and ethnic minorities among health care professionals.**
- Promote consistency and equity of care through the use of evidenced based guidelines.
- Support race/ethnicity data collection, quality improvement & conduct further research to identify sources of disparities and promising intervention strategies.

**Is there really a Link
Between Workforce
Diversity and Improving
Quality Health Care?.**

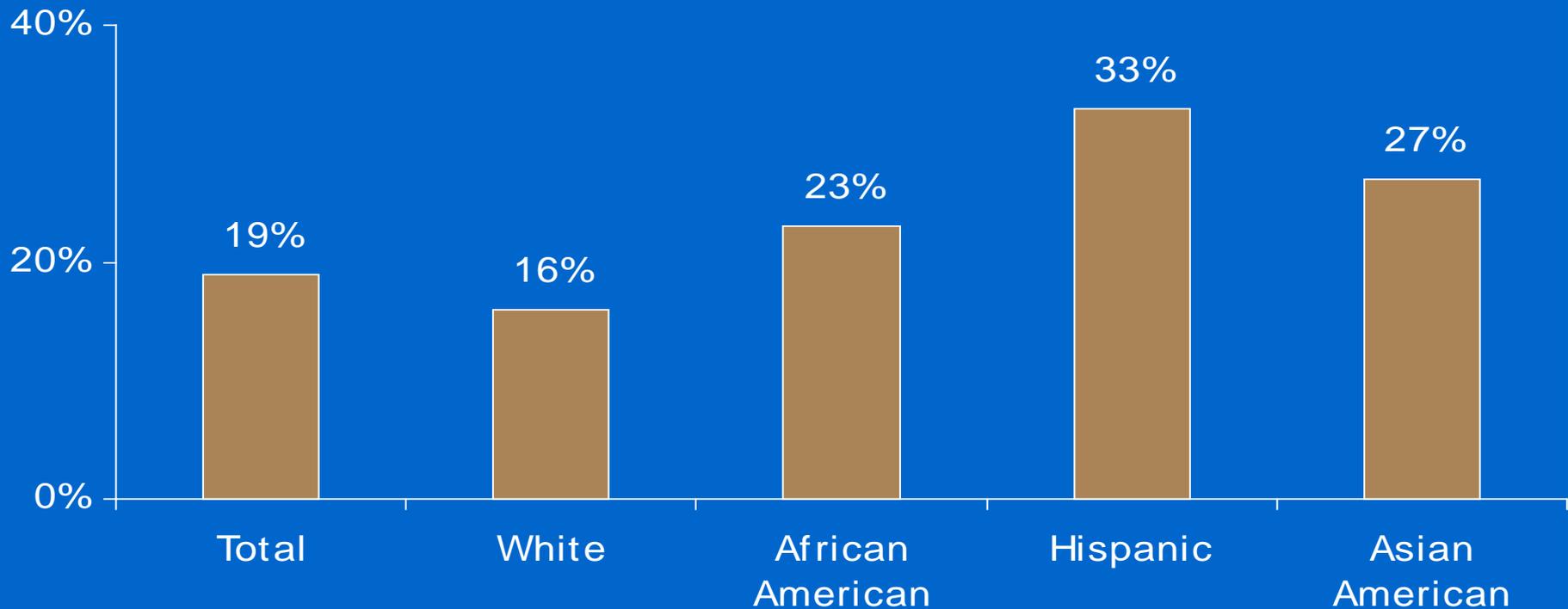
Health Disparities

Many Factors

- Patient-level risk factors,
 - differences in education and economic resources,
 - health behaviors (beliefs), nutrition,
 - genetic predisposition, and environmental exposures.
- Health care system **factors** that impact outcomes
 - Utility and Access to health care services
 - Quality & appropriateness of care provided.
 - Signage and infrastructure to support providers

Minorities Face Greater Difficulty in Communication with Physicians

Percent of patients with one or more communication problems *



Base: Adults with health care visit in past two years.

*** Problems include understanding doctor, feeling doctor listened, had questions but did not ask.**

Source: The Commonwealth Fund 2001 Health Care Quality Survey.

Race Concordance- One Way to Assess the Value of Diversity...

- Lisa Cooper and Neil R Powe-
Disparities in Patient Experiences,
Health Care Processes, and Outcomes:
The Role of Patient-Provider Racial,
Ethnic, and Language Concordance,
Lisa A. Cooper and Neil R. Powe, The
Commonwealth Fund, July 2004

Race Concordance- ...

- ◎ Race-concordance - Found
 - visits are longer and characterized by more patient positive affect.
 - Higher patient ratings of care
 - Higher ratings independent of patient-centered communication,
 - Suggests other factors, such as “attitudes” may be responsible for mediating the relationship.

Link to Quality Care

- Patients with racially concordant physicians were also more likely to report that they had received preventive services and needed medical care during the previous year.

Appropriate Health Care Results in Better Quality and Better Costs

- A 'usual source' of health care,
- A 'regular' physician
- A Health Home

- ⦿ African-American and Hispanic patients less likely to have a regular physician or medical home, which is strongly associated with prevention, screening, and specialty care referral
- ⦿ Hispanics nearly twice as likely to lack a usual source of care as Whites
- ⦿ African-American and Hispanic children more likely to lack a usual source of care than white children

Workforce Diversity Offers Primary Care Access

- African-American physicians care for more patients covered by Medicaid,
- Latino physicians care for higher proportions of uninsured patients than non-Latino white physicians.
- Latino and African-American physicians were much more likely to choose primary care specialties as compared with non-minority physicians,
- Primary care physicians were the most likely to serve in physician shortage areas.

Workforce Diversity Linked to Improving Health Disparities

These practitioners

- Are more likely to provide services for underserved poor and minority populations.
- Practice in Health Professional Shortage Areas
- Care for patients on Medicaid or uninsured
- Provide more primary care services
- Provide more routine prevention services
- Engender better patient satisfaction

Workforce Diversity Strategies

The Stats

- The U.S. population is increasingly Diverse-
underrepresented groups make up approximately
30% of the population
- Physicians from underrepresented groups make
up about 7% of the current workforce, Nurses 3%,
Pharmacy 3%
- **Health care workforce has not kept up with the
changing demographics**

Workforce Shortage

- Rural communities have a chronic shortage of physicians and federally supported community health centers report major deficits in physician recruitment .
- Workforce Need - Projections / Shortages:
 - By 2020: 89,000 physicians
 - By 2025: 1 million nurses

**Where Will They All
Come From??**

Strengthen Diversity in the Health workforce

- Increase the workforce pipeline
- Actively recruit culturally diverse clinicians
- Offer incentives to work in underserved communities
 - tuition reimbursement, and loan forgiveness programs that require service in Health Professional Shortage Areas (HPSAs).
- Expand use of Community Health Workers (CHWs) as a means of diversification.

When Concordance Isn't Possible

- Integrate cross-cultural education into the training of all current and future health care professionals *(IOM- Unequal Treatment)*
- Train clinic providers to conduct culturally appropriate outreach and services.
- Standardize screenings in primary care settings to ensure cultural and linguistic appropriateness.

Sullivan Commission 9/20/04

- Funded by Kellogg Foundation & Duke
- 36 Recommendations are based on 3 principles:
 - To increase the diversity in the health profession the culture of professional schools must change
 - New and non-traditional paths to the health professions should be explored
 - Commitments must be at the highest levels of our government and in the private sector

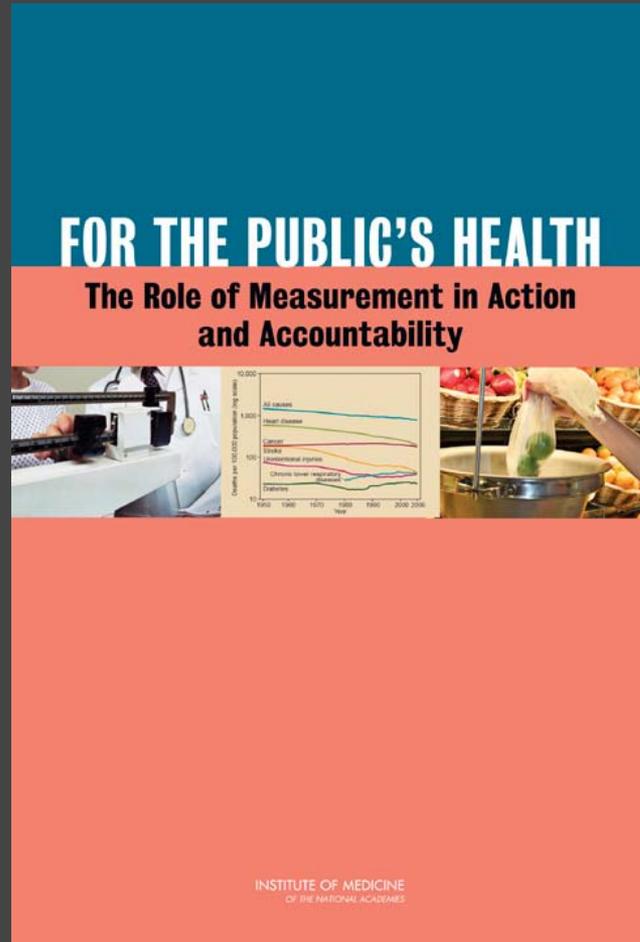
www.sullivancommission.org

Opportunities for Improvement

- “No data, no problem.”
- This is our challenge and opportunity. We need to be very disciplined and proactive about collecting data within the various racial ethnic communities and documenting the challenges, opportunities AND what is working.
- Including details for our federal program initiatives such as impact and progress by demographic populations of interest.

- ◎ Need to effectively collect race/ethnicity data related to programs and initiatives
 - Race/ethnicity, subgroup, language, SES (via education), insurance status
 - Linked to outcomes and health status
- ◎ Measure/monitor/track

Be Part of the Dialogue on Data



HRSA Supports Healthcare Workforce

HRSA Workforce Programs

- ⦿ Bureau of Health Professions
 - Workforce Training Titles VII and VIII
- ⦿ Bureau of Clinician Recruitment and Service
 - National Health Service Corps
 - Nursing Loan Repayment
 - Ready Responder

More HRSA Workforce Programs

- Area Health Education Centers - activities to educate and recruit high school students; innovative activities; reduces match requirement.
- Geriatrics - career incentives and traineeships for advanced education nurses.
- Diversity programs - workforce diversity efforts - Centers of Excellence and Scholarships for Disadvantaged Students programs.
- Preventive medicine residency program
- Nursing - training advance practice nurses and family nurse practitioners; enrollment of disadvantaged students; retention, stipends, loans.

NHSC Recruitment and Retention

- ◎ SEARCH- Student/Resident Experiences and Rotation in Community Health
 - State-based program-
 - students and residents to serve clinical rotation on multidisciplinary health care teams in underserved communities
- ◎ Goals:
 - Assist recruitment and retention efforts of health care professionals for primary care service.
 - Facilitate and strengthen partnerships between communities and academic institutions.

BHPR Programs

Diversity and Interdisciplinary Training

- **Scholarships for Disadvantaged Students (SDS)**

- **Centers of Excellence:**

Strengthen the national capacity to produce a culturally competent healthcare workforce whose diversity is representative of the U.S. population.

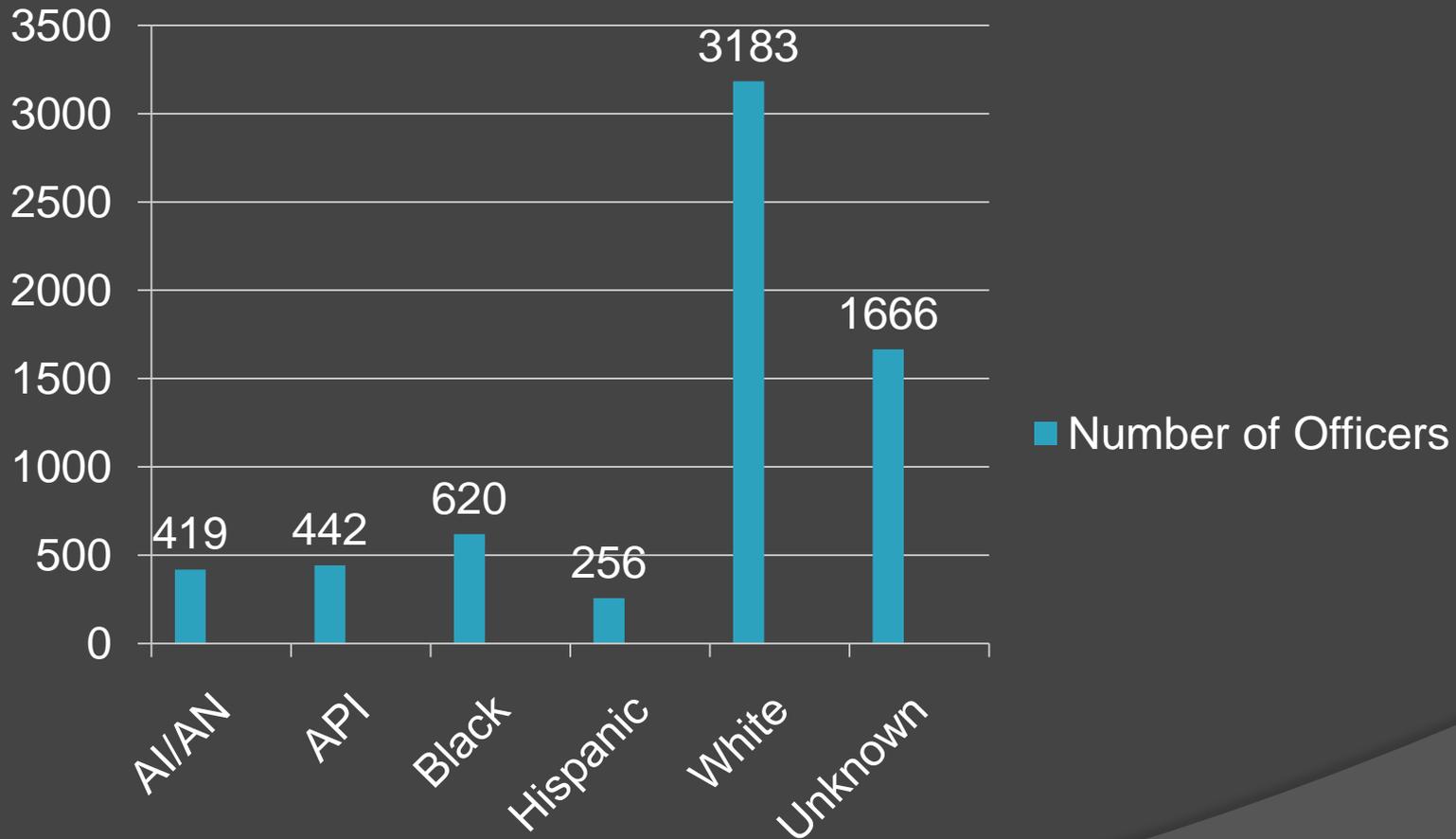
- **Area Health Education Centers:**

Improve the recruitment, distribution, supply, quality and diversity of personnel who provide health services in underserved rural and urban areas to populations with demonstrated serious unmet health care needs;

<http://bhpr.hrsa.gov/ahec/centers.htm>

What We Can Do

PHS Officer Demographics



Provider Characteristics Do Affect Adherence-

- ⦿ Communication- comprehension
- ⦿ Time Constraints- limits to relationship
- ⦿ Cultural understanding, knowledge
- ⦿ Biases, stereotyping
- ⦿ Concordant Race, sex ethnicity, religion

- ⦿ Be Trained and Train Others

Cultural Competency

- Cultural competency is a process of delivering health care within the context of a patient's beliefs, values, and customs.
- Race, Ethnicity, Culture are distinct variables

Be in Touch With Communities

- ⦿ Physician supply is inversely related to the concentration of African Americans and Hispanics in health service areas, even after adjusting for community income levels.
- ⦿ African-American and Hispanic physicians are more likely to provide services in minority and underserved communities, and are more likely to treat poor (e.g., Medicaid-eligible) and sicker patients.
- ⦿ On average, minority physicians treat four to five times the numbers of minority patients than white physicians do.
- ⦿ These practice patterns appear to be by choice (*Kington, Tisnado, and Carlisle*)

Community Based Training and Partnerships

- Consider ways to work with Tribal Colleges, Hispanic Serving Institutions and Historically Black Colleges and Universities

“Graduates of medical schools at historically black universities such as Howard and Morehouse are the most likely to practice the kind of medicine especially needed under the health care overhaul”

Washington Post Tuesday, June 15, 2010

What Else for PHS Officers?

As representatives of the health professions workforce-

- remain knowledgeable about the workforce initiatives-
- share broadly with community stakeholders
- Volunteer for workgroups and assignments where workforce strategies are developed-

The Ultimate Goal..

- **“In the end the ultimate goal is a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or English proficiency.”**

Betancourt, J. 2002. Cultural competence in Health Care: Emerging Frameworks and Practical Approaches. Field report.

Quote on health care inequality...

Of all the forms of inequality,
injustice in health care is
the most shocking and
inhumane

Rev. Dr. Martin Luther King, Jr.

Summary

The IOM – **Unequal Treatment** Recommendations (2002)

- Increase awareness of racial and ethnic disparities in health care
- Integrate cross-cultural education into the training of all current and future health care professionals
- Increase the proportion of underrepresented U.S. racial and ethnic minorities among health care professionals.
- Promote consistency and equity of care through the use of evidenced based guidelines.
- Support race/ethnicity data collection, quality improvement & conduct further research to identify sources of disparities and promising intervention strategies.

THANK YOU!

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HRSA Workforce Programs ARRA and the ACA

Community-Based Collaborative Care Networks

- ⦿ Authorizes but does not yet appropriate funds for grants to develop networks of providers to deliver coordinated care to low-income populations through community-based collaborative care networks.
- ⦿ Grants may be used to help low-income individuals access health services, provide case management, perform health outreach, provide transportation, expand capacity, and provide direct patient care services.

National Health Service Corps

The Affordable Care Act Builds on:

Significant Program Expansion

- \$300 million in expansion funds for the NHSC from the Recovery Act
- More than 6,700 clinicians presently serving
- 7,358 Primary Care Providers estimated in 2010 vs. 4,760 in 2009
- Over 8,600 NHSC-Approved sites; 46% Community Health Centers

Recent Program Improvements

- Simplifying the NHSC site application and approval process.
- Examining NHSC disciplines to ensure the primary care workforce needs are supported.
- Assessing NHSC program implementation with the goal of driving more people into primary health care careers to meet public needs.

National Health Service Corps and the Affordable Care Act

- Reauthorization of NHSC Program through 2015
- Increases Maximum Loan Repayment Award from \$35,000 to \$50,000
- Allows for Half-Time Opportunities; 2 & 4 Year
 - FY2011: \$290 million
 - FY2012: \$295 million
 - FY2013: \$300 million

Contracts

- Expanded to Include Loan Repayment & Scholarship Programs
- NHSC Funding in the Community Health Center & NHSC Fund
 - FY2014: \$305 million
 - FY2015: \$310 million

National Health Service Corps and the Affordable Care Act (cont.)

- Teaching as Clinical Practice - Up to 20% Credit for Service Obligation.
- Teaching Health Center Graduate Medical Program - Up to 50% Credit for Service Obligation.
- Provides for Reappointment of National Advisory Council
- Extends Tax-Free benefit to recipients of State Loan Repayment Program awards.
- Allows Indian Health Facilities that serve only Tribal members to qualify as an NHSC site.

National Health Service Corps and the Affordable Care Act (cont.)

- Investment in NHSC has more than doubled since FY2008
- By FY2011, funding will increase by over 400%
- Substantially increases access to care and grows primary care workforce



Health Professions Education and Training

- Primary Care Training: Title VII, Sec 747
 - Develop and operate family, general internal, pediatric medicine, and physician assistant programs; research; need-based fellowships/traineeships; new interdisciplinary joint degree program and community-based training for faculty.
- Oral Health Training: Title VII, Sec 748
 - Program development, financial assistance; new faculty loan repayment program; expands programs to public health dentistry and dental hygienists.
- New rural physician training grant program
 - Published an Interim Final Rule defining “underserved rural community” for this program. The comment period is open through July 26.

Support and Incentives for Student and Providers

- Area Health Education Centers - program name change; activities to educate and recruit high school students; innovative activities; reduces match requirement.
- Geriatrics - expanded career incentives and discipline eligibility for current programs, traineeships for advanced education nurses.
- Diversity programs - expands workforce diversity efforts by increasing authorized appropriations for Centers of Excellence and Scholarships for Disadvantaged Students programs.
- Preventive medicine residency program expanded eligibility.
- Nursing - training advance practice nurses and family nurse practitioners; enrollment of disadvantaged students; retention, stipends, loans.

Loan Repayment Programs in the Affordable Care Act

- Nurse Faculty are now eligible for Nursing Education Loan Repayment Program
 - Studies show that the capacity to produce nurses is limited by training opportunities and the related shortage of nursing faculty.
- Authorizes Pediatric Specialty Loan Program
 - Addresses shortages in specialist trained to treat children, such as pediatric rheumatologists
 - Requires 2-year Service Obligation
 - Requires new Pediatric Subspecialty Shortage Area Designation

Delivery System Provisions

- Nurse Managed Health Centers
 - Establishes funding for community-based clinical sites administered by advance practices nurses and increases primary care sites.
- Patient Navigator and Chronic Diseases Outreach Grant
 - Program requirement for minimum core proficiency standards
 - Includes \$5 million in FY2010 to fund community workers trained to assist patients and families in managing chronic conditions such as diabetes and cancer.
- Teaching Health Center Grants
 - Expands community-based training for primary care physicians.
 - FY2011 – 2016 \$230 million

Workforce Planning, and Assessment

- National Health Care Workforce Commission
 - An independent entity to develop a national strategic plan for the health care workforce.
- National Center for Health Care Workforce and Analysis
 - A national center to provide analysis, modeling, and data collection to project current and future workforce demands to inform policy making.
- Grants to States for Workforce Planning and Implementation
 - Funding to assist States in developing and implementing innovative plans to meet current and projected workforce needs.

Shortage Designation

- Instructs HRSA to redesign the Medically Underserved Areas (MUA) and Health Professional Shortage Areas (HPSA) designation process through negotiated rulemaking.
- HRSA Published a Federal Register Notice on 5/11 seeking public input on whether HRSA has:
 - Properly identified the key issues in this designation rulemaking effort;
 - Adequately identified key sources of subject matter technical expertise relevant to defining underservice and shortage and designating underserved areas and populations; and
 - Identified appropriate representatives of the various stakeholders/interests that will be affected by the final designation rules.
- Comments are due by 5pm on June 10.

Improved Data Banks: Increasing Transparency and Accountability

- Merges and eliminates the duplication between the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB) to expand access to data.
- These data banks serve as important flagging systems intended to facilitate a more comprehensive review of health care practitioners, providers, and suppliers who have been disciplined or named in a medical malpractice settlement.

New Workforce Programs Authorized

- Mid-career scholarships
- Public health loan repayment
- Cultural competency, prevention and public health and individuals with disabilities training
- Expanded public health training fellowships
- Geriatric workforce development fellowships
- New program for individuals to apply for and receive loan repayments if serving as nurse faculty
- Develop and implement programs to provide education and training in pain management
- Family and direct caregiver training
- Alternative dental health care providers demonstration project
- Mental and behavioral health education and training