

**NC IOM STEERING COMMITTEE ON  
PRIMARY CARE AND SPECIALTY SUPPLY  
Thursday, July 27, 2006  
NC Medical Society, Raleigh  
10:00-3:00**

**MEETING SUMMARY**

**WELCOME**

**E. Harvey Estes, Jr., MD**  
Chair, Steering Committee

**NORTH CAROLINA PROVIDERS: SUPPLY AND DISTRIBUTION BY RACE**

**Jennifer King**  
Research Associate  
Cecil G. Sheps Center for Health Services Research

Ms. King provided an overview of provider supply and distribution by race. African-Americans and Hispanics are underrepresented in the provider community, and Whites and Asians are overrepresented. Over one third of international medical graduates are Asian, which may contribute to their overrepresentation. American Indians have a much higher rate of practicing in rural areas, but there are only 75 American Indian (AI/AN) practitioners overall in the state. Black, Asian, and American Indian physicians have higher rates of practicing in rural and underserved areas as compared to White physicians. Primary care physicians, PAs, and NPs are also more likely to practice in rural and underserved areas. Non-white primary care providers are more likely to work in persistent health professional shortage areas (PHPSAs) than White primary care providers, and Hispanic providers are more likely to practice in underserved areas. There is a trend indicating that African-American physicians are more likely to practice in areas with larger African-American populations as a share of total population. There is a similar trend for Hispanic physicians practicing in areas with large Hispanic populations, but it is weaker and more sporadic. There also is a trend for more American Indian physicians to practice in areas with larger American Indian populations. However, many non-whites live in counties without physicians of the same race due to the raw disparity in numbers of non-white providers.

**MINORITY PROVIDER ISSUES: A BROADER PERSPECTIVE**

**Anita Jackson-Kelley, MD**  
First Vice President  
Old North State Medical Society

Dr. Jackson-Kelley began by thanking the steering committee for the opportunity to speak. Minority health providers have more stressful practice in the state and are under greater scrutiny than their White counterparts. Minority providers are less likely to survive in solo practice and work more as hospital employees and in group practices. However, long-term survival is

possible in diverse and supportive communities. There are professional battles at all levels for minority physicians/providers and their practices. Minority providers face difficulties in credentialing, reimbursements, attracting and retaining support staff, financial freedom, and protection from collegial attacks.

It is important to support minority physicians and health providers because they are patient advocates and provide care to the underserved. Also, North Carolina is becoming more diverse, so the need for cultural competency and patient comfort is increasing. Unfortunately, there are many barriers for minorities entering the health professions. Minorities often lack exposure to health professions and there are not enough mentors to help them through processes, such as medical school applications. There is also a lack of state financial support to help with family burdens and financial responsibilities.

There are sacrifices that sustain minority physicians in practice long-term: pledge to community and society, commitment to improve serious health problems and to provide economic opportunity for others, consistent patient and community practice support, interest in becoming a role model and community mentor, and continued interest in science and the ability to keep clinical practice fresh and challenging.

Recommendations from this Task Force should focus on attracting and, more importantly, retaining minority physicians. Financial barriers should be eased through multi-year loan repayment, financial incentives for community service, and support for group negotiated insurance contracts. Other recommendations include assisting current provider practices secure future partners, fostering supportive relationships between health facilities and minority physicians, and supporting additional opportunities for minority physicians' practices to grow and expand. To increase the number of minority health professionals in the state, Dr. Jackson-Kelley feels the state should a) start at least two minority health professional schools directed by minority leaders who have a relationship with multiple training sites, b) develop a Underserved Health Practice Fund to which all non-profit health institutions should be required contribute 15% of their profits annually and to which 3% of all for-profit institutions' annual tax dollars should be given, and c) that financial support and college credit should be given to minorities who are working in an allied health profession while pursuing health professional education.

There also may be benefits from linking diversity performance to licensure at institutions, hospitals, etc. Furthermore, the NC Medical Board should commit to diversity and protecting the providers in practice, as well as the citizens in the state. A State Diversity and Disparities Council for Health Corporations should be established to monitor and reward practitioners and to protect patients. The state should support minority physicians and allow them to expand their service through partnering and mentoring stipends.

## **NORTH CAROLINA HEALTH CAREERS ACCESS PROGRAM (NC-HCAP) OVERVIEW**

**Carolyn M. Mayo, PhD**

Executive Director

North Carolina Health Careers Access Program

An Inter-institutional Program of the University of North Carolina System

Dr. Mayo reiterated the point that it is important to encourage underrepresented minorities to pursue careers as health professionals because they are more likely to work in underserved areas or to treat underserved patient populations. However, the number of Black and Hispanic medical school graduates has remained the same for a number of years.

The North Carolina Health Careers Access Program (NC-HCAP) was first started in 1971 as the North Carolina Health Manpower Development Program. Cecil Sheps, at the University of North Carolina, was the visionary leader of the organization and Eva Clayton was the first director. The program was established through grants and was state funded in 1973. In 1990, the name changed to NC-HCAP. The mission of the organization is to increase the number of individuals from educationally or economically disadvantaged backgrounds, with an emphasis on under-represented minorities (African-Americans, Native Americans, Hispanics/Latinos, and Asian/Pacific Islanders of the Vietnam War Era), who are trained, educated and employed in the health professions.

NC-HCAP is considered an inter-institutional program implemented through three campus-based centers rather than as a statewide program. However, the organization does take advantage of partnerships across the state. The coordinating office is at UNC-Chapel Hill, but each campus has its own program. The organization seeks equitable access to culturally competent health care across all racial and ethnic groups, irrespective of geographic location (urban or rural) or socioeconomic status, and endeavors to ensure that no gap or disparity exists in the health status of racial and ethnic groups in NC and the US. These goals are consistent with the Healthy People 2010 Objective 1-8, which calls for an increase in degrees awarded to underrepresented populations in the health professions and allied and associated health fields. Similarly, one of the Healthy Carolinians 2010 objectives is to increase the number of minority and ethnic physicians in the workforce. NC-HCAP works towards those objectives.

NC-HCAP has an inter-institutional and inter-disciplinary approach to recruitment and retention. Its three centers work collaboratively with the Health Careers Opportunities Program (HCOP) partnership, pre-college schools, the NC Department of Public Instruction (DPI), the Math and Science Education Network, health professions programs, the NC Area Health Education Centers program Health Careers and Workforce Diversity Council, and community and faith-based organizations to achieve its goals. NC-HCAP provides information and technical assistance, and its interventions involve a comprehensive health professions education pipeline, mainly targeted at rising sophomores and juniors in college (Health Professions Preparation Program). NC-HCAP also has a kindergarten through grade 12 initiative providing Health Careers Information and Enrichment (HCIE) workshops (1500 students per year in 20-25 counties). The campus-based centers also provide an HCIE train-the-trainer initiative, personal health career portfolios, and an Adopt-a-School Program to expose students to health careers. There is also an Inspirational Speakers in Science (ISIS) Lecture Series in the spring to inspire students through discussion of barriers encountered and how they were overcome.

NC-HCAP tracks the students in its residential eight-week Science Enrichment Preparation (SEP) Program, which each year involves 35-51 rising sophomore and junior undergraduates. This program helps with academic skill development (including clinical/practitioner shadowing)

and psychosocial skill development. Forty-six percent of SEP graduates are health professionals, 6% are in health professional schools, and 31% are along the path to becoming health professionals.

The campus-based health careers centers conduct workshops, outreach, develop partnerships, provide career exploration seminars, run clinical health summer programs, and have NC-HCAP Ambassadors to serve as liaisons between campus communities and NC-HCAP. A major HCOP partnership grant was recently discontinued. NC-HCAP does have the Model State Supported AHEC Grant, a Robert Wood Johnson Pipeline Initiative with the UNC School of Dentistry, UNC/ECSU Pharmacy Program Collaborative, and it is continuously seeking funding since it lost one of its major funding sources. NC-HCAP also provides the Statewide Health Careers Information and Communications Network with publications, materials development, and specialized seminars.

The future visions and directions for NC-HCAP include continuing collaborations and partnerships; developing a statewide, shared uniform student tracking and evaluation system across the education pipeline (kindergarten through graduation); utilizing additional state funds to support and expand NC-HCAP programs; identifying and seeking external funding; and marketing NC-HCAP to youth and adult career changers. Recommendations from the Task Force should include making admissions campaigns culturally-appropriate; changing admissions committee composition, so that it acts less as a gatekeeper; supporting retention and graduation of underrepresented minorities in health sciences (decelerated programs, faculty/student mentor “buddy” system, minority academic/psychosocial counselor); providing more financial aid assistance and debt management counseling; offering job placement and loan forgiveness; and assuring cultural/linguistic competence education and training occur for all health sciences students (didactic, clinical, experiential).

### **Questions Comments**

Discussion surrounded the value of mentors and how important it would be to develop more. It was also noted that loss of Health Careers Opportunities Program (HCOP) funding is a critical issue. The US Congress drastically reduced funding for diversity programs and programs promoting health professions. In fact, the majority of Title VII funding was wiped out and this huge loss will be difficult to replace. Under such circumstances, expansion of the NC-HCAP program, which would cost approximately \$300,000 per campus expansion, seems unlikely.

Discussion also focused on which point in the pipeline has the most impact on the pursuit of a health professional degree. Many in the group felt that high school and undergraduate programs are the best targets for assistance because that is when students begin to think more seriously about what they want to do in the future and are choosing majors that can impact their likelihood of applying to health professional programs. One suggestion included developing more partnerships between historically black colleges and universities (HBCU) and health professional programs, such as the Harvard-Xavier example where 60% of black graduates from Harvard come from Xavier. East Carolina University has a seven year program for a limited number of students during which time they complete their undergraduate and medical school degrees through three years of undergraduate and four years of medical school education. This could be expanded to link with some HBCUs in the state. Another model comes from a Baylor program

in Texas. The program allows high school students with certain academic achievement to be automatically admitted into the University of Texas at Austin. If those students then maintain a defined academic achievement at UT Austin, they are automatically accepted into medical school at Baylor and their tuition is paid for throughout the process.

The group also emphasized the need for a uniform student tracking system to ensure that programs with a mission to achieve similar goals communicate and keep track of their impact on future career paths. The Area Health Education Centers program is developing an integrated tracking system, but it is focused on tracking the intensive program participants only. If it can be expanded, it could support tracking for other programs across the state, as well.

#### **UPDATE ON 2005 PROVIDER SUPPLY NUMBERS**

##### **Thomas C. Ricketts, III, PhD**

Deputy Director  
Cecil G. Sheps Center for Health Services Research  
The University of North Carolina at Chapel Hill

Physician supply, which had been decreasing, increased in 2005, but the numbers will not be official until printing is complete. It is not a dramatic increase, but it is an interesting increase that must be verified and checked. The Sheps Center for Health Services Research is working with the NC Medical Board to clarify some anomalies that appear in the dataset. Also, there have been some problems with the reporting classification.

Despite this increase in supply, the trend still remains. There was a long period where growth was smaller than it should have been, and there is still likely to be a decrease in physician to population ratio, especially with the prediction of an increase in the North Carolina population over the next few years. Even if there is an increase in medical school enrollment and residency positions, a decrease in supply is still likely because we are not producing enough physicians to replace those leaving. However, if this positive trend from this year continues, that will change the trends for the better. The good news is that the trend is coming back to a healthier point. The bad news is the overhang of the previous low rate of growth and the growing retirement issue. However, this analysis does not include physician assistant and nurse practitioner supply. Combining these data will help the state really determine what else may need to be done.

#### **DISCUSSION OF OVERVIEW RECOMMENDATIONS**

##### **Pam Silberman, DrPH, JD**

President & CEO  
NC Institute of Medicine

Dr. Silberman reviewed the recommendations from the overall supply fact sheet and the Task Force provided comments. Those comments have been incorporated into the recommendations and fact sheet.

**ATTENDEES**

*Steering Committee:* Tom Bacon, Harvey Estes, John Frank, Pam Highsmith, Anita Jackson-Kelley, Bruce Johnson, Kathy Johnson, Jay Kennedy, Jennifer King, James McDeavitt, Anthony Meyer, Lloyd Michener, Andrea Radford, Tom Ricketts, George Sheldon, Jeff Spade, Justine Strand, Marvin Swartz, Chuck Willson

*Interested Persons/Staff:* Vijay Brihmadeseam, Kristen Dubay, Thalia Fuller, Natasha Harrison, Mark Holmes, Carolyn Mayo, Perri Morgan, John Price, Pam Silberman, Cindy Connor