POLICY BRIEF

Underrepresented Minority Family Physicians More Likely to Care for Vulnerable Populations

Anuradha Jetty, MPH, Julie Hyppolite, MD, MP, Aimee R. Eden, PhD, MPH, Melina K. Taylor, PhD, MPH, and Yalda Jabbarpour, MD

Using data from 2016 to 2020, we found that family physicians who identify as underrepresented minorities in medicine were more likely to have a larger percentage of vulnerable patients in their panels. Increasing access to care for vulnerable patient populations will require a combination of advocating for policies to diversify the physician pipeline and those that encourage all primary care physicians to care for vulnerable patients. (J Am Board Fam Med 2022;35:223–224.)

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The physician workforce continues to lag behind the US population in terms of racial and ethnic diversity.[1] Only 10.8% of active physicians identified as an underrepresented minority (URM) and just 6.8% of academic faculty are URMs, while URMs make up 33% of the US population.[2,3] Diversifying the physician pipeline has important workforce and patient implications.[4] Studies have demonstrated that physicians identifying as URM are more likely to practice in underserved communities and provide care to people experiencing poverty.[5] To our knowledge, no studies have examined whether this pattern holds true in family medicine, where representation of URM physicians entering the discipline is greater than most some other primary care specialties.[6]

We used the 2016 to 2020 American Board of Family Medicine (ABFM) Certification Examination application data to investigate the race/ethnicity of physicians who provide outpatient continuity care to vulnerable populations. We excluded FPs who reported emergency department/hospital as their primary practice site. The survey asked recertifying family physicians (FP) to estimate the percentage of their patient population that is part of a vulnerable group (<10%, 10 to 49%, or >50%). Vulnerable populations were defined as uninsured, insured by Medicaid, homeless, non-English speaking, racial or ethnic minority or traditionally underserved populations. We calculated the proportion of recertifying FPs who serve vulnerable populations by race and ethnicity and performed chi-square (χ^2) tests to assess differences in the share of FPs provision of care to vulnerable populations across 7 racial and ethnic categories: non-Hispanic (NH) White, NH Black, NH Asian, NH American Indian or Alaskan Native (NH-AIAN), NH Native Hawaiian or Other Pacific Islander (NH-NHOPI), Hispanic/Latinx, and NH other.

Our total sample consisted of 38,133 FPs providing direct patient continuity care. Nearly 30% of the NH Black and Hispanic FPs and 20% of NH-AIAN FPs reported having greater than 50% of vulnerable patients in their panels ($P < .001$; Figure 1). On the other hand, over half of NH White, NH Asian, NH-NHPI and NH Other FPs reported that less than 10% of their patient population were from vulnerable groups.

We found that family physicians who identify as underrepresented minority groups were more likely to care for patients from vulnerable populations. As the largest and most widely distributed delivery platform in the US, family medicine has the opportunity

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Corresponding author: Anuradha Jetty, MPH, The Robert Graham Center, 1133 Connecticut Avenue NW, Suite 1100, Washington DC 20036. (E-mail: ajetty@aafp.org).

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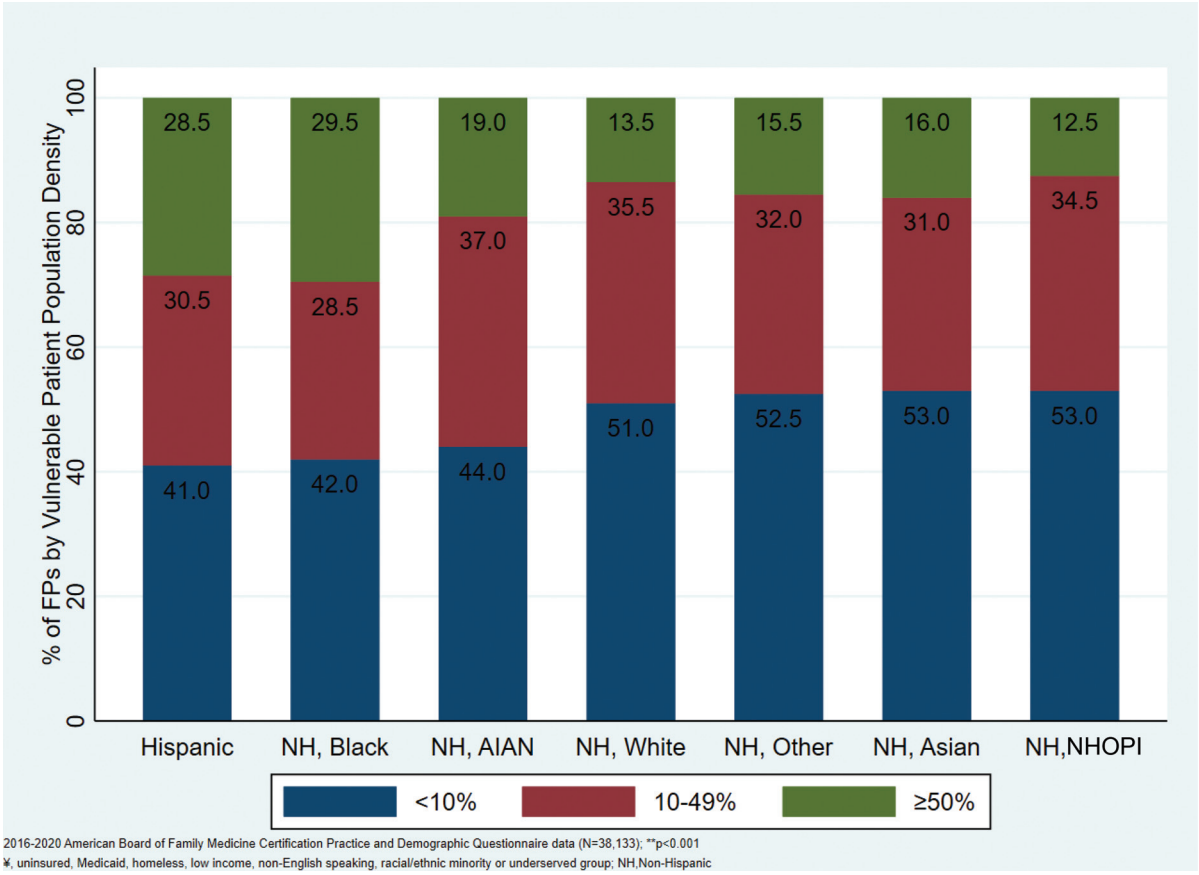
Figure 1. Proportion of Family Physicians' Vulnerable Patient Population by Race/Ethnicity. Abbreviations: ¥, uninsured, Medicaid, homeless, low income, non-English speaking, racial/ethnic minority or underserved group; NH, non-Hispanic; NH, Black = Non-Hispanic Black; NH, AIAN = Non-Hispanic American Indian or Alaska Native; NH, White = Non-Hispanic White; NH, Other = Non-Hispanic Other; NH, Asian = Non-Hispanic Asian; NH, NHOPI = Non-Hispanic Native Hawaiian or Other Pacific Islander. 2016–2020 American Board of Family Medicine Certification Practice and Demographic Questionnaire data (n = 38,133). $P < .001$**



to mitigate access to care issues for vulnerable patients. Increasing the number of URMs who go into medicine, including family medicine, is important for improving access to care for vulnerable populations, but so are policies that encourage family physicians of all races and ethnicities to care for patients in these groups. Increasing slots for programs such as the National Health Service Corps, exposing all residents to rotations in settings that serve vulnerable patient populations, creating more pipeline programs that encourage URM students to apply to medical school and fostering environments within medical education that support the needs of URM students are all essential in reducing racial and ethnic health care disparities.

To see this article online, please go to: http://jabfm.org/content/35/2/223.full.

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