ReachOut e-Diversity News

An Electronic Publication of the Ohio Developmental Disabilities Council

"Healthier Lives Are About All of Us"

1. **Diversity in the Nation's Workforce**
2. **Diversity in Clinical Trials**
3. **Patient Involvement**
4. **Best Practices**

August 2019 Edition | Volume 14 Issue 4

Read, Pass on to Friends, Family Members, Colleagues & Constituents

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Don't Miss an Issue!

It is the policy of the Ohio Developmental Disabilities Council to use person-first language in items written by staff. Items reprinted or quoted exactly as they originally appear may not reflect this policy.

There are many factors (such as age, gender, sexual orientation, race, ethnicity, disability, communication, etc.) that contribute to poor health outcomes resulting in health care disparities and health inequities. Closing the gap between health disparities and health equity requires all of us. All of Us must think differently about "who" needs to be… involved in our health care workforce, testing new medicines, engaged in providing information and making decisions.

This month's Reach Out e-Diversity Newsletter challenges us all to shift our mindset. The changing demographics of our nation and the state of Ohio suggest that each of us can no longer embrace a "one size fits all" mentality. While none of us can know the needs of all of us, each of us can be concerned about All of Us. Each of us can care about all of us. Each of us can ensure that All of Us live a healthier life. You are invited to help us "Pass It On" by sharing the information with others within your network and posting on the ODDC social media platforms.

Together, we can make a difference for us all.

Diversity in the Nation's Physician Work Force Saves Lives: Progress and the Threat of Regress

While 13% of Americans self-identify as Black or African American, only 4% of the country's physicians are Black. Despite facing significant obstacles to becoming physicians, Black doctors have contributed to the betterment of the health and wellness of the nation for centuries. Several decades ago, the nation had only two medical schools, Howard University in Washington, DC and Meharry Medical College in Nashville, Tennessee that regularly admitted Black students. It is known that diversity in medicine improves patient outcomes. Consider the evidence: research shows that women physicians are more likely to follow evidence-based guidelines (and that their patients benefit); that African American physicians are least likely of all physicians to harbor negative implicit racial biases; and that minority patients are more likely to follow recommendations and treatment plans from doctors who share their background. In short, DIVERSITY IN MEDICINE SAVES LIVES. While we still have a long way to go with regards to producing a physician workforce that reflects the beautiful diversity in the country we serve, progress has been made.

-READ MORE-

Diversity in Clinical Trials

The development of new medicines is a lengthy, complex process that would not be possible without the patients who volunteer to participate in clinical trials to evaluate potential therapies for safety and effectiveness. For trial results to apply to all patients, the demographic mix of patient volunteers must mirror that of the U.S. population. If FDA approves the medicines, they will be prescribed for people of different ages, genders, races, and ethnicities, so it is essential that data reflect the effectiveness and potential side effects for all groups.

All of Us RESEARCH PROGRAM

-READ MORE-

Our August Newsletter focuses on shifting our mindset to "all of us!"

Healthier Lives are about ALL OF US!

Patient Involvement

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A new study from the Mayo Clinic showed that doctors only spend about 11 seconds listening to a patient during appointment agenda-setting before interrupting the patient with their own viewpoint. These results point to a need to improve active listening on the part of the provider to drive better patient satisfaction.

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Diversity in the Nation's Physician Work Force Saves Lives: Progress and the Threat of Regress

By Quinn Capers, IV MD, and Christian A. Capers

This article is reprinted from The Columbus and Dayton African American News Journal (July 2019)

Introduction: While 13% of Americans self-identify as Black or African American, only 4% of the country's physicians are Black. Despite facing significant obstacles to becoming physicians, Black doctors have contributed to the betterment of the health and wellness of the nation for centuries. Several decades ago, the nation had only two medical schools, Howard University in Washington, DC and Meharry Medical College in Nashville, Tennessee that regularly admitted Black students. It is known that diversity in medicine improves patient outcomes. Consider the evidence: research shows that women physicians are more likely to follow evidence-based guidelines (and that their patients benefit); that African American physicians are least likely of all physicians to harbor negative implicit racial biases; and that minority patients are more likely to follow recommendations and treatment plans from doctors who share their background. In short, DIVERSITY IN MEDICINE SAVES LIVES. While we still have a long way to go with regards to producing a physician workforce that reflects the beautiful diversity in the country we serve, progress has been made.

Quinn Capers, IV MD

Christian A. Capers

Progress: In 2019, all 156 medical schools in the US and Canada train Black doctors. The Ohio State University is a national leader in training Black physicians. When I matriculated into The Ohio State University College of Medicine (OSUCOM) in 1987, it was one of the least diverse medical schools in the country. Three decades later, The OSUCOM is ranked #2 of 152 majority medical schools in terms of African American students enrolled, according to a May 15, 2019 article in the US News and World Report. Gender balance is another important aspect of diversity. In the last six entering classes at The OSUCOM, women have slightly outnumbered men. Importantly, coincident with the increased diversity

in OSUCOM's classes has been an increase in academic credentials; the average class grade point average from college and standardized test scores have gone up as the classes have become more diverse. These achievements in gender and racial diversity are the result of an intentional strategy that emphasizes recruiting, eliminating implicit bias in the admissions process, and embracing holistic review in admissions. This incredible turnaround is not only good for the health of Ohioans, but as OSUCOM graduates spread out all over the nation, good for America.

U.S.News 10 Medical Schools With the Most African Americans

Explore the med schools with the highest representation of African American students.

- University of Chicago (Pritzker): 14.6%
- Ohio State University: 12.6%
- Michigan State University College of Human Medicine: 11.9%
- University of California—Los Angeles (Geffen): 11.8%
- University of Connecticut: 11.8%
- Duke University: 11.5%
- Medical University of South Carolina: 11.0%
- Augusta University: 10.6%
- Emory University: 10.6%
- Florida State University: 10.6%

Updated on May 15, 2019: This slideshow has been updated to reflect ranks and data from the 2020 U.S. News Best Medical Schools rankings.

Regress: Under the current presidential administration, the United States Department of Education claims that race should not be a factor in admitting students to college or any other form of higher education and, despite the fact that the US Supreme Court has twice ruled that consideration of race in higher education admissions is legal, the Department of Education has stated that it will "investigate" schools that do so. The court's rationale for upholding the legality of using race as one factor to be considered in admissions is based on its recognition that diversity in the classroom has educational benefits that cannot be reproduced with any other educational tool. US officials recently visited Texas Tech University Medical School to "investigate" a claim that the medical school considered the race of applicants in its admissions decisions. Shortly thereafter, the university stated that they would no longer consider race in the admissions process. With only 156 MD schools in North America, having one of them vow to no longer consider race when making admissions decisions could be a significant blow to diversity enhancement in the medical profession.

In bygone years, many African Americans overcame structural racism, subtle discrimination, and social determinants of success to become physicians. In recent years, studies show that when reviewing applications for employment, potential employers down grade qualifications if the applicant has an "ethnic-sounding" name like Jamal or Keisha.

Our recent study showed that a majority of our medical school admissions committee members have "implicit white race preference," meaning* that when they see a Black person's face, they unconsciously associate it with negative words and concepts like "pain," "misery," "violence," or "fear." With education we can overcome these obstacles, and we are doing just that, but these studies suggest that today's higher education admissions process is far from a level playing field. Yet efforts to enhance diversity in the medical profession, so critical to reducing racial healthcare disparities, are currently under attack by the US Department of Education.

Summary/Conclusion: African Americans have made numerous contributions to the medical profession and continue to play an outsized role in caring for underserved and disadvantaged populations, and make tremendous contributions to biomedical research and education. I am proud of our nation's current attempts to diversify the medical profession, and particularly proud that The Ohio State University College of Medicine has become a beacon for diversity in this country. However, if we are not ever- vigilant progress can easily be halted or pushed backwards.

Diversity in medicine saves lives. This is a bold statement, but it is backed up by scientific studies published in the medical literature. For instance, recent studies show that Black male patients are more likely to consent to having flu vaccinations and having their blood drawn for cholesterol and blood sugar screening if recommended by Black, rather than White or Asian doctors. The study went on to show that the Black doctors took more time with the Black patients and were more likely to ask questions about their lives outside of the doctor's visit. The patients described the White/Asian doctors as "efficient", they were more likely to describe the Black doctors as "caring". In another recent study, it was found that elderly patients cared for by women physicians lived longer than patients cared for by male physicians, despite having similar diagnoses upon admission to the hospital.

The point: more women and minorities in medicine will translate into lives saved. At The Ohio State University College of Medicine we believe that diversity helps us do everything we do in medicine better. Through aggressive recruiting and training that reduces bias in the admission system, our College of Medicine has become one of the most diverse in the nation. Last month, the US News and World Report reported that, after excluding the four historically Black medical schools (Howard University in Washington, DC, Meharry Medical College in Tennessee, Morehouse School of Medicine in Georgia, and California's Charles Drew University), OSU is number 2 in the nation (out of more than 150 medical schools) in terms of enrollment of Black students.

The photos below show mentoring sessions between our Black women physicians and women students and our African American Male Mentoring Roundtable, a quarterly gathering of Black male physicians and students at OSU.

Quinn Capers, IV, MD
Professor of Internal Medicine (Cardiology) Associate Dean for Admissions
The Ohio State University College of Medicine
Christian A. Capers English major Howard University

We want more stakeholders to know how important it is to have representation of un/underserved populations with disabilities in the health care workforce.

Share this article with stakeholders.

Post on the ODDC social media platforms "to whom" you shared this article.

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Diversity in Clinical Trials

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However, African Americans, Latinos, Asians, and others are significantly underrepresented in clinical research in the U.S. According to U.S. Census data, Black or African Americans represent 13.4 percent of the U.S. population, yet FDA reports that those populations make up only 5 percent of clinical trial participants. The disparity is even greater for those of Hispanic or Latino origin. They represent 18.1 percent of the U.S. population but only 1 percent of clinical trial participants.

For decades, advocacy groups have urged the National Institutes of Health, the Food and Drug Administration, and the biopharmaceutical industry to include people of diverse racial and ethnic backgrounds, as well as women, in clinical trials. While all agree on this worthy goal, the actual results are discouraging.

The NIH Revitalization Act of 1993 requires all federally funded clinical research to prioritize the inclusion of women and underserved racial and ethnic groups. Yet between 1993 and 2013, less than 2 percent of cancer studies have included enough racial and ethnic group participants to report relevant results.

There is no single solution to the problem. But the NIH's recently launched All of Us Research Program is a good start. Building a national cohort of 1 million or more Americans that reflects the rich diversity of the American population is a hallmark of the federal effort to accelerate research in personalized medicine.

What is the *All of Us* Research Program?

The *All of Us* Research Program is a large research program. The goal is to help researchers understand more about why people get sick or stay healthy. People who join will give us information about their health, habits, and what it's like where they live. By looking for patterns, researchers may learn more about what affects people's health.

How long will the *All of Us* Research Program last?

All of Us may last for at least 10 years. We hope you will stay involved over time. If you join, you can withdraw at any time for any reason without penalty.

What will you ask me to do?

If you decide to join *All of Us*, we will ask you to share different kinds of information. We will ask you basic information like your name and where you live, questions about your health, family, home, and work. If you have an electronic health record, we may ask for access. We might also ask you to give samples, like blood or urine.

Why should I join the *All of Us* Research Program?

You will be contributing to research that may improve health for everyone. Here are some examples of what researchers might be able to discover:

- Better tests to see if people are sick or are at risk of getting sick.
- Better mobile apps to encourage healthy habits.
- Better medicine or information about how much of a medicine is right for each person.

What will you do to protect my privacy?

We will take great care to protect your information. Here are a few of the steps we will take:

- Information we have about you will be stored on protected computers. We will limit and keep track of who sees the information.
- We will remove your name and other direct identifiers (like your Social Security number) from your information and replace them with a code.
- Researchers must promise not to try to find out who you are.
- We will tell you if there is a data breach.
- The All of Us Research Program has Certificates of Confidentiality from the U.S. government. This will help us fight legal demands (such as a court order) to give out information that could identify you.

According to Jane L. Delgado, Ph.D., President and CEO of the National Alliance for Hispanic Health and Edward Abrahams, Ph.D., President of the Personalized Medicine Coalition (2019), as a next step, the NIH and FDA could develop incentives for sponsors of clinical trials to include underrepresented populations, such as rewarding the inclusion of information about demographic subgroups and the use of study designs that encourage subgroup comparisons. The FDA should also implement a system with industry to ensure real-time tracking of inclusion in clinical trials. Reporting would cover enrollment by age, sex, race, and ethnicity, and would encourage enhanced recruitment strategies in studies where inclusion goals are not met.

The NIH and FDA, along with other public health agencies and biopharmaceutical companies, should dedicate adequate resources to community education about clinical trials through one-to-one assistance from trusted sources in minority communities. Some of the most common barriers to inclusion in clinical trials are the lack of awareness about what clinical trials are, not being asked to participate, and misconceptions about the risks.

Having a trusted person to speak with and help guide research volunteers through the clinical trial process has worked in the past and will work in the future.

Watch and share this video about The All of Us Research Program.

Share on the ODDC social media platforms if you or anyone you know has joined the All of Us Research Program.

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Patient Involvement

FDA launches new portal to boost patient involvement Request to Connect (July, 2019)

The Food and Drug Administration (FDA) has launched a new online service, *Request to Connect*, offering patients and caregivers a quick, easy and direct link to regulators and a single-entry point for questions and meeting requests.

"The goal is to find better ways of reaching out to patients, understanding what their needs are, to better educate them on how decisions are made and how they can contribute to discussion about their health," the agency reveals.

"As patient populations and their needs evolve and become increasingly complex, [we] want patients and those who advocate on their behalf to know that our door is open. As a science-based agency, we continue to develop and engage programs that help [the] FDA understand the patient perspective and advance the science of patient input."

"Co-developed by the patient affairs staff and the medical product centers, the portal will route enquiries to the appropriate medical product center or office to ensure that they are received and responded to in an effective and efficient manner," says the agency in an announcement.

Request to Connect is part of the agency's ongoing program of patient involvement, which includes patient-focused drug development meetings and rare disease listening sessions. These are hosted in partnership with the National Organization for Rare Diseases (NORD) and aim to give the agency a better understanding of the needs of the patient community.

"The events are closed to the public and focus on a rare disease for which little is known, and effective treatments are more rare than the disease themselves," says the FDA in a video.

The human face to scientific decision making

The FDA Patient Representative Program ensures the patient voice is considered when drug approval decisions are being made. Two hundred patient representatives work with the agency across more than 300 diseases and conditions. They give a “human face” to the scientific decision-making process, the video explains.

Other forums include the Patient Engagement Collaboration, in partnership with Duke’s University’s Clinical Trials Transformations Initiative.

The Patient Engagement Advisory Committee meets once a year. During this time, patients and caregivers advise the FDAs Center for Devices and Radiological Health on issues related to medical devices.

“Over the years, we have developed forums, tables at which patients, caregivers, advocates and FDA staff can sit and exchange ideas.

“Each forum provides patients, caregivers and advocates with a seat next to FDA scientists, doctors and researchers. Their input is invaluable.”

Access the Request to Connect portal.

Watch the video on patient involvment.

SHARE ON THE ODDC Social Media Platforms what actions you have taken after watching the video.

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Best Practices for Patient-Centered Appointment Agenda-Setting

By Sara Heath

A new study from the Mayo Clinic showed that doctors only spend about 11 seconds listening to a patient during appointment agenda-setting before interrupting the patient with their own viewpoint.

These results point to a need to improve active listening on the part of the provider to drive better patient satisfaction.

In the study, researchers investigated how providers elicited a patient's own appointment agenda and how long it took before the clinician interrupted the patient. Providers ended up asking the patient about her own agenda about one-third (36 percent) of the time, and in those cases only allowed the patient to talk for about 11 seconds before being interrupted.

A new study from the Mayo Clinic showed that doctors only spend about 11 seconds listening to a patient during appointment agenda-setting before interrupting the patient with their own viewpoint.

Sara Heath

Primary care clinicians tended to allow the patient to set the agenda more often than specialists. Just under one-half (49 percent) of primary care providers elicited the patient agenda, compared to only 20 percent of specialist providers.

These results point to some considerable pitfalls in the patient-provider interaction. As value-based care has taken hold in healthcare, medical experts have asserted the importance of patient engagement in care. This requires integrating the patient as an equal member of the care team, engaging in shared decision-making, and integrating the patient voice into care.

If providers are truly neglecting to listen to and consider their patients' preferred appointment agendas, they must consider better patient engagement strategies. Appointment agenda-setting has been tied to more effective use of time during a care encounter, as well as more patient satisfaction and adherence to patient preferences.

UNDERSTANDING THE BASICS OF AGENDA-SETTING

Appointment agenda-setting may appear very simple, requiring providers to simply elicit the different concerns they and the patient want to address during the clinic visit. However, providers must understand the full scope of agenda-setting to apply the strategy to their patient interactions.

Appointment agenda-setting should include five basic questions, according to a paper on the subject published in the Annals of Internal Medicine:

- What are the patient's main concerns for today?
- What are the clinician's concerns about this patient?
- What are the patient's specific requests?
- How much of the patient's or the doctor's concerns need to be addressed today, and which ones or parts of ones can be deferred to a subsequent contact?
- What disagreements about priorities exist, and how will they be negotiated?

Medical assistants, nurses, or other patient intake support staff can address some of these concerns, such as the reason for visit, before the treating clinician comes into the room. From there, the treating clinician can ask further questions to determine a course of action, said Annals article authors Laurence H. Baker, PhD, Daniel O'Connell, PhD, and Frederic W. Platt, MD, all from the Institute for Healthcare Communication.

COMMUNICATION STRATEGIES FOR AGENDA-SETTING

Providers should lean on open-ended questions to see the full scope of patients' medical needs. Some successful agenda-setting phrases include:

- What are the patient's main concerns today?
- What are the clinician's concerns?
- What are the patient's most important tasks?
- What must be attended to, what can be postponed?

READ MORE: Patient-Provider Communication Vital for Appointment Agenda-Setting

It is natural for a provider to feel inclined to begin diagnosing while a patient is still addressing agenda-setting questions, but providers must refrain, according to an appointment agenda-setting guide from Virginia Mason Hospital's continuing medical education program.

This will not only make the patient feel listened to but will also allow providers to see the entire scope of a patient's condition. A patient may list an exceptionally troubling concern last in her agenda, but if a provider interrupts at the beginning of the list, she may never be able to address it.

While the patient is setting the agenda, providers need to show the patient that they are listening. Active listening skills, such as making eye contact and nodding to display understanding, will help to reinforce a positive patient-provider interaction.
Using agenda-setting for appointment time management

Once the patient has set her agenda, patient and provider can determine appointment priorities. Patients may come with these priorities prepared, but providers must anticipate that a patient may not begin her agenda list with the concerns that are most pressing to her or to the provider.

Additionally, there may be situations during which patient and provider priorities do not match. A patient may wish to discuss an ache in her shoulder, while the provider may think addressing a rash is more pressing.

This is where the provider can display her medical expertise and explain why addressing the rash is a better use of in-office time, Baker, O'Connell, and Platt explained in their Annals article.

However, the provider should not discount the shoulder pain. Instead, the provider must make a plan to follow up on this concern either via secure message, phone call, office visit, or specialist referral.

Many providers neglect to set an agenda during an appointment because they believe it will consume too much time. However, research has shown that agenda-setting can help providers prioritize their time and reduces the likelihood of a patient bringing up a significant health issue at the end of an appointment.

Agenda-setting is essential for time management, said Baker, O'Connell, and Platt. "Sometimes patient discussion becomes tangential during a visit," the trio wrote. "Clinicians searching for a way to bring the conversation back to a more productive track will find an empathic bridge helpful. It is easier to interrupt a patient and return him or her to the purpose of the visit if we have previously established an agenda and identified the patient's top priorities."

Integrating the patient into appointment agenda-setting helps incorporate the patient as a part of the care team. Providers need to work alongside patients to set the appointment agenda to ensure they are addressing issues that impact a patient's daily life and they are dedicating enough time to each of those concerns.

"Setting the agenda at the beginning of the visit reduces last-minute additions by the patient," Baker, O'Connell and Platt said. "Sharing responsibility for agenda setting allows the patient to feel respected as a participant in that process. Shared responsibility does not end with the agenda but continues throughout the interaction."

Share these "best practices" with others.

Post on ODDC's social media platforms "to whom" you shared the best practices.

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