William C. Hsu, MD

It does not take long for a health care provider to realize that changing patient behavior is one of the most challenging aspects in clinical medicine. While there are a dozen effective medication choices at our disposal for the treatment of diabetes, an improvement in clinical outcomes can only come about when patients are actively engaged in the self-management of diabetes. In ethnic populations, many factors affect an individual’s ability to self-manage diabetes, including cultural beliefs, immigration experience, language abilities/health literacy, educational background, employment, and accessibility of healthcare services. Cultural values regarding health and healthcare offer another layer of complexity that affects an individual’s perception and management of a disease. We will explore how behaviors arose from an individual’s cultural values and ultimately explanatory models for diseases. As a next step, we will use examples illustrating the integration of this understanding in our approach to behavior modification.

References:

Lorena Drago, MS, RD, CDN, CDE

1. Cultural competency?
2. How to become more culturally competent?
   a. Awareness
   b. Knowledge
   c. Skills
3. Distribution of US population by Race/Ethnicity 2010
4. Racial Ethnic Differences in Diagnosed Diabetes over age 20, 2010-2012
5. Culturally Specific Communication Tools
   a. LEARN
   b. BATHE
   c. ETHNIC
6. Tool for providers to elicit patient’s health beliefs and perceptions
7. Foods in health and disease
8. Teach-Back
References:


Lenore T. Coleman, PharmD, CDE, FASHP

African American and Latino populations have a higher risk of diabetes compared to Caucasians (77% higher). In addition, African Americans with diabetes were 1.5 times more likely to be hospitalized and 2.3 times more likely to die from diabetes than Caucasians. The healthcare industry continues to spend millions of dollars per year to treat the complications of diabetes rather than focus on prevention and education. Healing Our Village has developed an interactive model of care that supports strong collaborative links between the patient’s primary care provider and two additional healthcare team members: Pharmacists and Wellness Coaches. The core components of the model include: Comprehensive patient interview / assessment; Individualized Patient Education; Clinical Follow Up; Specialty Training; and Pattern Management using a “talking” blood glucose monitor. Our program has been able to demonstrate the following clinical outcomes:

- 50-60% reduction in emergency room and urgent care visits in patients with diabetes;
- 50% reduction in hospital admissions for Diabetic Ketoacidosis (DKA); significant reduction in hemoglobin A1C (decrease of 1.6% over 8 months);
- 30% increase in overall knowledge of the disease process;
- reduction in both systolic and diastolic blood pressure of 10-13 mmHg;
- increase in participants’ consumption of fruits and vegetables by 40%;
- increase in physical activity by participants by 20%.

The success of the program is based on understanding the learning styles of diverse populations and ways to use culturally sensitive communication techniques that prove to be
effective. Utilization of appropriate strategies and tactics can ultimately change patient behaviors related to lifestyle and medication usage.

References:
2. AOA Health Watch – Overcoming Barriers in Treating African Americans. Dos against Diabetes, January 2011
Working with Diverse Populations

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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:

William C. Hsu, MD

Disclosed no conflict of interest.

The Rising Tide of Diabetes Worldwide at the Turn of the Millennium

Time Magazine
November 5, 2001

Age-adjusted prevalence of obesity, by sex and race and Hispanic origin, among adults aged 20 and over: United States, 2011–2012

Prevalence of and Trends of Diabetes Among Adults in the U.S 1988-2012

JAMA. 2015;314(10):1021-1029
Sensitivity at Selected BMI Cut Points, by Asian-American Subgroup

ADA Position Statement

Understanding Patient’s Explanatory Models of Disease

What’s Most Important?
Working with Diverse Population: Cultural Competency in Diabetes Education

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February 19, 2017

Which Foods do you?

• Eat?
• Stay healthy?
• Cold?
• Avoid?

Distribution of U.S. Population by Race/Ethnicity 2010

What is Cultural Competency?

“Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural and health beliefs and practices, preferred languages, health literacy, and other communication needs.”

Racial/Ethnic differences in diagnosed diabetes aged 20 > US 2010-2012

How to Become More Culturally Competent
**Culturally Specific Communication Tools**

- **L.E.A.R.N. MODEL**
  - Guidelines for Overcoming Obstacles in Cross-Cultural Communication with Patients

- **B.A.T.H.E. MODEL**
  - Elicit the Psychosocial Context

- **E.T.H.N.I.C. MODEL**
  - Framework for Culturally Competent Clinical Practice


**LEARN: Guidelines for Health Practitioners**

- **L:** Listen with sympathy and understanding to the patient’s perception of the problem
- **E:** Explain your perceptions of the problem
- **A:** Acknowledge and discuss the differences and similarities
- **R:** Recommend treatment
- **N:** Negotiate agreement

**Berlin and Fowkes 1983, 934-938**

**B.A.T.H.E.**

- **Background:** A simple question, “What is going on in your life?” elicits the context of the patient’s visit.
- **Affect:** (The feeling state) Asking “How do you feel about what is going on?” or “What is your mood?” allows the patient to report and label the current feeling state.
- **Trouble:** “What about the situation troubles you the most?” helps the physician and patient focus, and may bring out the symbolic significance of the illness or event.
- **Handling:** “How are you handling that?” gives an assessment of functioning and provides direction for an intervention.
- **Empathy:** “That must be very difficult for you.” legitimizes the patient’s feelings and provides psychological support.

**ETHNIC MODEL**

The ETHNIC model can be effective in identifying patient’s explanation of illness, treatment, and traditional treatment practices accepted in the patient’s culture. This model can also help negotiate the treatment options, determine the appropriate intervention, and collaborate with patients and family members.

**ETHNIC: A Framework for Culturally Competent Clinical Practice**

- **E:** Explanation
  - What do you think may be the reason you have these symptoms? What do friends, family, and others say about these symptoms? Do you know anyone else who has had or who has this kind of problem? Have you heard about/read/seen it on TV/radio/newspaper? (If the patient cannot offer an explanation, ask what most concerns them about their problems).

- **T:** Treatment
  - What kinds of medicines, home remedies or other treatments have you tried for this illness? Is there anything you eat, drink or do (or avoid) on a regular basis to stay healthy? Tell me about it.

- **H:** Healers
  - Have you sought any advice from alternative/folk healers, friends or other people (non-doctors) for help with your problems? Tell me about it.
ETHNIC

N: Negotiate
Negotiate options that will be mutually acceptable to you and your patient and that do not contradict, but rather incorporate your patient’s beliefs.

I: Intervention
Determine an intervention with your patient. May include incorporation of alternative treatments, spirituality, and healers as well as other cultural practices (e.g., foods eaten or avoided in general and when sick).

C: Collaboration
Collaborate with the patient, family members, health care team members, healers and community resources.

Tool for Providers to Elicit Patient’s Health Beliefs and Perceptions

The Explanatory Models Approach

- What do you call this problem?
- What do you believe is the cause of this problem?
- What course do you expect it to take? How serious is it?
- What do you think this problem does inside your body?
- How does it affect your body and your mind?
- What do you most fear about this condition?
- What do you most fear about the treatment?
- How long will this problem last?


Foods in Health and Disease

- Which foods do you eat to stay healthy?
- Which foods do you avoid?
- Which foods do you eat more of now that you have this medical condition?
- Which of these recommended foods contradict your beliefs?
- We all take remedies or certain foods when we are sick, which ones do you use?

Teach Back/Show Me Method

- Can you explain in your own words what I said?

Summary

- How do you become culturally competent?
- Which tools can you use?
- Ask the right questions
- Use Teach-Back

Thank YOU

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Why do I care??

- More than 9000 lower extremity amputation per year
- More than 4000 new cases of end-stage renal disease per year
- More than 3000 new cases of blindness per year
- More than 400,000 hospitalizations per year (115,000 due to CVD)

Cultural Barriers and Differences in Diverse Populations

Empowering patients to modify their behavior to effectively manage their chronic diseases

Myths about Minorities with Diabetes

- Highly Educated patients have a high Health Literacy
  - TRUE FALSE
- Poor educated patients cannot understand complex information
  - TRUE FALSE
- Patients are not willing to PAY CASH for Diabetes Education and Diabetes Supplies
  - TRUE FALSE
- Minority populations are not interested in improving their diabetes control - Competing priorities – NEED to SHOW VALUE

Myths about Minorities with Diabetes

- Standardized Diabetes Education Programs are equally effective in Caucasians and Minority patients
  - TRUE FALSE
- Enjoy Less Structure - Informality, and flexibility to adjust to various conditions/situations
  - False
- African Americans have a fear of needles and do not like to take insulin shots
  - True (Especially Men)
- Benefit more from individual counseling – T or F
  - False: Enjoy small groups versus one-on-one
- Spirituality does not play a factor in glycemic control
  - TRUE FALSE
African American Cultural Norms

• Strong extended family system more pronounced than other ethnic groups
• Respect for the elderly and their role in the family
• Use of Ebonics and use of slang in some subgroups
• Do not necessarily believe EDUCATION is the key to a better life
• Direct eye contact when speaking, less eye contact when listening
• Independent, competitive, and achievement oriented (pride in overcoming obstacles and barriers to success)
• Communicating with passion, expression, spontaneity, and animation – PATIENT IS NOT UPSET

Hispanic Culture

• Personal and interpersonal relationships highly valued and come first
• Commitment to the Spanish language
• Direct physical contact expected, affectionate hugging and kissing on the cheek are acceptable for both the same sex and opposite sex
• Become relaxed with time
• Strong religious beliefs (primarily Catholicism)
• Tendency toward more traditionally defined family structure (father as head of house) and more defined sex roles

Build TRUST FIRST!! Cultural Sensitivity

• Creating an atmosphere of understanding, respect, and support. Evaluate your clinic environment. IS IT USER FRIENDLY
• Establishing meaningful connections. DO NOT HAVE AN AGENDA
• Knowledge of the history, culture, traditions, customs, language or dialect, values, religious or spiritual beliefs, art, music, learning styles
• Written information and visual aids must reflect the population served (content and design)

Shared Decision Making (SDM)

• Studies have found that engaging diabetes patients in shared decision making can results in better control of diabetes and hypertension, higher ratings of self-reported health, and shorter hospitalizations.
• African Americans want to participate in SDM but physicians do not offer them the option

Barriers to Shared Decision Making in Minority Populations

• Patient Identified Barriers
  – Familial experiences, Self Efficacy
• Physician Identified Barriers
  – Interpersonal skills, accessibility, availability
• Patient/Provider imbalance
  – Physician bias/ discrimination
  – Cultural discordance (less likely to share test results)
  – Lack of Trust - negative attitudes / internalized racism = patient is less forthcoming with information and less likely to adhere to therapy

SDM impacts ownership and adherence to treatment plan

• Patients should be taught to:
  – ask more questions - information seeking particularly about the risks/benefits of tests/treatments;
  – give more detailed information (information provision), especially about lifestyle issues, preferences for quality vs. quantity of life, etc.;
  – clarify/restate what the practitioner says (Teach – Teach Back) information verified to ensure full patient understanding;
  – share in the decision-making process by explicitly stating preferences for tests and treatments that reflect lifestyle choices

TeleHealth Diabetes Management Program – Focus on Medication and Pattern Management

Culturally Sensitive Diabetes Education via Telehealth Platform

Outpatient Diabetes Education Program – AADE or ADA Certified

- “Sugar Busters”
  - Customarily on Saturdays from 10am to 2pm
- “Fit and Fabulous” - Nutrition Support Groups
  - Weekdays
  - Evenings
- “Choices and Changes” – Prevention and Behavior Change
- “Heart of the Matter” – Focus on cardiovascular health – Hypertension, CAD, Heart Failure
- Referrals generated by physician staff, and community based clinics and community outreach
- Individual appointments provided for specialty patients (i.e. newly diagnosed, pediatric, gestational diabetes)

Medication Therapy Management (MTM)

Medication Reconciliation is the KEY
Seamless Transition between Inpatient and Outpatient Medication Non-adherence - >50%

Medication Therapy Management
Wellness Coaches (navigators = certified medical assistants) – Home Visits

- Customized programs that close the gaps within an integrated health care system – “Medical Home Model”
- HOV trained Wellness Coaches located in
  - Hospitals / Emergency Departments
  - Clinics
  - Physician offices
  - Patient’s homes
- Deploy and infuse technology into the system in order to improve access and coordination while capturing clinical and outcome data
- Patients are systematically directed to hospital/clinic/ community based support programs
Clinical Pharmacist
“Personalized Touch”

- Medication Therapy Reconciliation— “Specialized” Pharmacists
- Pharmacist provide “live” appointments in physician offices, clinics and via the telephone
- Telehealth appointments using Housecall / HealthEC
- Comprehensive Medication Review
  - Perform a complete medication history and medication review
  - Analyze medication therapy regimen for compliance issues, side effects, inappropriate medication, drug interactions, etc.
  - Identify all inappropriate medication utilization patterns and recommendations for drug therapy changes
  - Provide a Care Plan to the attending physician with all drug related problems and point of care testing results
  - Educate patients via the internet or telephonically regarding medication adherence and provide tools and strategies to improve medication adherence

HOV Solution to Closing the Gaps

- Pattern Management through the use of Talking Meter (English/Spanish) - Patients need to know their numbers
  - Adjust diet and medication to match the physiology of the disease
  - Understand the importance of postprandial hyperglycemia

Diabetes Transitional Care Program
United Medical Center / Department of Health – 9 months

- 301 patients with complete pre post data thus far - 65% female, 35% male – Mean age 52
- Reduction in Emergency Room Visits – 50%

<table>
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<th>Averages</th>
<th>Pre 12 months</th>
<th>Post Interven</th>
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<td>A1C</td>
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<td>222.4lbs</td>
<td>208.3lbs</td>
<td>-14.1 lbs</td>
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</tbody>
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Questions??
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