Tailoring Treatment for Social Context
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Presenter Disclosure Information

In compliance with the accrediting board policies, the American Diabetes Association requires the following disclosure to the participants:

Rosanna Fiallo-Scharer, MD
Disclosed no conflict of interest
Learning Objectives

• Tailor treatment of diabetes for cultural, environment and social context
• Identify how to refer patients to community resources
• Summarize the importance of individual treatment based on individual preferences, social context, prognoses, and comorbidities

Diabetes and Population Health

• Clinical practice guidelines are key to improving population health

• For optimal outcomes – diabetes care must be individualized for each patient
Patient Centered Care

- Be respectful and responsive to individual patient preferences, needs and values
- Ensure patient values guide all clinical decisions
- One size does not fit all

Care Delivery Systems

- 33-49% of patients still do not meet targets for A1C, blood pressure, or lipids.
- Only 14% of patients meet targets for all A1C, BP, lipids, and nonsmoking status.
- Progress in CVD risk factor control is slowing.
- Substantial system-level improvements are needed.
- Delivery system is fragmented, lacks clinical information capabilities, duplicates services & is poorly designed.
Chronic Care Model (CCM)

The CCM includes Six Core Elements to optimize the care of patients with chronic disease:
1. Delivery system design
2. Self-management support
3. Decision support
4. Clinical information systems
5. Community resources & policies
6. Health systems

Strategies for System-Level Improvement

- Care team should prioritize timely and appropriate intensification of lifestyle and/or pharmacologic therapy for patients who have not achieved metabolic targets.

- Strategies for intensification include:
  - Explicit and collaborative goal setting with patients
  - Identifying and addressing language, numeracy, and/or cultural barriers to care
  - Integrating evidence-based guidelines and clinical information tools into the process of care
  - Soliciting performance feedback, setting reminders, and providing structured care
  - Incorporating care management teams
Support Patient Self-Management

- Implement a systematic approach to support patient behavior change efforts, including:
  - High-quality diabetes self-management education and support (DSMES)
    - Clinical content & skills
    - Behavioral strategies (goal setting, problem solving, etc.)
    - Engagement with psychosocial concerns
  - Addressing barriers to medication taking

Access to Healthcare at the System Level
Diabetes and Population Health: Recommendations

• Ensure treatment decisions are timely, rely on evidence-based guidelines, and are made collaboratively with patients based on individual preferences, prognoses, and comorbidities. B

• Align approaches to diabetes management with the CCM, emphasizing productive interactions between a prepared proactive care team and an informed activated patient. A

Diabetes and Population Health: Recommendations (2)

• Care systems should facilitate team-based care, patient registries, decision support tools, and community involvement to meet patient needs. B

• Efforts to assess the quality of diabetes care and create quality improvement strategies should incorporate reliable data metrics, to promote improved processes of care and health outcomes, with simultaneous emphasis on costs. E
Strategies for System-Level Improvement

The National Diabetes Education Program (NDEP) maintains an online resource to help health care professionals design and implement more effective health care delivery systems for those with diabetes:


Health Inequities And Social Context
Health Inequities

• Health inequities related to diabetes and its complications are well documented and are heavily influenced by social determinants of health

• Social determinants of health are defined as:
  – Economic, environmental, political, and social conditions in which people live
  – Responsible for a major part of health inequality worldwide

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Health Inequities

• Social determinants of health are not always recognized and often go undiscussed in the clinical encounter

• Creating systems-level mechanisms to screen for social determinants of health may help overcome structural barriers and communication gaps between patients and providers.

• Validated screening tools for some social determinants of health exist for clinical use

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- Food Insecurity
- Homelessness
- Language Barriers
  - Non-English speaking/low literacy

Food Insecurity

- Food Insecurity is the unreliable availability of nutritious food and the inability to consistently obtain food without resorting to socially unacceptable practices
- 14% of the US population is Food Insecure
  - XXX% of people in XXXX
- Rates are higher among African American and Latino populations, low-income households, and homes headed by a single mother
Food Insecurity: Treatment Considerations

• Increased risk for uncontrolled hyperglycemia
  – Steady consumption of inexpensive carbohydrate-rich processed foods, binge eating, financial constraints to filling of diabetes medication

• Increased risk for severe hypoglycemia
  – Inadequate or erratic carbohydrate consumption following administration of sulfonylurea or insulin

Food Insecurity: Treatment Considerations

• If using Sulfonylurea
  – Glipizide may be considered due to its relatively short half-life
  – Taken before meals

• Patients in need of insulin
  – Rapid-acting insulin analogs, preferably delivered by pen, may be used immediately after meal consumption
  – Insulin analogs are expensive; Look for patient assistant programs through pharma companies
  – Alternatively, prescribing a low dose of an ultra-long-acting insulin analog can prevent marked hyperglycemia
  – Tight control may not be achievable
Homelessness

- Homelessness often accompanies additional barriers to diabetes self management, including
  - Food Insecurity
  - Literacy
  - Numeracy deficiencies
  - Lack of insurance
  - Cognitive dysfunction
  - Mental health issues
Homelessness

Patients with diabetes who are homeless need
– Secure places to store diabetes supplies
– Refrigerator access if on insulin

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Community Resources for Homelessness
Language Barriers

• Providers who care for non-English speakers
  – develop or offer educational programs and materials in multiple languages with specific goals of preventing diabetes and building diabetes awareness

Language Barriers: National Resources

Center for Linguistic and Cultural Competency in Health Care at the Office of Minority Health

• The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care
  – The site offers a number of resources and materials that can be used to improve the quality of care delivery to non-English–speaking patients.
Language Barriers

• ADA website fully translated to Spanish with click of a button diabetes.org
• Living with Type 2 Program translated into Spanish diabetes.org/atdx
• Downloadable patient ed handouts in several languages professional.diabetes.org/patiented

Community Resources for Language Barries
Community Support

- Identification or development of community resources to support healthy lifestyles is a core element of the CCM
- Community health workers, peer supporters and lay leaders may assist in the delivery of DSMES services, particularly in underserved communities.

Community Health Workers

- A frontline, public health worker who is a trusted member of and/or has an unusually close understanding of the community served
- CHWs can be part of a cost-effective, evidence-based strategy to improve the management of diabetes and cardiovascular risk factors in underserved communities and health care systems
Case Study

- 34 y.o. AA female who is a single mother of 2 school age children, non-smoker
- Unable to perform SMBG due to work. Often loses meter and/or test strips. Tries to come to office for visits when kids are in school so she doesn’t have to bring them. Has trouble remembering appts and is often late.
- PMHx: T2DM, HTN, and hyperlipidemia
- Labs: BMI 32, last A1C 8.5, BP 128/82, LDL 94, normal microalbumin/cr ratio
- Meds: metformin 750mg bid, atorvastatin 40 mg, chlorthalidone 25 mg, paragard IUD

More information: living with various relatives and friends, + FI (kids eat mostly at school, but she skips meals to make sure that they have enough to eat). Difficulty storing and preparing food. Works 2 part time jobs; neither provides health insurance.

- Is she at goal?
- What questions need to be asked?
- Who is on her care team? Who should be on her care team?
What next?

- Could add glipizide since relatively short acting with largest meal
- Consider patient assistance programs for GLP-1 use since uninsured, liraglutide would offer additional weight and CV protection without hypoglycemia risk
- Care team support for housing, insurance, resources, nutrition education for prepared foods
- Set SMG and follow with team-based care approach. Engage patient between office visits to check on progress and offer support

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Key Recommendations:

- Providers should assess social context, including potential food insecurity, housing stability, and financial barriers, and apply that information to treatment decisions. A
- Refer patients to local community resources when available. B
- Provide patients with self-management support from lay health coaches, navigators, or community health workers when available. A
Thank you