Past Event: 2022 NCSBN APRN Roundtable- Diversity in the APRN Workforce: Evidence and Impact Video Transcript

Event
2022 NCSBN APRN Roundtable

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Presenter
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Good morning. I am so thrilled and honored to join you this morning for the APRN round table. And I'm especially thrilled to have time to speak to you about a topic that is near and dear to me, Diversity in the APRN Workforce.

It's a topic that is personal to me but, also, one that is important given my role as a health equity researcher, interested very much in ways that we might improve health outcomes, increase health equity, and reduce health disparities.

And so, before I begin, I always like to share what brings me to a topic. And so I've been a nurse practitioner for over 20 years, and I completed a psychiatric primary care nurse practitioner program at the University of Pittsburgh in the late '90s. And it was during my time as a nurse practitioner student that I had a preceptor.

Her name was Ms. Anne, and we worked in a community health center together. And it was while working with Ms. Anne that> I saw myself in her and I knew that I wanted to center my practice in community health. At the time that she was my preceptor, I didn't realize that it was very rare or it would be very uncommon over the course of my nurse practitioner practice that I would ever see another nurse practitioner who looked like me.

In fact, during my first six years of practice, I saw literally no nurse practitioners who looked like me. And during my time at Pitt, in my classrooms, I saw no other nurse practitioners who looked like me. And so the lack of diversity in the APRN workforce certainly is one that is personal to me, but it also has implications for patient care, particularly care of patients or individuals from underrepresented and diverse communities.

And so it's with that that I share some concerns about diversity that I have but, also, look forward to a conversation about how we might meet the urgency of the moment. And so to start off our time together, I thought I would share a few objectives. Yes, they're a little ambitious, but we're going to do it.

And so for the next 40 minutes or so, I'm going to lay the groundwork for what the current racial and ethnic composition of the APRN workforce is. How is the advanced practice nurse workforce impacted by the lack of diversity? How do APRN regulators and other stakeholders benefit from improved diversity, inclusivity, and equity?

And what are the patient implications for quality, safety, access? And then I'd like to ask about the quality of the data. Is it good? If not, why not? And what do we need to get a more complete picture about what diversity in the APRN workforce looks like?

We're then going to move on to describe the current environment and barriers to increasing diversity. And lastly, I'm going to leave you with a few strategic activities to help advance DEI objectives, but it's really a launching point for our conversation during the Q and A to discuss what you are currently doing, what some of your barriers are, and what are the collective activities that we should be engaging in together.

Before I begin, an acknowledgment. And so diversity is certainly expressed in multiple forms, including but not limited to race/ethnicity, gender, gender identity, sexual orientation, SES status, national origin, religious beliefs, disability status, political views.

And I want to acknowledge this because we have such a short time together. And so I won't be touching on all forms of diversity during our time today, but I will be specifically discussing diversity through the lens of race and ethnicity of the APRN workforce. But I want to say that as a caveat because we should be thinking about diversity in its broadest sense, particularly for those individuals who may have been systematically excluded from the APRN workforce.

And so I want to make sure we're all on the same page and singing from the same hymnal. And so what then is workforce diversity? And so diversity in health occupations is measured by the representation of minority groups in the health occupation relative to their representation in the U.S. populace. And so lower representation of racial and ethnic minority members in a health occupation relative to their numbers in the general population signifies that the racial or ethnic group is underrepresented in the occupation.

And so just for a point of reference, about 60% of the U.S. populace is white, and that means 40% would identify as a racial or ethnic minority. And so with that platform, we're going to see the state of diversity in the APRN workforce. And so the first slide that I'll share with you is from the National Center for Health Workforce Analysis from 2017.

And so if you look at this data, which actually was derived between 2011 and 2015, for advanced practice registered nurses at that time, 84% of the APRN workforce was white. About 5.7% is black or African American, 4.5% self-identified as Hispanic, 4.1% as Asian, American-Indian self-reported less than a half a percentage, and Native Hawaiian and Pacific Islanders was not reported.

And so that signifies that it's too small a number to be able to report. And so this gives us a sense for what the APRN workforce looked like between 2011 and in 2015. And so, quite rightfully, these numbers may have improved over the last seven years, but we know that shifts in the composition of the workforce actually shift quite slowly.

And so we should surmise that this is probably about where we are today. And so using another data source, this one is from the American Community Survey from 2019, so a little bit more up to date, but this is looking only at nurse practitioners and nurse midwives.

However, again, we see 77.5% of nurse practitioners and nurse midwives are white, non-Hispanic black is the second most common race or ethnicity in this occupation, representing about 8.72% of nurse practitioners and nurse midwives. And so depending on who is being accounted for, whether we're including all APRNs or we're just looking at a cross-section of nurse practitioners and nurse midwives, there can be some shifts or changes in the percentages of minorities.

And so more minorities represented here likely because more minorities in the nurse practitioner workforce. And I say that because, next, we're going to talk about specialties. And so using data from the American Midwifery Certification Board, their 2020 Demographic Report, we see about 85% of nurse midwives in the U.S. self-identify as white or Caucasian.

And this is across just short of 13,000 certified midwives in the United States. We see approximately 7% of AMCB-certified midwives self-identify as black. And we see about 4.73% self-identify as Hispanic or Latino.

When we look at CRNAs, we see a similar picture. Of the 59,000-plus CRNAs n the United States, about 12% in total self-identify as nurses or CRNAs of color, 3% self-identify as African American, 4% as Hispanic, 4% as Asian Pacific Islander.

And so I think if we look across various data sources, across APRN specialties, we get a pretty clear picture that across APRN specialties, with some variation with nurse practitioners, that white APRNs are overrepresented in the profession. So what about other data sources?

And what do we think about the quality of the data, about the completeness? And so when we evaluate the types of data sources that are most available to us, many are providing a quantitative assessment of composition based off self-identity, whether that be race or ethnicity.

What is missing, at least I would argue, are other types of data sources, perhaps qualitative. So what are the experiences of APRNs of color? What are the historical contributions of APRNs of color? And what is the impact, evidence of impact of their contributions to the workforce?

And because this data is often not available, or we're not collecting it, it renders the contributions in the mere presence and the experiences of APRNs of color as either incomplete or obscured.

And I would go as much as to say, is that the lack of sufficient data, particularly about the contributions of APRNs of color, limits their representation, their visual and their cultural representation, in the APRN workforce. And it almost whitewashes the profession in a way that fails to provide students of color with an archetype toward which they can aspire.

And so we often hear you cannot be what you cannot see. And so I really would like to challenge us about our data, the level of completeness, and the ways in which we think about completing a much more complete and accurate portrayal of APRNs from diverse backgrounds.

And so let me provide a few examples that I found as I was preparing for our time together today. This is a video that was developed by the American Association of Nurse Practitioners. It's a five-minute

video. It's available on YouTube. It was published and produced in 2005 to celebrate the first 40 years of the nurse practitioner workforce.

And so it's interesting because, as you know, the nurse practitioner profession was developed in the 1960s in the throes of the civil rights movement. And its purpose, in part, was to address the needs of the underserved. And in many respects, those underserved community members were black and brown patients, and individuals, and community members.

And so this video uses as the backdrop images of the civil rights movement, and there are black and brown patients throughout the imagery of the video. And it's really compelling. What also happens in this video is that you see no, absolutely no APRNs of color providing care. So you see all white nurse practitioners providing care to black and brown patients, but you never see nurse practitioners of color represented in the first 40 years of the profession.

And it's not because they weren't there. And so I just offer this as an opportunity for us to think about how are we representing the profession and in what ways does this representation inadvertently, again, obscure the contribution, obscure the very presence of APRNs from diverse backgrounds?

So this video is from 2005. And so I imagine that there might be other ways that APRNs of color are represented. But it was interesting because as I continued to prepare, I came across a more up-to-date manuscript. And so this manuscript was published in 2020 in the "Journal of the American Association of Nurse Practitioners."

And ironically, the title of this particular article is called "The Perils of Not Knowing the History of the Nurse Practitioner Role." And this isn't to pick on the manuscript itself. It's actually a very interesting manuscript, and its purpose is important. It is so important for us to acknowledge our history as a profession.

And in order to conduct this particular study, the researchers, they interviewed six trailblazers in the nurse practitioner profession. They're referred to as pioneer nurse practitioners. And there were six in total, five female, one male.

And they were asked about how the NP role developed and what pushback was met from healthcare professionals, the patients, what hindered their practice, how it was resolved, how the NP practice had changed. And they discussed pearls of wisdom.

And I enjoyed the article, but as I reviewed it, I wondered what would this article have looked like if we had asked these same questions of nurse practitioners or APRNs from diverse backgrounds? What would we have learned about their experiences in the healthcare profession, about their pushback barriers to their practice?

What would we have learned from the Latino, Latinx, or Hispanic nurse practitioner caring for immigrant populations? What would we have learned from the native nurse practitioner caring for Indigenous populations? What would we have learned about nurse practitioners who not only practiced with underserved communities but lived in those communities themselves?

And so I use this as an example for us to contend with ourselves as a profession and to think about the ways in which we provide a more holistic and complete history. And so I think, or I hope that you join me in thinking that we have work to do. Right? And so if you're like me, I am solution oriented.

And when presented with a problem, I'm very interested in how we improve. And so if you're like me, you want to know what are the strategies? What are the tactics? What do we do? And if we don't do it, what are the consequences, right, to the patients and the communities we care for? Before we can strategize about solutions, we have to take a little bit of a step back and ask ourselves, how did we get here?

Because we know that any forward progress to address and to increase workforce diversity must acknowledge that the composition of the current workforce did not happen in a vacuum, right? So it didn't happen by accident. It happened by design. And so if we want to strategize or even use design thinking, we have to recognize that this is a challenge that occurred by design, and then it can be redesigned.

Okay? And so with that understanding, one of the reasons that we have such lack of diversity in the APRN workforce is that the RN workforce isn't very diverse. And so we're drawing for graduate students from a pool that's not very diverse. And so one of the ways that we might think about increasing our APRN representation is by increasing the representation of diverse nurses working in the healthcare workforce.

And so, again, as you can see, about 81% of RNs are white. And while the percentage of Hispanic and black RNs have increased over time, you can see that even between 2013 and 2020, the representation of black RNs increased from 6% to 6.7% in 7 years.

And so, once again, these demographic shifts occur very slowly. And so if we expect to see real change over time, we have to get to work today. Another challenge to the APRN workforce diversity is the very limited diversity among APRN faculty. And so, again, when we think about faculty and when we think about preceptors, drawing back to the antidote that I shared at the top of my time with you today, it is so critically important for students to see themselves mirrored so they can see their actual and eventual self.

And so as we think about efforts for recruitment and diversity into the APRN workforce among the diverse APRNs we have now, we have to think about strategic ways to provide opportunities for faculty and preceptorships as well. And so we have acknowledged that the workforce, the APRN workforce, lacks diversity due to the limited pool in the RN workforce into faculty.

But we also have to acknowledge and reckon with decades and decades of systemic and structural racism that has actively excluded admission of diverse nurses into the APRN workforce. So you might say, well, what do I mean by that? And so to that, I draw your attention to restrictive admissions processes that did not necessarily allow nurses from diverse backgrounds into graduate education.

And so those restrictive admission policies, over time, result in fewer opportunities for diverse nurses to be able to achieve or access graduate training. Many admissions criteria continue to utilize standardized testing, such as the GRE, which are known to have little predictive value for success in graduate education.

And finally, there continues to be anecdotal and research studies to suggest that educational and work environments for RNs and APRNs of color continue to be hostile, hostile with overt racism, hostile with microaggressions.

And this type of structural and environmental context impedes our opportunities to draw individuals from diverse backgrounds into APRN professional roles. And so at the same time that we're thinking

about recruitment, we have to think about these systemic and structural ways that recruitment and retention is challenged, unless we deal with some of these systemic and structural barriers.

Another reason for us to deal with systemic and structural racism is because both of these factors are inextricably linked to health disparities. And so this is a Kaiser Foundation Framework. And you can see the ways in which health disparities are driven by social and economic inequities. And all of these factors, all of these social and economic factors, whether it be neighborhood, education, food, community, and healthcare system, yes, there are structural factors, but racism and discrimination is the thread that is linked across all of them and leads to disparities and inequities in employment, in food and security, in social integration.

And for the healthcare system, racism and discrimination leads to disparities in healthcare coverage and provider availability, and access to linguistically and culturally appropriate care. It certainly leads to a decrease in quality of care. What I would add to this is that racism and discrimination has led to the lack of diversity that we see in the RN and the APRN workforce today.

And I will go on to argue that that lack of diversity in the nursing and the APRN workforce due to systemic and structural racism has direct effects and an impact on disparate outcomes that we see today in many settings. And so for us to address and create solutions for the lack of diversity in the APRN workforce, we have to really, again, contend and reckon with these systemic and these structural barriers.

And so in 2017, a colleague and I, Lusine Poghosyan, a professor at Columbia University, began to contend not so much with structural racism, but certainly, factors and mechanisms that might influence the nurse practitioner's ability to provide holistic and comprehensive care. And so in thinking about these mechanisms, we reviewed the literature to look to see the ways in which regulatory barriers, such as scope of practice, context, and working conditions such as the work environment, nurse practitioner supply, primary care capacity, how might all of these things, including the diversity of the NP workforce, how might these factors or mechanisms influence racial and ethnic health disparities?

When it came to the nurse practitioner workforce diversity component, in particular, we argued that the value of nurse practitioner workforce diversity was linked to four important factors.

We argued that APRNs from diverse backgrounds are more likely to work in underserved communities. And with that being the case, that this may help to increase access and utilization of services. So those are two reasons that increasing or having diverse APRNs in the workforce. And, again, this model is related to nurse practitioners, but I argue that it extends more broadly to APRNs.

So access and utilization. Nurse practitioners from underrepresented backgrounds bring diverse perspectives. And because of that, because of this knowledge of community, you're able to bring to bear cultural responsiveness. That is important for care of patients because it enhances culturally responsive care, but it's also important to the other providers who are in that setting, where the APRNs or nurse practitioners serve as experts, as liaison experts, in how to provide culturally responsive and linguistically responsive care.

And finally, the third rationale for increasing diversity in the workforce. And I'll say that this isn't an exhaustive list. There are surely other reasons to increase diversity, but also because of increased rapport. I can't tell you how many times I've had patients from diverse backgrounds tell me, " When you

walked in the room, I just took a sigh of relief because I knew that you'd be able to just understand where I was coming from."

And so mitigating those feelings of frustration, of communication barriers, of overt discrimination and bias from the healthcare system and providers, mitigating mistrust and the avoidance of healthcare services overall. We can't undercount the importance of rapport, relationship, and trust-building. And so for those reasons, representation matters to patients but also to environments because we know that diverse perspectives helps everyone in the healthcare setting, including patients as well as providers.

And so, you know, over the past two years, in particular, as a country, we've been contending with structural and systemic racism. Structural and systemic racism go well beyond the last two years, but we have been more overtly and honestly contending with those constructs.

So I don't want to confuse in this place, structural and systemic racism have a long history in the U.S. And so the reason I bring this up is that when you look at that 2017 model that I shared with you, structural and systemic racism wasn't mentioned. And as we continue to evolve in the way that we understand the importance of diversity and inclusivity, how, in fact, to improve diversity, we have to contend with the ways that structural and systemic racism interact with our regulatory policies, interact with practice environments to, directly and indirectly, influence health disparities.

And so what I've been thinking about more recently is the ways in which these constructs represent cumulative disadvantage, right? And so what does it mean for patients from diverse backgrounds to live in a state with reduced scope of practice while being cared for in a practice environment that is unsupportive of nurse practitioners by a nurse practitioner workforce that lacks health disparities, right?

And so instead of thinking about the direct effect of one of these constructs, it may do us well to think about the ways in which having any one or a combination of these disadvantages may ultimately represent cumulative disadvantage.

And so, in that way, this helps us think about a more complex engagement with some of these constructs. And this is where my thinking has evolved over time and the ways in which, as a researcher, I'm hoping to really complicate some of the ways that we've looked at these relationships previously. And so my work, admittedly, has not looked directly at diversity in the APRN workforce, but I do want to highlight a few things that I've noticed along the way.

In particular, in 2020, our research team was really interested in the relationship between supportive clinical practice environments and reports of delivery of patient-centered care.

And so we know patient-centered care is important. And for this particular study, we surveyed nurse practitioners working across more than 1500 practices in 4 states. We wanted to know, in particular, whether nurse practitioners routinely integrated the cultural needs and preferences of their patient-centered care.

And we wanted to know whether or not there was an association with the likelihood of integrating patient-centered care in the practice environments where nurse practitioners were employed. And so to answer that first question, I will tell you, yes. In practice environments that were more supportive of nurse practitioners, nurse practitioners reported more frequently integrating cultural needs and preferences of their patient-centered care.

So that's the answer to that particular question, that aim, and that is the summary of what you'll find in this particular article. But I wanted to draw your attention to something that we thought was interesting and that in future research would require more explication. And so when you looked at this total sample, over 1700 nurse practitioners working across 1500 practices, and what you'll see is about 75% to 76% of nurse practitioners reported that they routinely and frequently integrated cultural needs and preferences into care.

And so that's a good thing. We would hope 100% do, but three-quarters of nurses say, "We routinely integrate patient needs and preferences," compared to 24% who said they did not. But one of the things that we thought was interesting is that when we looked at routine integration of patient-centered care and we looked across race and ethnicity, that there were definitely some differences.

And so if you look, for example, across racial groups, 74% of white nurse practitioners said that they integrate cultural needs and preference, compared to 89%, nearly 90%, of black nurse practitioners reported that they routinely integrate the needs, cultural needs, and preferences of their patient-centered care.

Eighty-four percent of Asian nurses, or excuse me, nurse practitioners say the same. Eighty-three percent of Latino nurse practitioners report routinely integrating their cultural needs and preferences into care. And so I'll admit that these are descriptive findings. The goal of the study wasn't to then go on to see if there was a relationship between diversity and patient-centered care, though that is the natural next step in this line of inquiry.

But I wanted to say that this is at least suggestive of something. You know, one of the reasons and the rationale we offered in our prior framework about the value of diversity was very much due to an increase in utilization, an increase in access, an increase in rapport, and an increase in culturally responsive care.

And we pause at that in a framework, but I suggest that we're starting to see some of that empirical evidence if you see some of the outcomes across the nearly 1800 nurse practitioners that we surveyed here. And our goal moving forward is to advance this empirical knowledge to look at, in particular, the outcomes of patients from diverse backgrounds who may or may not be in these racially or ethnically concordant clinician-patient, or provider-patient dyads.

And so what do we do, right? Where do we move forward? And I think we can take some of our marching orders from the recently published Future of Nursing report, 2030. In it, the report says, "While higher proportions of people of color individuals, with the exception of Hispanics, are obtaining a master's or a Ph.D. degree, and especially a DNP degree, APRNs have a long way to go to match RNs in achieving a more diverse workforce."

It goes on to add that the APRN workforce will need to rapidly become more diverse over the next decade or it will fall further behind in reflecting the racial makeup of many of the people it serves. And so what I believe that The Future of Nursing report provides us is a clarion call to get to work and get to work urgently and rapidly.

And so I'm going to leave you with a few strategies and suggestions, but really I believe this to be an opportunity for further discussion and reflection. And so one of the ways, I think, that we integrate diversity into the APRN workforce is by integrating diversity, equity, and inclusion into our mission,

vision, and values. And I say that because as someone who has been on many a diversity task force, committee, workgroup over the past 20-plus years, this work is often an aside.

It's a service. It's service. It's extra. And it may not always be a part of the organizing framework of the organization itself, right? And so instead of DEI being something on the side, if it's really, really in the middle and everything flows from it, you begin to see some of your strategies and your tactics.

You develop evaluation metrics to ensure that what you've identified as a strategic goal is actually being actualized in the mission, vision, and value through tactic strategies and evaluation metrics. So that's one. So no matter where you sit, if you're a regulator, if you're a credentialer, if you're a faculty member, you have the positionality and the opportunity to ensure that DEI is not a side project.

It is deeply embedded and rooted in the core values of your organization. And then if you are a regulator or a credentialer, or you're in leadership in a professional organization, you know, particularly accrediting bodies can play an important role because you help to set the standards.

And so by requiring reporting and by insisting on policies and practices for the institutions or organizations that you're evaluating, these organizations and institutions respond. So if they know they're being evaluated on it, then they know they'll go back and they need to address it in a more comprehensive way.

But it's not just about regulators and credentialers ensuring that others are doing it, regulators and credentialers need to do this internal work. You know, what are your own policies, and practices, and systems related to diversity? And in what ways are you holding yourselves accountable? And if you don't have the expertise to do so, then what are you doing to outsource it to ensure that you're able to address some of these systemic ways that exclusion and systemic racism occur?

And sometimes it occurs underneath, right? We don't overtly see it because you're saying, "Well, we're not overtly racist." And so the ways in which exclusion occurs can be more implicit, which is why it's so important for us to have these really honest dialogs with one another.

And then to those of you who are in funding opportunity spaces, you know, I would encourage you to think about the way diversity and inclusivity is integrated into your funding priorities. Many times, the priorities of funders don't include DEI as a recognized intellectual scholarly endeavor. And when we do that, we fail to validate the very importance of diversity and particularly evaluating the ways in which diversity and regulatory constraints may, in fact, represent these cumulative disadvantages for our marginalized communities.

And so it's so important for us to lend the weight and the credibility of DEI scholarship so that we're able to continue to really move the needle forward in terms of the way we think about evaluating the impact of DEI on the profession and also the patients we serve. Regulators, credentialers, professional organizations, how diverse is your leadership, right?

Representation matters. And we know without a seat at the table, that we continue to kind of reinforce what we've always done. And so if you look around the table, you look around your offices, you look around your board of advisors and everyone is very homogenous, there are opportunities to think about the ways in which to increase the heterogeneity of composition, but also the heterogeneity of thought, right?

When we bring diverse perspectives into our conversations, into our meetings, and into our boards, it really enriches the dialog and our outcomes. And so I'd encourage you to look for opportunities to increase representation in your membership, in your leadership, in your processes, in your disciplinary actions, in the way you manage continuing education and your licensees.

Like, whatever you do, how are you valuing DEI in every facet of what you do? And there are certainly opportunities to do so. Finally, invest, right? This is an invest and a develop moment. There are really good examples of diversity pipeline programs directly into APRN roles.

I bring to your attention the Diversity in Nurse Anesthesia Mentorship Program, which was founded and developed by Dr. Wallena Gould. She and I were actually inducted into the academy in the same year, and her work in mentoring and fostering nurses from diverse backgrounds into CRNAs roles is nothing short of stunning.

So if you know of a nurse of color who is interested in going into a CRNA role, this is a program that you certainly want to refer. If you can't refer, develop. And there are really good exemplars of evidence-based practices to develop pipeline programs.

Our work, which was developed or published in 2014, describes the results of a national survey for recruitment and retention in U.S. nursing schools. And what we found even in that study is that most pipeline programs are developed to increase diversity in the baccalaureate.

We found very few pipeline programs that were geared to the APRN. So this is a opportunity for development, but evidence-based development. And so the reason we did this type of study is because diversity pipeline programs include a host of interventions, some of which are very, very important and some of which you can see in a direct association for recruitment and retention.

And so if you're developing these pipeline programs, it's important to ensure that you're developing the ingredients that lead to success. And so there's evidence to support that work. And so I'll leave you with the need for data, and I'm kind of coming back full circle to where we started. And, again, this is to urge us to create a more complete picture of APRN from diverse backgrounds. Beyond the quantitative surveys and assessments, there are ways to determine the experiences and perspectives, there are ways to center their experiences and their leadership.

If we want to address health inequity, then we need to draw from practitioners who have keen and precise expertise in living with and being from diverse communities. And so what are those opportunities for leadership? What are those opportunities to bring them to the table?

What are those opportunities to co-create models of care to address and reduce health disparities? And then there's always the need, and I am biased because I'm a researcher, to evaluate impact and outcomes. And so we need to measure, and we need to really reproduce knowledge so that we can continue to expand, replicate, and really provide opportunities for a diverse workforce to render care to diverse and underrepresented communities.

And so, with that, I'm going to end our time together from the formal presentation, but I really, really look forward to your questions. Thank you.