

**A RECOMMENDATION REPORT FROM
THE HHS ADVISORY COMMITTEE ON MINORITY HEALTH (ACMH)**

Reflecting America's Population
Diversifying a Competent Health Care Workforce for the 21st Century

**A Statement of Principles and
Recommendations**

September 2011

Submitted to

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Office of Minority Health**



In memory of

Rubens J. Pamies, MD, FACP

Chair, U.S. Department of Health and Human Services

**Advisory Committee on Minority Health
2009 – 2011**

“Diversity and excellence are not mutually exclusive. They go hand-in-hand. We need to address this like we do all issues – with passion, determination, and persistence – with our ultimate goal to be world class.”

- Dr. Rubens J. Pamies

Advisory Committee on Minority Health:
Section 1707 of the Public Health Service Act, as amended, by the Minority Health and Health Disparities Research and Education Act of 2000 (P. L. 106-525) authorizes the establishment of an Advisory Committee on Minority Health. The Committee also is governed by provisions of Public Law 92-463, as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory committees. The Act directs the Advisory Committee on Minority Health to advise the Department of Health and Human Services, through the Deputy Assistant Secretary for Minority Health, on improving the health of racial and ethnic minorities and on the development of the program activities of the Office of Minority Health.

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Executive Summary

At least 90% of the U.S. population growth between 2010 and 2050 is expected to come from minority groups, making the issue of workforce diversity critical. People of color are already a majority in 48 of the largest cities in the U.S., and five states have “minority majorities.” Furthermore, immigration to the U.S. has tripled in the last 30 years, representing the largest continuous wave of immigration in U.S. history and a dramatic increase in globally mobile populations. Given the increased diversity of the U.S. population, migration, and globalization, health providers must be equipped to provide care in a cross-cultural context. Hence, increased diversity in the health care workforce is a critical part of a comprehensive strategy to reduce health disparities. Workforce diversity includes adequate representation; cultural understanding; and linguistic competency of professionals and health professional students to ensure that consumers receive care that is appropriate, responsive, effective, and acceptable. Diversity in the health care workforce helps increase access to care, leads to an acceleration of advances in medical, behavioral, and public health research, shapes education for all students interested in a career in health care, and advances cultural competency and humility. Other benefits of diversification include: an increase in racial/ethnic minority health care providers who are more likely to serve underserved communities; greater levels of satisfaction with their care among racial/ethnic minority patients; reductions in cultural and linguistic barriers to quality care; and better educational outcomes among all students. Beyond benefiting underserved populations, workforce diversity enriches intellectual and cultural perspectives and contributes to advances that improve the quality of care for all people.

Despite current efforts, several significant gaps remain to successfully diversify the health care workforce. First, as a result of a poorly diversified workforce, racial and ethnic disparities persist in patient outcomes and quality care. Cross-cultural differences between immigrant/refugee patients and providers trained in Western medicine, as well as insufficient language access for limited English proficiency (LEP) patients and their families, may contribute to these disparate outcomes. Secondly, resource challenges exist for a number of health care facilities that serve primarily minority communities. Thirdly, gaps are evident in the education pipeline to the health care workforce, such as inequalities in primary and secondary educational opportunity and the quality of education for racial/ethnic minority students. Until these gaps are addressed, the health care workforce will remain insufficiently diversified.

The Advisory Committee on Minority Health (ACMH) deliberates and carries out its charge through the following guiding core values:

- **Health for the Common Good:** Pursuing the status of a healthy nation includes access to improved health status and quality health care for all U.S. communities;
- **Cultural Humility:** Redressing power imbalances that exist between minority communities and health providers, health systems, and government;
- **A Patient-Centered Approach to Improving Population Health and Achieving Health Equity:** Advancing and implementing the concept of patient-centeredness that considers individuals’ needs as they impact improving health status, providing quality health care and achieving health equity;
- **Accountability for the Health and Health Care of Minority Communities:** Promoting compliance with existing laws, regulations, and financing systems affecting health and health care of minority communities with an emphasis on societal responsibility for

advancing health and quality health care for these communities and the specific responsibilities of the Department of Health and Human Services (DHHS) in this regard;

- **Respect for the Diversity of U.S. Communities:** Understanding and placing value on diversity of our populations in the health care system, including among other factors race, ethnicity, culture, language, sexual orientation, and age;
- **Effective Engagement of Diverse Communities:** Viewing communities not just as recipients or consumers of health care, but rather as equal partners in improving health status and providing quality care for all; and
- **A Diverse and Competent Health Care Workforce:** Developing a workforce to improve the health status and provide quality care for all communities and to address health disparities.

In stating this last core value, ACMH asserts its position regarding the necessity of developing a diverse national health workforce. In this report, ACMH focuses on diversifying and strengthening the health care workforce as a central component of addressing racial and ethnic health disparities, with the ultimate goal of effectively meeting the health needs of all individuals in our nation and U.S. territories. This report outlines the problems and issues that impede the diversity and competency of the health care workforce and provides recommendations for actions that will move the health care workforce towards better serving the country's diverse communities and tribal nations.

The Business Case for Diversifying the Workforce

The gaps in research, data, and practice provide a compelling argument for the need for enhanced efforts to diversify the workforce in health care. Health care and services that are not sufficiently responsive to the backgrounds and needs of our increasingly diverse population have negative implications for safety and the quality of health education and health care people receive. A workforce that is, at minimum, reflective of the racial and ethnic makeup of the U.S. population can have a number of important benefits:

- Improved access to high-quality care for the medically underserved;
- Expanded pool of medically trained executives, policymakers ready to assume leadership positions in the health care system of the future;
- Greater patient choice and satisfaction;
- Better patient-practitioner relationships, increased trust, and communication;
- Increased likelihood of patients receiving and accepting appropriate medical care; and, ultimately,
- Improved health.

Four Principles of Workforce Development

ACMH asserts that every health care reform strategy must be assessed regarding its implications and impact for ameliorating health disparities and improving the health of minority communities. Four of the 14 principles that the ACMH proposes to meet health care needs specifically speak to a diverse health care workforce. These principles build upon the current

efforts in health care workforce development and training as well as address the gaps in research and use of best practices to move our nation forward in achieving health equity and reducing health disparities:

- 1) The development of a health care workforce that is representative and reflective of the communities served is vital for health care reform to achieve its potential to serve a diverse and growing minority population and to create an affordable and sustainable health care system that produces positive health outcomes.**

The national shortage of health care professionals is a major challenge to achieving the desired goals, results, and outcomes of health reform and care. As culture and language impact people's perceptions of health and health care, their decisions to seek treatment, and their level of trust and understanding, it is vital to seek and implement strategies that train, recruit, and retain health providers to understand and appreciate the cultures, languages, backgrounds, and histories of all residents in the U.S.

- 2) Health care professional schools must be affordable and must reflect the diverse communities they serve. Their curricula must promote a trans- and multi-disciplinary, team-oriented, and community-responsive approach to teaching, training, mentoring, and matriculating to ensure the availability of health care providers necessary to implement comprehensive health care reform.**

Workforce issues will not improve until disparities in the educational pipeline from pre-kindergarten through college, graduate education, and post-doctoral education are addressed. It is important to provide opportunities for minority students to pursue careers in health care, especially given the under-representation of minorities among the health workforce. Strategies such as community-based programs, pipeline initiatives, and public-private partnerships that address financial, geographic, cultural, and institutional barriers and create opportunities for all children to succeed are needed to strengthen educational opportunities and the future workforce.

- 3) The development of diverse executive leadership and governance bodies of the health care system as well as diversity of faculty and leadership in K-16 and health care professional schools are essential for implementing effective health care reform that meets the needs of a diverse minority population and works toward eliminating health disparities/inequities.**

Although diverse leadership is critical to the success and effectiveness of organizations, people from minority groups are grossly under-represented in executive leadership positions in the health care service and education systems. Efforts such as diversity seminars, leadership development programs, and the incorporation of diversity into criteria for faculty evaluations have been enacted to increase minority leadership in all health care disciplines, but much more work is needed to reshape, enhance, and improve the infrastructure of institutions and develop pathways for leadership.

- 4) Accrediting and licensing agencies should include strong and robust requirements, benchmarks, and oversight processes for ensuring the provision of patient-centered, culturally and linguistically sensitive/competent training and care in all health care settings. This includes, at a minimum, meeting the National Standards on Culturally and Linguistically Appropriate Services (CLAS). These benchmarks must ensure a diverse health workforce including diverse executive leadership and governance.**

There is an urgent need to ensure that health professional schools are equipped to provide culturally and linguistically competent training that will enable graduates to provide quality care to all. Therefore, standardized mechanisms to assess the adequate inclusion of cultural competency, health equity, and diversity requirements for accreditation, credentialing, and licensing are needed.

Conclusions and Recommendations

The ACMH recognizes the importance and impact of diversifying the health care workforce, current diversification efforts, and the vital need to continue to bolster efforts to increase workforce diversity to ensure health equity. The charge of the ACMH is to provide recommendations to improve the health of racial and ethnic minority populations. Among ACMH's values are health for the common good and a diverse and competent health care workforce. The ACMH makes four overarching actionable and measurable recommendations to increase the diversity of the health care workforce. Some of the recommendations are within HHS' purview and others are beyond the scope of HHS and therefore require collaborative public-private efforts to facilitate change:

Recommendation 1: Expand multifaceted partnerships and funding sources to make the health care workforce more representative and reflective of diverse communities. The ACMH recognizes the resource challenges involved in diversifying the health care workforce; however, the benefits of such efforts in health reform outweigh the costs. The ACMH encourages the use of strategies to further workforce development that are consistent with the best practices around education and curriculum, inventory/repository for pipeline, and opportunities for community-based training.

Recommendation 2: Strengthen the quality of the K-16 educational system and access to professional schools. Ensuring that educational programs are accessible and reflective of the diversity of the nation will enhance the pipeline for health professions and serve as an avenue to improve the health of communities. Pipeline development from primary school to professional school is critical to expand the pool of applicants for health careers. Hence, ACMH encourages a stronger state and federal role in national strategies to improve educational systems.

Recommendation 3: Increase the diversity of leadership in the health care service and education systems and build the capacity of institutions to support the ongoing development and advancement of leaders. Health care leadership and management, health care providers, and key committees that are reflective of the communities served are necessary to effectively address health care reform. ACMH encourages the use of strategies to recruit, train, and retain diverse leaders.

Recommendation 4: Reexamine and modify accreditation and licensure procedures to ensure cultural competency, diversity, adequate training opportunities, and quality of health care providers. Credentialing (e.g., certification, licensure, continuing education) assures training program directors, the health care field, and the public that health professionals have met the minimum standards to provide health services. ACMH encourages the use of strategies that help standardize accreditation and licensure processes and provide supports to ensure that domestically- and internationally-trained health professionals are adequately prepared for examinations and the provision of quality care.

Workforce Development Report

Introduction

Charge of the ACMH

The charge of the Advisory Committee on Minority Health (ACMH) is to advise the Secretary of the Department of Health and Human Services (DHHS) on ways to improve the health of racial and ethnic minority populations and on the development of goals and program activities within the Department. The Committee plays a critical role in ensuring that health care reform, as embodied in H.R. 3950, *The Patient Protection and Affordable Care Act (ACA) of 2010* (P. L.111-148)¹ is implemented equitably and that health disparities are incorporated into the reform bill. This process should be monitored to guarantee that the provisions of the bill adequately respond to the needs of vulnerable populations and propel the nation toward health equity.

The ACMH deliberates and carries out its charge through integrated guiding core values. In formulating these core values, the Committee adopts and promotes a perspective for health care professionals and advocates entering into an area where the professionals are no longer experts. ACMH believes that it is necessary to risk being the “student” and relinquish control to share ideas and strategies for building accountability with the minority communities and tribal Nations it represents. Accordingly, these core values are:

- **Health for the Common Good:** Pursuing the status of a healthy nation includes access to improved health status and quality health care for all U.S. communities;
- **Cultural Humility:** Redressing power imbalances that exist between minority communities and health providers, health systems, and government;
- **A Patient-Centered Approach to Improving Population Health and Achieving Health Equity:** Advancing and implementing the concept of patient-centeredness that considers individuals’ needs as they impact improving health status, providing quality health care and achieving health equity;
- **Accountability for the Health and Health Care of Minority Communities:** Promoting compliance with existing laws, regulations, and financing systems affecting health and health care of minority communities with an emphasis on societal responsibility for advancing health and quality health care for these communities and on the specific responsibilities of DHHS in this regard;
- **Respect for the Diversity of U.S. Communities:** Understanding and placing value on diversity of our populations in the health care system, including among other factors race, ethnicity, culture, language, sexual orientation, and age;
- **Effective Engagement of Diverse Communities:** Viewing communities not just as recipients or consumers of health care, but rather as equal partners in improving health status and providing quality care for all; and
- **A Diverse and Competent Health Care Workforce:** Developing a workforce to improve the health status and provide quality care for all communities and for addressing health disparities.

In stating this last core value, ACMH asserts its position regarding the necessity of developing a diverse national health workforce that includes human resources strategies for recruiting,

orienting, and training health workers and leaders to provide culturally and linguistically appropriate care and services. This approach has particular importance in building and maintaining a robust public health system with effective prevention programs to protect the public's health. A genuinely diverse workforce includes strategies that move an organization's care programs beyond cultural sensitivity (i.e., "I *mean* well") toward cultural competency and humility (i.e., "I am *doing* well for the patient's and the public's health") and the elimination of health disparities. Critical to creating and sustaining this diverse health workforce are executive leadership teams and governance bodies that are representative of, and are responsive to, our diverse communities. The goals of achieving improved health status and equitable health care for diverse communities need to be part of health systems' organizational environments, reflected in policies and practices, supported with effective operational and administrative infrastructures, and key elements in determining organizational effectiveness.

With the responsibilities of ACMH in mind, the Committee's first 2009 report, *Ensuring that Health Care Reform Will Meet the Health Care Needs of Minority Communities and Eliminate Health Disparities: A Statement of Principles and Recommendations*, proposed 14 Principles for Minority Health Equity in Health Care Reform to ensure that health policy reform will meet the health care needs of minority communities to eliminate health disparities.² Recognizing the U.S.'s history of health inequities and the need for systematic vigilance and corrective action, ACMH proposed the development and establishment of a Federal Health Equity Commission, which would provide oversight and monitoring of health care reform implementation in a manner designed to eliminate health inequities for minority and vulnerable populations. ACMH's second 2009 report, *A Federal Health Equity Commission will Promote the Public's Health and Ensure Health Equity in Health Care Reform: A Statement of Principles and Recommendations*, describes the ACMH's proposal for this Commission.³ In its third 2010 – 2011 report, *Assuring Health Equity for Minority Persons with Disabilities: A Statement of Principles and Recommendations*, ACMH focused on an especially underserved and vulnerable population: minorities with disabilities.⁴ ACMH believes that the circumstances and needs of this population should be specifically addressed to ensure that the benefits of health care reform are available to all people.

In this **Fourth 2011 report**, ACMH focuses on developing the health care workforce. Given the values of ACMH, the importance of addressing disparities and equity as part of health reform, and the demographic trends in the U.S., it is vital to diversify and strengthen the health care workforce to effectively meet the needs of *all* persons in our nation. To increase diversity in health professions, the culture of educational and service institutions must change, new and non-traditional paths to health professions must be explored, and commitments must be at the highest levels of our government and private sectors.⁵ Such health care reform will provide for the development, dissemination, and evaluation of best practices related to cultural competency, training, prevention, and public health.⁶

The ACMH recognizes that the health care workforce is a component of a larger health workforce that includes public health, behavioral health, oral health, specialty care, and allied health. Assuring diversity in the health workforce as a whole is critical, and diversifying the health workforce overall would further efforts to eliminate inequities. By focusing on the health care workforce, we aim to identify recommendations that may be applied or can be refined and tailored to the other segments of the health workforce. Similarly, we acknowledge that diversity goes beyond race and ethnicity. Complementary efforts to assure diversity that accounts for age, gender, sexual orientation, and abilities are needed. The recommendations put forth in this

report should be viewed as a platform to continue building upon to assure that the nation has a health workforce that meets the needs of all.

Context for the Report

At least 90% of the U.S. population growth between 2010 and 2050 is expected to come from minority groups,⁷ making the issue of workforce diversity critical. People of color are already a majority in 48 of the largest cities in the U.S., and five states have “minority majorities.” Furthermore, immigration to the U.S. has tripled in the last 30 years, representing the largest continuous wave of immigration in U.S. history, and the number of people crossing international boundaries is expected to increase from 1 billion to 1.5 billion people per year by 2020, indicating a dramatic increase in globally mobile populations.⁸ Given the increased diversity of the U.S. population, migration, and globalization, health providers must be equipped to provide care in a cross-cultural context. Hence, increased diversity in the health care workforce is a critical part of a comprehensive strategy to reduce health disparities. This diversity includes adequate representation; cultural understanding; cultural and linguistic competency of executive leadership, faculty, providers, and health professional students to ensure that consumers receive care that is appropriate, responsive, effective, and acceptable.⁹ The benefits of increased racial and ethnic diversity in the health care workforce are many:¹⁰

1. Racial and ethnic minority health care providers are more likely to serve minority and medically underserved communities, thereby increasing access to care;
2. Racial and ethnic minority patients report greater levels of satisfaction with care provided by minority health care professionals;
3. Racial and ethnic minority health care providers can help health care systems’ efforts to reduce cultural and linguistic barriers and improve cultural competence; and
4. Diversity in higher education/health care profession training settings is associated with better educational outcomes for all.¹¹

Addressing the health care workforce is a major component of the ACA (Title V – Health Care Workforce). The ACA specifically calls out the need to assure to access to and delivery of health care services for all individuals including minority and health disparity populations and has multiple sections within the law that are aimed at increasing the diversity of the healthcare workforce. Provisions that specifically pertain to (but are not limited to) assuring a diverse and culturally competent workforce include:

- Section 5101 that creates a National Health Care Workforce Commission, which will submit an annual report that includes a review of and recommendations to address the health care workforce needs of special populations including minorities.
- Section 5307 that makes explicit the development, dissemination, and evaluation of model curricula on cultural competency, prevention, public health, and training on working with individuals with disabilities.
- Section 5404 that expands the Workforce Diversity Grants to include stipends for diploma or associate degree nurses to enter a bridge or degree completion program.
- Section 2104 that extends funding for programs at minority-serving institutions (MSIs) such as Historically Black Colleges and Universities (HBCUs), Hispanic Serving

Institutions (HSIs), and Tribal Colleges and Universities (TCUs), including programs that help low-income students attain degrees in the fields of science, technology, engineering and mathematics.¹²

The following report explores the key issues around workforce development, which stem from the core principles of the ACMH, particularly a diverse and competent health care workforce that will promote the health for the common good. The workforce issues raised in the report serve to reinforce the need to address the diversity of the workforce through the ACA and beyond. The report concludes with ACMH's recommendations for actions that will move the health care workforce forward to better serve the country's diverse population and help reduce the disparities in health and health care that many communities face.

Presenting Problems and Concerns Related to Workforce Development

Current Status and Literature

A number of organizations have articulated the importance of diversity in the workforce and embarked upon efforts to increase diversity. The Association of American Medical Colleges (AAMC) asserts that diversity (i.e., race/ethnicity; gender; ability; rural, urban, or suburban geographic location; nationality; religion; culture; age) in the health care workforce 1) helps increase access to health care; 2) leads to an acceleration of advances in medical and public health research; and 3) makes good business sense.¹³ Diversity also shapes education for all students interested in a career in health care as well as advances cultural competency. The ACA includes specific provisions for strengthening healthcare workforce such as expanding Health Resources and Services Administration (HRSA) activities to build the primary care workforce. HRSA's Bureau of Health Professions (BHP) is working to implement health reform legislation and expand existing programs as appropriations are available. The workforce provisions focus on providing financial resources to ensure the education of individuals from disadvantaged backgrounds; awarding grants to institutions of higher learning such as HBCUs, HSIs, and TCUs; and strengthening the national capacity to produce a culturally competent and demographically representative health care workforce.¹⁴

To successfully diversify the medical and behavioral health workforce, several major gaps will have to be addressed. First, racial and ethnic disparities in patient outcomes and quality care, cross-cultural value differences between immigrant/refugee patients and providers trained in Western medicine, and insufficient language access for limited English proficiency (LEP) patients and their families persist. Second, resource challenges (e.g., human, financial) exist for various health settings that serve primarily minority communities. There is a severe lack of racial diversity among health professionals and health care managers/executives in the U.S. The representation of racial and ethnic minorities among health professionals has grown only modestly over the past 25 years, despite rapid increases in the size of these populations. Only three of the 130 medical schools in the U.S. are at HBCUs, which has graduates that disproportionately care for the un- and under-insured and underserved.¹⁵ Additionally, health-related facilities often either avoid or do not have the capacity to collect the data on minorities needed to inform care planning. Third, gaps are evident in education and the pipeline to the health care workforce. Inequalities in primary and secondary educational opportunity and quality for racial/ethnic minority students continue, and a higher proportion of White students enter higher education than do students from other racial/ethnic backgrounds. Public referenda, judicial decisions, and lawsuits have led some higher education institutions to abandon the use of race and ethnicity as factors in admissions decisions and financial aid. There also is an

increased financial burden for medical professionals' education in the face of decreasing financial aid. Such realities will cause the workforce to remain insufficiently diversified.

The Business Case for Diversifying the Workforce

The aforementioned challenges provide a compelling argument for the need for enhanced efforts to diversify the workforce in health care. Health care and services that are not sufficiently responsive to the backgrounds and needs of our increasingly diverse population have negative implications for quality; safety; and understanding of health conditions, diagnoses, treatment, and medication. A workforce that is reflective of the U.S. population in general and historically underserved communities in particular can have a number of important benefits:^{16,17,18}

- Improved access to high-quality care for the medically underserved;
- Expanded pool of medically trained executives and policymakers ready to assume leadership positions in the health care system of the future;
- Greater patient choice and satisfaction;
- Better patient-practitioner relationships and communication;
- Increased likelihood of patients receiving and accepting appropriate medical care; and, ultimately,
- Improved health.

Diversifying the workforce not only improves the quality of care for racial/ethnic minorities and other underserved populations but the quality of care for *all* people.¹⁹ As the primary gap in current medical and behavioral health services revolves around insufficient access to quality care, promising practices and assessment tools,²⁰ such as those from the Georgetown University National Center for Cultural Competence,^{21,22,23} can be used to identify and track measures of success for developing a workforce that meets the needs of the historically underserved as well as the entire nation.

Four Principles of Workforce Development

ACMH asserts that every health care reform strategy must be assessed regarding its implications and impact for ameliorating health disparities and improving the health of minority communities.²⁴ Four of the 14 principles that the ACMH proposes to meet health care needs specifically speak to a diverse health care workforce:

- 1) The development of a health care workforce that is representative and reflective of the communities served is vital for health care reform to achieve its potential to serve a diverse and growing minority population and to create an affordable and sustainable health care system that produces positive health outcomes.
- 2) Health care professional schools must be affordable and must reflect the diverse communities they serve. Their curricula must promote a trans- and multi-disciplinary, team-oriented, and community-responsive approach to teaching, training, mentoring, and matriculating to ensure the availability of health care providers necessary to implement comprehensive health care reform.
- 3) The development of diverse executive leadership and governance bodies of the health care system as well as diversity of faculty and leadership in K-16 and health care

professional schools are essential for implementing effective health care reform that meets the needs of a diverse minority population and works toward eliminating health disparities/inequities.

- 4) Accrediting and licensing agencies should include strong and robust requirements, benchmarks, and oversight processes for ensuring the provision of patient-centered, culturally and linguistically sensitive/competent training and care in all health care settings. This includes, at a minimum, meeting the National Standards on Culturally and Linguistically Appropriate Services (CLAS).²⁵ These benchmarks must ensure a diverse health workforce with diverse executive leadership and governance.

These four principles build upon the current efforts in the health care workforce and help address the gaps in research and practice to move the work forward to help reduce disparities and increase health equity.

Key Issues Related to the Workforce Diversity Principles

A Representative and Reflective Health Care Workforce

According to Dr. Julian Tudor Hart's inverse care law, "the availability of good medical care tends to vary inversely with the need for it in the population served."²⁶ Unfortunately, this law remains true in every major city in the U.S. Many people of color live in medically underserved areas and do not have access to primary care physicians. The disparities in the composition of providers also is evident, as racial/ethnic minorities account for only 6% of the pharmacists, 2% of dentists and Registered Nurses (RNs), and 8% of all Ph.D. degree students. Similar gaps are evident in the proportion of minorities in the U.S. population and within the student body of U.S. medical schools.²⁷

The national shortage of health care professionals is a major challenge to achieving the desired goals and outcomes of health reform and care.²⁸ Groups (e.g., AAMC) are examining new data to better understand the extent of the shortage, and research and key publications provide strong arguments for diversifying the health workforce. Knowledge of and the ability to relate to different cultural beliefs and practices are necessary to understand the impacts of culture on people's perceptions of health and health care (e.g., how they describe illnesses, cope with illnesses and stress, whether they are willing to seek treatment, and their level of trust and understanding).²⁹ Language also plays a crucial role in health care. An inability to communicate creates barriers to access, undermines trust and appropriate follow up, and results in medical errors. Diversity in the physician workforce can counteract these barriers by increasing access to underserved populations, culturally responsive care, patient satisfaction and trust; and broadening the research agenda with respect to racial and ethnic disparities.³⁰ Therefore, it is necessary to develop and implement strategies to train, recruit, and retain health providers that understand the cultures, languages, backgrounds, and histories of all residents in the U.S.

Globalization, or the international movement of technology, ideas, products, labor markets, and professional education and standards,³¹ has implications for the international pipeline in health care; recommendations related to equity must take globalization into account. The U.S. relies heavily on the global pipeline of physicians, importing 350,000 international medical graduates (IMGs; physicians who obtain their medical degree from medical schools outside the U.S. and Canada, regardless of their country or origin) per year since 1950.³² Many of these physicians work in safety net hospitals, family practice, or underserved communities. To date, increased

diversity in the health care workforce is primarily due to an increase in the number of medical school graduates from certain Asian American groups. Some professional schools have engaged in efforts to increase the proportion of other well-trained students of color, but more efforts are needed to increase the pipeline of health professional from underrepresented minority (URM) groups. For example, the University of California Los Angeles (UCLA) IMG program is a unique and successful approach to quickly increase the number of bilingual, bicultural Hispanic family physicians. The UCLA IMG program is consistent with the goals of health care reform and the mission of the Office of Minority Health (OMH). The program does not contribute to the problem of “brain drain,” because it targets immigrant physicians from Latin America who are already living in the U.S. and prepares them to serve their own communities. It also has provided residencies for many Hispanic/Latino medical school graduates. With a stable source of funding, such a model could be expanded to other states.

Affordable and Representative Education

Workforce issues will not improve until disparities in the educational pipeline starting from pre-kindergarten are addressed.³³ Thirty percent of White students enrolled in kindergarten will go on to achieve a bachelor’s degree, compared to only 17% of African American/Black students and 11% of Hispanic/Latino students.³⁴ The pipeline similarly looks bleak for American Indians/Alaska Natives. In 2007, approximately 13% of American Indians/Alaskan Natives 25 years or older held a bachelor’s or graduate degree.³⁵ In comparison, 25% of Vietnamese, 17% of Native Hawaiians and Pacific Islanders, and 13% of other Indochinese – Cambodians, Laotians and Hmong – had a college degree.³⁶ Furthermore, despite the expansion of professional schools, there is little focus on creating accredited programs in MSIs. It is important to provide opportunities for students from underrepresented groups to pursue careers in health care, especially given the high rate of unemployment among minorities. Health care reform can expand health profession pipeline programs for low-income students at MSIs; programs to help students attain degrees in science, technology, engineering, and mathematics; and the modification of components of admission criteria that can serve as barriers into professional schools (e.g., standardized exams). A better coordinated strategy to expand health professional schools, with encouragement to develop schools that serve to address shortage of minority health care providers or that focus on health disparities and cultural competency, is critical.

Strategies that address structural barriers and create opportunities for all youth to succeed will strengthen education and the workforce. Community-based solutions and pipeline initiatives have shown some promise. For instance, the W. K. Kellogg Foundation (WKKF) funds programs through three parallel tracks: education, policy, and service. WKKF funds middle school and high school programs to prepare children in underserved communities to enter the health care workforce. It also funds MSIs, including mentoring programs for first-generation college students. In terms of policy, WKKF funds programs to increase the diversity of the health care policy pipeline at the local, tribal, State, and Federal levels. In terms of service, WKKF recognizes that health needs are unique for different communities. Therefore, WKKF looks at the quality, cultural competence, safety, and benefits of care as well as community members’ satisfaction with the care they receive.³⁷ Federal agencies such as the Centers for Disease Control and Prevention (CDC) supports a number of activities related to health and science education to strengthen the health workforce. For instance, CDC supports science, public health, and epidemiology secondary education, and promotes public health careers through activities for students and teachers (e.g., Science Ambassador and Disease Detectives EXCITE! programs).³⁸

Public-private partnerships are another strategy to help bridge the gap between the educational system and health care workforce. Partnerships between health centers and educational institutions (e.g., the Jobs to Career Initiative of the Robert Wood Johnson Foundation, U.S. Department of Labor, and Hitachi Foundation) can help frontline workers to develop the skills they need to advance their careers in health care, at little or no cost to workers. The Sullivan Alliance has focused its efforts on the development of State Alliances between higher education institutions, MSIs, and majority schools, which allow states to be directly involved in addressing the health access needs and education gaps of their citizens. Formalizing these relationships can result in a direct increase in the number of minority students who gain entry to, and graduate from, a health professions program; continuing such efforts is necessary to increase minority representation in health professional schools and health professions.³⁹ Furthermore, training diverse candidates bolsters the executive leadership of health organizations.

These are just some examples of various workforce efforts that are in place. State and local efforts supported by public and private agencies, foundations, and organizations serve as the basis for much more coordinated, enhanced, and targeted efforts towards building the health care workforce.^{40,41}

Development of Diverse Leadership and Governance in Health Care Organizations

As stated in the ACMH's previous report,⁴² responsive and accountable executive leadership and governance are critical for providing quality health care for minority populations and for addressing health disparities. The leadership, oversight, and infrastructure required to initiate and sustain strategies for achieving health equity, especially in the face of severe resource constraints, depend upon the vision, skill, and commitment of the organization's governance. Building an effective infrastructure for achieving health equity requires a style and practice of executive leadership and governance that understands that workforce diversity and culturally competent care are not separate projects or programs but rather are a context for continuous quality improvement of all areas of executive leadership and governance responsibility.

The Joint Commission, in its *Hospitals, Language, and Culture: A Snapshot of the Nation*⁴³ study, showed that, when a health care organization and its leadership do not consider the language and cultures of those they serve, language and cultural issues have a significant impact on disparities. Its subsequent report, *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*,⁴⁴ builds upon the exploration of patient-centered care in the nation's hospitals, asserting that the blueprint for organizational cultural competence is unique for each organization and dependent on the quality of leadership and governance. Without trying to provide all of the answers for meeting the needs of diverse patient populations, The Joint Commission report offers a framework, derived from current practices employed by U.S. hospitals, for executive leaders and governing bodies to think systemically about how they provide health services that are truly patient-centered.

The development of diverse executive leadership and governance in the nation's health care organizations is essential for implementing effective health care reform.⁴⁵ Corporate leadership studies have found that companies with diverse management teams outperform homogeneous management teams.⁴⁶ Effectively engaging the diverse communities for achieving health equity requires executive leadership and governance that is representative of, and responsive to, those communities. Such leadership should view the community as a crucial partner in developing and providing quality healthcare – not just as consumers or recipients of healthcare services. The engaged health executive and governing body will develop and maintain an open

dialogue with the community through interaction with trusted community leaders and members to identify key issues and effective strategies for improving the public's health.⁴⁷ Current research has demonstrated overall improvement of quality of care when there is a concerted effort to improve care and to address disparities for minority patients. Minority executives and governing bodies can bring this increased awareness and responsiveness to the health care needs of their communities and be instrumental in improving the quality of care for all.^{48,49}

Although diverse leadership is critical to the success and effectiveness of organizations, people from minority groups are grossly underrepresented in executive management and leadership positions in the health care service and education systems. For instance, most foreign educated nurses rarely are considered for leadership positions, regardless of their level of education. Similarly, although racial/ethnic minorities represent nearly half of the U.S. population, faculty of color represent only 10% of nursing, 9% of dental, and 4% of medical school faculty; there also is a lack of leadership and program development specific to the behavioral health needs of people of color. There also are lower rates of full-time faculty appointments, tenure, administrative appointments, or positions as principal investigator for grants for people of color and for women.⁵⁰

This disparity also is evident in health care organizations. In 2004 the Puerto Rican Legal Defense and Education Fund (PRLDEF) published the report, *Condition Critical: The Absence of Latinos among Policy Makers in New York City's Voluntary Hospitals*,⁵¹ which highlighted not only the lack of Latino representation in hospital administration and boards but also the barriers that minority patient populations face in receiving care. Although Latinos now make up 14% of the U.S. population, only 2% of hospital chief executives in the U.S. are Latino. Such a disparity illustrates a critical issue for health care organizations to tackle to appropriately recognize and respond to the health care needs of an increasingly diverse population. This PRLDEF report spurred the Board of Governors of the Greater New York Hospital Association (GNYHA) to convene a blue ribbon task force on diversity and health care leadership. As a result, the GNYHA Center for Trustee Initiatives was created in 2005 to help member organizations achieve diversity reflecting all minority communities on their governing boards as a critical strategy for advancing health equity for the diverse communities in New York City.

Among programs that address the underrepresentation of minorities in executive leadership positions, the American Hospital Association's (AHA) Institute for Diversity in Health Management (IFD) operates to close the gap between the percentages of minority and non-minority executives in hospitals.⁵² Notable among their programs is the IFD's Summer Enrichment Program (SEP). Established in 1995, the SEP places first and second year graduate students pursuing healthcare degrees in U.S. hospitals for 12 weeks of intensive, hands-on administrative development. This placement provides hospitals with a multicultural/multiracial applicant pool for entry level management positions and provides the students with a competitive advantage of practical work experience. The program places between 40 and 60 graduate students in hospitals each year. With greater participation from hospitals, the IFD has the capacity to double this number. In 2008, the Veterans Administration adopted this program as its official pipeline for increasing diversity in its hospital leadership.

AHA's IFD has established several significant private and public partnerships to provide annual scholarships, fellowships, and mentoring programs to ensure minority graduate students remain in the pipeline from the classroom to the C-suite. IFD also offers monthly web seminars (*Diversity Dialogues*), national leadership and education conferences on diversity in health care,

a certification program for diverse professionals in healthcare, and the first benchmarking survey of U.S. hospitals to measure the hospital industry's progress in managing diversity and eliminating disparities while identifying best practices and promising programs.

Additionally, AHA's Minority Trustee Recruitment and Training Program is a model program that could be replicated nationally for building responsive and accountable governance structures that promote a linkage between understanding the importance of workforce diversity, culturally competent care, and governance responsibilities associated with quality and patient safety. This promising program is a result of the creation of the AHA's Special Advisory Group (SAG) on Improving Hospital Care for Minorities. The SAG, composed of national civil rights organizations, hospitals, public health agencies, state and federal government representatives, academic medical schools, and research organizations, was created in 2007 to provide guidance on how hospitals can eliminate disparities in care. In 2008, the SAG commissioned the AHA's Institute for Diversity in Health Management and the Center for Healthcare Governance to design and implement a program to increase minority trustees serving on hospital boards. To date, approximately 450 qualified professional minorities have been trained for hospital board placement in eight major cities across the country. A national and state registry is maintained, which provides hospitals with a viable pool of applicants to diversify local and national hospital system boards.

A number of initiatives to increase leadership diversity in academia also exist. The AAMC diversity initiatives include minority faculty diversity seminars. BHPR sponsors leadership development programs that such as Centers for Excellence, which helps recruit, train, and retain URM students and faculty at health professions schools, and the Minority Faculty Fellowship Program, which helps health profession schools identify, recruit, and select individuals to increase the number of URM individuals to be members of their faculty. The National League for Nursing is helping schools of nursing integrate diversity throughout their curriculum and incorporate diversity in criteria for faculty evaluations. The Disparities Solutions Center at Massachusetts General Hospital also provides a number of education, leadership training, and evaluation resources (e.g., the Disparities Leadership Program) to develop and assess efforts to increase diverse leadership in health care settings.⁵³ The Josiah Macy Yale-Howard Interdisciplinary Health Scholars Program, established in 2007, aims to increase the number of ethnically diverse students seeking graduate degrees in the health professions, students who engage in health equity research, and the future number of ethnically diverse health professional leaders. Additionally, the Indian Health Service's Health Professions Scholarship Program aims to provide culturally and clinically competent health care and allied health professionals to serve in American Indian/Alaskan Native communities and to develop future Indian health care leaders.⁵⁴

Various groups recognize the need to increase minority leadership in all health care disciplines and have therefore created diversity programs; however, much more work is needed to reshape, enhance, and improve the infrastructure of institutions and develop pathways for leadership.^{55,56} At the federal level, ACMH believes strongly that genuine diversity in leadership and senior positions, particularly in DHHS, which is last among federal agencies in terms of employing Latinos, is critical towards assuring that workforce diversity as a value for the nation's health systems. On the legislative front, U.S. Senator Daniel Kahikina Akaka (D-Hawaii) has sought for the last two Congressional sessions to expand and embrace diversity of the Senior Executive Service (SES). He has co-sponsored with Congressman Danny K. Davis (D-Illinois) the *Senior Executive Service Diversity Assurance Act* (H.R. 3774/S. 2148). This act would

establish provides guidance on how diversity should be monitored in the SES. At present there are no legal or policy barriers that would prevent federal agencies from examining and monitoring its hiring, retention, and promotion processes from a diversity standpoint prior to the passage of this bill. The bill calls for the establishment of a Senior Executive Service Resource Office, with a mission of improving the efficiency, effectiveness, productivity, and diversity representation of the SES through policy formulation, oversight, and guidance to federal agencies.

Cultural Competence through Accreditation and Licensure

There is an urgent need to ensure that health professional schools are equipped to provide culturally and linguistically competency training that will enable graduates to provide quality care to all.⁵⁷ The CLAS standards provide guidance for all recipients (health care organizations) of Federal funds, which includes ensuring that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. Currently, schools and curricula on cultural competency differ widely. One strategy towards assuring cultural competency nationwide would be to develop national standards for cultural competency curricula and health disparities, using extant educational tools as a guide (e.g., OMH).⁵⁸

Modifying accreditation requirements also can strengthen the cultural competence and adequacy of training in health professions. For instance, schools of public health have a higher number of minority faculty members because it is part of their accreditation requirements. A similar provision can be made in the accreditation requirements for all health professions programs.⁵⁹

To assure that existing providers are also culturally competent, states, such as New Jersey and California, require existing providers to take courses that include cultural competency courses as part of their continuing medical education requirements. This approach to expanding and assuring a culturally competent workforce should be prioritized. Providing CME on health disparities and cultural competency should be mandated for providers in general and frontline and primary care providers in particular. OMH's Cultural Competency E-learning continuing education programs should be promoted as promising practices for this type of work. Likewise, increased reimbursement from insurance companies for all practices that incorporate strategies that improve cultural competency and health disparities into their practice will further enhance the quality of training and continuing education.

International Graduates. The certification process for health care professionals to work in the U.S. should be examined as well. To practice in the U.S., IMGs must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG), a private, nonprofit, nongovernmental organization that Federal regulations authorize to certify IMGs entering the U.S. workforce as trainees in postgraduate medical education. ECFMG certification assures that IMGs have met minimum standards to enter U.S. residency programs. ECFMG certification entails an examination component that includes the U.S. Medical Licensing Examination (USMLE). Organizational members of the ECFMG include the American Board of Medical Specialties (ABMS), the American Medical Association (AMA), AAMC, the Association for Hospital Medical Education (AHME), the Federation of State Medical Boards (FSMB), and the National Medical Association (NMA).⁶⁰

Although approximately 25% of practicing physicians and residents in the U.S. are IMGs, there has been criticism that the U.S. is subsidizing IMGs; furthermore, many IMGs did not attend accredited schools with cultural competency curricula or requirements. Many IMGs also are not of nationalities that are highly represented in the U.S., and few are of Hispanic/Latino origin or of African descent (i.e., two minority groups with a large population in the U.S.). Some people purport that the reliance on international graduates leaves other countries at a disadvantage (e.g., brain drain) and that there is a need to focus more on training U.S. students. There have also been calls for alternative certification processes. There must be a mechanism to ensure that those who are board certified are still competent, and that those who are not board certified remain current with licensing requirements. Therefore, uniform mechanisms to assess the contribution, credentials, and acculturation of professional students are needed. Many IMGs are interested in becoming licensed practitioners but may lack the knowledge and skills to pass licensing tests and compete for residencies. Challenges include written and spoken language barriers; Visa issues; the variable quality of schools; lack of permanent funding; lack of familiarity with the process to enter training in the U.S., and the cost of U.S. medical licensing exams. Asian American and Hispanic communities, for example, have a large, untapped pool of internationally educated health care professionals who cannot obtain licenses in the U.S. due to language limitations. As a result, many of these individuals take jobs that do not fully utilize their skills, continuing to leave a need for competent and diverse health providers.⁶¹

Conclusions and Recommendations

The ACMH recognizes the importance and impact of diversifying the health care workforce, current diversification efforts, and the vital need to continue to bolster efforts to increase workforce diversity to ensure increased health equity. The charge of the ACMH is to provide recommendations to improve the health of racial and ethnic minority populations. Among ACMH's values are health for the common good and a diverse and competent health care workforce. To address and improve cultural representation within the health care workforce, development of diverse leadership, accrediting and licensure, and pipeline development in the educational system, the ACMH makes the following recommendations which are actionable and measurable for accountability. Some of the recommendations are within HHS' purview and others are beyond the scope of HHS and therefore require collaborative public-private efforts to facilitate change:

1. *Expand multifaceted partnerships and funding sources to make the health care workforce more representative and reflective of diverse communities:*

Recognizing resource challenges (e.g., financial), the benefits of diversification outweigh the costs of doing so. Best practices in workforce development include education and curriculum, inventory/repository for pipeline, and opportunities for community-based training. The ACMH encourages the use of specific strategies to further workforce development that are consistent with the best practices:

- A. The use of federal funds to expand the health care workforce. Additional funding for student loans authorized through health reform legislation should be targeted to areas of need in the national workforce. Funding of solution-oriented research on health disparities also should be expanded to increase the understanding of beneficial outcomes and the health care needs of all consumers.

- B. Interagency agreements on strategies and programs between the Departments of Health and Human Services, Labor, Education, and Housing and Urban Development to advance the health workforce development agenda.
- C. Increased recruitment of members of the Armed Forces who are interested in health professions, especially minority veterans.
- D. Expansion of public-private partnerships.
- E. Increased resources to ensure that providers have global clinical competency (e.g., the ability to conduct culturally competent examinations and histories; knowledge of cross-cultural medical ethics; use of qualified medical interpreters; understanding of language access laws; and knowledge of patients' country of origin, travel history, and diseases endemic to particular geographic regions).⁶²
- F. Creation of a national inventory of pipeline programs, sources of financial aid, solution-oriented best practice models, and workforce development resources to be shared with states and policy-making officials.

2. Strengthen the quality of the K-16 educational system and access to professional schools:

There is a need for a national strategy on workforce development that includes a stronger state and federal role in the expansion of health professions schools. Ensuring that educational programs are accessible and reflective of the diversity of the nation will enhance the pipeline for health professions, expand the pool of applicants from underrepresented groups, and lead to improved overall health of communities. The following strategies can bolster the educational system and career pipeline:

- A. Federal role
 - 1. Think strategically regarding issues of diversity and health disparities.
 - 2. Develop minority workforce initiatives across a variety of federal departments.
 - 3. Use Presidential Executive Orders for Minority-serving Institutions to provide funding to support workforce development efforts.
- B. State and community role
 - 1. Engage community members, as community input is critical to this expansion process.
 - 2. Build public-private partnerships.
- C. Infrastructure and system development
 - 1. Assure the quality of education in all public schools.
 - 2. Understand and address social determinants of health (e.g., cultural barriers to care, etc.).
 - 3. Build the capacity of faculty and administration.
 - 4. Utilize best practice models around minority education, literacy programs, and curricula development related to health sciences.

5. Promote policies to ensure pipeline development for students from historically underserved and disadvantaged backgrounds.

D. Matriculation and Graduation

1. Monitor graduation and drop out rates.
2. Develop efforts and incentives to increase school attendance and reduce truancy.

E. Student support and preparation for postsecondary opportunities and the transition into the workforce

1. Increase resources for mentoring, tutoring, and after school programs.
2. Expand the availability, visibility, and awareness of academic enrichment and fellowship programs to provide opportunities for both the highest achieving students and students who need encouragement and support to improve academically.
3. Increase parent/family involvement.
4. Expand support for MSIs (e.g., support from professional medical associations and institutions).
5. Create strong collaborations with community colleges, as many minority youth attend these institutions.
6. Increase affordability for training via loans, scholarships, and assessment of licensure and health traineeships to reduce costs.
7. Expand the public health service core and employer networking.
8. Measure the outcomes and effectiveness of workforce development supports for students and retention over time.

F. Encouragement of minority populations to pursue health care careers

1. Strengthen the infrastructure of MSIs to support students' successful introduction and entry into health care fields.
2. Adapt community health education promoter model to help families navigate the educational system around health professions.
3. Increase use of tele-training (e.g., tele-health and tele-education) to increase exposure to health care fields.
4. Provide incentives to attract students who are familiar with the cultures in underserved communities and committed to practice there long term.

3. Increase the diversity of leadership in the health care profession and education systems and build the capacity of institutions to support the ongoing development and advancement of leaders:

Health care leadership and management, health care providers, and key committees that are reflective of the communities served are necessary to effectively address health

care reform. Specific strategies to recruit, train, and retain representative and responsive leadership include:

- A. Diversity initiatives such as minority faculty workshops and mentoring programs.
- B. Development of pathways for leadership.
- C. Efforts to strengthen institutions' infrastructure to support diversity in leadership programs (e.g., sustainability plans, increased funding).
- D. Development of mechanisms to monitor the diversity of executive leadership, educators, and direct service providers in the health workforce.
- E. Recognition and advancement (e.g., promotion, tenure) of faculty for work done on health disparities and cultural competency.

4. Reexamine and modify accreditation and licensure procedures to ensure cultural competency, adequate training opportunities, and quality of health care providers:

Certification, licensure, and continuing education assure training program directors, the health care field, and the public that health professionals have met the minimum standards to provide health services. ACMH encourages the use of the following strategies to change accreditation and licensure processes:

- A. Development of a standardized national health professional curriculum on health disparities and ongoing cultural and linguistic competency development that encompasses training on how to care for minority and ethnically diverse populations to ensure clinically competent global providers.
- B. Integration of cultural competency into the criteria for accreditation of programs, and including licensure requirements about cultural and linguistic competency and health disparities to ensure a competent workforce.
- C. Training of all providers on factors influencing racial and ethnic health disparities, cross-cultural medicine, patient-centered care, and the realities of unconscious bias.
- D. Continued increase of the international and domestic diversity of the American health care workforce.
- E. Implementation of national cultural and linguistic competency standards in physical and behavioral health training programs.
- F. Addressing barriers to licensure encountered by international students and U.S. students from historically underserved backgrounds.

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