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ABSTRACT

This report examines five major components that affect minority children's access to health care. They are: health status, barriers to access, workforce, organizational response, and the role of the American Academy of Pediatrics (AAP). Recommendations are included for each of these components. Health status indicators for minority children include: premature death and disability caused by controllable illnesses and high infant mortality, differential rates of immunization, teenage pregnancy, and injuries associated with violence. Minority children also encounter barriers to health care access. Among these barriers are: economic factors, such as a lack of financial resources and inadequate insurance, and geographic factors that result in limited availability of providers and facilities. Other barriers are: poverty and lack of education, which often translate into delayed health care and poor compliance with treatment, cultural insensitivity, racism, and classism. Workforce factors that affect minority children's health care access include the relative absence of minority group pediatricians and the geographic maldistribution of practitioners. The AAP Task Force recognizes the organizational response of other groups that have addressed this issue. The Academy's role is to ensure that the perspectives of minority pediatricians and children are considered in AAP educational programs, policy, developmental advocacy and research. (Three appendices include the directive to the AAP Task Force on Minority Children's Access to Pediatric Care, a review of relevant programs, and copies of the Task Force surveys. Contains 120 references.) (VL)

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EXECUTIVE SUMMARY

Health care reform offers unparalleled opportunities for the American Academy of Pediatrics (AAP) to address impediments to the physical well-being of all children, and especially those which affect minority group children. This report represents the Academy's comprehensive consideration of the multiple factors that contribute to the discrepancies in the health status between children in minority and non-minority groups.

Since their first meeting in 1992, the AAP Task Force on Minority Children's Access to Pediatric Care has been collecting information, considering the issues, and devising strategies for implementation within the Academy, as well as in the public policy arena and in collaboration with other organizations. Contained in the report, and listed at the end of this Executive Summary, are 66 recommendations. Beyond these recommendations, however, this report is intended to serve as a reminder of the critical nature of this problem and as a stimulus for ongoing AAP initiatives.

The report is divided into five major components:

HEALTH STATUS — One of the first issues encountered by the Task Force was the paucity of data relative to the health status of minority group children. This lack of information not only impedes the development of responses to undisclosed problems, it also interferes with the monitoring and evaluation of proposed responses. The report reviews current health status indicators and describes the current types of national data collection on minority group populations.

The recommendations in this section of the report include actions that can be taken by the Academy to improve and clarify data collection and reporting of minority group children's health status. They suggest that federal agencies that conduct surveys should expand efforts to garner information regarding racial/ethnic background and data collection on subpopulations. Data from existing surveys should be comprehensively analyzed and the findings disseminated. Finally, minority group children in the United States should be a component of future research studies — whether generated by the Academy or other research agencies.

ACCESS BARRIERS — The impetus for forming the Task Force resulted from a recognition of the plethora of barriers that impede the access of minority group children to excellent health care. This report confirms that the impediments are, indeed, multifaceted and often interrelated. The different, yet unique needs of the children of migrant workers (particularly in the US/Mexico border region) and Native American children are considered in this section of the report.

The recommendations represent a considered response to barriers that range from geographic factors to lack of cultural sensitivity, racism, and classism. They call for the Academy to continue to develop educational tools to increase the cultural competency of pediatricians and to provide information and guidelines on caring for children who live in border regions or who are recent urban immigrants. Advocating for increased funding for Native American health care programs and encouraging active community-based outreach approaches to address the health care needs of minority group children are among the strategies addressed in this section of the report.

WORKFORCE -- The relative absence of minority group representation within the pediatric workforce and the geographic maldistribution of practitioners in the workforce are continuing problems that have direct links to health care access limitations. The report identifies that pediatricians, as well as their patients, face geographic barriers. Attention is given to those who work under the auspices of the National Health Service Corps and the Indian Health Service. Further, the report addresses the need to recruit more minority group medical students into careers in pediatrics. A significant conclusion is that such efforts must begin at the grammar and secondary school levels with strategies to foster an interest in science and math.

The report recommendations pertinent to this issue include actions that can be taken by the Academy to increase the number of minority group pediatricians and enhance the pediatric presence in currently underserved areas. Working to ensure that existing programs have increased funding to meet the health care reform demands for more primary care physicians is an important step. To ensure that there is an increase in the number of minority group pediatricians, the report recommends a multifaceted approach that encompasses the efforts of individual pediatricians, as well as those of the Academy at Annual Meetings and Spring Sessions.

ORGANIZATIONAL RESPONSE — In the process of preparing this report, the Task Force found that many other organizations have recognized the importance of the issues pertinent to the health of minority group children. A review of all the programs and projects considered by the Task Force is included in the Appendices. The report also recognizes the significant contributions of other organizations. Participating in the medical student mentoring programs of minority group physician organizations is one example of a collaborative activity that will address the needs identified in the previous section.

The recommendations in this section of the report include suggestions for specific collaborative activities with other organizations. Working with other groups to develop plans to increase the numbers of minority group faculty members in medical schools, and continuously exploring possibilities for additional collaborative activities are but two of the approaches that are proposed. It is anticipated that such collaborative activities will enhance the realization of the goals of the Academy.

ACADEMY'S ROLE — Ultimately the Academy can be most effective if it can ensure that the perspectives of minority pediatricians (in practice, research, and academia) and the unique needs of minority children are considered in AAP educational programs, policy development, advocacy efforts, and research. Corresponding to the desire to increase the number of minority group pediatricians is the need to ensure that they will participate in the Academy. Further, as stated above, the Academy needs to make certain that qualified minority group fellows are well represented within the leadership structure of the Academy. Since the overall goal is to enhance the Academy's sensitivity to minority group health issues, the report identifies strategies to increase the number of AAP minority group staff members at the management and/or policy-making levels.

The final set of recommendations, therefore, includes actions that target the participation of minority group members in all aspects of the Academy. The report notes the pivotal role that AAP chapter presidents can play in this process. Indeed, when surveyed about the desirability of increasing minority group pediatrician involvement at the chapter level, 60% of the presidents who responded answered affirmatively. The recommendations in this section are built upon the insights and perspectives garnered from chapter presidents, minority group AAP Fellows, and others. They are deemed to be in keeping with the capacity and mission of the Academy.

This report cannot address every issue and problem that confront those who seek to provide optimal health care for minority group children. It does, however, strive to identify both short-term and long-range strategies that can make a positive impact. The report advocates strongly for a multilevel approach. This ranges from the efforts of an individual pediatrician, working with the grammar school student who is enthusiastic about science, to national level advocacy in the legislative and health policy arena. Health care reform has created the environment of opportunity. This report is intended to provide those who are interested in improving the health status of minority group children with a blueprint for action.

Recommendations

Health Status

1. Contact those federal agencies that conduct surveys and suggest that information regarding racial/ethnic background be collected and/or expanded in order to document the needs of children in subpopulations of society: in particular, African Americans, Latino/Hispanic individuals, Asian Americans and Pacific Islanders, and urban Native Americans.

2. Make appropriate recommendations to the National Center for Health Statistics (NCHS) regarding the necessary information for documenting and tracking the health status and health care needs of minority group children. In particular, urge the NCHS to consider a special supplement to the National Health Interview Survey on the health status of Asian Americans.

3. Consider the feasibility of collaboration with the National Committee on Vital Statistics. Attend their public hearings to provide input and lobby for increased statistical information on racial/ethnic minority group children.

4. Take every appropriate opportunity to educate the government on the importance of expanding the funding for data collection, monitoring, and research to identify and understand further the contributing causes of racial differences in the health status of children and access to health care by minority group children.

5. Initiate efforts to educate the scientific and academic research community that current measures of children's health status may not adequately reflect the health of our children. As appropriate, support the efforts of the research community to improve data collection and monitoring of the health status and health care needs of minority group children.

6. Work through the Pediatric Research in Office Settings (PROS) Network to develop a research agenda that addresses the health status (including access and access barriers) of minority group children. Take all reasonable steps to promote this activity to minority group pediatricians so as to solicit their involvement in the Academy and to demonstrate the AAP commitment to minority group children.

7. Comprehensively analyze the data from the *National Health Interview Study - Child Health Supplement, 1988 and 1991*. All or several of the following analyses should be undertaken; and the findings should be shared with appropriate AAP committees and published:

- Descriptive analysis of measures of health status by racial/ethnic category; multivariate analysis of sociodemographic predictors of health status for each racial/ethnic category
- Analysis of measures of access to care by racial/ethnic category, with separate analysis of the effect of geographic region
- Analysis of the health status of newborns as well as an analysis of prenatal care by racial/ethnic category
- Analysis of health insurance coverage and sources of medical care by racial/ethnic category as well as by geographic region
- Descriptive analysis of the distribution of common medical conditions of childhood by racial/ethnic group
- Descriptive analysis of the distribution of health care resources for behavioral, emotional, and learning problems

8. Educate members on the heterogeneity of the Asian American population. Consider incorporating a series of articles into the PREP program, which will focus on the heterogeneity of the United States population and the implications for the health care system, as well as for pediatricians.

9. Ensure that analyses for the major minority groups of children in the United States are a component of future research projects, and that the findings are widely shared so as to ensure that a minority children's perspective is incorporated in future AAP statements, testimony, publications, and promulgations.

10. Recommend that appropriate terminology for ethnic groups is used in all documents, publications, and promulgations of the Academy and the journal, *Pediatrics*. This may include substitution of African American for black, and Latino (or Hispanic) for Spanish origin, and Native American for Indian.

Access/Barriers

11. Continue to utilize every avenue available to assure a universal system of financing health care for all children and pregnant women, regardless of income level, race, employment status of parent, or geographical location.

12. Continue to endorse the medical home as the optimal source of health care for minority group children. Also, continue to stress that pediatricians are the best providers of health care for all children.

13. Support programs that shift emphasis from technology-intensive, high-cost care to incentives to identify high-risk children, especially those in minority groups, and pregnant women, and to provide risk-reducing interventions for them.

14. Work for decreased dependence on categorical funding, and finance most special services through the same system used for routine care to assure greater stability and uniformity of health care delivery in different communities and improved access as family situations change.

15. Promote both the philosophical concept and the practice of requiring hospital emergency rooms to ensure that physicians with appropriate training in pediatric care are available.

16. Take every opportunity to dispel the common belief that the terms "poor," "minority," and "uninsured" are synonymous. Ensure that in AAP documents and promulgations, minority group health status is separated from many of the socioeconomic conditions with which it is associated.

17. Respond systematically, on behalf of children, to reports that exaggerate negative issues in health care delivery for children in general and minorities in particular. Negative publicity includes exaggerated or one-sided reports on costs, utilization of resources, outcomes, and self-care responsibility.

18. Devise an educational program for pediatricians regarding health care in the border regions and health care of migrant workers' children who cross borders, both national and interstate. The program should include the following:

- Reliable information about the legal status of international workers' children in terms of health care access, as well as information about health care as a human right
- Criteria to establish relations with workers' families

19. Develop a book (in the style of *Guidelines for Perinatal Care*), that shall address health care needs of migrant workers (both national and international), with emphasis on those in the border regions and recent urban immigrants. The book should include the following:

- Demographic data pertinent to the geographic distribution of Latino/Hispanic children, the children of migrant workers (national and international), and children of recent immigrants in urban and suburban areas
- Guidelines for pediatricians to address access to health care for international workers' children relative to their immigration status in the country, and access to health care for children born in the United States of foreign national parents (both federal and state-by-state policy)
- Methods to attract and retain within the health care system, children of marginated families (either by migration or by national origin)
- Guidelines to promote preventive medicine in areas of need: border regions, fields where migrant workers work, and in areas in which the inner-city migrant child with poor acculturation lives
- Guidelines to promote cultural sensitivity and to facilitate the recognition and prevention of racial prejudice

20. Encourage the Indian Health Service (IHS) to take steps to increase the cultural awareness of physicians who are paying back a service obligation and have little knowledge of Native American children and their families. Urge the IHS to provide cross-cultural workshops for new health care providers as part of their orientation. Foster collaborative activities between the Academy, the IHS, and the Association of American Indian Physicians to achieve these goals.

21. Advocate for increased financial aid to the urban Native American health care programs and urge the IHS to aid the urban centers in grant writing (eg, provide technical assistance and/or training), stressing the need to better address the health care needs of Native American children.

22. Incorporate a component that addresses the special health care needs (needs resulting from access barriers) of minority children into the Academy's health care reform proposal, and, as appropriate, into the AAP evaluation of and response to other health care reform proposals or initiatives.

23. Encourage active community-based outreach approaches to address the health care needs of minority group children and support programs to increase access in inner-city and rural areas.

24. Expand the AAP community-based programs to more states and include such problems as limited knowledge concerning the health care delivery process; violence; environmental hazards, including handguns; accident prevention; and safety — all of which can be best addressed by public action. Ensure that a minority group perspective is included. Work with the National Medical Association (NMA) and/or the American Medical Association (AMA), or other organizations (as appropriate) that have developed or are considering similar initiatives.

25. Explore the feasibility of compiling and periodically updating information received from AAP chapters on the availability of opportunities to practice in areas of need (rural and urban).

26. Ensure that all AAP health education materials are culturally appropriate for all minority groups as well as nonminorities. When this is not feasible, develop separate materials for the minority group(s). Work to achieve the goal of having all AAP patient education materials available in Spanish.

27. Urge pediatricians, other child health providers, and health policymakers to be educated about and sensitive to the sociocultural background of their patients, and to appreciate the impact that cultural norms may exert on health status. Involve minority group Fellows in this endeavor, as appropriate.

28. Continue to advocate for increased collaboration and coordination among providers and between providers and the public and private health care systems to ensure that the health care needs of minority group children are addressed.

29. Ensure that all councils, committees, sections and task forces that deal with child health issues be cognizant of the unique health care needs resulting from barriers to access.

Workforce

30. Work to increase the number of minority group pediatricians and health care providers at all levels of the health care system, with special attention to areas of health policy, health care delivery, and health services research. In particular, support (as appropriate) legislative proposals designed to increase the number of minority group physicians and/or enhance science and math curricula at the elementary and secondary school levels.

31. Work with the Indian Health Service on recruitment and retention programs to increase the number of pediatricians.

32. Develop a program to address the problem of geographic maldistribution of primary care providers in pediatrics:

- Support expanded funding of the National Health Service Corps (NHSC) program

- Influence the NHSC to expand the listing of medically underserved areas in the United States, including areas such as South Texas, Mississippi, and Alabama
- Develop incentives and/or support current programs to encourage pediatricians to locate in underserved areas
- Encourage implementation of programs at the chapter level to highlight areas where pediatricians are needed and inform residency programs of these areas

33. Support federal, state, and private sector programs that enhance the health resources and services targeting underserved minority group areas. Also, support the inclusion of valid items (eg, rates of insurance coverage and level of education) that yield a more equitable profile and a criteria scale to be used in awarding health resources and services programs targeting underserved minority group populations. Programs targeting disparities in health resources and services should be population-based.

34. Emphasize changes in medical education and training that promote community-based clinical training experience. Encourage pediatricians, residents, and medical students to become trained in the medicosocial problems of the poor, enabling them to deliver care better and contribute more effectively to the solutions of the broad arena of medicosocial problems that severely impact health outcomes. Provide the resources needed to ensure that pediatricians attain cultural competency by addressing pertinent issues in AAP publications and manuals and through workshops at AAP meetings.

35. Working through the Residency Review Committee for Pediatrics and the Association of Pediatric Program Directors (APPD), recommend curricular changes in residency training that will involve integration of cultural sensitivity, tailored to the local patient population. Strive to ensure that upon the completion of their training, pediatricians are prepared to deal effectively with culturally diverse, multilingual patient populations of varying socioeconomic status.

36. Continue to advocate positively the role of the international medical graduate (IMG) in health care delivery. Work to dispel negative perceptions of IMGs.

37. Continue to expand efforts to inform minority group college and medical students about the availability of loan/scholarship programs and the attributes of pediatrics.

38. Develop workshops on topics pertinent to preparing for medical school and selecting a career in pediatrics, to be held on the weekend prior to the AAP Annual Meeting and Spring Session. On a rotating basis, these should be targeted to area high school and/or college and to college and/or medical student audiences. Work with appropriate student organizations (eg, Student National Medical Association, Interamerican College of Physicians and Surgeons) to ensure minority group student participation.

39. Contact high school guidance or career counselors (via the publication(s) of national organizations of same), and encourage them to contact the Academy (nationally and at the chapter level) for information on careers in pediatrics as both a reference tool and as a means of more broadly promoting the availability of such material to students.

40. Solicit information from chapters and/or districts to determine what types of student recruitment activities are in place; if there are some recruitment programs that are particularly focused on the needs and interests of minority group students, ascertain if any "tools" are needed to enhance this activity. Publicize successful programs.

41. Foster the selection of a career in pediatrics by minority group students. Encourage pediatricians to serve as role models for the minority group children they encounter in their practices and through area schools. Also, at the chapter level, actively encourage pediatricians in community-based office settings to offer a clerkship(s) for a minority group medical student(s) — using the "Guidelines for Medical

Student Education in Community-based Pediatric Offices." Utilize these strategies as ongoing opportunities to involve minority group pediatricians in chapter activities. Create an awareness of these projects by promoting same at the district and chapter meetings, through newsletters, etc.

42. Encourage chapters to become actively aware of and involved in local medical student recruitment activities. Urge this activity to be a directive to each chapter level committee on Careers and Opportunities and/or Committee on Manpower. Medical student recruitment into pediatrics activities could include the following:

- Ascertaining when area grammar, high schools, and colleges are having "career days" and ensuring that pediatrics is represented
- Offering workshops for medical students in conjunction with the regional or annual meeting of a minority group medical student association or group (eg, the Student National Medical Association)
- Fostering the development of pediatric clubs, particularly in those medical schools that have a significant number of minority group students

Organizational Response

43. Pursue and/or continue collaborative relationships with other organizations of minority group pediatricians, including organizations that represent the primary subgroups of minority group children (eg, National Medical Association (NMA), Interamerican College of Physicians and Surgeons, Association of Indian Physicians, Student National Medical Association, etc).

44. Encourage Fellows, especially minority group pediatricians, to participate in mentor programs for medical students, such as those sponsored by the Interamerican College of Physicians and Surgeons and the National Medical Association. Promote this activity, and the experiences of Fellows who have participated, in order to foster ongoing interest.

45. Work with organizations, such as the Association of American Medical Colleges (AAMC) and Association of Medical School Pediatric Department Chairs to increase: the number of minority group pediatricians by requiring affirmative action programs in medical school admissions policies; the number of minority group faculty members at medical schools; and the number of recruitment programs at the grammar, high school, and college level, as well as at the graduate levels.

46. Work with the AAMC and other pediatric organizations to promote training (at all levels) in cultural competency and sensitivity. Establish collaborative activities with the American Public Health Association centered around cultural issues as they relate to the health of children in minority groups.

47. Actively monitor, and participate in when feasible, the AAMC's "Project 3000 by 2000."

48. Explore collaborative activities with the Department of Health and Human Services' Office of Minority Health in order that their Task Force on Black and Minority Health might incorporate a children's health component into their study of the health status of minority group populations.

49. Work with the American College of Obstetricians and Gynecologists to ensure that there is a minority group component in its efforts to develop a national program to recognize high-risk pregnancies and referral systems.

50. I...roduce a minority group children's health care perspective, as appropriate, into all current AAP liaison activities with other organizations. In those instances in which the Academy has already established an issue-specific liaison with an organization (eg, the American Medical Association and medical liability), determine if that organization has a minority group health initiative and pursue linkages with that activity.

The Academy's Role

51. Further study the issue of board certification of minority group pediatricians and assess whether or not this is the primary barrier to

membership in the Academy for minority group members. If lack of board certification is found to be a major factor in explaining low levels of membership in the Academy, undertake efforts to aid minority group pediatricians in board certification.

52. Continue to use the Blue Book Verification Card system to determine the number of board-certified minority group Fellows. Develop strategies to promote to the membership the importance of this activity and increase the response rate. Explore alternative methods for obtaining and/or verifying this information.

53. Design and implement a proactive leadership recruitment process of minority group members at the chapter committee level, and nationally at the council and committee levels, to ensure that minority group pediatricians are represented in all levels of AAP leadership.

54. Continue to monitor the involvement of minority group pediatricians in chapters and on AAP councils and committees using the tracking system designed by the Committee on Careers and Opportunities; disseminate this information to chapters and the Academy Advisory Committees to the Board, as appropriate, prior to the nomination/appointment process.

55. Expand the current number of programs that focus on topics of particular relevance to the health of minority group children and/or for minority group pediatricians at AAP Annual Meetings and Spring Sessions.

56. Redouble efforts to increase the number of minority group pediatrician presenters at AAP Annual Meetings, Spring Sessions, and other meetings as appropriate.

57. Explore options to increase the participation of minority group Fellows at AAP Spring Sessions and Annual Meetings, such as providing a forum for minority group Fellows.

58. Implement suggestions gained through the Task Force Survey of Chapter Presidents as a means of increasing the involvement of minority group pediatricians at the chapter level:

- Personal recruitment of minority group pediatricians
- Developing programs and projects at the chapter level that focus on the health of minority group children
- Forming a committee or caucus of minority group pediatricians within the chapter
- Appointing minority group chapter members to leadership positions within the chapter

59. Acknowledge chapters who have developed and implemented initiatives and programs on minority group children's health through the "Chapter Connections" newsletter, and encourage all chapters to develop such programs.

60. Through AAP communication tools and other public relations avenues, increase the Academy's visibility as an organization that deals with issues relevant to the health of minority group children and to minority group pediatricians in order to increase participation of minority group pediatricians as members of the Academy.

61. Develop a written plan to increase the number of minority group members in AAP management and senior policy level positions. Utilize strategies and resources, such as *The Black Journal* and Access Minority Resume Bank Program, to increase the pool of qualified minority group applicants for positions in the Academy.

62. Revise the Academy's current equal opportunity policy and incorporate an affirmative action component in order to increase the number of minority group members in management/policy-making roles.

63. Continue periodic reports on the number of minority group members in AAP staff positions in order to assess progress in increasing the number of minority group members in all staff positions, especially at the management and policy-making levels.

64. Adopt employee programs that might enhance career development of minority group members who are in or striving for advancement to management/policy-making roles in

the Academy (eg, scholarships, executive mentors, training, etc)

65. Ensure that the implementation of Task Force recommendations is a coordinated effort within the Academy. Require a system for tracking the status of the implementation of Task Force recommendations that incorporates the following:

- The Executive Committee will require a status report 18 months after the report is disseminated
- The Executive Committee will ask the Committee on Careers and Opportunities (COCO) to prepare same
- COCO will send a memo to all councils/committees/departments, etc that were assigned recommendation(s). The memo will ask that they report on the status of the implementation (similar to the type of information provided on Chapter Forum Resolutions)
- COCO staff will collect all responses and share them with the COCO
- A COCO member(s) — most likely a former Task Force member(s) — will undertake the responsibility of reviewing the status reports and writing a report from COCO to the Executive Committee

The report to the Executive Committee can be divided into the same five sections (ie, Health Status, Access/Barriers, etc) identified in the original Task Force report. Each section could contain a synopsis of what has been accomplished and what remains to be done. If the status reports provided to COCO identified problems with implementation, this could be noted, too. At the discretion of the COCO, the report could identify strategies or time lines for continuing to address recommendations.

66. Demonstrate the Academy's ongoing commitment to the health and well-being of minority group children through the widespread distribution of this report to Fellows, policymakers, and other health care associations and agencies that have a vested interest in the health care of minority group children.

INTRODUCTION

The keystone of the philosophy, advocacy efforts, and activities of the American Academy of Pediatrics (AAP) is a commitment to improving the health status of America's children. The Academy recognizes, with increasing concern, that there are disparities in the health status and access to care between minority group children and the nonminority population. In this environment of health care reform, the Academy believes that priority must be given to addressing the impediments to optimal health status faced by minority group children. Therefore, in September 1991, the Executive Committee of the Academy approved a Directive that called for the formation of the AAP Task Force on Minority Children's Access to Pediatric Care.

The Directive (see Appendix A) included eight specific charges or assignments. Under this rubric, the Task Force was asked to assess current data/information on the health status of minority group children and their barriers to access to pediatric care. The Task Force was to review the relevant programs and activities of other organizations, and identify opportunities for collaboration. Additionally, the Task Force was asked to consider far-reaching issues — such as the low numbers of minority group students choosing careers in medicine. Finally, the Directive called upon the Task Force to generate a report that would recommend organizational strategies for the Academy. The goal of such strategies would be to ensure that the perspectives of minority group pediatricians (in practice, research, and academia) and the unique needs of minority group children are considered in AAP educational programs, policy development, and advocacy efforts, and research.

The first meeting of the Task Force was held in January 1992; the fourth and final meeting, in January 1993. During this time, the Task Force energies were turned to a number of activities including the following: reviewing existing data sources; considering trends in health care delivery financing; delineating barriers to access to pediatric care; articulating the cultural norms that influence the receipt of health care; looking at the needs of special populations, such as the children of migrant workers; compiling information on the programs of other organizations; learning from invited guests (from both the public and private sector) of programs of particular note; conducting surveys of pediatricians; developing ideas to address the paucity of minority group pediatricians; and a host of other responsibilities. Throughout this process, the Task Force worked to develop recommendations that are appropriate to the capacity of and consistent with the mission of the Academy.

The Academy recognizes, with increasing concern, that there are disparities in the health status and access to care between minority group children and the nonminority population.

This report is the outcome of the activities outlined above. The recommendations contained therein have been approved by the AAP Board of Directors. It should be noted that in the formulation of the Directive to the Task Force the Academy used the "definition" of minority group subscribed to by the Association of American Medical Colleges (AAMC). The AAMC includes African American, Mexican American/Mainland Puerto Rican, and Native American in the category of underrepresented minority groups. Asian Americans are not included because this population is well represented in medicine. The Task Force, however, recognizes that the Asian/Pacific Islander population needs to be factored into any consideration of the health status of minority group children. As discussed in the first section of this report, the efforts of the Task Force were encumbered by a lack of information concerning issues related to specific Asian American populations.

The report is divided into five major sections: Health Status, Barriers to Access, Workforce, Organizational Response, and Academy's Role. At the end of each section are presented a series of recommendations for actions that the Academy should implement to facilitate minority

group children's access to health care and improved health status. Some recommendations include suggestions for collaborative activities. Others propose actions that can be taken by the Academy to increase the number of minority group pediatricians and enhance the pediatric presence in currently underserved areas. The recommendations following the section on the Academy's Role include initiatives that target the participation of minority group Fellows at all levels of the Academy.

The Task Force believes that some of the recommendations can be addressed at once. Others, the Task Force realizes, will take considerable planning and the marshalling of financial and staff resources. The Task Force has developed recommendations that encompass both short term and long-range strategies. However, no attempt has been made to suggest a schedule. Rather, the Task Force envisions the collected recommendations as a template for impending and future AAP initiatives and policy development.

Throughout this process, the Task Force worked to develop recommendations that are appropriate to the capacity of and consistent with the mission of the Academy.

A noteworthy aspect of this report is that the Task Force was asked to identify staff units and groups within the Academy (including councils, committees, and task forces) that could take ownership of these recommendations. This is in keeping with the mandate, stated in the Directive, that the implementation of Board-approved strategies be Academy-wide, and not relegated to a specific committee or council within the Academy. To foster this collaborative spirit, the Task Force — in almost every instance — has assigned the recommendations to more than one group.

. . . the Task Force envisions the collected recommendations as a template for impending and future AAP initiatives and policy development.

The Task Force has also proposed a strategy that will enable the Executive Committee to monitor the implementation of Task Force recommendations, and make "course adjustments" along the way. Finally, the Task Force has endorsed the decision to appoint two Task Force members to the Committee on Careers and Opportunities (COCO). These new COCO members stand ready to provide advice and counsel on the implementation of Task Force recommendations, facilitate the transition from Task Force ideas to Academy-wide initiatives, and participate in the full range of COCO activities.

The Task Force applauds the Executive Committee and the Board of Directors for having the foresight to make minority group children's access to pediatric care a priority for the Academy and for their ongoing support of Task Force endeavors.

ASSESSMENT OF CURRENT DATA AND INFORMATION ON THE HEALTH STATUS OF MINORITY GROUP CHILDREN

Introduction

The Directive to the Task Force by the Academy (see Appendix A) calls for an assessment of current data/information on the health status of minority group children; their barriers to access to care; and the availability of physicians and other health care resources for this population. In this section of the report, the Task Force reviews the available data and information on minority group populations and, in particular, minority group children. Specific attention is given to Asian American children, as the Task Force believes that the lack of information on this segment of the population is particularly noteworthy. Finally, this section addresses the problems of nomenclature that impede data collection and confuse attempts to assess the health status of ethnic and racial minority group children accurately.

Health Status Indicators

The Directive to the Task Force identifies the fact that minority group children and adolescents have, overall, a poorer health status than their nonminority counterparts. The Task Force notes that health status of children in the United States compares unfavorably with that of children in other Western industrial democracies. These differences are more sharply revealed in the disparity in the health status of children in minority groups compared to nonminorities. Premature death and disability caused by controllable illnesses and high rates of infant and child mortality are salient examples. In regard to the infant mortality rate, a common indicator of child health, the United States ranks 21st among other industrialized countries. Although steadily declining over the past 35 years, African American infant mortality rates remain twice as high as those for whites (HHS, *Health Status of the Disadvantaged*, 1990). These disparities are partially explained by high rates of premature and low birthweights in African American infants. However, even African American infants of normal birthweight are at greater risk of death than white infants.

Differential rates of immunization and frequency of infections and injuries persist throughout childhood. The Centers for Disease Control and Prevention (CDC) identified 871 cases of pediatric acquired immunodeficiency syndrome (AIDS) in white children (under the age of 13) in the 1991-92 reporting year. During the same year, the CDC reported over 2,300 cases of pediatric AIDS among African Americans in the same age group, and 1,027 cases among Hispanic children. There were 19 cases of AIDS reported among children of Asian/Pacific Islanders, and 13 cases among children of Native Americans. Injuries associated with violence, predominantly automobile accidents and homicide by handguns, are disproportionately seen in the African American adolescent male. Homicide is the leading cause of death among minority group males aged 15 to 24.

Injuries associated with violence, predominantly automobile accidents and homicide by handguns, are disproportionately seen in the African American adolescent male.

Teenage pregnancy, posing a risk to both infant and mother, is three times higher among minority groups compared to nonminorities. Increasing rates of teenage pregnancy reinforce poverty, poor health, and adverse outcomes. The Task Force further notes that minority group adolescents and young adults are incarcerated in greater proportion than nonminorities. The Academy, in keeping with its advocacy role, should continue to work (in collaboration with other groups or agencies, if appropriate) to ensure that those in the nation's prison system have access to adequate health care.

The Task Force recognizes that infant mortality rates are used as a standard indicator of health status. Conversely, this indicator may in itself present a problem in assessing the overall efficiency of the health care system. It may be unreasonable to view death rates as useful

measures of the health status of a population. Infant mortality rates do not capture severity, variety, coexistence, recurrence, or persistence over a period of time of children's health problems. Outcome measures need to capture the distribution and severity of problems in the population so that resources can be distributed accordingly. For these types of data, the Task Force turned to large, comprehensive, national surveys to develop a more informed view of the health status of minority group children.

Assessment of Current Data and Information

The Task Force has found that the overall quality of the information collected on a national basis is suboptimal with respect to minority group health status. A recent article in *The Nation's Health* (May-June 1992) detailed the shortcomings of national health statistics. A panel from the Institute of Medicine and National Research Council noted, "Current surveys are inadequate, for example. . .in addressing the health care needs of the poor, minorities, and those without health insurance."

Increasing rates of teenage pregnancy reinforce poverty, poor health, and adverse outcomes.

The following lists the Task Force assessment of seven national studies that evaluate minority group health status:

- **Hispanic Health and Nutrition Examination Survey (HHANES):** This was the first special population survey undertaken by the National Center for Health Statistics (NCHS) and represents the most comprehensive survey of Latino health status in the United States. It was conducted from 1982 to 1984 in the three regions of the United States where Latinos are concentrated. The total population was 9,000 and NCHS estimated that the survey represented 76% of the 1980 Latino civilian, noninstitutionalized population from age 6 months to 74 years living in the United States. The information includes demographics, economic conditions, health insurance coverage, health services use and satisfaction, acculturation and health assessments. There has been no follow-up to date.
- **National Ambulatory Medical Care Survey (NAMCS):** This survey has been performed somewhat episodically, but has been annual since 1985. The survey format is based on a sample of nonfederal office-based physicians, excluding visits in the emergency department or hospital outpatient departments. The data base contains information about patient symptoms, diagnoses, and treatments, in addition to patient provider characteristics. The specific reporting of minority group status in this survey is poor.
- **National Hospital Discharge Survey (NHDS):** This is an annual survey of discharge abstracts from nonfederal short-stay hospitals. Although information is available on patient diagnosis and surgical procedure, it lacks socioeconomic status or racial identifiers.
- **National Health Interview Survey (NHIS):** This is an annual, household-based survey conducted by the National Center for Health Statistics that focuses on health status, the use of services, and sociodemographic information. The information about access is derived from medical and dental visits, recent illnesses, health status, and differentials in sites of medical delivery.

  Supplemental sections are needed to study specific problems. These include the 1981, 1988, and 1991 Child Health Supplement; the 1987 Cancer Control Supplement; and the 1988 AIDS Supplement.

  The 1988 Child Health Supplement contains information on a variety of subjects including child care, injuries, exposure to cigarette smoke, school attendance, behavioral problems, health insurance, and sources of medical care. Information is also available regarding racial/ethnic group.

  The most recent NHIS, conducted in 1989, over-sampled Mexican-Americans.

- **National Maternal and Infant Health Survey (NMIHS):** This survey of mothers and providers is conducted by the National Center for Health Statistics. It was conducted in 1988 with longitudinal follow-up in 1991.
- **National Medical Expenditure Survey (NMES):** This survey is conducted every 8 to 10 years by the Agency for Health Care Policy and Research. The most recent survey was conducted in 198[illegible] but the information is not yet publicly available. It provides information regarding health services utilization, expenditures, insurance coverage, and estimates of people with functional disabilities and impairments. It over-samples the Latino population, allowing for national estimates. The data base also includes information on Native Americans.
- **National Survey of Family Growth (NSFG):** This household interview survey of noninstitutionalized women 15 through 44 years of age in the continental United States is conducted periodically by the National Center for Health Statistics. It includes information regarding family planning in addition to other maternal and child health issues. The 1982 survey includes information on the major national origin subgroups of Latinos in the United States.

The standard birth certificate was revised in 1989 in ways that have important implications for understanding the health of minority women and children. Variables documenting behavioral issues that impact on pregnancy outcome, such as the use of alcohol and tobacco, were added to the information collected. Perhaps most importantly, the algorithm for assigning infant race was changed. The National Center for Health Statistics formerly used a complicated algorithm that assigned the non-white race of a parent to the infant, with the exception that if both parents were non-white, the infant was assigned the race of the father. The revision assigned the race of the mother to the infant, which has increased the number of white births.

Although the Task Force uncovered limited available health statistics for African American, Latino, and Native American children, an extensive review of the biomedical literature failed to uncover any nationally representative sources of information on Asian American children. There are, however, investigators interested in documenting the health status of Asian children from countries such as the United States, United Kingdom, Canada, and Australia.

The Task Force has found that the overall quality of the information collected on a national basis is suboptimal with respect to minority group health status.

The US literature is often descriptive in format and addresses a range of issues, including provider perceptions of Asian patients and various measures of health status, such as infant mortality and injury death rates. Some of the international articles detail the dental status of immigrant Asian children.

The Asian/Pacific Islander subgroup is currently the fastest growing population in the United States. Three fifths, or 60%, of the Asian American population is of either Japanese, Chinese, or Filipino origin, and these groups are of approximately similar size. The remaining 40% of the Asian population in the United States is approximately evenly divided between South Indians, Koreans, and Southeast Asians. Although the Task Force has already noted the relative lack of consistent representative data for other minority groups, Asian Americans should be highlighted as a group about whom even less is known. There is no nationally representative information available about Asian Americans (Nickens, *Western Journal of Medicine*, July 1991).

Despite the lack of national information, however, it has been noted that the refugee populations of Southeast Asia, which migrated to the United States following the Vietnam War, face significant socioeconomic and health problems. Tuberculosis and other diseases of poverty are especially prevalent in this group. Despite the overall median family income of Asian/Pacific Islanders, which is higher than that of whites,

the Vietnamese have an average family income that is approximately half that of the Asian/Pacific Islander population.

The opportunities for the Academy to have a positive impact on the collection and dissemination of information are twofold. First, the Task Force encourages the Academy to call for more comprehensive data collection on the health status of Asian American children and adolescents and to support the efforts of other organizations (in both the public and private sector) in this endeavor. Second, the Academy can educate Fellows on the heterogeneity of the Asian American population. The Task Force recommends that consideration be given to incorporating a series of articles into the PREP program that will focus on the heterogeneity of the US population and the implications for the health care system, as well as for pediatricians.

The Asian/Pacific Islander subgroup is currently the fastest growing population in the United States.

The Task Force concludes that the current measures do not adequately reflect the health of our children, particularly minority group children, adolescents, and young adults. The Task Force urges the Academy to support the efforts of the research community to improve data collection and monitoring of the health status of minority group children. An important first step is to contact those federal agencies that conduct surveys and suggest that information regarding racial/ethnic background be collected and/or expanded — so as to document the needs of children in subpopulations of society: in particular, Latino/Hispanic individuals, Asian Americans, Pacific Islanders, and urban Native Americans. Beyond this, the Task Force encourages the Academy to direct the same efforts to the scientific and academic research community and support their endeavors to improve data collection and monitoring of the health status and health care needs of minority group children.

In addition to promoting the research efforts of the public and private sector, the Task Force believes that the Academy itself should develop a research agenda that will, over time, address the health status (including access) of minority group children. Further, the Task Force believes that the Academy can benefit from an analysis of the data from the National Health Interview Study - Child Health Supplement (1988). Several specific types of analyses are outlined in a following recommendation. This is, the Task Force recognizes, a significant undertaking that will likely require new resources. Although labor-intensive, these analyses can dramatically enhance the Academy's ability to assume a leadership role in addressing the health status and access to pediatric care of minority group children.

Standardized Nomenclature

During an extensive review of national studies and numerous articles by the Task force, the issue of appropriate and/or consistent nomenclature became apparent. The problems regarding nomenclature have been due to the inadequacy of the terminology used to reference racial and ethnic groups in publications. Professional groups such as the American Public Health Association have begun an effort to substitute terminology that reflects ethnic categorization rather than race. The primary

theoretical explanation for this change is that the concept of "race" as a biological construct is being challenged, and ethnicity is a more accurate manner of describing the socio-cultural experience of individuals. Moreover, groups such as Latinos can be of any race, including white, black, Native American, and Asian. This racial heterogeneity among Latinos precludes the use of the term "Latino" as a racial category.

The acknowledgment of the diversity of the US population requires modifications to pre-existing terminology. The increasing emphasis on ethnicity, rather than race per se, has implications for the standard terminology utilized in AAP publications. The Task Force recommends that the Academy adopt the following substitutions of terminology:

- African American for black
- Asian/Pacific Islander for Asian origin
- Latino or Hispanic for Spanish origin
- Native American for American Indian
- White for non-Latino white

Although the term "non-Latino white" is the most accurate manner of designating those individuals of non-Latino origin and white race, it has not been widely implemented, and "white" appears to be appropriate despite this imprecision.

Health Status Recommendations

1. Contact those federal agencies that conduct surveys and suggest that information regarding racial/ethnic background be collected and/or expanded in order to document the needs of children in subpopulations of society; in particular, African Americans, Latino/Hispanic individuals, Asian Americans and Pacific Islanders, and urban Native Americans. Assign to:

- Department of Research
- Council on Pediatric Research

2. Make appropriate recommendations to the National Center for Health Statistics (NCHS) regarding the necessary information for documenting and tracking the health status and health care needs of minority group children. In particular, urge the NCHS to consider a special supplement to the National Health Interview Survey on the health status of Asian Americans. Assign to:

- Department of Research
- Council on Pediatric Research

3. Consider the feasibility of collaboration with the National Committee on Vital Statistics. Attend its public hearings to provide input and lobby for increased statistical information on racial/ethnic minority group children. Assign to:

- Department of Research
- Council on Pediatric Research

4. Take every appropriate opportunity to educate the government on the importance of expanding the funding for data collection, monitoring, and research to identify and understand the contributing causes of racial differences more completely, as they affect the health status of children and the access to health care by minority group children. Assign to:

- Department of Government Liaison
- Council on Government Affairs

5. Initiate efforts to educate the scientific and academic research community that current measures of children's health status may not adequately reflect the health of our children. As appropriate, support the efforts of the research community to improve data collection and monitoring of the health status and health care needs of minority group children. Assign to:

- Department of Research
- Council on Pediatric Research

6. Work through the Pediatric Research in Office Setting (PROS) Network to develop a research agenda that addresses the health status (including access and access barriers) of minority group children. Take all reasonable steps to promote this activity to minority group pediatricians so as to solicit their involvement in the Academy and to demonstrate the AAP commitment to minority group children. Assign to:

- PROS Steering Committee
- Department of Communications
- *AAP News*
- Department of Membership

7. Comprehensively analyze the data from the National Health Interview Study - Child Health Supplement, 1988 and 1991. All or several of the following analyses should be undertaken; the findings should be shared with appropriate AAP committees and published:

- ◆ Descriptive analysis of measures of health status by racial/ethnic category; multivariate analysis of sociodemographic predictors of health status for each racial/ethnic category
- ◆ Analysis of measures of access to care by racial/ethnic category, with separate analysis of the effect of geographic region
- ◆ Analysis of the health status of newborns as well as an analysis of prenatal care by racial/ethnic category
- ◆ Analysis of health insurance coverage and sources of medical care by racial/ethnic category as well as geographic region
- ◆ Descriptive analysis of the distribution of common medical conditions of childhood by racial/ethnic group

- ◆ Descriptive analysis of the distribution of health care resouces for behavioral, emotional, and learning problems

Assign to:

- Department of Research
- Council on Pediatric Research

8. Educate members on the heterogeneity of the Asian American population. Consider incorporating into the PREP program a series of articles, that will focus on the heterogeneity of the US population and the implications for the health care system, as well as for pediatricians. Assign to:

- PREP Advisory Group

9. Ensure that analyses for the major minority groups of children in the United States are a component of future research projects and that the findings are widely shared. This will ensure that a minority group children's perspective is incorporated in future AAP statements, testimony, publications, and promulgations.

Assign to:

- Council on Pediatric Research
- Office of the Executive Director
- Executive Committee

10. Recommend that appropriate terminology for ethnic groups is used in all documents, publications, and promulgations of the Academy and the journal, *Pediatrics*. This may include substitution of African American for black, Latino (or Hispanic) for Spanish origin, and Native American for Indian. Assign to:

- Office of the Executive Director
- *Pediatrics* Editorial Board
- All AAP committees, councils, sections, and task forces

BARRIERS TO ACCESS

Introduction

The ability of any individual to gain access to health care services is a function of the availability, obtainability, and acceptability of those services. Although access has been documented to be a major determinant of health outcomes, numerous barriers exist in our society that impede entrance into the health care system. These barriers — which vary in extent and impact as influenced by the culture of the affected group(s) — act to deny, constrain, deter, delay, discourage, handicap, and present other physical, psychological, or economic factors that prevent the acquisition of adequate health care.

Studies (eg, Wyszewianski and Donabedian, *Medical Care*, December 1981; and Wood, et al *Pediatrics*, November 1990) have commented on the effects of these barriers. The previously cited authors, in particular, have noted that members of minority groups consistently:

- Receive fewer health care services per person
- Receive fewer services in relation to need
- Receive a greater proportion of services from a non-optimal or inappropriate source of care
- Receive services that are more often not corresponding to the type needed
- Experience a greater proportion of unfavorable outcomes attributable to care

For minority group children the barriers that contribute to these undesired outcomes are related to economic factors, geographic factors, poverty/lack of education, and cultural/racial/ethnic factors. These barriers are described in greater detail below. Particular attention is given to the unique situations of the children of migrant workers and children who receive health care under the auspices of the Indian Health Service.

Economic Factors

Unemployment among minority group members has been approximately twice that of non-minorities for the past 50 years. About one third of minority groups live below the poverty level. Nearly half (49%) of minority group children less than 6 years of age compared to 18% of white children (in the same age group) live in a poverty-level household (Nickens, *Health Affairs*, Summer 1990).

Perhaps the largest barrier to needed health care is the lack of financial resources to obtain it. Over half of the population living in poverty by the government's own definition, (population consisting disproportionately of women and children), is not eligible for federal health care assistance. Greater than one fifth of all African Americans lack health insurance, comprising 17.5% of the uninsured, but only 12.4% of the population.

Perhaps the largest barrier to needed health care is the lack of financial resources to obtain it.

The lack of insurance has a clear impact upon access to health care and is associated with family income level. Uninsured persons report fewer visits to doctors and have fewer hospitalizations than those who have insurance, even though they are in worse health. Approximately 37 million Americans are without any form of public or private health insurance. Of this 37 million, 12 million are children (under age 21). Another 50 million are underinsured; that is, they have inadequate insurance protection for major hospital and medical expenses (*American College of Physicians* position paper, *Annals of Internal Medicine*, May 1991; and Cleveland, *American Journal of Diseases of Children*, May 1991). Native American, African American, and Hispanic children make up a large portion of the children with either no or inadequate insurance.

This lack of insurance translates into difficulty in obtaining medical care for children who are already at a greater disadvantage because of socioeconomic status and environmental conditions. Poor children lack a "medical home" or a usual source of care, resulting in fragmented care with fewer preventive services being delivered. Routine counseling, anticipatory guidance, and early screening for developmental aberrations are health care modalities that are rarely utilized in a non-continuous source of care. This fragmentation has especially serious effects since disadvantaged minority groups are already burdened with excess disease, have less skills to negotiate a complicated bureaucracy, and face continual pressures to meet the needs of daily survival.

The Task Force believes that minority group children would benefit from incentives to identify high-risk children—especially minority group children and pregnant women, in order to provide risk-reducing interventions—rather than placing the emphasis on technology-intensive, high-cost care. In addition, coordination among providers and between the public and private health care systems is lacking. The Task Force recommends that the Academy continue to promote the medical home concept, emphasizing the special needs of minority group children.

Since 1966 Medicare for the elderly and Medicaid for those of low income have provided some relief in the health care of people who need it the most. However, in the 1970s and 1980s fluctuating eligibility and benefits, and declining provider reimbursement, have made these programs less effective. The overall picture of access to health care for minority group members has become more complex and further removed from the goals initially established for those programs.

Medicaid expenditures increased from approximately $3.5 billion in 1968 to approximately $20 billion in 1979, and the number of Medicaid recipients more than doubled from 11.5 million in 1968 to 23.5 million in 1976. In the late 1970s and early 1980s, however , eligibility restrictions reduced the population that those programs were designed to serve.

Although eligibility for low-income children expanded substantially in the late 1980s and early 1990s, many low-income minority group children eligible for Medicaid and other preventive programs (such as EPSDT) do not participate. This low utilization rate is often the result of physicians who refuse to accept Medicaid because of the following reasons:

- Low reimbursement rates
- Payment delays and administrative "red tape"
- Bureaucratic obstacles (forms returned, clarifications, additional information, etc)
- Lack of awareness of a population at need in the area
- Misperceptions of increased risk of medical liability

Furthermore, Medicaid eligibility fluctuates at a rate health care providers may not be able to track. Physicians often render care to a patient only to learn that Medicaid eligibility status has changed, thus denying reimbursement. The National Center for Health Services Research has estimated that up to 57% of Medicaid recipients are not covered continuously throughout a year. Since minority group children are four times as likely as all other children to have public insurance, they are disproportionately affected. Consequently, even with some form of insurance, minority group children have limited access to available health care.

Poor children lack a "medical home" or a usual source of care, resulting in fragmented care with fewer preventive services being delivered.

The financial barriers to health care were substantially reduced in the third quarter of this century in the United States. Unfortunately, those gains were tied to the economy and have suffered from recession, inflation, and increased costs of health care. A "two class" system of health care is emerging as program cutbacks, health care cost, and inflation marginate the poor and the near-poor. The Academy has proposed a "one class" system of medical care

for pregnant women and children. Yet, the separation of marginated groups from the adequately insured is increasing.

In many areas of this country, health care for minority group children is provided in public clinics, emergency rooms, and those hospitals remaining in the inner cities after private practices have migrated to the suburbs.

The Task Force does not endorse emergency rooms as the appropriate site for the provision of health care for minority group children. Recognizing, however, that they are often the only available source of health care, the Task Force urges the Academy to promote both the philosophical concept and the practice of requiring hospital emergency rooms to ensure that physicians with appropriate training in pediatric care are available.

In discussing the types of economic barriers to access to pediatric care encountered by minority group children, the Task Force has noted two trends. Too often, the Task Force has observed, minority group children are considered as one category. Here and throughout this report, the Task Force maintains that the Academy will need to adapt strategies to meet the unique needs of specific minority group populations. Similarly, the Task Force realizes that there is a common belief that the terms "poor," "minority," and "uninsured" are often regarded as synonymous. The Task Force encourages the Academy, in its documents and promulgations, to separate minority group health from socioeconomic generalizations, as appropriate.

The second trend that the Task Force has noted is the tendency, in the literature on the costs of health care for children, to exaggerate reports on the cost of health care for children without providing a balance or perspective relative to the cost of taking care of other age groups or categories of patients. Here, too, the Task Force asks the Academy, through appropriate publications and public relations activities, to address this misleading perception.

Geographic Factors

Geographic factors refer broadly to the availability of health care providers or health care facilities in a given location. With respect to location, minority groups in the United States have tended to be concentrated in urban centers or isolated rural pockets. In the rural Mississippi Delta, for example, African Americans constitute approximately 70% of the population. In the Delta, health and medicine are linked inextricably to numbing poverty, lack of education, and a social structure in which many African Americans remain fundamentally powerless, unable to control their own lives. Physicians are too few and specialists are fewer in a haphazard, patchwork assembly of a nonintegrated health care system. Clarksdale, a small town in the Mississippi Delta, only has two pediatricians within a radius of 150 miles. The nearest tertiary care center is 75 miles away in Memphis, TN. The efforts of these physicians are undermined by employers who fail to provide insurance for employees, and by Medicaid systems that inadequately reimburse doctors and leave many patients uninsured. As Dr Anne Brooks, a nun and osteopath, (the only doctor in Tutweiler, MS) states: "I think people are sicker longer before they get help, because of lack of money and transportation. When we finally get them into the hospital, they are worse off."

The efforts of these physicians are undermined by employers who fail to provide insurance for employees, and by Medicaid systems that inadequately reimburse doctors and leave many patients uninsured.

Furthermore, the rural population in this society is more likely to have difficulties with access to health care as the health care facilities cater to the larger population centers where they are more likely to find paying clients. The 1978 amendments to the federal Medicare and Medicaid law targeted the expansion of the availability of services to rural residents; however, those conditions have not been met. The programs had to rely on nonphysicians for primary care, like nurse practitioners and physician's assistants, who often gravitated to large urban areas, seeking the same kinds of economic goals and stability that attract physicians to those centers.

The declining Medicaid reimbursement rates and the declining number of physicians who are willing to serve Medicaid patients have contributed to the development of substandard health care facilities (often referred to as "Medicaid mills"), particularly in areas where large populations of Medicaid recipients are located. This is clearly a perversion of the intent that enacted Title 19 of the Social Security Amendments of 1965. The problem has become critical in many cities. In certain areas of New York, for example, 97% of the physicians will not see Medicaid recipients.

Minority group children in migrant families present a special set of health access problems related to geography. The border towns along the United States/Mexico border have survived many economic crises. However, the latest changes in immigration policy and economic development have resulted in a rapid growth of population that is not paralleled by the growth of health care facilities. The poor and migratory workers are finding it increasingly difficult to obtain medical services for themselves or their children. Lack of access to comprehensive and preventive health care is one of the region's most acute problems. Along the border of Mexico and the United States, approximately 73% of the population is Hispanic; in some counties more than half have no insurance. This trend is diminished in populations further North. Yet, in Tucson, AZ, and San Antonio, TX, the uninsured Hispanic population comprises 30% of the total population.

The problems of access to health care in the border regions are often similar to the problems of minority group children in other parts of the United States. In these areas, however, the problems are often exacerbated because, even for Medicaid eligible people, there are fewer physicians, dentists, and nurses available. Public health in the border region is also inadequate. Dysentery and intestinal parasites result from poor sanitation in the migrant "colonias." Preventable diseases (such as measles) are still prevalent in some areas, causing a significant number of deaths.

Recent media attention highlighted the plight of migrant workers' children, and children as young as 6 years of age were seen harvesting tomatoes. These children live in the most abject of circumstances, traveling over long distances with no access to health care or even adequate education. Children of migrant workers are exposed to a variety of hazardous materials and have a high incidence of death by accidental and nonaccidental violence.

The Task Force has devised recommendations that call upon the Academy to develop an educational program and materials for pediatricians that address the health care needs of migrant workers' children. These activities should include information on demographics, legal status, guidelines to promote preventive care in areas of need, and others.

Children of migrant workers are exposed to a variety of hazardous materials and have a high incidence of death by accidental and nonaccidental violence.

Health care for Native Americans and Alaskan Natives is one of the treaty rights guaranteed by the federal government. Health care is provided under the auspices of the Indian Health Service, established in 1924. In spite of the intent of Public Law 83-568 and subsequent legislation designed to ensure health care provision, cultural differences (including time perception), poverty, and differences between rural and urban care delivery are obstacles to providing health care. Geographic isolation is a significant barrier to access to health care that is encountered by Native Americans.

The IHS service population (those who are eligible for IHS services; even though they may not use these services) is increasing at a rate of about 2.35% per year, excluding the impact of new tribes. It is estimated to be approximately 1.33 million in 1994 (HHS, *Trends in Indian Health 1993*). Approximately half of the Native American population reside on reservations. The Navajo reservation, for example, encompasses over 25,000 square miles and has a population of 201,583. In 1992 there were 6 hospitals, 8 health centers, 12 health stations, and 1 school health center providing services (HHS, *Regional Differences in Indian Health*, 1993). In some areas

of the reservation, the nearest health care facility may be 2 to 3 hours away. In addition to the distance, obtaining reliable transportation can be an obstacle to receiving adequate health care, and, at certain times of the year, the roads may also be impassable.

Native Americans who leave the reservation will forfeit the protection of some of their health care benefits. Services available to those living in urban areas are provided through a network of 37 urban Indian programs that receive only partial funding through IHS contracts. Between 1979 and 1987, IHS appropriations for Native American urban programs increased by 1.5%, while the urban Native American population increased by 20.6%. Therefore, there is a large segment of the Native American population, including children, that is receiving inadequate, or at best, minimal health care.

In preparation for the development of this report, the Task Force met with members of the AAP Committee on Community Health Services and the Rural and Inner-City Children's Initiative. The Task Force learned that the Academy's community-based programs have proved successful in many states. The Task Force urges the Academy to seek both the resources and the opportunities to expand these programs in order to address problems (including barriers to access) that disproportionately affect minority group children.

Therefore, there is a large segment of the Native American population, including children, that is receiving inadequate, or at best, minimal health care.

Problems such as violence, environmental hazards including handguns, accident prevention, and safety, the Task Force notes, are often best dealt with at the community level and through public action. In addition, the Task Force encourages the Academy to continue to investigate new strategies designed to foster active community-based outreach approaches and support programs to increase access to pediatric care in inner-city and rural areas.

In addition to community-based programs, the Task Force believes that there is a need for qualified pediatricians to be informed about practice opportunities in underserved areas. As a specific strategy for addressing the health care needs of minority group children in underserved areas (both urban and rural), the Task Force recommends that the Academy explore the feasibility of compiling, and periodically updating, information received from AAP chapters on practice opportunities in areas of need.

Finally, in support of these community-based programs, the Academy must ensure that all of its health education materials are culturally appropriate for all minority groups. Further, the Task Force urges the Academy to set a goal to have all AAP patient education materials available in Spanish. Other aspects of cultural sensitivity are considered below.

Poverty/Lack of Education

Poverty is not merely the lack of money; it is associated with a range of economic and social problems. Sometimes referred to as the "culture of poverty," it is a complex phenomenon of deprivation, manifested in attitude and behavior, and engendered by lack of education, low self-esteem, and lack of trust. General limitations in education and especially limited knowledge of health-related issues will lead to delay in seeking health care, inattention to preventive services, and poor compliance with medication and medical instructions. Distrust of the traditional medical system leads to fear of participation in clinical trials, which limits access to medical innovations.

General limitations in education and especially limited knowledge of health-related issues will lead to delay in seeking health care, inattention to preventive services, and poor compliance with medication and medical instructions.

Language barriers interfere with access for not only non-English-speaking groups such as Latinos and Asians, but also for subgroups of

Asian Americans and subgroups of African Americans with different regional accents, as well. Cultural values that deny illness or values that emphasize traditional healing methods may interfere with proper use of available medical care.

The consequences of poverty result in a different prioritization of values, that is, the need for basic survival supersedes all. Therefore, the need to address inadequate housing, insufficient food, and hazardous environments precludes seeking preventive health care.

Provisions must be made to educate minority group parents and guardians on how to access the health care system effectively, use preventive health services, and promote and maintain healthy life-styles for themselves and their children.

Cultural Sensitivity/Racism/Classism

The racial complexion of the American population changed more dramatically in the past decade than at any other time in the 20th century. Today, one in every five Americans is of African American, Asian, Hispanic, or Native American ancestry. Because minority group population growth is substantially greater than that of the nonminority population, these groups will make up an increasing share of America's populace in the future. It is estimated that by the year 2020 approximately 40% of school-age Americans will be minority group children. In some states, such as California, white Americans of European descent will probably be in the minority (Nickens, *Health Affairs*, Summer 1990; and Jones, *Association for the Care of Children's Health Network*, Summer 1991).

It is estimated that by the year 2020, approximately 40% of school-age Americans will be minority group children.

The Task Force is concerned that the association between America's growing diversity and barriers to health care access may not be readily apparent. In most instances, the institutions providing health care reflect the values of the majority (ie, white European) culture. Taking into consideration the fact that differences in values and beliefs affect the interaction between people, it follows that cultural differences have an enormous impact on the sick and can be a source of untold, albeit unintentional, suffering. As Blum and Blank state in the *American Journal of Diseases of Children* (May 1991): "Racism and classism make it easier to ignore children in poor neighborhoods, indeed, racism and classism may even make it more attractive to care for babies in the highly technological professional neonatal environment than in the communities to which they return."

Not enough attention is given to the impact that cultural norms may exert on health status.

Researchers at the CDC have concluded that there is something unique about being African American that leads to excess infant mortality and morbidity as well as to excess deaths due to other causes. In a report on racism, sexism, and social class, Diane Rowley, MD, notes the following:

> We think this unique factor is not genetic, but environmental, and that racial discrimination, sexism, and class distinctions may be environmental factors that contribute to infant mortality. We hypothesize that discrimination is an historic, continual important exposure for black women that not only influences their chance of being in poverty and having limited access to care, but should be studied as a factor that may cause physiologic reactions that result in pre-term birth. Discrimination is an environmental stressor that influences a women's susceptibility to having a poor pregnancy outcome in the same way that the physical environment influences susceptibility to disease.

In addressing the social/racial/ethnic barriers to access to pediatric care, the Task Force calls upon the Academy to urge pediatricians and other child health providers to be educated about and sensitive to the sociocultural back-

ground of their patients. Not enough attention is given to the impact that cultural norms may exert on health status. Further, however, the Task Force believes that those who are involved in health policy, especially health systems reform, need to have a heightened awareness of the prevalence of cultural insensitivity, racism, and classism. In the "Workforce" section of this report, the Task Force revisits this issue with a focus on education and residency training. Here, however, the Task Force sees this critical barrier to access as one that can be addressed in the health policy arena.

The Task Force urges the Academy to develop a cohesive position and strategy designed to eliminate racial and cultural disadvantages in the health care system. Taking advantage of the Clinton administration's stated goal of eliminating racial, ethnic, and cultural disparities in health care delivery, the Academy has an opportunity to press for the needs of minority group children. The Task Force is cognizant of the Academy's desire, as stated in the Task Force Directive, to ensure that the perspectives of minority group pediatricians are considered in AAP policy development and advocacy efforts. Therefore, the Task Force recommends that minority group Fellows be involved in this endeavor, as appropriate.

Equity in access is linked to disparity by the cost of health services. There has been considerable debate in the United States regarding the supply of some medical services and the over-utilization of health care systems by some segments of society. Utilization of health care by minority group and underprivileged people has increased in the last 50 years, but it has not achieved the level that those who created Medicaid and Medicare envisioned.

In the United States, accessibility to health care has to overcome barriers established between the public that needs health care and the health care system itself. Health care systems have developed by obeying marketplace economic rules. Public health needs, however, obey biological, sociological, and economical rules, which do not match those of the health care system.

Utilization of health care by minority group and underprivileged people has increased in the last 50 years, but it has not achieved the level that those who created Medicaid and Medicare envisioned.

The disparity in the health status of minority group children compared to nonminorities was demonstrated in the first section of this report. Since barriers to access to care for minority group children are different, or more severe than those of their nonminority counterparts, attention needs to be focused on the special-needs of minority group children and the effect their different cultures have on obtaining health care. The Task Force maintains that it is important that all councils, committees, and task forces in the Academy be cognizant of the unique needs of minority group children resulting from their barriers to access to pediatric care.

Access/Barriers Recommendations

1. Continue to utilize every avenue available to assure a universal system of financing health care for all children and pregnant women, regardless of income level, race, employment status of parent, or geographical location. Assign to:

- Executive Committee
- Department of Government Liaison
- All AAP councils, committees, sections, and task forces

2. Continue to endorse the medical home as the optimal source of health care for minority group children. Also, continue to stress that pediatricians are the best providers of health care for all children. Assign to:

- Department of Communications
- Committee on Communications
- All AAP councils, committees, sections, and task forces

3. Support programs that shift emphasis from technology-intensive, high-cost care to incentives to identify high-risk children, especially minority groups, and pregnant women and to provide risk-reducing interventions for them. Assign to:

- Council on Pediatric Practice
- Committee on Fetus and Newborn

4. Work for decreased dependence on categorical funding, and finance most special services through the same system used for routine care to assure greater stability and uniformity of health care delivery in different communities and improved access as family situations change. Assign to:

- Department of Government Liaison
- Committee on Child Health Financing
- Committee on Children With Disabilities

5. Promote both the philosophical concept and the practice of requiring hospital emergency rooms to ensure that physicians with appropriate training in pediatric care are available. Assign to:

- Committee on Hospital Care
- Section on Emergency Medicine
- Committee on Practice and Ambulatory Medicine
- Committee on Pediatric Emergency Medicine

6. Take every opportunity to dispel the common belief that the terms "poor," "minority," and "uninsured" are synonymous. Ensure that in AAP documents and promulgations minority group health is separated from many of the socioeconomic conditions with which it is associated. Assign to:

- Department of Communications
- *AAP News*
- *Pediatrics* Editorial Board
- Committee on Communications
- Department of Maternal, Child, and Adolescent Health

7. Respond systematically, on behalf of children, to reports that exaggerate negative issues in health care delivery for children in general and minorities in particular. Negative publicity includes exaggerated or one-sided reports on costs, utilization of resources, outcomes, and self-care responsibility. Assign to:

- Department of Communications
- *AAP News*
- *Pediatrics* Editorial Board
- Committee on Communications
- Department of Maternal, Child, and Adolescent Health

8. Devise an educational program for pediatricians regarding health care in the border regions and health care of migrant workers' children who cross borders, both national and interstate. The program should include the following:

- ◆ Reliable information about the legal status of international workers' children in terms of health care access, as well as information about health care as a human right
- ◆ Criteria to establish relations with workers' families

- ◆ Health care of Latino/Hispanic families in urban and rural areas, with a plan to reconcile the lack of Latino/Hispanic pediatricians and pediatric health care

Assign to:

- Committee on Community Health Services
- Rural and Inner-City Children's Initiative of the Committee on Community Health Services
- Section on Community and International Child Health

9. Develop a book (in the style of *Guidelines for Perinatal Care*), that shall address health care needs of migrant workers (both national and international), with emphasis on the border regions and recent urban immigrants. The book should include the following:

- ◆ Demographic data pertinent to the geographic distribution of Latino/Hispanic children, the children of migrant workers (national and international), and children of recent immigrants in urban and suburban areas
- ◆ Guidelines for pediatricians to address access to health care for international workers' children relative to their immigration status in the country, and access to health care for children born in the United States of foreign national parents (both federal and state-by-state policy)
- ◆ Methods by which children of marginated families (either by migration or by national origin) can be attracted to and retained within the health care system
- ◆ Guidelines to promote preventive medicine in areas of need: border regions, fields where migrant workers work, and areas in which inner-city migrant children with poor acculturation live
- ◆ Guidelines to promote cultural sensitivity and to facilitate the recognition and prevention of racial prejudice

Assign to:

- Rural and Inner-City Children's Initiative of the Committee on Community Health Services
- Committee on Community Health Services
- Committee on International Child Health
- Section on Community and International Child Health

10. Encourage the Indian Health Service (IHS) to take steps to increase the cultural awareness of physicians who are paying back a service obligation and have little knowledge of Native American children and their families. Urge the IHS to provide cross-cultural workshops for new health care providers as part of their orientation. Foster collaborative activities between the Academy, the IHS, and the Association of American Indian Physicians (AAIP) to achieve these goals. Assign to:

- Provisional Committee on Native American Child Health
- Resident Section

11. Advocate for increased financial aid to the urban Native American health care programs and urge the IHS to aid the urban centers in grant writing (eg, provide technical assistance and/or training), stressing the need to better address the health care needs of Native American children.

- Provisional Committee on Native American Child Health
- Department of Government Liaison

12. Incorporate a component that addresses the special health care needs (needs resulting from access barriers) of minority children into the Academy's health care reform proposal, and, as appropriate, into the AAP evaluation of and response to other health care reform proposals or initiatives. Assign to:

- Executive Committee
- Department of Government Liaison
- Access Strategy Committee
- Committee on State Government Affairs

13. Encourage active community-based outreach approaches to address the health care needs of minority group children, and support programs to increase access in inner-city and rural areas. Assign to:

- Committee on Community Health Services

- Rural and Inner-City Children's Initiative of the Committee on Community Health Services
- Office of Community Pediatrics

14. Expand the AAP community-based programs to more states and include such problems as limited knowledge concerning the health care delivery process; violence; environmental hazards, including handguns; accident prevention; and safety—all of which can be best addressed by public action. Ensure that a minority group perspective is included. Work with the National Medical Association and/or the American Medical Association, or other organizations (as appropriate) that have developed or are considering similar initiatives. Assign to:

- Executive Committee
- Committee on Community Health Services
- Office of Community Pediatrics
- Committee on Injury and Poison Prevention
- Committee on Environmental Health

15. Explore the feasibility of compiling and periodically updating information received from AAP chapters on the availability of opportunities to practice in areas of need (rural and urban). Assign to:

- Division of Chapter Services
- Committee on Community Health Services
- Rural and Inner-City Children's Initiative of the Committee on Community Health Services
- Office of Community Pediatrics

16. Ensure that all AAP health education materials are culturally appropriate for all minority groups as well as nonminorities. When this is not feasible, develop separate materials for the minority group(s). Work to achieve the goal of having all AAP patient education materials available in Spanish. Assign to:

- Division of Public Education

17. Urge pediatricians, other child health providers, and health policymakers to be educated about and sensitive to the sociocultural background of their patients, and to appreciate the impact that cultural norms may exert on health status. Involve minority group Fellows in this endeavor, as appropriate. Assign to:

- Department of Communications
- *AAP News*
- Committee on Communications
- *Pediatrics* Editorial Board
- Council on Pediatric Education
- Committee on Careers and Opportunities
- Resident Section

18. Continue to advocate for increased collaboration and coordination among providers and between providers and the public and private health care systems to ensure that the health care needs of minority group children are addressed. Assign to:

- Committee on Child Health Financing
- Committee on Children With Disabilities

19. Ensure that all councils, committees, sections and task forces that deal with child health issues be cognizant of the unique health care needs resulting from barriers to access. Assign to:

- Executive Committee
- All appropriate AAP councils, committees, sections, and task forces

WORKFORCE

Introduction

The AAP Task Force on Minority Children's Access to Pediatric Care firmly believes that the health status of minority group children can be enhanced by increasing the number of pediatricians and by facilitating the location of these providers in underserved areas. However, the Task Force notes that placement of more pediatricians in underserved areas, in and of itself, will not be sufficient. Medical students, pediatric residents, and practicing pediatricians can enhance their ability to provide needed health care to minority group children effectively by receiving training in cultural competence and sensitivity.

Finally, the Task Force notes with alarm the paucity of minority group pediatricians. No attempt is being made to suggest that minority group children should be served solely by minority group pediatricians, nor that minority group pediatricians should care only for minority group children. However, a number of studies, referenced in the bibliography (eg, Jones and Flowers, *Academic Medicine*, November 1990; and Kassenbaum, *Academic Medicine*, June 1993), state unambiguously that minority group physicians are more likely to treat underserved and impoverished minority group children and accept Medicaid patients at increased rates. Moreover, in graduate medical education and in practice, minority group physicians choose primary care specialties more often than nonminority physicians. As such, increasing the number of minority group pediatricians should expand access to health care services for minority group children. This is particulary of current importance because of the focus on expanding the primary care workforce as part of the health care reform movement.

The concluding portion of this section, therefore, is devoted to the consideration of programs designed to interest minority group students in careers in medicine, and, specifically, pediatrics. The Task Force encourages the independent initiatives of individual pediatricians. However, the Task Force contends that if the goal is to work effectively to increase the number of culturally diverse pediatricians at all levels of the health care system (with special attention to areas of health policy, health care delivery, and health services research), then the Academy must be proactive. A number of specific activities are proposed. Collaborative activities with chapters and other organizations are suggested.

The Task Force notes with alarm the paucity of minority group pediatricians.

Geographic Distribution of the Providers of Pediatric Care

The "Barriers to Access" section of this report provides an overview of the geographic barriers encountered by minority group children. This portion of the report revisits this important constraint. Here, however, the Task Force endeavors to emphasize the problems in the health care delivery system and their impact on physicians. Particular attention is given to the delivery of pediatric care to Native Americans under the unique system of the Indian Health Service (IHS).

Problems associated with the geographic distribution of pediatricians under the IHS are unique and yet equally challenging for this segment of the US population.

Dispersed rural populations and clustered urban/inner-city populations present a great challenge to the delivery of adequate health care. Physician distribution is a very significant problem, one that is increasing as the outward migration of physicians continues from the cities to the suburbs. Minority groups who live in rural areas also suffer from lack of access to health care services. In a recent study (*Health Affairs*, Summer 1993), Kindig

and Yan demonstrate that rural counties with the highest proportions of African Americans and Hispanics had fewer physicians per capita than did nonmetropolitan counties in general. For a significant proportion of the US population, including ethnic and racial minorities and those who live in urban ghettos and in rural areas, access to health care services is constrained.

Problems associated with the geographic distribution of pediatricians under the IHS are unique and yet equally challenging for this segment of the US population. The Native American population is younger, less educated, and poorer than the US All Races population (IHS, *Regional Differences in Indian Health*, 1993). Data from the IHS provides information on the total IHS user population, which is defined as those who have used IHS services at least once during the past 3-year period. This number is estimated at 1,135,000 for fiscal year 1991. Approximately 13% of this population (compared to 7.5% of the US general population) is less than 5 years old. As of November 1991, there were 125 pediatricians in all IHS areas. A combination of shrinking incentive programs for the IHS and the National Health Service Corps (NHSC), relatively low pay, and difficult working conditions in many remote IHS sites makes recruitment and retention of all types of health care providers difficult.

Some pediatricians join the IHS through state and federal scholarship and loan repayment programs that require service for a designated time period in exchange for loan forgiveness. Some of these pediatricians remain in the IHS after they have completed their service obligation; many, however, do not. The result is a high turnover rate at many service units, often resulting in inadequate staffing. The situation is exacerbated by increases in service demands resulting from increases in tribal membership. As a result, the IHS becomes a less attractive employment option for all providers, including pediatricians.

A number of impediments must be addressed to encourage the location of pediatricians in underserved areas, particularly those with a large minority group(s) population. Barriers include limited availability of medical resources; location of health care facilities; lack of access to allied health professionals and tertiary care subspecialists; and poor language skills. Other commonly cited problems include the lack of cultural activities for the physician and his or her family, and the lack of collegial networking and information-sharing opportunities. Even dedicated physicians may abandon underserved areas and areas of racial minorities because of lack of understanding, or because they may be afraid of bodily harm or loss of property.

Inadequate reimbursement (ie, lower income), is a significant barrier to increasing the number of pediatricians in underserved areas. Low reimbursement represents an even greater challenge to those who must repay sizable medical school loans. As a result of these considerable barriers, current distribution of physicians does not adequately serve the needs of ethnic and less affluent minority group populations.

A number of impediments must be addressed to encourage the location of pediatricians in underserved areas, particularly those with a large minority group(s) population. Barriers include limited availability of medical resources; location of health care facilities; lack of access to allied health professionals and tertiary care subspecialists; and poor language skills.

The Task Force believes that any scheme to address the geographic maldistribution of pediatricians and the consequent effects on access to pediatric care by minority group children must be multifaceted. Starting now, the Task Force recommends that the Academy work with existing organizations and agencies, such as the National Health Service Corps (NHSC) and the IHS to strengthen programs that are intended to address the geographic maldistribution of physicians and other health care providers. Given the impediments to practice in underserved areas (described here briefly) and the barriers to access to pediatric care faced by minority group children (discussed in an earlier section) the Task Force does not believe that the Academy should anticipate that expanding access to

health insurance under health care reform will automatically or immediately ameliorate this crisis. While many infants, children, adolescents, and young adults currently encounter barriers to access to care, minority group children are disproportionately affected by these barriers and/or face impediments that are unique. Continuing to address the geographic maldistribution of pediatricians, discussed here, and increasing the number of minority group pediatricians, discussed later in this section, must be priorities for the Academy.

Incentives have been established to recruit practitioners to areas that are underserved and have a shortage of health professionals and a high number of minority group children. The NHSC provides scholarships and loan forgiveness programs to promote the placement of physicians, and to a lesser extent dentists and nurses, in prioritized shortage/underserved regions. Renewed interest and funding for the NHSC (after a number of years of dwindling support) in addition to substantial funding increases for community/migrant health centers should improve minority group children's access to health care.

Even dedicated physicians may abandon underserved areas and areas of racial minorities because of lack of understanding, or because they may be afraid of bodily harm or loss of property.

The NHSC program, however, needs to improve the matching of physicians and other health professionals with clinical sites that will result in greater retention of these practitioners on a long-term basis, and not merely for their temporary service obligation time. This might be achieved by having applicants perform their service in regions in which they have lived or have demographic/cultural links. Greater coordination of participant placements by networks involving the academic health center and community health center may also be effective.

Cultural Competence of the Providers of Pediatric Care

Looking to the future, the Academy should help focus attention on the special needs of minority group children and relationships between the health status of these children, their unique cultural attributes, and access to pediatric care.

While many infants, children, adolescents, and young adults currently encounter barriers to access to care, minority group children are disproportionately affected by these barriers and/or face impediments that are unique.

Further, the Academy should encourage pediatricians, residents, and medical students to become trained in cultural competency and sensitivity. This should enable them to deliver care better and contribute to the solutions of the broad arena of medicosocial problems that severely impact health outcomes. Through its existing publications for pediatricians in practice settings (eg, *Management of Pediatric Practice*) as well as new venues, the Academy should provide information on cultural sensitivity as it pertains to minority group children and their families. The resources of appropriate AAP sections should be utilized to offer programs/workshops at AAP Annual Meetings and Spring Sessions.

The ability to interact and communicate competently with minority group parents and children enhances the effectiveness of the pediatrician. A special bond is needed between the patient/patient's family and the pediatrician to promote a sense of trust and improved patient compliance with the management plan. Unfortunately, the education and/or training of medical and other health professionals often lack adequate experience or observation of role models in dealing with cultural issues as they relate to minority group children.

The Task Force has identified countless examples of cultural differences that often impede access to pediatric care or the actual delivery of health care to minority group children. Some of the most striking, and therefore used here as

examples, are the long-standing beliefs and practices that persist among the Native American population. Most notable are cultural perceptions of illness. A Native American, for example, may have predetermined ideas about the cause of his/her illness, as well as an appropriate treatment. Because of cultural differences, this may conflict with the physician diagnosis. Among Navajos, as with most tribes, health and religion are inseparable. Navajo metaphysics is a complex philosophy. However, one attribute is the belief that good health is a result of a person being in harmony with nature and the supernatural. Illness, therefore, can be caused by a breach in taboo, witchcraft, intrusive objects, animals, or natural phenomena. Because of these beliefs, and reliance on traditional healing, a Native American may not access western medicine until the later stages of his/her illness. Consequently, as recently as 30 years ago, IHS hospitals were perceived by the Navajos as places to die, because patients agreed to hospitalization only when their disease(s) was very advanced. As Native Americans adopt western ways, the trend is to combine both traditional and western medicine in the delivery of health care. Today, it is not unusual for a traditional medicine man to refer a patient to a western physician if the medicine man feels that the patient will benefit from this method of care.

Increasingly, Native Americans have woven a western life-style in with their traditional beliefs. The result is a unique approach to life and a new approach to health care.

Cultural differences in communication, both verbal and nonverbal, may affect interactions in the health care settings. For many Native Americans English is a second language, and western mannerisms may be foreign as well. In some tribes, the "healer" is expected to know by instinct what has caused the patient to seek his/her services. Therefore, the physician's practice of taking a medical history or asking personal questions may be considered rude. It is also considered a breach of Navajo etiquette to look directly at a person during conversation. A western physician may misinterpret this behavior as inattention.

In summary, the Task Force recognizes that it is difficult to generalize about this diverse minority group. Just as Native Americans are moving off the reservations and becoming part of mainstream America, some are returning to the reservations. Increasingly, Native Americans have woven a western life-style in with their traditional beliefs. The result is a unique approach to life and a new approach to health care. The health care system should be cognizant of the diversity of these people and of how this diversity may inadvertently hinder attempts to provide the best care.

The incorporation of medical ethics, cultural issues, and public health perspectives into medical school and residency training could provide the resident physician with a better understanding of how to meet the needs of all minority group children. Increased time in community-based ambulatory training, particularly in settings with underserved populations, would also be a positive influence. Activities such as these might also increase the number of pediatricians willing to practice in low-income, minority group communities.

Community-based training sites for health professional students and residents/postgraduates are becoming increasingly available through Area Health Education Centers (AHECs) funded through the Public Health Service. The aim of the AHEC is to expose students, residents, and postgraduates to clinical experiences in community-based settings distant from, but affiliated with, university teaching hospitals/clinics. These programs also enhance practice environments through their various support systems (continuing education, library/educational resource centers, local faculty development) and the recruitment of students from the local areas to health professional careers. Despite its modest federal appropriation level, the AHEC program continues to have a major impact on improving the health professional resources that provide access to underserved, minority populations.

However, problems exist with the criteria that are routinely used for awarding health professional educational and health service delivery

programs, such as those described above. These criteria traditionally include rates of infant mortality and low birth weight infants. However, in some underserved populations these clinical findings are not a problem, in contrast to major problems that are seen with postnatal morbidity and mortality (Sumaya, Testimony Before the Congressional Hispanic Caucus, 1993). Further, very low education levels and insurance coverage, although intimately tied to health status and health service access, are not appreciably emphasized as criteria for publicly funded programs targeting health professional site placements and assistance programs dealing with health education and training or health care delivery. It is important to incorporate all of these specific features into the criteria used for awarding federal, state, and private monies because they are valid indicators of poor health care access and health status.

Pediatric International Medical Graduates

The Task Force recognizes the significant contributions made to the provision of health care by International Medical Graduates (IMGs). In the course of their work, the Task Force has noted that there are often negative perceptions regarding IMGs. An important first step in changing these perceptions is for the Academy to continue to advocate positively the role of IMGs in health care delivery. Further, the Academy should continue to address health policy and legislative proposals (eg, graduate medical education) that will affect IMGs. Other issues, such as credentialing, career trends and career options, and immigration options, should be monitored, as well. In testimony and other promulgations, the Academy should speak consistently and in support of IMGs.

Increasing the Number of Pediatricians From Underrepresented Minority Groups

Presently, approximately 20% of the US population is from an underrepresented minority group. This is expected to continue to increase, and — as noted earlier — by the year 2020 it is projected that 40% of school-age children will belong to a racial or ethnic minority group. In contrast to this growth, the percentage of minorities entering medical school remains at approximately 10%. Recent and highly publicized gains in the number of minority group students applying to medical school (a 15% increase in 1993–1994 applications over the previous year), will not ameliorate the disparity (Moon, *Pediatric News*, April 1993). This disparity contributes to access problems for minority group children.

There are other findings relevant to the education and training of minority physicians. The unmatched rates for underrepresented minorities are much higher than those for nonminority residency applicants (Association of American Medical Colleges Data Report, *Academic Medicine*, March 1991). The proportion of underrepresented minority faculty is very small, comprising only 2.9% of the faculty at US medical schools. Also, 40% of the minority faculty are employed in only 10 of the nation's schools. Further, there is a large disparity between the percentage of minority group faculty that have achieved the rank of professor or associate professor compared with other nonminorities.

The Task Force notes that a number of studies address the importance of having more minority group physicians. In the Third Report of the Council on Graduate Medical Education (COGME), *Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century* (1993), the need for more minority group physicians is clearly delineated. COGME called for increasing the number of minorities in the medical profession for the following reasons:

- Equity, justice, and morality
- The much greater morbidity and mortality among minorities as compared with the white population
- Minorities tend to practice more in minority/underserved communities where there is the greatest need for practitioners

- Cultural and language differences are best addressed by physicians from the respective minority group, although all physicians should be sensitive to and competent in addressing such racial/ethnic differences
- Minority physicians have historically provided much needed leadership to their communities that the nation cannot afford to ignore

Echoing these conclusions, the Task Force maintains that reversing the underrepresentation of minority physicians in the workforce is pivotal to improving the access to pediatric health care for minority group children.

The Task Force was specifically charged with recommending strategies appropriate to the capacity of and consistent with the mission of the Academy to increase the number of qualified pediatricians from underrepresented minority groups. They have concluded that the Academy must initiate both short-term and long-range strategies. These strategies should include a broad spectrum of initiatives that look beyond medical students, and also address the needs of grammar/secondary/college students. Additionally, the Academy must develop networks of pediatricians to serve as mentors for all age levels, including minority group medical students.

Intervention at various stages of the educational process is needed to correct the barriers preventing the training of more minority group physicians.

The Academy must be aggressive in its endeavors to recruit more minority group medical students into pediatrics. In order to be successful in increasing the number of minority group pediatricians, programs specific to the needs and interests of minority group medical students must be devised. Finally, existing AAP medical student recruitment efforts must have a defined minority group component.

Intervention at various stages of the educational process is needed to correct the barriers preventing the training of more minority group physicians. Some of these measures include improvements in science/math and preprofessional education of minority group applicants; greater emphasis by medical school admissions committees on the personal attributes of applicants; and increased minority group medical faculty that can serve as mentors and role models, including representation on admissions committees. Further, minority group students and their families should receive more information, taking socioeconomic and cultural differences into account, about the financial resources available for college and medical education.

The financing of the education for a physician or other health professional is another major barrier for minorities. More than twice as many minority group students as nonminority students state they have abandoned their plans for a medical career because of financial considerations. In addition, a 1993 AAMC study of the educational debt of underrepresented minority group medical students reveals that this group is twice as likely to have some level of educational debt as their nonminority counterparts.

Further, indebted minority group graduates tend to accumulate higher levels of debt (especially in private schools) than their nonminority colleagues. The Academy, therefore, can provide an important service by: (1) continuing to advocate for financial aid and loan repayment options that will encourage minority group students to choose careers in medicine; and (2) making information about these programs available to minority group students.

More than twice as many minority group students as nonminority students state they have abandoned their plans for a medical career because of financial considerations.

An emerging priority in initiatives designed to increase the number of minority group members in the medical profession is the need to ensure that grammar and secondary school students have sufficient preparation in science and math to facilitate their successful matricu-

lation through college and medical school. The Task Force has learned that a number of organizations — in both the public and private sectors — have developed programs to target this need. Several of these programs are described in greater detail in Appendix B. The Task Force urges the Academy to both support and participate in these endeavors.

Additionally, the Task Force believes that the Academy should encourage individual pediatricians to be involved as mentors and supporters of students in grammar and secondary schools, college, and medical school. Pediatricians need to be reminded that they alone are in a unique and enviable position. On an ongoing basis, pediatricians positively interact with the future generation of physicians. The Academy should encourage its Fellows to proactively take advantage of this opportunity by talking to children, especially the minority group children with whom they are in contact, about their future, their plans, careers in medicine, and the attributes of pediatrics.

Encouraging grammar and secondary school students to take an interest in science and math is a vital component of any program that is designed to spark an interest in the medical profession. Additionally, pediatricians should make themselves available to their area schools by offering to participate in career days.

An emerging priority in initiatives designed to increase the number of minority group members in the medical profession is the need to ensure that grammar and secondary school students have sufficient preparation in science and math to facilitate their successful matriculation through college and medical school.

On a less structured basis, pediatricians can be available to counsel individual students who have an aptitude for science or math, or who have expressed an interest in the medical profession. Contacting the school counselor(s) is one way to initiate this effort. The Task Force notes with interest that the health care reform environment already has generated legislative proposals that focus on improving science and math curricula at the elementary and secondary school levels, and this will most likely continue. The Academy should monitor and, as appropriate, support such legislation, as it will have significant implications for the future of pediatrics.

Pediatricians, by their training and through their experience, are best able to foster and nurture an interest in a career in medicine and/or pediatrics, and the Academy should stand ready to support this activity. This can be done by making Fellows aware of existing programs on the local and national levels in which they can participate. Further, the Academy should determine what guidance or tools (eg, resource packets) will best facilitate this endeavor and develop the same. Encouraging pediatricians to serve as role models for the minority group children they encounter in their practices and through area schools are two important activities. A third opportunity is for Fellows to participate in the established "mentor" networks of minority group medical organizations. This activity is discussed in greater detail in the next section ("Organizational Response") of this report.

Encouraging pediatricians to serve as role models for the minority group children they encounter in their practices and through area schools are two important activities.

The Task Force believes that at the national and chapter levels the Academy must utilize every opportunity to reach out to minority group students. At the national level, the Academy should continue their collaborative activities with minority group medical student organizations, such as the program developed by the Committee on Careers and Opportunities (described in the next section of this report). In the 1993 US Public Health Service report, *Toward Equality of Well-Being: Strategies for Improving Minority Health*, a number of immediate and short-, medium-, and long-term objectives were identified to promote education for the health professions. Here, too, an emphasis was placed on working with students prior to their matriculation through medical school. Two of the immediate objectives that the Task Force

found noteworthy and appropriate for the Academy and its Fellows to undertake are as follows: (1) Use innovative communications to promote health professions career choices among minority groups at all levels of the education system; and (2) Develop leadership conferences and incentives to interest young minority group persons in health professions careers. The Task Force believes that the Academy (through individual Fellows, chapter level, and national programs/activities) has both the resources and the opportunities to realize these same objectives for pediatrics.

The Academy's Annual Meetings and Spring Sessions represent important opportunities for contacting area students. On the weekend prior to these meetings, the Task Force recommends that the Academy implement half-day programs designed to encourage local high school and college students to pursue careers in the health professions. Workshops developed by the Interamerican College of Physicians and Surgeons (ICPS) can serve as a model. Local area medical students should be involved in workshops designed to attract them to pediatrics. Every effort should be made to include minority group Fellows on the roster of presenters.

Programs for secondary students could feature topics such as preparing to enter college; opportunities for career preparation; importance of science and math; and life-styles and career options in pediatrics. Gaining acceptance to medical school and finding a mentor are but two of many topics suitable for a college audience. Medical students who attend these programs would likely be interested in workshops pertaining to transition to residency; selecting a residency in primary care; and pediatric residency training. The COCO publication, *Selecting a Pediatric Residency: An Employment Guide*, would be a good resource. The Academy's strongest asset in ensuring the success of these programs, however, is the involvement of the AAP Resident Section in all phases of planning and implementation.

Recognizing that attending a national meeting as large as the Academy's can be an overwhelming experience for some students, the Academy should have a registration or "sign in" booth that is specifically designated for students. Handout materials on careers in medicine and specifically pediatrics should be readily available. These programs can be open to all area students, but special efforts should be taken to invite minority group medical students to attend. (Both the ICPS and the SNMA can provide lists of members, regionally, for a special invitation.)

The Academy's Annual Meetings and Spring Sessions represent important opportunities for contacting area students.

The Task Force suggests that the Academy contact high school guidance or career counselors by placing a notice in the publications of national organizations of guidance counselors, encouraging them to contact the Academy for information on careers in pediatrics. This contact can also alert them to other AAP efforts to recruit minority group students into medicine, such as those identified above.

The Task Force urges the Academy to send strong and consistent messages to districts and chapters that student recruitment into medicine, and particularly into pediatrics, is a priority, especially among minority group students. Furthermore the Academy, in order to be successful, must work with the AAP chapters to foster the implementation of programs designed to recruit minority group students into pediatrics.

Many chapters are already involved (at varying levels) in medical student recruitment activities. The Academy, on an ongoing basis, should encourage chapters to become or to continue to be actively aware of and involved in local medical student recruitment activities. The Task Force recommends that the Academy survey chapters to determine what types of student recruitment activities are in place and if there are some that are particularly focused on the needs and interests of minority group students. Further, the Academy should determine whether or not there are any "tools" that are needed to enhance activities at the chapter level. As noted earlier, career information (eg, the brochure, *PEDIATRICS: A Rewarding Career Choice*) should be available in Spanish. Also, the Academy should make multiple copies (or a copy suitable for photocopying) available to chapters on request. Finally, information con-

cerning successful programs that are identified as a result of the survey should be promulgated.

For those chapters that are not involved in student recruitment activities or are not engaged in these activities on a consistent basis, several steps can be taken. For organizational purposes, chapters may wish to delegate student recruitment activities to their Committee on Careers and Opportunities or their Committee on Manpower.

A number of studies have described the attributes of clerkship programs for medical students. The Task Force believes that clerkship opportunities for medical students in community-based settings offer an important avenue to promote careers in pediatrics. Clinical experiences in settings where large numbers of minority group children are cared for also serve to increase the awareness of the unique needs of these patients and their families. As clerkships can best be fostered locally, the Task Force urges districts and chapters to work with area medical schools to facilitate this opportunity. The article "Guidelines for Medical Student Education in Community-Based Pediatric Offices" can serve as a resource to facilitate this program. This effort could also serve as an ongoing program for involving minority group pediatricians in chapter activities (discussion of minority group pediatricians appears in the next section of this report).

Other steps that chapters can take include ascertaining when area grammar and secondary schools, colleges, and medical schools are having "career days," and ensuring that pediatrics is represented. The AAP headquarters office should be contacted for handouts or other information (eg, current data) on pediatrics. Chapters should consider offering students programs or workshops (or receptions, if appropriate), such as those described above, possibly in conjunction with the regional or annual meeting of a minority group medical student association or group (eg, SNMA).

Regional linkages with other student associations and other medical organizations should be pursued, as well. Often a county or state medical society will be engaged in medical student recruitment activities and will welcome a pediatric minority group component in their program. Related to this idea, some school districts maintain career "libraries" or computerized information services for students from the secondary school level through college. Chapters should ensure that accurate information about pediatrics, and the need for more minority group students to consider careers in medicine, is contained therein.

The Task Force urges the Academy to send strong and consistent messages to districts and chapters that student recruitment into medicine, and particularly into pediatrics, is a priority, especially among minority group students.

One of the most important linkages that a chapter can make is with a pediatric interest group or pediatric club — particularly in medical schools that have a significant number of minority group students. In light of the previously identified lack of minority group role models in pediatrics, this is an activity wherein the chapter may wish to make particular efforts to enlist the perspectives and services of their minority group members.

In some chapters, a pediatric club(s) may already exist. In this instance, the chapter can perform a service by ensuring that the following issues — to name but a few — are considered: issues related to cultural competence and sensitivity; the provision of care to underserved minority group communities; and health policy and health care reform and the implications for access to care for minority group children. The Academy is urged to include materials pertinent to topics such as these in materials that they develop and/or revise pertinent to pediatric clubs.

In the initiation or enhancement of chapter involvement in pediatric clubs–and indeed in all of the activities described in this component of the report–the Task Force sees the involvement of chapters, minority group pediatricians, and pediatric residents as pivotal. Additionally, the Task Force encourages two-way networking between the AAP national office and chapter to foster the implementation or ongoing development of these activities. The sharing of good ideas is seen as crucial to the success of both national and chapter level programs.

Workforce Recommendations

1. Work to increase the number of minority group pediatricians and health care providers at all levels of the health care system, with special attention to areas of health policy, health care delivery, and health services research. In particular, support (as appropriate) legislative proposals designed to increase the number of minority group physicians and/or enhance science and math curricula at the elementary and secondary school levels. Assign to:

- Committee on Careers and Opportunities
- Council on Pediatric Education
- Resident Section
- Committee on State Government Affairs
- Council on Government Affairs
- Department of Government Liaison

2. Work with the Indian Health Service (IHS) on recruitment and retention programs to increase the number of pediatricians. Assign to:

- Provisional Committee on Native American Child Health
- Resident Section

3. Develop a program to address the problem of geographic maldistribution of primary care providers in pediatrics using the following measures:

- Support expanded funding of the National Health Service Corps (NHSC) program
- Influence the NHSC to expand the listing of medically underserved areas in the United States, including areas such as south Texas, Mississippi, and Alabama
- Develop incentives and/or support current programs to encourage pediatricians to locate in underserved areas
- Encourage implementation of programs at the chapter level to highlight areas where pediatricians are needed and inform residency programs of these areas

Assign to:

- Chapter Presidents
- Committee on Careers and Opportunities
- Council on Pediatric Education
- Rural and Inner-City Initiative of the Committee on Community Health Services
- Department of Government Liaison
- Resident Section

4. Support federal, state, and private sector programs that enhance the health resources and services targeting underserved minority group areas. Also, support the inclusion of valid items (eg, rates of insurance coverage and level of education) that yield a more equitable profile and a criteria scale to be used in awarding health resources and services programs targeting underserved minority group populations. Programs targeting disparities in health resources and services should be population-based. Assign to:

- Rural and Inner-City Children's Initiative of the Committee on Community Health Service
- Council on Government Affairs
- Department of Government Liaison
- Committee on State Government Affairs
- Division of State Government Affairs
- Committee on Child Health Financing

5. Emphasize changes in medical education/training that promote community-based clinical training experience. Encourage pediatricians, residents, and medical students to become trained in the medicosocial problems of the poor, enabling them to deliver care better and contribute more effectively to the solutions of the broad arena of medicosocial problems that severely impact health outcomes. Provide the resources needed to ensure that pediatricians attain cultural competency by addressing pertinent issues in AAP publications and manuals and through workshops at AAP meetings. Assign to:

- Council on Pediatric Education
- Office of Community Pediatrics
- Committee on Community Health Services
- Committee on Practice and Ambulatory Medicine

- Provisional Section on Administration and Practice Management
- Resident Section
- Committee on Careers and Opportunities

6. Working through the Residency Review Committee for Pediatrics and the Association of Pediatric Program Directors, recommend curricular changes in residency training that will involve integration of cultural sensitivity, tailored to the local patient population. Strive to ensure that upon the completion of their training, pediatricians are prepared to deal effectively with cu' rally diverse, multilingual patient populations of varying socioeconomic status. Assign to:

- Council on Pediatric Education
- Resident Section

7. Continue to advocate positively the role of the international medical graduate (IMG) in health care delivery. Work to dispel negative perceptions of IMGs. Assign to:

- Committee on Communications
- Department of Communications
- Department of Government Liaison
- Resident Section
- Committee on Careers and Opportunities

8. Continue to expand efforts to inform minority group college and medical students about the availability of loan/scholarship programs and the attributes of pediatrics. Assign to:

- Committee on Careers and Opportunities
- Resident Section

9. Develop workshops on topics pertinent to preparing for medical school and selecting a career in pediatrics, to be held on the weekend prior to the AAP Annual Meeting and Spring Session. On a rotating basis, these should be targeted to area high school and/or college and to college and/or medical student audiences. Work with appropriate student organizations (eg, Student National Medical Association, Interamerican College of Physicians and Surgeons) to ensure minority group student participation. Assign to:

- Department of Education
- Committee on Careers and Opportunities
- Resident Section

10. Contact high school guidance or career counselors (via the publication(s) of national organizations of same), and encourage them to contact the Academy (nationally and at the chapter level) for information on careers in pediatrics as both a reference tool and as a means of more broadly promoting the availability of such material to students. Assign to:

- Division of Public Education
- Committee on Careers and Opportunities

11. Solicit information from chapters and/or districts to determine what types of student recruitment activities are in place; if there are some that are particularly focused on the needs and interests of minority group students; and ascertain if any "tools" are needed to enhance this activity. Publicize successful programs. Assign to:

- Committee on Careers and Opportunities
- Division of Chapter Services
- Alternate District Chairpersons Committee
- Resident Section
- Department of Communications
- *AAP News*

12. Foster the selection of a career in pediatrics by minority group students. Encourage pediatricians to serve as role models for the minority group children they encounter in their practices and through area schools. Also, at the chapter level, actively encourage pediatricians in community-based office settings to offer a clerkship(s) for a minority group medical student(s) — using the "Guidelines for Medical Student Education in Community-based Pediatric Offices." Utilize these strategies as ongoing opportunities to involve minority group pediatricians in chapter activities. Create an awareness of these projects by promoting same at the district and chapter meetings, through newsletters, etc. Assign to:

- Committee on Careers and Opportunities
- Alternate District Chairpersons
- Chapter Presidents
- Council on Pediatric Education

13. Encourage chapters to become actively aware of and involved in local medical student recruitment activities. Urge this activity to be a directive to each chapter level committee on Careers and Opportunities and/or Committee on Manpower. Medical student recruitment into pediatrics activities could include:

- Ascertaining when area grammar schools, high schools, and colleges are having "career days" and ensuring that pediatrics is represented
- Offering workshops for medical students in conjunction with the regional or annual meeting of a minority group medical student association or group (eg, the Student National Medical Association)
- Fostering the development of pediatric clubs, particularly in those medical schools that have a significant number of minority group students

Assign to:

- Chapter Presidents
- Division of Chapter Services
- Committee on Careers and Opportunities
- Resident Section
- Provisional Senior Members Section
- Alternate District Chairpersons Committee

ORGANIZATIONAL RESPONSE

Introduction

The Task Force was given two specific cl rges pertaining to the programs of AAP co..mittees, chapters, and other organizations (eg, American Medical Association, National Medical Association, etc). First, the Task Force was asked to survey and review these programs. Second, the Task Force was asked to recommend specific types of collaboration between the Academy and other public and private organizations. The activities of chapters and committees are discussed elsewhere in this report. In this section, an overview is presented of the organizations and their programs that were considered by the Task Force.

At their meetings, the Task Force reviewed information on the pro rams of approximately 40 organizations. The programs were both public and private, academic and in organized medicine. A representative sample is listed below:

- National Rural Health Association's Rural Minority Populations (Access to Care)
- National Conference on Rural Minority Health Issues
- National Science Foundation
- American Academy of Dermatology
- Association of Minority Health Professions Schools
- National Academy of Sciences Institute of Medicine (IOM)
- Agency for Health Care Policy and Research
- American Academy of Family Physicians

The Task Force also reviewed a listing of Maternal and Child Health Programs that focus on ethnocultural diversity produced by the National Center for Education in Maternal and Child Health. Programs studied by the Task Force by no means provide a comprehensive review of existing initiatives for minority group members, but instead provide background for the development of recommendations for future AAP initiatives. It should be noted that the Office of Minority Health Resource Center keeps a comprehensive data base on initiatives related to minority group health.

. . . the Academy can encourage Fellows, especially minority group pediatricians, to participate in established mentoring programs, such as those of the National Medical Association (NMA) and the Interamerican College of Physicians and Surgeons (ICPS).

The Task Force sorted programs and/or initiatives into two broad categories: programs dealing with recruiting minority group members into the health professions, and programs pertaining to minority group health status. These broad categories were divided into subgroups based on the type of activity the program involves. Designated subcategories under recruiting minority group members into the health professions include the following:

- Partnerships With Local School Systems
- Retention Programs
- Scholarships and Fellowships
- Training and Education Programs

Programs with the main goal of improving minority group health status were divided into the following subgroups:

- Presentations and discussions for students (at various levels)
- Improving Health Status and Access to Care for Minority Group Members (through public education and enhanced health services)

A complete review of programs is contained in Appendix B.

Collaborating With Other Organizations

This review of programs aided the Task Force in developing several of the recommendations categorized under the various sections of this

report, as well as several strategies for collaborating with organizations who share goals similar to those of the Academy. The Task Force commends AAP initiatives already in place such as the Committee on Careers and Opportunities program for minority group medical students. This program, which was implemented in 1992 through the Student National Medical Association, has proved to be successful at reaching minority group medical students and providing them with practical career information about pediatrics. In 1993 this program was expanded to include activities sponsored through other minority group medical student groups (Interamerican College of Physicians and Surgeons, an organization of Hispanic physicians that hosts activities for medical students, and the Association of Native American Medical Students). The Task Force recommends that the Academy continue and expand these collaborative relationships.

In the first instance, the Academy can encourage Fellows, especially minority group pediatricians, to participate in established mentoring programs, such as those of the National Medical Association (NMA) and the Interamerican College of Physicians and Surgeons (ICPS). The Academy should provide pediatricians who participate in these programs with information and/or materials that will facilitate their participation (eg, the COCO fact sheet, "Specialty Profile"). Describing and promoting these activities through AAP publications (eg, *AAP News*), and fostering an ongoing relationship with these organizations on other medical student recruitment programs are important initiatives.

As discussed at length in the "Workforce" section, the Task Force recognizes the need for enhancing minority group students' interest and capacity throughout the educational pipeline, if they are to enter a career in pediatrics successfully. It is recommended that the Academy actively monitor, and participate in when feasible, the Association of American Medical College's (AAMC) "Project 3000 by 2000." Although the activities encompassed in this AAMC initiative are directed to medical schools, the Task Force believes that many are applicable to chapter activities and merit a closer evaluation.

As noted previously, there are additional factors that affect the education of future minority group pediatricians. One such factor is the limited number of role models due to the low percentage of minority group faculty at US medical schools. The Task Force strongly encourages the Academy to work with organizations like the AAMC and the Association of Medical School Pediatric Department Chairs on issues pertinent to strengthening affirmative action programs that affect medical school admissions policies as well as faculty recruitment and retention programs. These activities, the Task Force believes, are a logical extension of earlier proposals designed to foster an interest in medicine and pediatrics at the grammar school through medical school levels.

As noted previously, there are additional factors that affect the education of future minority group pediatricians. One such factor is the limited number of role models due to the low percentage of minority group faculty at US medical schools.

A second component of the education of pediatricians is that of cultural sensitivity and cultural competence. In addition to those activities described in the previous section, the Task Force recommends that the Academy work with the AAMC and other pediatric organizations to promote training (at all levels) in cultural sensitivity. Further, the Academy should establish collaborative activities with the American Public Health Association centered around cultural issues as they relate to minority group children's health.

During the Task Force review of data on minority group health status, it was noted that in 1984 the Office of Minority Health, Department of Health and Human Services (HHS), established a Task Force to study the

health status of minority group populations. Their report, *Report of the Secretary's Task Force on Black and Minority Health*, was issued in 1985. This report provides the first federal study of minority group health issues from a comprehensive perspective. Through collaboration with this HHS Task Force, and through AAP programs already in place (eg, the PROS Network), the Academy has the opportunity to develop a research agenda in order to improve assessment of health status (including access and access barriers) of minority group children.

. . . the Task Force believes that the Academy should continuously seek opportunities to work with other organizations to advance the agenda of improving the health status of minority group children.

The focus of this section of the report has been to identify potential, existing opportunities for collaborative activities. While a significant number of programs are listed in Appendix B, the Task Force believes that the Academy should continuously seek opportunities to work with other organizations to advance the agenda of improving the health status of minority group children. The Academy should, for example, work with the American College of Obstetricians and Gynecologists to ensure that there is a minority group component to their efforts to develop a national program to recognize high-risk pregnancies and referral systems. With other organizations, the Academy may have, in some capacity, already established an issue-specific liaison (eg, the Academy's involvement in the AMA medical liability project). The Academy should determine if those organizations also have a minority group health initiative and pursue linkages with that activity, as well.

Organizational Response Recommendations

1. Pursue and/or continue collaborative relationships with other organizations of minority group pediatricians, including organizations that represent the primary subgroups of minority group children (eg, National Medical Association, Interamerican College of Physicians and Surgeons, Association of Indian Physicians, Student National Medical Association, etc). Assign to:

- Executive Committee
- Committee on Careers and Opportunities
- Department of Membership

2. Encourage Fellows, especially minority group pediatricians, to participate in mentor programs for medical students, such as those sponsored by the Interamerican College of Physicians and Surgeons and the National Medical Association. Promote this activity, and the experiences of Fellows who have participated, in order to foster ongoing interest. Assign to:

- *AAP News*
- "Chapter Connections"
- Chapter Presidents
- Alternate District Chairpersons Committee
- Committee on Careers and Opportunities
- Resident Section
- Provisional Section for Senior Members

3. Work with organizations, such as the Association of American Medical Colleges (AAMC) and Association of Medical School Pediatric Department Chairs, to increase: the number of minority group pediatricians by requiring affirmative action programs in medical school admissions policies; the numbers of minority group faculty members; and the number of recruitment programs in grammar and high school, and college, as well as at the graduate levels. Assign to:

- Executive Committee
- Council on Pediatric Education
- Committee on Careers and Opportunities

4. Work with the AAMC and other pediatric organizations to promote training (at all levels) in cultural competency and sensitivity. Establish collaborative activities with the American Public Health Association centered around cultural issues as they relate to minority group children's health. Assign to:

- All AAP councils, committees, task forces, sections, and AAP staff — as appropriate

5. Actively monitor, and participate when feasible, in the AAMC: "Project 3000 by 2000." Assign to:

- Executive Committee
- Committee on Careers and Opportunities
- Resident Section
- Council on Pediatric Education

6. Explore collaborative activities with the Department of Health and Human Services' Office of Minority Health in order that their Task Force on Black and Minority Health might incorporate a children's health component into their study of the health status of minority group populations. Assign to:

- Executive Committee
- Department of Research
- Department of Government Liaison
- Committee on Community Health Services
- Committee on Careers and Opportunities

7. Work with the American College of Obstetricians and Gynecologists to ensure that there is a minority group component to their efforts to develop a national program to recognize high-risk pregnancies and referral systems. Assign to:

- Department of Maternal, Child, and Adolescent Health
- Committee on Fetus and Newborn

8. Introduce a minority group children's health care perspective, as appropriate, into all current AAP liaison activities with other organizations. In those instances in which the Academy has already established an issue-specific liaison with an organization (eg, American Medical Association and medical liability), determine if that organization has a minority group health initiative, and pursue linkages with that activity. Assign to:

- Executive Committee

THE ACADEMY'S ROLE

Introduction

Many of the recommendations proposed by the Task Force on Minority Children's Access to Pediatric Care address issues discussed in other sections of this report. The recommendations included in this section propose initiatives and activities within the purview of the American Academy of Pediatrics. These recommendations respond to several of the specific charges in the Task Force Directive. The rationale behind this section of the report is to provide vision in defining the Academy's role in order to progress from the charges outlined in the Task Force Directive to a more developed plan for meeting the goals of the Task Force.

In this section, the Task Force responds to three specific charges or assignments. In their Directive, the Task Force was charged with recommending strategies to increase the number of minority group Fellows. To ensure that the perspectives of minority group pediatricians (in practice esearch, and academia) and the unique needs of minority group children are considered in AAP programs, policy development, advocacy efforts, and research, the Task Force was asked to recommend strategies to increase the proportion of minority group Fellows represented within the leadership ranks of the Academy. As a correlative activity, the Task Force was further charged with identifying strategies to enhance the recruitment for minority group members represented in AAP staff positions, particularly management and/or policy-making roles. Finally, the Task Force outlines a system for monitoring the progress of the Academy in achieving the goals delineated in the Directive.

Increasing the Number of Minority Group Fellows and Their Involvement in the Leadership of the Academy

No data exist on the number of board-certified minority group pediatricians. Therefore, the percentage of this group that holds membership in the Academy is unknown. While results of various surveys solicited by the Task Force have not demonstrated whether or not board certification can be considered one of the primary barriers to membership in the Academy, many believe this relationship exists. If lack of board certification is indeed a major barrier for membership in the Academy for minority group pediatricians, the Academy must take action to improve board certification rates for minority group pediatricians. The Task Force recommends that efforts be initiated by the Academy and, if feasible, by the American Board of Pediatrics, to determine board certification rates of minority group pediatricians. Further, the Task Force notes the advisability of working with other medical organizations (eg, NMA) to address this potential barrier to membership.

The rationale behind this section of the report is to provide vision in defining the Academy's role in order to progress from the charges outlined in the Task Force Directive to a more developed plan for meeting the goals of the Task Force.

Currently the Academy tracks minority group member Fellows through the Department of Membership's Blue Book Verification Card system. The Task Force recommends that this system be continued and heavily promoted in order to increase the response rate. In addition, the Academy could explore alternative methods for obtaining and verifying this information.

Council, committee, and task force activities will benefit from the perspectives and expertise of minority group pediatricians as they address the health care needs of minority group children. Therefore, particular attention must be given to the consideration of minority group pediatricians during the nomination process. Here, chapter presidents play a seminal role. Their ability to foster the involvement of minority group Fellows at the chapter level and support the nomination of qualified minority group Fellows for national leadership roles cannot be underestimated. The AAP Committee on Careers and Opportunities routinely tracks levels of involvement of women

and minority group members on AAP committees and councils. This information would serve as a useful resource to chapters and the Academy's Advisory Committees to the Board during the nomination and appointment process, and should be shared with them.

If lack of board certification is indeed a major barrier for membership in the Academy for minority group pediatricians, the Academy must take action to improve board certification rates for minority group pediatricians.

Findings From Task Force Surveys

The Task Force developed several surveys in an effort to determine those factors that might influence minority Fellows' active participation in the Academy (see Appendix C). The Task Force conducted a confidential survey of chapter presidents during 1992. The original mailed survey was complemented by a direct survey at the 1992 Annual Chapter Forum. Overall, the response rate was 75%, with many chapter presidents providing detailed information.

The intent of the questionnaire was to learn, from the perspective of the chapter president, the extent of minority group pediatrician involvement in the Academy at that time and solicit opinions regarding barriers to involvement. Suggestions and recommendations were also requested from the respondents.

The rationale behind a second survey was the determination that it would be important to survey the minority group pediatricians who belong to other medical societies. The goal of this survey was to contact those who philosophically support the concept of organized medicine, but who may or may not extend that support to the Academy.

In a third survey, the Task Force took the opportunity to query the attendees at their 1992 Open Forum and Reception. Respondents were asked about their level of involvement in the Academy. Their perceptions regarding the benefits and/or barriers to involvement in AAP activities by minority group Fellows were solicited, as well. Finally, a short questionnaire accompanied an article in *AAP News* that described the Task Force.

Survey of Chapter Presidents — One of the basic descriptive questions, regarding proportional minority membership at the chapter level, received a wide range of responses. Unfortunately, there is no other source of reliable information at present that would allow verification of the validity of the chapter presidents' estimates. The range of minority group pediatrician membership was quite wide, as would be expected given the heterogeneity of the geographic areas represented within the Academy.

In response to a general question about the desirability of increasing minority group pediatrician involvement at the chapter level, 60% of the respondents answered affirmatively. The primary reasons were the following:

- The benefits of involving individuals with a different perspective
- The recognition of unique practice issues for minority group pediatricians
- The need to address the needs of minority group children

In response to a general question about the desirability of increasing minority group pediatrician involvement at the chapter level, 60% of the respondents answered affirmatively.

Those chapter presidents who did not note a need to increase the involvement of minority group members at the chapter level of the Academy usually responded that there were too few minority group members in the chapter to engage them in a deliberate manner. When asked about any difficulties encountered in the process of increasing minority group pediatricians' involvement at the chapter

level, several chapter presidents identified a variety of problems. One example cited is lack of knowledge of the minority group status of their members. Another is an inability to engage minority group members in participation due in part to the time and distance constraints experienced by minority group Fellows.

The great majority of chapter presidents believe that the AAP structure for chapter participation enhances the opportunities for minority group pediatrician involvement and that the national Academy is "user friendly." The barriers to national involvement of minority group members in the Academy, as identified by the respondents, were varied and included the following:

- Personal conflicts (eg, there are a significant number of demands on their limited "volunteer" time)
- A paucity of role models within the Academy
- A lack of local involvement on the part of minority group members

The primary barrier to chapter involvement, as identified by chapter presidents, is the reliance on personal relationships and networking, which may impede the integration process for minority group Fellows. It is interesting to note that many respondents believe that the Academy, as a democratic organization, is open to all interested members.

When the Task Force asked for suggestions for increasing the number of minority group Fellows at the national level, a strategy of personal recruitment of minority group members to leadership positions within the Academy was recommended. Several chapter presidents also noted the importance of prioritizing minority group health issues within the larger structure of the Academy as an effective means of involving minority group pediatricians.

Survey of Minority Group Pediatrician Members of Other Medical Societies — In an effort to understand the relationship between minority group pediatricians who are involved in professional organizations, but may or may not be members of the Academy, the Task Force surveyed the members of three organizations. These are the Pediatric Section of the National Medical Association, the Association for Academic Minority Physicians, and the Pediatric Section of the Association of American Indian Physicians.

Several chapter presidents also noted the importance of prioritizing minority group health issues within the larger structure of the Academy as an effective means of involving minority group pediatricians.

Despite the fact that only 30 persons responded to this survey, they supplied a great deal of information that will be useful to the Task Force and the Academy.

Overall, 73% of the respondents were board certified and the gender composition was 47% female and 53% male. The ethnic categorization of the sample was 77% African American, 13% Native American, 3% Asian, 3% white, and 3% other. There were no individuals identified as Hispanic in the sample. With respect to membership status within the Academy, 50% were current members, 10% had been members at some time in the past, and 40% had never been members.

In response to an open-ended question about benefits derived from membership in the Academy, 43% mentioned educational benefits as their primary response, with advocacy and belonging to a professional organization recorded by 30%.

The primary barrier to chapter involvement, as identified by chapter presidents, is the reliance on personal relationships and networking, which may impede the integration process for minority group Fellows.

A similar question about barriers to membership in the Academy elicited a variety of responses. Cost was listed as the primary barrier by 28%; board certification, by 12%, lack of representation within the Academy and racism, by 8% each; the sense of an "old boys network," by 4%; other barriers, by 16%; and no barriers identified, by 24%.

Twenty-four percent of the minority group pediatricians who completed the evaluation cited the lack of minority group pediatricians as the primary barrier to national participation in formal bodies of the Academy. Further, 19% of respondents felt minority group pediatrician participation at the national level was lacking due to the existence of the "old boys network." Ten percent felt the cost of membership prevented minority group pediatricians from joining the Academy, therefore creating a barrier to participation in national committee/council activities. Lack of acceptance of minority group pediatricians (10%) and age (5%) were also cited as barriers. When questioned directly about barriers to participation at the local (chapter) level, the responses were as follows: none, 23%; "old boys network" and lack of acceptance within the Academy, 15%, each; time conflicts and lack of representation in the Academy, 8% each; age, 4%; and other, 27%. The Table has been prepared in order to facilitate comparison.

Survey of Minority Group Pediatricians Who Are Members of Other Medical Societies - 1992*

PROPORTIONAL RESPONSES (BARRIERS)

Perceived Barriers	Reasons for Not Joining the Academy	Barriers to National Participation in AAP Councils/ Committees, etc	Barriers to Local (Chapter) Participation
Cost	28%	10%	. . .
Board certification	12%	. . .	. . .
Lack of representation	8%	24%	8%
Racism	8%	. . .	. . .
"Old boys' network"	4%	19%	15%
Lack of acceptance	. . .	10%	15%
Time conflicts	. . .	. . .	8%
Age	. . .	5%	4%
Other	16%	19%	27%
None	24%	14%	23%

*Percentages may not total 100% due to rounding.

The suggestions received in response to an open-ended question soliciting suggestions of any type were very interesting and can be summarized as follows:

Modifying AAP structure with activities such as educational programs or forming a minority group within the larger organization	29%
Actively involving minority members	24%
Collaborating with other professional organizations	24%
Recruitment of minority members	10%
Working toward health reform	10%
Other	5%

1992 Open Forum and Reception — The Task Force held an Open Forum at the 1992 Annual Meeting of the American Academy of Pediatrics in San Francisco in an effort to inform the general membership of the Academy of the goals and activities of the Task Force, as well as to solicit input and recommendations. In addition to a formal presentation by the Task Force members, a discussion period and reception were included in the Open Forum. A survey was distributed to all attendees and 30 responses were received.

The AAP members attending the Open Forum were mostly women (70%) and the predominant racial/ethnic group was African American (41.9%). The representation of the other groups was as follows: white (35.4%), Latino (12.9%), and Asian American/Pacific Islander (6.5%). The majority (63.3%) of respondents are currently involved in the Academy in a variety of capacities.

Most of the survey respondents (76.7%) had attended a previous national meeting of the Academy and learned about the Open Forum through the program booklet. The reasons given for attending the Open Forum were to learn more about the Task Force (30.4%) and to learn more about AAP initiatives directed toward minority pediatricians (31.9%). Overall, 86.7% considered the Task Force presentations informative, although 53% responded that additional issues should be considered. Seventy-three percent (73%) believed that the Forum provided them with the opportunity to meet other minority group Fellows.

The structure of the Academy was not considered to be user friendly by 51.6% of the respondents, and the reasons included lack of representation, lack of outreach, and the old boys' network. Forty-seven percent believe that the structure of the Academy impedes involvement by minority members, and the range of reasons was essentially the same.

The barriers to their involvement, as perceived by the Fellows who responded to the survey, were lack of representation in AAP leadership, time pressure, cost, and certification requirement.

When asked about the benefits of involvement in the Academy, the responses fell into the following categories in decreasing order: advocacy for children, networking opportunities, policy impact, and educational improvement. The barriers to their involvement, as perceived by the Fellows who responded to the survey, were lack of representation in AAP leadership, time pressure, cost, and certification requirement.

A supplemental question solicited other issues or concerns that had not been included in other questions. The responses included suggestions for modifying residency curricula, sensitization of AAP members to minority group concerns, actively promoting minority group AAP members as role models, pursuing access alternatives that focus on minority groups, and future research.

AAP News Article — An article entitled "Minority Group Children Face Barriers to Care," that described the Task Force, its members, and its objectives, was published in the August 1992 issue of *AAP News*. A solicitation for written comments was included with the article. Five written responses were received following the publication of the article. The suggestions from the responses are as follows:

- Modifying the educational process in medical schools to include minority group pediatrician role models
- Improving access to culturally sensitive and culturally appropriate pediatric care
- Instilling a sense of community service in all pediatricians
- Improving the financial remuneration of pediatricians
- Providing patient education materials in Spanish.

Suggestions and recommendations gained through these surveys form the basis or are the primary source of Task Force recommendations that aim to increase the proportion of minorities represented in AAP committees, councils, task forces, sections, and liaisons to outside organizations. In addition to increasing opportunities for minority group pediatricians to become involved in the Academy, these strategies aim to enhance perceptions of the Academy by minority group members. Implementing these recommendations and others contained in the Report of the Task Force on Minority Children's Access to Pediatric Care will demonstrate the AAP commitment to issues relevant to the health of minority group children and the participation of minority group pediatricians. As the Academy gains greater visibility in this arena, minority group pediatricians will be more likely to become involved members of the Academy.

Minority Group Representation in AAP Staff Positions

In addition to recommending strategies for increasing the number of qualified pediatricians from underrepresented minority groups and increasing minority group membership and leadership in the Academy, the Task Force has been charged with recommending strategies to enhance recruitment of minority group members for AAP staff positions, particularly management and/or policy-making roles. According to the Academy's December 1991 Equal Opportunity Employment Report, the Academy employs one African American in "officials and managers" capacity and one African American female and one Hispanic male in the professional capacity. The remaining 99 positions in these categories are filled by non-Hispanic white individuals. It has been suggested that the geographic location of the Academy might be a barrier in obtaining minority group candidates to fill staff positions. The Task Force noted, however, that many who currently hold AAP staff positions in management and/or policy-making roles commute from locations where the pool of qualified minority group applicants is not limited. Therefore, it is difficult to conclude that the location of the AAP central office in Elk Grove Village, IL, is, in and of itself, a barrier to employment for minority group members.

The Task Force applauds strategies utilized by the Department of Finance and Administration to increase the number of minority group applicants. Currently employment opportunities are advertised in the *Chicago Tribune* and the *Black Journal*. In addition, the Academy lists openings with the Illinois Job Service and uses the Access Minority Resume Bank Program. While the Department of Finance and Administration has implemented numerous strategies to attract minority group applicants, low levels of employment of minority group members suggest the need to develop a written plan designed to increase the number of minority group members in management and senior level policy-making positions and to investigate additional strategies.

. . . it is difficult to conclude that the location of the AAP central office in Elk Grove Village, IL, is, in and of itself, a barrier to employment for minority group members.

During discussion of the issues involved with regard to increasing the number of minority group members who are employed by the Academy, the Task Force consulted the Academy's affirmative action policy that has been in place since 1987. While the policy upholds that all individuals be given equal opportunity when being considered for AAP staff positions, it could more clearly outline

affirmative action strategies. The fact that it cannot be determined whether or not location of the central office is a barrier to attracting a qualified pool of minority group applicants validates the need for expanding this policy.

In 1988 the Office of Federal Contract Compliance Programs (OFCCP) issued Order No. 831a1 to track progress of women, disabled workers, and minority group members in positions beyond entry level. The Task Force recommends that the Department of Finance and Administration continue to report progress levels in employing minority group members in AAP staff positions, especially in management/policy-making roles. In addition to publications and resources already being utilized, the Academy might work through other associations (eg, American Society for Public Administration Section for Minority Group Members, National Consortium for Black Professional Development, National Black MBA Association, etc). Through their publications and activities, the Academy could garner information on qualified minority group members who may be seeking employment opportunities.

The Task Force feels strongly that representation of minority group members in management/policy-making roles at the staff level could provide far-reaching results in enhancing the inclusion of a minority group perspective into management and policy-making at the Academy.

In addition to attracting qualified minority group members to serve in management/policy-making roles in AAP staff positions, it is important for minority group members currently employed to be encouraged to strive for advancement to management/policy-making roles. This can be accomplished through employee programs to enhance career development such as scholarships, use of executive mentors, and training.

The Task Force feels strongly that representation of minority group members in management/policy-making roles at the staff level could provide far-reaching results in enhancing the inclusion of a minority group perspective into management and policy-making at the Academy. The presence of minority group members in this capacity would further the inclusion of unique insights in committee, council, and task force discussion, which could, in turn, foster an increase in the participation of minority group member pediatricians in the Academy's activities.

Implementation and Monitoring of Task Force Recommendations

During the time of the Task Force's existence, many had suggested that a permanent body be appointed to deal with issues addressed in the Task Force Directive and to implement and monitor new activities resulting from the recommendations outlined in this report. From the outset, however, the Executive Committee had determined that the implementation of the recommendations posed in the Task Force report should be a coordinated effort involving all areas of the Academy. The Task Force endorses the concept of Academy-wide involvement. In this manner, the Task Force believes AAP councils/committees/task forces/sections/departments will be provided with a better opportunity for addressing issues relating to minority group children and minority group pediatricians. In turn, AAP Fellows will be able to participate in an all-encompassing effort to achieve the goals of the Task Force.

Monitoring progress of the Task Force recommendations will be assumed by the Executive Committee. The Committee on Careers and Opportunities will coordinate the reporting function by collecting reports on the status of the implementation of Task Force recommendations from the various AAP councils, committees, departments, etc. A member(s) of the committee on Careers and Opportunities (COCO) — most likely those formerly involved with the Task Force — will review individual status re-ports and compile a comprehensive summary that will be submitted to the Executive Committee. This report might use a format similar to this document that includes five sections (ie, Health Status, Access/Barriers, etc).

Each section might contain a synopsis of what had been accomplished and what remains to be done. If the original status reports had identified problems with implementation,

From the outset, however, the Executive Committee had determined that the implementation of the recommendations posed in the Task Force report should be a coordinated effort involving all areas of the Academy.

this could be noted, too. At the discretion of the COCO, the report might identify strategies or timelines for continuing to address recommendations. The AAP Executive Committee will require the first status report 18 months after the Task Force report is disseminated.

As the Executive Committee has exhibited a strong commitment to the Task Force Directive, the Task Force relies on the Executive Committee to undertake other efforts, as needed, to ensure that the recommendations in this report gain the support and commitment of the membership. In addition, the Report of the Task Force on Minority Children's Access to Pediatric Care should be distributed widely to Fellows, policymakers, and other health-care associations and agencies that share the Academy's concern regarding minority group children. In so doing, the Academy can demonstrate that it serves as an advocate for the improved health status of all children, yet recognizes the special health care needs of minority group infants, children, and adolescents.

Academy's Role Recommendations

1. Further study the issue of board certification of minority group pediatricians and assess whether or not this is the primary barrier to membership in the Academy for minority group members. If lack of board certification is found to be a major factor in explaining low levels of membership in the Academy, undertake efforts to aid minority group pediatricians in board certification. Assign to:

- Department of Membership
- Council on Pediatric Education
- Department of Research
- Department of Education

2. Continue to use the Blue Book Verification Card system to determine the number of board-certified minority group Fellows. Develop strategies to promote to the membership the importance of this activity and increase the response rate. Explore alternative methods for obtaining/verifying this information. Assign to:

- Department of Membership

3. Design and implement a proactive leadership recruitment process of minority group members at the chapter committee level, and nationally at the council and committee levels, to ensure that minority group pediatricians are represented in all levels of AAP leadership. Assign to:

- Executive Committee
- Chapter Presidents
- Division of Chapter Services

4. Continue to monitor the involvement of minority group pediatricians in chapters and on AAP councils and committees using the tracking system designed by the Committee on Careers and Opportunities; disseminate this information to chapters and the AAP Advisory Committees to the Board, as appropriate, prior to the nomination/apointment process. Assign to:

- Committee on Careers and Opportunities

5. Expand the current number of programs that focus on topics of particular relevance to the health of minority group children and/or for minority group pediatricians at AAP Annual Meetings and Spring Sessions. Assign to:

- Department of Education
- Committee on Scientific Meetings

6. Redouble efforts to increase the number of minority group pediatrician presenters at AAP Annual Meetings, Spring Sessions, and other meetings as appropriate. Assign to:

- Department of Education
- Committee on Scientific Meetings

7. Explore options to increase the participation of minority group Fellows at AAP Spring Sessions and Annual Meetings, such as providing a forum for minority group Fellows at AAP Annual Meetings. Assign to:

- Department of Education
- Committee on Careers and Opportunities
- Provisional Committee on Native American Child Health

8. Implement suggestions gained through the Task Force Survey of Chapter Presidents as a means of increasing the involvement of minority group pediatricians at the chapter level:

- Personal recruitment of minority group pediatricians
- Developing programs and projects at the chapter level that focus on the health of minority group children
- Forming a committee or caucus of minority group pediatricians within the chapter
- Appointing minority group chapter members to leadership positions within the chapter

Assign to:

- Executive Committee
- Chapter Presidents
- Division of Chapter Services
- Committee on Careers and Opportunities

9. Acknowledge chapters that have developed and implemented initiatives and programs on minority group children's health through the

"Chapter Connections" newsletter, and encourage all chapters to develop such programs. Assign to:

- ◆ Division of Chapter Services
- ◆ Executive Committee

10. Through AAP communications tools and other public relations avenues, increase the Academy's visibility as an organization that deals with issues relevant to the health of minority group children and minority group pediatricians in order to increase participation of minority group pediatricians as members of the Academy. Assign to:

- ◆ Committee on Communications
- ◆ Department of Communications
- ◆ Division of Public Relations
- ◆ Department of Membership

11. Develop a written plan to increase the number of minority group members in AAP management and senior policy-making level positions. Utilize strategies and resources, such as *The Black Journal* and Access Minority Resume Bank Program, to increase the pool of qualified minority group applicants for positions in the Academy. Assign to:

- ◆ Division of Human Resources

12. Revise the Academy's current equal opportunity policy and incorporate an affirmative action component in order to increase the number of minority group members in management/policy-making roles. Assign to:

- ◆ Division of Human Resources

13 .Continue periodic reports on the number of minority group members in AAP staff positions in order to assess progress in increasing the number of minority group members in all staff positions, especially at the management and policy-making levels. Assign to:

- ◆ Division of Human Resources

14. Adopt employee programs that might enhance career development of minority group members who have or are striving for advancement to management/policy-making roles in the Academy (eg, scholarships, executive mentors, training, etc). Assign to:

- ◆ Division of Human Resources

15. Ensure that the implementation of Task Force recommendations is a coordinated effort within the Academy. Require a system for tracking the status of the implementation of Task Force recommendations that incorporates the following:

- The Executive Committee will require a status report 18 months after the report is disseminated
- The Executive Committee will ask COCO to prepare same
- COCO will send a memo to all councils/committees/sections /departments, etc that were assigned recommendation(s). The memo will ask that they report on the status of the implementation (similar to the type of information provided on Chapter Forum Resolutions)
- COCO staff will collect all responses and share them with the COCO
- A COCO member(s) — most likely a former Task Force member(s) — will undertake the responsibility of reviewing the status reports and writing a report from COCO to the Executive Committee

This report can be divided into the same five sections (ie, Health Status, Access/Barriers, etc) identified in the original Task Force report. Each section can contain a synopsis of what had been accomplished and what remains to be done. If the status reports provided to COCO identified problems with implementation, this could be noted, too. At the discretion of the COCO, the report could identify strategies or timelines for continuing to address recommendations. Assign to:

- ◆ Executive Committee
- ◆ Committee on Careers and Opportunities

16. Demonstrate the Academy's ongoing commitment to the health and well-being of minority group children through the widespread distribution of this report to Fellows, policymakers, and other health care associations and agencies that have a vested interest in the health care of minority group children. Assign to:

- ◆ Executive Committee
- ◆ Committee on Careers and Opportunities

APPENDIX A

DIRECTIVE TO THE TASK FORCE ON MINORITY CHILDREN'S ACCESS TO PEDIATRIC CARE

Task Force Rationale

A number of empirical studies have found that minority children have substantially less access to medical services than nonminority children and that this reduced access persists independent of health insurance status, family income, health status, and/or place of residence. Compared to their nonminority counterparts, minority children are less likely to see a physician, more likely to be behind in their immunizations, and more likely to be unable to obtain needed medical services. Recently, the US Public Health Service has identified reduction in disparities in health status and access to care between minorities and the nonminority population as one of its three broad goals in its "Healthy People 2000" initiative.

The Task Force on Minority Children's Access to Pediatric Care has been created to recommend realistic, achievable strategies to remediate the unequal access to health care which minority children face (as reflected in the "Healthy People 2000," as well as being an essential component of the AAP's top organizational priority of access to health care for all American children).

Rather than evolving into a national committee, the task force is asked to recommend to the Executive Committee/Board organizational strategies for the AAP to ensure that the perspectives of minority pediatricians (in practice, research, and academia) and the unique needs of minority children are considered in AAP educational programs, policy development and advocacy efforts, and research. The overall goal is to increase AAP sensitivity to minority health issues and to increase credibility for the AAP as it speaks out on these issues in future years.

Task Force Charge

1. Assess current data/information on:
   a) the health status of minority children;
   b) the unique barriers to access to care resulting from status as a minority;
   c) the availability of physicians and other health care resources for this population; and
2. Survey and review programs being planned and/or implemented by the AAP Committees (eg, Careers and Opportunities, Indian Health PAC), chapters, and by other organizations (eg, Association of Medical School Pediatric Department Chairmen, American Medical Association, National Medical Association, Institute of Medicine, and others) designed to address the problems minority children face.
3. Recommend strategies appropriate to the capacity of and consistent with the mission of the AAP to increase the number of qualified pediatricians from underrepresented minority groups.
4. Recommend minority membership recruitment goals for the AAP.
5. Recommend strategies to increase the proportion of minorities represented in AAP appointed positions, (eg, committees/councils, task forces, liaisons to outside organizations).
6. Recommend strategies to enhance recruitment for minorities represented in AAP staff positions, particularly in management/policy-making roles.
7. Recommend strategies to foster optimal collaboration between the AAP and other public and private organizations to implement approved AAP strategies.
8. Complete a report with the above recommendations within 18 months of inception.

APPENDIX B

AMERICAN ACADEMY OF DERMATOLOGY

Committee on Diversity

Mission Statement:

1. To serve as a resource and as the conscience of the Academy on issues of minorities.

2. To promote greater minority participation on Academy committees and in Academy academic affairs.

3. To help insure that all minorities have ample opportunity for academic and administrative positions in the Academy.

AMERICAN ACADEMY OF FAMILY PHYSICIANS

AAFP Committee on Minority Health Affairs "Minority Resident/Student Scholarships"

The committee has funds available to support attendance by 10 minority students and 13 minority family practice residents at the annual National Congresses of Family Practice Residents and Student Members. The scholarship program is an effort to expose minority medical students to family practice and to encourage involvement of minority family practice residents.

Student National Medical Association Conference

Each year the AAFP supports the SNMA annual meeting by exhibiting, presenting a workshop, and providing funds to support a conference function.

Annual Minority Health Affairs Reception

Each year the committee hosts a reception for minority physicians and physicians interested in minority health affairs issues at the AAFP annual scientific assembly. This reception/discussion forum provides an opportunity for those interested in minority health issues to network and share information. The committee is working to provide a mechanism for input of ideas from this reception into the work of the committee and also the National Conference of Women, Minority and New Physicians, which is held each year.

National Conference of Women, Minority and New Physicians

This conference was first held in 1990 as an effort to encourage family physicians who represent these three constituencies to become involved in leadership roles within the Academy.

Sunday Morning Messages About Health

An ongoing project of the committee has been its Health Promotion Through Churches project. The committee developed a series of brochures titled "Sunday Morning Message About Health." This project is an effort to provide information to individuals who may not have adequate access to health care professionals. The brochures are available in both English and Spanish. These brochures are made available through family physicians to their community churches for insertion in Sunday church bulletins.

Video Vignette Series

The committee developed a video vignette series titled "Racial and Cultural Bias in Medicine." The tape consists of 27 dramatized situations that deal with a variety of issues, each of which has some relevance to racial or cultural bias that may be experienced by medical students or resident physicians. The tape is available for purchase from AAFP headquarters.

Liaison Activity

The committee has maintained liaison activity with various minority groups and hopes to increase the level of this involvement in the future.

AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

Minority Affairs Committee Project Access

Physician Assistants (PAs) and PA students will meet with high school and college students for small group discussions, followed by a question and answer session in conjunction with the Annual Conference in the San Francisco Bay area.

Minority Affairs Committee and Student Minority Affairs Subcommittee Workshops

The committee will host programs on the "Impact of Infant Mortality on Minority Communities" and "Improving the Health Status on Minority Children" during the annual PA Conference May 25, 1992.

AMERICAN MEDICAL ASSOCIATION

Advisory Committee on Minority Physicians

The goals and objectives of the committee were to analyze pertinent data, trends, policy, and ongoing activities regarding three interrelated issues and to develop programs to respond to these issues:

- The health status of minorities in America,
- Membership and representation of minority physicians and medical students in the AMA, and
- The number of minority students and faculty in US medical schools.

At the initial meeting of the committee, three subcommittees were established that set about to define critical concerns regarding the three issues of health, membership, and representation and manpower. These three subcommittees continued their deliberations at the second meeting in Nashville.

Also in Nashville, the committee hosted a reception for over 115 minority medical students from Meharry and Vanderbilt medical schools. The next meeting of the committee is planned for an Apache Indian Reservation in Arizona where the committee will observe the delivery of care in this setting. Other on-site meetings are planned for the future.

The Advisory Committee will study the issues presented and develop strategies and recommendations to impact the delivery of care to minority children positively.

AMERICAN MEDICAL STUDENT ASSOCIATION (AMSA)

Minority Affairs Task Force

Current Projects:

- booklet containing scholarship information for minority students
- guide to premedical summer programs

The Minority Affairs Task Force Quarterly is a newsletter that highlights activities and provides information about clerkship programs, minority research opportunities, mentor programs, and other topics and issues of concern to minority medical students.

ASPIRA ASSOCIATION, INC.

National Health Careers Program

ASPIRA's National Health Careers Program provides a comprehensive range of support services designed to address specific academic, motivational, and counseling needs of program participants.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES (AAMC)

Project 3000 by 2000

Supported by a grant from the National Institutes of Health (NIH) and the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Science Education Partnership Award Program, this project has the goal of nearly doubling, by the end of the twentieth century, the number of underrepresented minorities admitted each year to medical schools. The project focuses on the high school/college/medical school pipeline, a 12-year educational continuum during which students' interest in and capacity for study of medicine is either enhanced or dissipates. Through Project 3000 by 2000, the AAMC is providing leadership and technical assistance to medical schools seeking to:

- form partnerships with local school systems and undergraduate colleges, including articulation agreements to minimize social, financial, and academic barriers that impede the progress of talented minority students from one academic level to another;
- support the development of rigorous magnet high school health professions program in areas with large minority populations;
- track the progress of minority students who show a commitment to medicine in high school; and
- integrate all of the above with academic enrichment programs that medical schools have long administered to produce a comprehensive, well-coordinated strategy to increase underrepresented minority enrollment in medical schools.

ASSOCIATION OF BLACK NURSING FACULTY IN HIGHER EDUCATION (ABNF)

"I'm Ready" Program

The University of IL at Chicago (UIC) College of Nursing program was developed by a member of ABNF, and funded by the Robert Wood Johnson Foundation.

The program works with Chicago public school students, teachers, guidance personnel, parents, and College of Nursing academic counselors and mentors in related health care professions. Members of the Association recruit, advise, and provide educational assistance to African American and Hispanic students from grade school through high school and at the university level. The program is open to any student, but its focus is African American and Hispanic students.

(This program may be replicated on other campuses in the future.)

Indiana University Comprehensive Retention Program

This program involves investigating the needs of minority students, providing flexible program scheduling and financial aid, increasing representation of minority faculty and speakers in university programs, providing counseling and tutorial services, and increasing direct contact with professors.

Health Education Program for Inner-City High School Youth

This 7-week program deals with reported health behaviors of inner-city high school youth. A positive shift in reported health behaviors from high risk to low risk was found in youths surveyed before and after the program.

BAYLOR COLLEGE OF MEDICINE PROGRAM FOR CAREER ENHANCEMENT IN SCIENCE AND MEDICINE

Since 1972 Baylor College of Medicine, Rice University, and the Houston Independent School District have implemented programs designed to address the quality of science education at a local level, while enhancing opportunities for minority students to access careers in science and the health professions.

Public school efforts have included the co-founding of the High Schools for Health Professions, both in Houston and in Mercedes, TX; the operation of science enhancement programs for elementary, secondary, and college teachers; the implementation of a series of minority student projects designed to increase opportunities for individuals to access health and science-based careers; the establishment of science materials development projects at all grade levels; the co-founding of two high school science academies in Texas; and the establishment of a national science education reform center.

Baylor's career access enhancement efforts are designed to attract more youth to, and retain them in, the pipeline leading to science, medicine, and/or health care careers. This goal is accomplished through:

- teacher enhancement
- science reform/curriculum development
- career access
- collaborative planning

Elementary School Programs

Houston Elementary Science Alliance

Faculty members from Baylor and Rice University, as well as teachers and scientists from the community, serve as instructors for this 6-week summer program.

Science Kit Loan Program

Baylor sponsors a program through which local elementary schools borrow and utilize "hands-on" science materials developed to reinforce their science curricula.

Houston Science Education Partnership (BRAINLINK)

BRAINLINK is an innovative science education program targeted for three learning environments—the classroom, the home, and a museum setting. It is intended to present the latest factual information about the brain and behavior while conveying the excitement of "doing" science to teachers, parents, and elementary school (grades 1-6) students.

Middle School and High School Programs

Science Curriculum Reform: A Working Paradigm

The new program coordinates the sciences of every grade level in an integrated manner to reinforce student learning.

Southwest Center for School Science Reform

The National Science Foundation has designated the Southwest Center as one of five national demonstration sites to develop and evaluate local models to reform the scope, sequence, and coordination (SS&C) of science education including program development, teacher training, and field testing and demonstration of instructional components and resources.

High School for Health Professions (HSHP), Houston

Students apply for admission to the High School for Health Professions and are selected according to academic performance, test scores, conduct, teacher and/or principal

recommendations, and personal interviews. Under a contract from the District, Baylor provides the School with one of its own faculty members to serve as Dean of Instruction. The Dean works with the school's Principal, an adjunct faculty member at Baylor, to oversee the ongoing review and improvement of the curriculum, which combines a rigorous pre-college academic program with learning experiences in health-related activities. At the 9th- and 10th-grade levels, health-related experiences focus on career exploration and acquisition of basic knowledge and skills in health care. In 11th and 12th grade, students participate in clinical rotations at Baylor-affiliated teaching hospitals.

To date, 2,732 students have graduated from the school, and each year over 95% of the school's graduates access postsecondary education. Of the respondents, 92% had attended college and 64% of this group had chosen science or health-related majors.

Science and Health Center-Corpus Christi

Summer enrichment activities are held at the College. Baylor faculty also provide instruction and clinical experiences, support curricular development, and make presentations on the high school campus.

Health Professions Summer Academy

These activities are funded by the US Department of Health and Human Services and include two 3-week summer programs for 200 9th-grade students in both Houston and the Rio Grande Valley, to (1) strengthen academic skills in science and communication, (2) provide information and "hands-on" learning experiences that promote an understanding of pathways to health professions careers, and (3) develop social and study skills necessary for success at the precollege level.

The Science Academy of South Texas

The Science Academy offers a new magnet school program for grades 9-12.

Minority High School Student/Teacher Research Apprentice Program

Through this program participants are paired with research scientists for an 8-week period as part of a research team.

DocPrep

This program encourages the development of peer relationships between black and Hispanic senior students in specialized health professions and neighborhood high schools.

Health Career Awareness Video Program

The goal of this program is to promote interest in health careers among middle school students. The videos focus on (1) the value of staying in school and receiving an education, (2) awareness of professional health career options, (3) realistic career choices and the foundations necessary to access various professional health careers, and (4) the excitement, opportunity to serve, and job security offered by careers in the health professions.

Undergraduate/Graduate Programs

Honors Premedical Academy

Selected students participate in a 6-week program which combines critical thinking in science and communication skills with clinical experiences in the Texas Medical Center.

Medical Scholars Program

Newly implemented Medical Scholars Program (MSP), jointly sponsored by Baylor College of Medicine and Rice University, is designed to promote the education of future physicians who are scientifically competent, compassionate, and socially conscious. Students in the 8-year MSP are accepted to Baylor directly from high school, but must complete an undergraduate degree at Rice University.

Summer Medical Training Program (SMART)

The Graduate School of Baylor College of Medicine has established a 10-week summer program offering approximately 100 promising undergraduate students each year unique laboratory experiences in biomedical sciences. The SMART Program offers the following: (1) student-mentor pairing with Baylor scientists from basic science and clinical research departments; (2) specially-designed seminar programs; (3) off-campus field experiences; (4) career counseling workshops; (5) social and cultural activities for participants and Baylor faculty; and (6) a housing stipend.

Alliance for Minority Participation

The Southwest Minority Alliance is a consortium of eight undergraduate institutions, selected public school districts, and public and private research and business organizations in central and southeast Texas. Its purpose is to attract and retain minority students in science-based careers by (1) increasing the number of minority students who enter and/or remain in the science and engineering educational "pipeline" from junior high school through graduate school; (2) providing academic, counseling, and financial support to individuals at various levels within the science and engineering "pipeline" to increase the likelihood of their successful transition to subsequent levels; (3) exposing students to science and engineering work environments and working professionals so that they gain accurate perceptions about science and engineering careers; and (4) identifying minority students with the greatest potential for attaining graduate level degrees and assuming leadership roles in science and engineering education and research, and nurturing them through secondary and postsecondary study until they attain a doctoral degree in science or engineering

CHILDREN'S DEFENSE FUND

Project Head Start

Project Head Start is a comprehensive program within the Administration for Children, Youth, and Families at the Department of Health and Human Services that is designed to meet the emotional, social, health, nutritional, and psychological needs of children aged 3 to school entry. The program is locally administered by community-based nonprofit organizations and school systems. Grants are awarded by the Health and Human Services Regional Offices. The program is endorsed and supported by the Children's Defense Fund.

There are four major components in Project Head Start: education, health, parent involvement, and social services.

1. Education - Head Start's educational program is designed to meet each child's individual needs as well as the need of the community served and its ethnic and cultural characteristics. If programs have a majority of bilingual children, for example, at least one teacher or aide must speak their native language.

   Every child receives a variety of learning experiences to foster intellectual, social, and emotional growth. Children participate in indoor and outdoor play and are introduced to the concepts of words and numbers. They are encouraged to express their feelings and to develop self-confidence and the ability to get along with others.

   Head Start programs have a low child-staff ratio. Staff members receive training in child development and early childhood education, and learn how to work with handicapped children.
2. Health - Head Start emphasizes the importance of early identification of health problems. Head Start provides every child with a comprehensive health care program, including medical, dental, mental health, and nutritional services.
   A. Medical and Dental - Children receive a complete examination, including vision and hearing tests, identification of handicapping conditions,immunizations, and a dental exam. Follow-up treatment is provided for identified health problems.
   B. Nutrition - Many children entering Head Start have not received good, nourishing meals at home. In the

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program, children are served a minimum of one hot meal and snack each day, in order to meet at least one-third of their daily nutritional needs. A trained nutritionist supervises the nutritional activities of each Head Start program and helps the staff identify the nutritional needs of the children. The nutritionist plans an educational program to teach parents how to select healthy foods and prepare well-balanced meals, and how to obtain food stamps and other community assistance when needed.

C. Mental Health - Head Start recognizes the importance of providing mental health and psychological services to children of low-income families, to encourage their emotional and social development. A mental health professional must be available to every Head Start program to provide mental health training to staff and parents and to make them aware of the need for early attention to the special problems of children.

3. Parent Involvement - An essential part of every Head Start program is the involvement of parents in parent education, program planning, and operating activities. Many serve as members of Policy Councils and Committees and have a voice in administrative and managerial decisions.

   Through participation in classes and workshops on child development and through staff visits to the home, parents learn about the needs of their children and about educational activities that can be carried out at home. Many parents also serve in Head Start on a volunteer or paid basis as aides to teachers, social service personnel, and other staff members, and as cooks, story tellers, and supervisors of play activities. They receive preference for employment in non-professional Head Start staff jobs.

4. Social Services - The social services component of Head Start represents an organized method of assisting families to assess their needs, and then providing those services that will build upon the individual strengths of families to meet their own needs. Some of the activities that the social services staff use to assist families to meet their needs are: community outreach, referrals, family needs assessments, providing information about available community resources and how to obtain and use them, recruitment and enrollment of children, and emergency assistance and/or crisis intervention.

GROUP HEALTH ASSOCIATION OF AMERICA

Minority Training Proposal

The GHAA's Minority Training Proposal offers training to minorities for first level and middle management positions in HMO and other managed care organizations.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

The Healthy Start Initiative

The "Healthy Start" Initiative is a demonstration project funding 15 urban and rural communities with infant mortality rates at least 1.5 times the national average.

The goal of the Initiative is to reduce infant mortality by 50% in these selected high risk areas in 5 years. Resources will be concentrated where they are needed most: to mobilize and capitalize on the initiative of families and communities; to address infant mortality in a comprehensive manner with improved access to multiple services; to evaluate carefully what works and use this knowledge to address infant mortality nationwide.

A major feature of the Healthy Start Initiative is the development of strong coalitions of local and state governments, the private sector,

schools, religious groups, and neighborhood organizations. Together the Healthy Start projects and their community coalitions are working to develop effective health care and social and support services for women and their babies. Each Healthy Start project proposes a unique local approach in addressing the high infant mortality rate.

In Fiscal Year 1991, $25 million was appropriated for planning and program coordination in the Healthy Start communities. For FY 1992, $65 million was directed toward comprehensive services for women and infants in the Healthy Start sites; an additional $10 million was provided for community health centers for similar purpose. For FY 1993, the program was funded with $79 million of appropriations.

Objectives of the Initiative include:

- encouraging early entry into prenatal care
- improving pregnancy outcomes
- improving health status of women and infants
- reducing behavioral risk factors and encouraging behaviors needed to give all babies a healthy start
- improving access to care and improved coordination of key service programs
- increasing utilization of services
- improving family and community support for pregnant women and women with infants
- increasing public awareness of the seriousness of the problem of infant mortality, factors that contribute to its cause, and steps toward prevention

In the 15 Healthy Start communities, grantee projects will expand and improve existing systems of care in a comprehensive manner by addressing health care, social, and other support services for women and infants. The following are some of the specifics:

A. *RESPONSE TO HEALTH CARE NEEDS*
   - Expand, or establish, "one-stop" comprehensive community health centers to address the multidimensional needs of mothers, infants, and their families, including substance abuse prevention and intervention;
   - Develop multiple one-stop sites, two will be developed in collaboration with local churches;
   - Develop adolescent comprehensive care clinics in local schools and facilitate/organize pregnancy prevention programs in local schools;
   - Employ additional multidisciplinary professionals to staff existing and proposed facilities;
   - Provide staff, volunteer, and other provider training and continuing education to enhance the quality of care.

B. RESPONSE TO SOCIAL AND OTHER SUPPORT SERVICE NEEDS
   - Activities planned to address the problems related to entitlement programs include the outstationing of eligibility workers, development of common intake/application forms for entitlement programs, and training in presumptive eligibility for Medicaid;
   - All projects plan aggressive case management and/or outreach programs with activities such as hiring and training of personnel; placement of staff in jails, schools, shelters, mobile vans, and other service delivery centers; development of a data base and automated case management system;
   - Eleven of the projects plan to increase the availability and accessibility of child care through activities such as the provision of on-site child care and the development of neighborhood support networks for cooperative child care;
   - Transportation issues are being addressed through the use of vans, the provision of tokens, or contracting with transportation service providers;
   - Private funding will be obtained to build new housing and to rehab existing housing stock in five of the projects, including the development of housing for vulnerable populations

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such as substance abusing women, pregnant and/or parenting women, and their children and families;
- Employment opportunities will be increased through employing area residents as outreach workers and family advocates, providing and referring for job counseling, and developing job banks, increasing resources for apprenticeships, helping residents start their own businesses, and, in one city, creating a revolving loan fund with low interest rates to residents seeking to become family day care providers;
- Neighborhood safety will be increased through activities such as developing neighborhood watch groups, providing education and counseling for domestic violence, public awareness campaigns, playground cleanups, fairs, and male responsibility programs.

HENRY J. KAISER FAMILY FOUNDATION

More Minorities in the Health Professions

This program supports efforts to improve middle and high school students' academic and social preparation for college and provide exposure to health issues and health professionals.

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

Ad Hoc Committee on Minority Populations Fourth National Forum on Minority Health Issues "Minority Health Issues for an Emerging Majority"

This program consists of 2 days of presentations, workshops, and roundtable discussions that examine research, community interventions, and health policy. Participation of minority organizations in this forum has increased since the program began in 1975. The Institute also partici pates in meetings of the National Medical Association and American Association of Indian Physicians.

NATIONAL INSTITUTE OF MENTAL HEALTH

MARC (Minority Access to Research Careers) Program

The MARC Program provides institutional grants to support honors undergraduate research training programs, and faculty fellowships.

NATIONAL MEDICAL ASSOCIATION/ US PUBLIC HEALTH SERVICE

National Minority Mentor Recruitment Network

The goal of this program is to increase the number of interested African American and other minority medical students in the health professions through recruitment, training, and retention strategies. Students are matched with physicians to obtain experience in the practice setting.

NATIONAL RURAL HEALTH ASSOCIATION (NRHA)

Rural Minority Populations and Their Access to Care Activity

This program seeks to improve access to health services for rural minority populations through the following:

- mandated increased representation on the board of minority populations
- greater minority involvement in the NRHA
- minority focused sessions at conference and other programmatic changes

National Conference on Rural Minority Health Issues

In FY 1992, the NRHA will develop a plan for a national conference on rural minority health issues that will discuss the barriers to provision of access to appropriate care for rural Black, Hispanic, Native American, and Asian populations. The NRHA will work with the Rural Minority

Research Center at Morehouse College in Atlanta, First Nations Financial Project and other national associations and professional organizations. The NRHA has requested inter-agency support from the Bureau of Health Care Delivery and Assistance, the Office of Minority Health, the IHS, and the Bureau of Health Professions.

OFFICE OF MINORITY PROGRAMS NATIONAL INSTITUTES OF HEALTH

Minority Health Initiative ($45 million)

Improving health in minority communities and attracting minorities into careers in medicine and research are the goals of this program. The NIH spent $8.3 million on similar programs in 1992 (see Table, p 63). In addition, $21 million was spent on supplements program to supplement grants in order to attract minorities into biomedical research.

NIH MINORITY HEALTH INITIATIVE

Health Initiatives	Description	Budget ($ Millions) '92 Estimate	'93 Proposed
Infant Mortality	Behavioral intervention trial, perinatal research on causative factors, such as nutrition and low birth weight	0.5	5.0
Adolescent Health	Research on behavioral interventions aimed at ages 10-24: emphasis on violence and sexual behavior	2.0	5.0
Young Adults	Encourage minority participation in health screening and adherence to medical regimens	0.5	5.0
Older Adults	Research on factors affecting severity and progression of chronic diseases, and relieving impairment from disease	0.6	2.0
Minority Male at Risk	NIH's contribution to a program started by the Secretary of Health and Human Services to modify behaviors that adversely affect health	—	8.0
Regional Training and Research Centers	Modeled on NSF education centers: a consortium of academic institutions will provide research training	—	5.0
MS/PhD Program in Biological Sciences	Provides support for students receiving MS degree to move to institutions that grant PhDs	1.2	5.0

NIH MINORITY HEALTH INITIATIVE (continued)

Health Initiatives	Description	Budget ($ Millions) '92 Estimate	'93 Proposed
2-Year/4-Year Bridge Program	Provides incentives and support for students attending junior colleges to continue on to baccalaureate degrees	0.8	5.0
Pre-College Intervention Program	Cooperative program with NSF. Will support middle and high school life science programs	2.5	5.0
Evaluation of NIH Minority Training	Data collection from each NIH institute on level of support and effectiveness of recruiting minorities to research	—	—
TOTAL		8.3	45.0

ROBERT WOOD JOHNSON FOUNDATION

1991 Summary of Grants for Minorities

Minority Medical Faculty Development Program

8-12 fellowships are awarded to minority medical school graduates in order to facilitate development of successful minority role models on medical school faculties

$5,000,000 (Education and Training)
National Medical Fellowships, Inc.

Need-based scholarships for minority medical students (for 5 years)

$381,928 (Demonstration)
University of Oklahoma College of Public Health

Technical assistance and direction for improving the health of Native Americans (for 1 year)

$393,716 (Education and Training)
Harvard Medical School

Technical assistance and direction for the Minority Medical Faculty Development Program (for 1 year)

$50,000 (Education and Training)
National Academy of Sciences - Institute of Medicine

Workshops to reassess minority strategies (for 1 year)

$50,000 (Education and Training)
New York University

Planning project to increase minority medical school enrollment (for 1 year)

$257,164 (Education and Training)
University of Oklahoma Health Sciences Center

Technical assitance and direction for the Minority Medical Education Program (for 1 year)

$437,983 (Research)
Center for Health Economics Research, Inc.

Racial differences in health care utilization among Medicare enrollees (for 2 years)

$50,000 (Research)
The New York Hospital Cornell Medical Center

Pilot study to care for blacks and Latinos with arthritis (for 1 year)

$182,239 (Communications)
Alaska Public Radio Network

Reporting on Native American health issues (for 3 years)

$40,000 (Communications)
University of Minnesota Medical School, Minneapolis

Dissemination of results of health survey of Native American youth(for 1 year)

$40,000 (Communications)
NAACP Legal Defense and Educational Fund, Inc.

Conference on African-American health care advocacy (for 1 year)

$37,068 (Communications)
Hazelden Foundation

Conference to spur action on substance abuse problems by black churches (for 4 months)

ROBERT WOOD JOHNSON FOUNDATION GRANTS FOR MINORITIES (continued)

Minority Medical Education Program

$2,838,462

Improving the Health of Native Americans

Support for innovative programs addressing health care needs of American Indians and Alaska Natives

$2,398,928

Minority Medical Education Program

Summer enrichment program to help minority students successfully compete for medical school acceptance (for 2 years)

$2,459,008

Minority Medical Faculty Development Program

Four-year program to provide 2-year Biomedical, Postdoctoral Research Fellowships

NATIONAL ACADEMY OF SCIENCES INSTITUTE OF MEDICINE (IOM)

The IOM offers a 12-month project directed at setting a priority research and action agenda for increasing participation of underrepresented minorities in clinical practice and academic medicine. The program consists of two invitational workshops on different aspects of the issue. One workshop will focus on strategies to enhance the educational and career opportunities for minority students in clinical practice and primary care. The other will address the role of mentoring, role models, and supportive environments for enhancing the participation of minorities in academic medicine.

The objective of the workshops will be to analyze past initiatives in light of a changed economic, policy, and political environment for the purpose of shaping a future-oriented research and action agenda responsive to the realities of the 1990s. An outcome of these activities will be a publication that will include the background commissioned papers, a summary of the workshop discussion, and recommendations about future strategies for increasing minority participation in the health professions.

US CONFERENCE OF LOCAL HEALTH OFFICERS

Minority Health Initiative

The Minority Health Initiative seeks to identify current efforts of local health departments (LHDs) and other community organizations to improve minority access to health resources and services, and to ascertain their capacity to assess the health status of minority populations and the community in general.

This initiative is funded by HRSA, BPHC/DPSP. The funding supports staff, case profiles, a national minority health profile questionnaire, and workshops.

The Minority Health Initiative has convened several national sessions on minority health dealing with such subjects as primary care, violence as a public health issue, health care in public housing, school-based clinics, and multilingual health care assistance.

Health care in public housing will constitute a major focus for the project and will include the compilation of a comprehensive report on three of the seven currently funded clinic projects. The survey/questionnaire component will be expanded to include a multi-year, in-depth assessment of the barriers to LHD efforts to access minority populations and identify ways in which such barriers were successfully overcome.

APPENDIX C

AAP TASK FORCE ON MINORITY CHILDREN'S ACCESS TO PEDIATRIC CARE
CONFIDENTIAL SURVEY OF CHAPTER PRESIDENTS

1. Approximately what percent of the members of your chapter fall into the following ethnic/cultural categories? If you have no members in a particular group, please indicate by placing "O" in the group space.

   _____% African American

   _____% Hispanic

   _____% Native American

   _____% Asian or Pacific Islander

   _____% White, non-Hispanic

   _____%Other (specify) _____

2. Approximately what percentage of the following minority group members hold elected or appointed positions or volunteer for short-term assignments in your chapter?

   _____% African American

   _____% Hispanic

   _____% Native American

   _____% Asian or Pacific Islander

   _____% White, non-Hispanic

   _____% Other (specify) _____

3. Do you feel there is a need for increasing involvement of minority group Academy members in your chapter? Why or why not?

   _____

   _____

   _____

   _____

4. What difficulties have you experienced in appointing minority group members to your chapter?

_____ don't know of any minority group chapter members

_____ have contacted minority group chapter members but they have declined to participate

_____ other barriers Please describe: _____

_____

_____

_____

5. Please describe and rate any programs that your chapter has implemented or utilizes to encourage participation of minority group members

Name of program, year, and description	Rate 1-4 (4 being very successful)
_____	_____
_____	
_____	_____
_____	
_____	_____
_____	

Would you be interested in utilizing a program in your chapter if one was made available to you?

_____ Yes _____ No

6. Do you have any suggestions on how chapters could increase the involvement of minority group members at the chapter level? (Please list your suggestions)

_____

_____

_____

_____

7. Do you think that the structure for participation in the AAP impedes or enhances minority group members' involvement in chapter activities?

_____ Impedes _____ Enhances _____ No opinion

Please explain: _____

_____

_____

_____

8. Do you feel the Academy at the national level is "user friendly" for minorities?

_____Yes_____No

Why or why not? _____

_____

_____

_____

9. What do you perceive are the main barriers to involvement in AAP activities faced by minority group members at the national level?

_____

_____

_____

10. Do you think the structure for participation in the AAP impedes or enhances minority group members' involvement in AAP activities at the national level?

_____ Impedes _____ Enhances _____ No opinion

Please explain: _____

_____

_____

11. Do you have any suggestions for increasing the number of minority group member Fellows on National Academy committees or councils? (Please list your suggestions)

_____

_____

_____

12. Additional comments:

_____

_____

_____

Your responses to this survey will be treated confidentially. Thank you for your cooperation.

Please use the provided envelope to return this survey to:

Mary Ruth Back,
Division of Pediatric Practice

AMERICAN ACADEMY OF PEDIATRICS

Task Force on Minority Children's Access to Pediatric Care Questionnaire

About you:

1. Year of graduation from medical school: _____
2. Are you a board-certified pediatrician? _____ Yes _____ No
3. Gender: _____ F _____ M
4. Cultural or ethnic group (check one):
   _____ American Indian or Alaskan Native
   _____ Asian or Pacific Islander
   _____ Black, non-Hispanic
   _____ Hispanic
   _____ White, non-Hispanic
   _____ Other (please specify) _____
5. AAP membership status (check one):
   _____ Currently a member
   _____ Have never been a member
   _____ Former member for _____ years, but not a current member. **Will you please tell us why you chose to discontinue your AAP membership?**

   _____
   _____
   _____
   _____

About the American Academy of Pediatrics:

6. One way that the AAP hopes to increase its sensitivity to minority health issues is by increasing the number of minority group pediatricians who are members.
   What do you see as the benefits of and/or barriers to AAP membership? — **Please respond even if you are not an AAP member.**

   Benefits: _____
   _____
   _____

   Barriers: _____
   _____
   _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

7. The Task Force wants to encourage more minority group pediatricians to actively participate on AAP committees, councils, task forces, etc.

   What do you think are the barriers to such participation? **Again, please share your views, even if you are not an AAP member.**

   Barriers, locally: (chapter level) _____

   _____

   _____

   Barriers, nationally: _____

   _____

   _____

Suggestions for the Task Force:

8. Please give us any suggestions that will help the Task Force in developing recommendations and strategies to ensure that the AAP is more responsive to the perspectives of minority group pediatricians.

   _____

   _____

   _____

   _____

RESPONSE REQUESTED BY *DECEMBER 15, 1992*

Thank you very much for your assistance.

Please return this form in the envelope that is provided.

You may fax your form to the AAP: **(708) 228-5097**
Attention: Mary Ruth Back

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AAP TASK FORCE ON MINORITY CHILDREN'S ACCESS TO PEDIATRIC CARE

Open Forum and Reception
Sunday, October 11, 1992

Your responses to the questions below will be greatly appreciated.

1. Year of graduation from medical school: _____

2. Gender: _____ F _____ M

3. Cultural or ethnic group (check one):
   _____ African American, non-Hispanic
   _____ American Indian or Alaskan native
   _____ Asian or Pacific Islander
   _____ Hispanic
   _____ White, non-Hispanic
   _____ Other (please specify) _____

4. Are you involved in the AAP, locally or nationally, in an elected or appointed position?

   _____ yes _____ no, never involved _____ no, but formerly involved

   If yes, please list: _____

   _____

5. Do you think the presentations during this Forum were informative or not?

   _____ informative _____ not informative

6. Are there additional issues that you think the Task Force should consider?

   _____ yes _____ no other issues

   If yes, please list: _____

   _____

7. Did this Forum provide you with an opportunity to meet other minority group Fellows, or not?
   _____ yes _____ no

8. Have you attended a previous national AAP meeting (Annual Meeting or Spring Session)?
   _____ yes _____ no

   If yes, how many national meetings would you estimate that you have attended? _____

PLEASE! TAKE ANOTHER MOMENT TO COMPLETE THE REVERSE SIDE OF THIS FORM.

9. How did you learn about this Forum? _____

10. What prompted you to attend this Forum?

_____ to learn more about the Task Force
_____ to learn more about AAP initiatives directed toward minority group pediatricians
_____ to learn how I might become involved in AAP activities
_____ to network
_____ other - please note - _____

11. Do you feel the Academy is "user friendly" for minority group pediatricians?

_____ yes _____ no

Why or why not? _____

_____

12. Do you think that the structure for participation in the AAP (committees, councils, task forces, etc) impedes or enhances minority group members' involvement?

_____ impedes _____ enhances _____ no opinion

Please explain? _____

_____

_____

13. What do you think are the benefits/barriers to involvement in AAP activities for minority group Fellows?

Benefits: _____

_____

Barriers: _____

_____

Please use this space to identify any issues or concerns that were not addressed above.

_____

_____

_____

THANK YOU!
Please give this form to a Task Force member.

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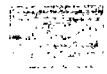

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