COMMUNITY INCLUSION & CULTURAL HUMILITY IN DIABETES PREVENTION

December 14, 2022 @ 2:00 -3:00PM EST

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

National Nurse-Led Consortium

The **National Nurse-Led Care Consortium (NNCC)** is a membership organization that supports nurse-led care and nurses at the front lines of care.

NNCC provides expertise to support comprehensive, community- based primary care.

- Policy research and advocacy
- Technical assistance and support
- Direct, nurse-led healthcare services

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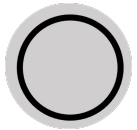

Record

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AGENDA

- Welcome & Introductions
- Didactic Presentation and showcase
- Q&A
- Wrap up

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Learning Objectives

- Describe cultural humility and recognize strategies for community inclusion in diabetes prevention and care
- Identify gaps in cultural humility and community inclusion in current diabetes prevention programs
- Adapt and apply cultural humility best practices for community inclusion when preparing patient-centered diabetes prevention program and treatments, especially for residents of public housing

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Subject Matter Expert

TIANA MATTHEWS-MARTINEZ, MS, RD, LDN

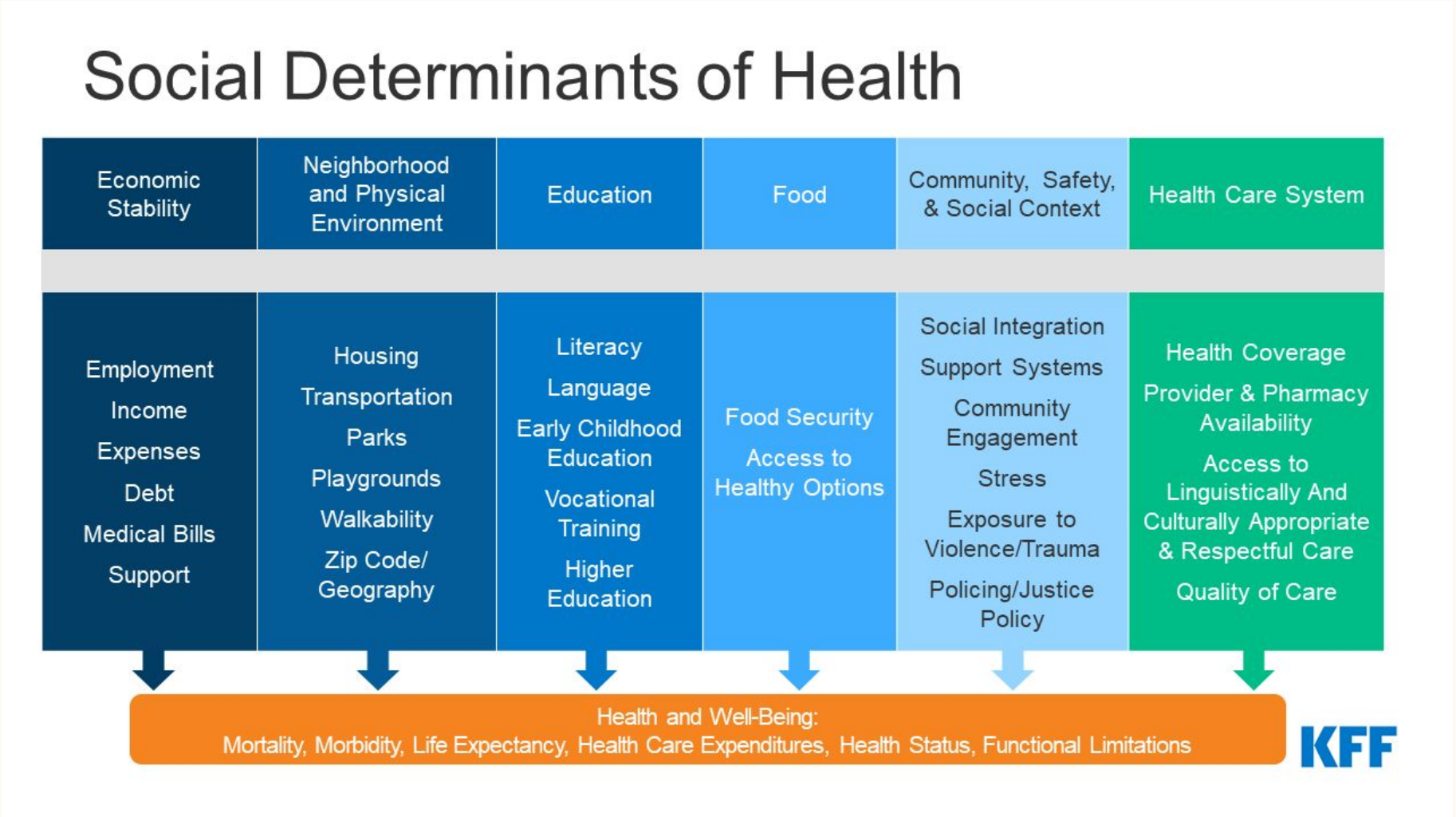
Registered Dietitian and Nutrition Educator

Drexel University 11th St Family Health Services

POLL QUESTIONS

1. How familiar are you with the topic of providing cultural humility in diabetes care?
2. Does your healthcare organization currently offer diabetes self-management community programs?
3. Does your organization currently have a culture of training staff to be aware of how the social determinants of health impact diabetes prevention and treatment?

SOCIAL DETERMINANTS OF HEALTH



STATE OF DIABETES

U.S. DIABETES STATISTICS

According to the American Diabetes Association, in 2019 37.4 million Americans, or 11.3% of the population, had diabetes. 96 million Americans ages 18 and older had prediabetes (1)

ETHNICITY:

- 14.5% of Native Americans/Alaskan Natives
- 12.1% of non-Hispanic blacks
- 11.8% of Hispanics
  - 8.3% of Central and South Americans
  - 6.5% of Cubans
  - 14.4% of Mexican Americans
  - 12.4% of Puerto Ricans
- 9.5% of Asian Americans
  - 5.6% of Chinese
  - 10.4% of Filipinos
  - 12.6% of Asian Indians
  - 9.9% of other Asian Americans
- 7.4% of non-Hispanic whites

FAMILY INCOME LEVEL:

- 14.1% - Less than 100% FPL
- 10.8% - 100%-299% FPL
- 7.8% - 300%-499% FPL
- 5.6% - 500% FPL

EDUCATION:

- 13.4% Less than high school
- 9.2% High school diploma
- 7.1% More than high school

RISK FACTORS FOR DIABETES

- **Have 3 out of 5 metabolic syndrome criteria:** (e.g., BMI ≥25 kg/m^2, triglycerides ≥150 mg/dl, low sex-specific HDL cholesterol, blood pressure >130/>85 mmHg, and fasting glucose >110 but <126 mg/dl)
- **1st degree relative with diabetes** or **history of gestational diabetes** w/ at least one metabolic syndrome criteria

Risk factors for metabolic syndrome:

- Abdominal obesity
- Lifestyle habits
- Work schedule
- Age
- Socioeconomics
- Family history and genetics
- Sex
- Other medical conditions and medications

CARE GAPS AND CHALLENGES IN DIABETES PREVENTION

- Rosal MC et al (2008) sought to identify patient-, provider-, and system-level opportunities and challenges to deliver diabetes prevention services in community health clinics
- Results:
  - Medical chart audits showed limited documentation of diabetes risks.
  - Provider surveys showed knowledge gaps
  - Patient focus groups showed knowledge gaps related to risks, prevention, and challenges with lifestyle changes

Chart audit data	
Medical record eligibility (*n*)	
Total number of records registered	450
Total records available and eligible	303
Patient characteristics	
Age (years)	42.6 ± 10.0
Female sex (%)	50
Ethnicity (%)	
Hispanic	41
African American	29
White	27
Marital status (not married) (*n*)	73
Weight (lb)	186.2 ± 46.5 (*n* = 262)
Height (in)	67.7 ± 5.3 (*n* = 38)
Type of primary care provider (%)	
Resident	75
Attending	22
Nurse practitioner/physician assistant	4
Documented factors related to diabetes risk (%)	
Family history	17
Hypertension	17
Hyperlipidemia	13
History of gestational diabetes	0.3
Obesity	11
Screening tests recommendations (%)	
Lipids (ever)	46
Fasting blood glucose (ever)	1.3
Oral glucose tolerance test (ever)	0.3
Random blood glucose (ever)	40
A1C (ever)	3
Behavior change recommendations (%)	
Weight loss	
Ever	7.3
Past 3 years	0
Exercise	
Ever	13
Past 3 years	74
Diet	
Ever	11
Past 3 years	0
Referrals to a nutritionist	2
Pharmacological prescriptions for reduction of a known diabetes risk factor	5

Data are means ± SD unless otherwise indicated. *Measurement tool is available from the corresponding

Rosal MC, Benjamin EM, et. Al. Opportunities and Challenges for Diabetes Prevention at Two Community Health Centers. Diabetes Care 2008;31(2):247–254

Constructs explored	Findings
Health care history*	• Almost all reported seeing their health care provider at least once a year. • Most reported having been screened for diabetes in the past. • Compared with African Americans, more Latinos reported *1*) being told by their health care provider that they had an increased risk for developing diabetes and *2*) being in fair or poor health.
Experience with/exposure to diabetes	• Almost all indicated that a family member had diabetes. • Most had knowledge of symptoms and complications. • Most were aware of the elevated prevalence of diabetes in the general population.
Knowledge of diabetes risk factors and attitudes toward diabetes prevention	• Both groups endorsed family history, overweight, dietary factors, and lack of exercise as risk factors. • Both were aware of the elevated diabetes risk in their minority group. However, although most Hispanic patients expected to develop diabetes at some point, few African Americans articulated an understanding of higher individual risk.
Attitudes toward and experiences regarding weight loss	• Both groups had strong perceptions that motivation (Hispanics) and discipline (African Americans) are important in making lifestyle changes. • Most Hispanics (and few African Americans) reported a history of weight loss efforts. • Hispanics' weight loss efforts included following a diet and exercise regimen, changing cooking habits, meeting with a dietitian, taking medications, drinking "teas," and "willpower." • Hispanics' weight loss motivations included health reasons, being overweight/obese, and fatigue. • Facilitators of exercise for Hispanics included motivation, will power, not wanting to gain weight, social support for exercise (groups), and free access to an exercise facility. • Walking appeared to be an acceptable form of exercise for both groups.
Barriers to weight loss and lifestyle change	• Both groups identified lack of willpower (Hispanics) or discipline (African Americans) as the main barriers to weight loss (low self-efficacy). • Other commonly discussed barriers include *1*) limited financial resources to buy healthy foods; *2*) preferences for culturally based, less healthy foods; and *3*) comorbid conditions perceived to limit physical activity (asthma, bone aches, leg swelling, and back and neck pain). • Hispanics also reported stress, lack of family support, and lack of professional help to address psychological aspects of weight control as barriers to weight loss. • African Americans also reported fatigue, laziness, and lack of social support as additional barriers to physical activity.
Usual health information sources	• Common information sources for both groups are family members and print media (brochures, pamphlets, and magazines). • Hispanics also reported obtaining health information from the television, classes at a health center, and doctors and dietitians. Providers' role was perceived primarily as the source of referral for screenings. • Although African Americans portrayed a mistrust of the medical care system in general, there were strong opinions in favor of their own providers as credible sources of health information.
Preferences for health information	• Both groups favored group interventions for education and exercise groups at the CHC. • In addition, Hispanics referred to *1*) the use of "promotores de salud" to do outreach work and *2*) the use of radio programs to disseminate information. They pointed out their need for transportation to attend programs. • African Americans referred to *1*) opportunities for participation of family members and *2*) written information in public places and schools (for children).

*Health care history data were obtained.

Table 3: Summary of patient focus group findings with Hispanic (n=11) and African-American (n=7) participants

Rosal MC, Benjamin EM, et. Al. Opportunities and Challenges for Diabetes Prevention at Two Community Health Centers. Diabetes Care 2008;31(2):247–254

CRITICAL TIMING FOR PCP INTERVENTIONS AND REFERRALS

ADA has identified four critical times to evaluate need for diabetes self-management education to promote skills acquisition in support of regimen implementation, medical nutrition therapy, and well-being:

1. At diagnosis
2. Annually and/or when not meeting treatment targets
3. When complicating factors develop (medical, physical, psychosocial
4. When transitions in life and care occur

American Diabetes Association. Standards of Medical Care in Diabetes – 2022 Abridged for Primary Care Providers. *Clin Diabetes* 2022;40(1)10-38

DIABETES SELF MANAGEMENT PROGRAMS

- All people with diabetes should participate in diabetes self-management education:
  - Improves diabetes knowledge and self-care behaviors
  - Lowers A1C
  - Lower self-reported weight
  - Improved quality of life
  - Reduced all-cause mortality risk
  - Positive coping behaviors
  - Reduced health care costs
- Incorporates MNT delivered by registered dietitian/nutritionist, physical activity, smoking cessation, psychosocial care
- Can be modeled after the CDC Diabetes Prevention Program (DPP)

Photo Credit: Towfiqu Barbhuiyah 2021

American Diabetes Association. Standards of Medical Care in Diabetes – 2022 Abridged for Primary Care Providers. *Clin Diabetes* 2022;40(1)10-38

CULTURAL HUMILITY

CULTURE AND INTERSECTIONALITY

- **Culture** is a changing system of beliefs and values shaped by our interactions with one another, institutions, media and technology, and socioeconomic determinants
- **Intersectionality** - the overlapping characteristics (i.e. religion, sexual orientation, ethnicity, gender) that make up a person's identity.
  - Often used to identify characteristics of privilege

Lekas HM et al. Rethinking Cultural Competence: Shifting to Cultural Humility. Health Services Insights 2020; (13)1-4

CULTURAL COMPETENCE VS. CULTURAL HUMILITY

Cultural Competence

- Process in which the healthcare professional learns about other cultures to inform how they may interact with others.
- Typically refers to racial/ethnic or sexual "minority" groups.
- Work effectively within the cultural context of the patient (individual, family, community)
- It is often seen as a goal that can be reached after a certain amount of training and expertise

Photo credit: Debashis RC Biswas 2018

Lekas HM et al. Rethinking Cultural Competence: Shifting to Cultural Humility. Health Services Insights 2020; (13)1-4

CULTURAL COMPETENCE VS. CULTURAL HUMILITY

Cultural Competence Critiques:

- Reproduces social stereotypes and an imbalance of power between patients and providers.
    - May increase risk of *othering* patients – "us" vs "them" orientation
- Challenged by the concept of intersectionality
- Training in cultural competence primarily increases provider knowledge attitudes and skills but have had little or no effect on patient satisfaction and/or patient health outcomes to decrease disparities
- Higher post training confidence in cultural competency may compete with the ability to practice cultural humility

Lekas HM et al. Rethinking Cultural Competence: Shifting to Cultural Humility. Health Services Insights 2020; (13)1-4

CULTURAL COMPETENCE VS. CULTURAL HUMILITY

Cultural Humility

- Patient-centered approach that involves an orientation towards caring for one's patients that is based on: self-reflexivity and assessment, appreciation of patients' expertise on the social and cultural context of their lives, openness to establishing power-balanced relationships with patients, and a lifelong dedication to learning.
- Foronda et al. (2016) defined cultural humility has having five attributes:
    - Openness
    - Self-Awareness
    - Egoless
    - Supportive Interaction
    - Self-Reflection and Critique
- It is a lifelong process of continual reflection and refinement.
- Admitting that one does not know and is willing to learn from the patient

Lekas HM et al. Rethinking Cultural Competence: Shifting to Cultural Humility. Health Services Insights 2020; (13)1-4

Foronda C et al. Cultural Humility: A Concept Analysis. Journal of Transcultural Nursing 2016; 27(3) 210-217

DISCUSSION QUESTIONS

1. What are the consequences of practicing cultural humility in diabetes care with public housing residents?
2. Is there a place for both cultural competence and cultural humility?

HOW TO PRACTICE CULTURAL HUMILITY IN HEALTHCARE

The 5 Rs were developed as a coaching framework for the clinician-patient environment.

The aim is to help providers assess and address their unconscious biases which may affect patient communication and health outcomes.

1. **Reflection**
   - Hospitalists will approach every encounter with humility and understanding that there is always something to learn from everyone.
   - **What to ask:** What did I learn from each person in that encounter?
2. **Respect**
   - Hospitalists will treat every person with the utmost respect and strive to preserve dignity at all times.
   - **What to ask:** Did I treat everyone involved in that encounter respectfully?
3. **Regard**
   - Hospitalists will hold every person in their highest regard while being aware of and not allowing unconscious biases to interfere in any interactions
   - **What to ask:** Did unconscious biases drive this interaction?
4. **Relevance**
   - Hospitalists will expect cultural humility to be relevant and apply this practice to every encounter.
   - **What to ask:** How was cultural humility relevant in this interaction?
5. **Resiliency**
   - Hospitalists will embody the practice of cultural humility to enhance personal resilience and global compassion
   - **What to ask:** How was my personal resiliency affected by this interaction?

Robinson D et al. The 5Rs of Cultural Humility: A Conceptual Model for Health Care Leaders. Journal of the Alliance for Academic Internal Medicine 2021 134(2)161-163

DISCUSSION QUESTION

What is an example of a question that you, or those in your discipline, could ask community members to assess their diabetes care needs in a way that promotes cultural humility?

Dietitian example: What aspects of your identity most influence the way that you eat at this point in your life?

PERSON CENTERED-COMMUNICATION

Person centered communication is a practice of cultural humility and can promote real patient-provider relationship, improve communication and quality of care

Tips for person centered communication

- 1. Ask about diabetes understanding and how patients like to receive information
- 2. Listen to the patient and acknowledge their emotions – practice *empathetic* medicine
- 3. Recognize patient and family expertise about what is important to them
- 4. Create time and space for conversation focused on the patient as a person
- 5. Invite caregivers to talk about the supports they may need
- 6. Provide helpful tools to encourage conversations about what is important

GAPS IN CULTURAL HUMILITY IN DIABETES PROGRAM DELIVERY - A CASE STUDY

- **Purpose:** To explore the experiences of Coeur d'Alene tribal members living with type 2 diabetes in the context of tribal culture and history
- **Methods:** Face-to-Face interviews with 10 tribal members
- **Results:** Perceived unsatisfactory care was the major barrier for participation in DSM programs
- **Communication barriers**
  - Miscommunication
  - Provider distrust
    - Rooted in historical mistreatment by government and church officials.
    - Being diagnosed with a condition without provider/patient engagement
    - Clinic not viewed as tribal
    - Paternalism

Tiedt JA, Sloan RS. Perceived Unsatisfactory Care as a Barrier to Diabetes Self-Management for Coeur d'Alene Tribal Members with Type 2 Diabetes. Journal of Transcultural Nursing. 2014: 26(3) 254-260

GAPS IN CULTURAL HUMILITY IN DIABETES PROGRAM DELIVERY - A CASE STUDY

Communication Barriers

- Teaching/learning methods – individual consults were culturally acceptable
  - The words "school" and "education" have a negative connotation linked to tribal history with boarding schools
  - Visual preferred over verbal
  - Community preferences identified in the literature included:
    - storytelling, talking circles, community members as peer facilitators, culturally based videos and visual aids, and cooking demonstrations with traditional foods

Organizational issues

- Patient access
- Perceived substandard care quality

Patient participants desired: collaborative partnership, understanding the cultural value of "connectedness" – listening with the heart instead of the head

Tiedt JA, Sloan RS. Perceived Unsatisfactory Care as a Barrier to Diabetes Self-Management for Coeur d'Alene Tribal Members with Type 2 Diabetes. Journal of Transcultural Nursing. 2014: 26(3) 254-260

STRATEGIES FOR CULTURAL HUMILITY IN A DIABETES INTERVENTION PROGRAM – A CASE STUDY

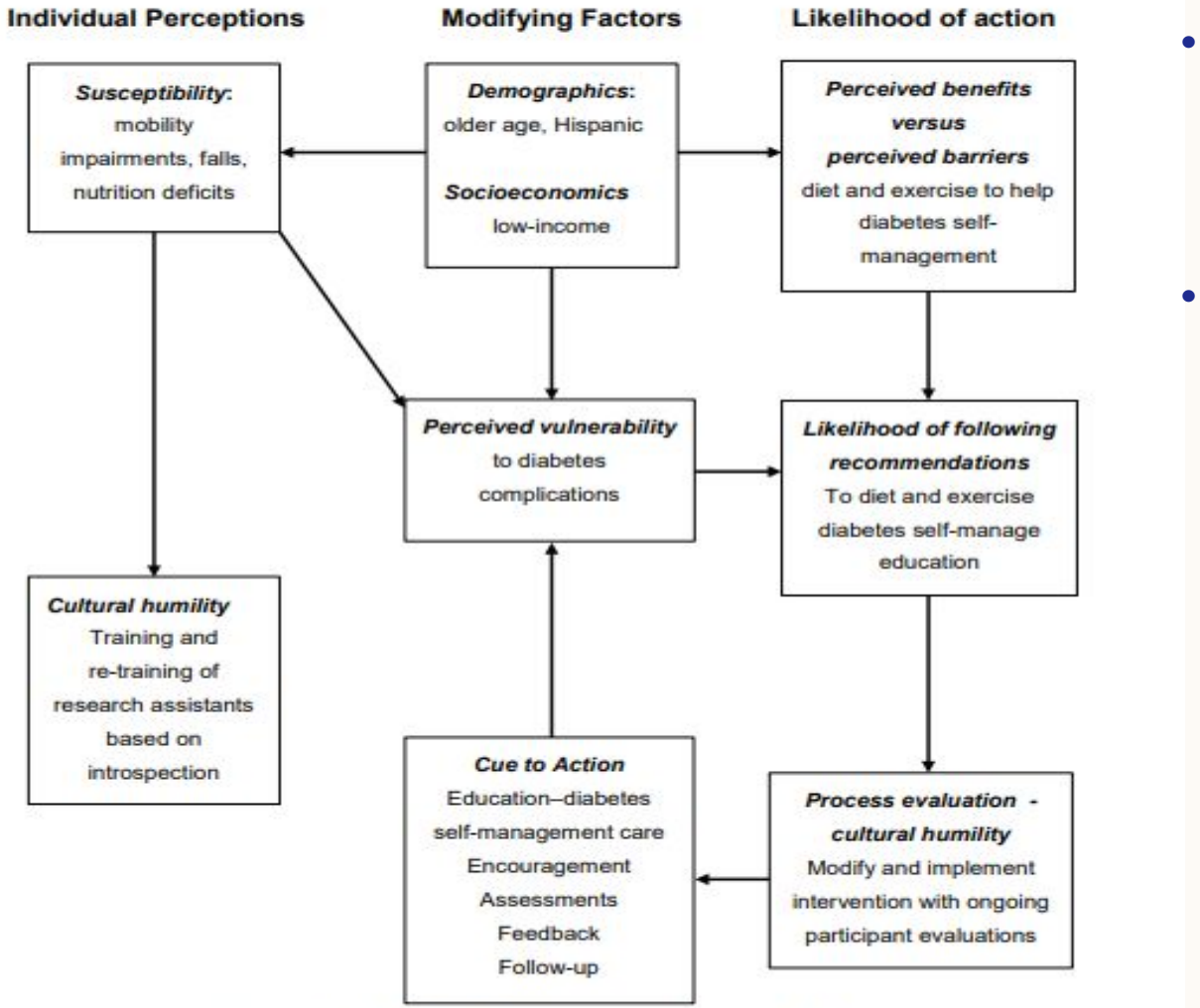


Figure 1: Health Belief Model with Cultural Humility.

- **Purpose:** To discuss how cultural humility was implemented into a diet and exercise intervention aimed at assisting low-income Hispanic older adults with type 2 diabetes formulate, reach and maintain diet and exercise goals.

- **Methods:** Process observation/evaluation study
  - N= 39 older adults recruited at congregate meal sites serving primarily Spanish speaking adults.
  - The study of each site lasted for 6 months from delivery to evaluation.
  - Continual process of observing research assistants and participant interactions by co-investigators. Co-investigators and assistants met weekly to retrain in cultural humility

Gaillard T et al. Integrating Cultural Humility Within the Health Belief Model: Application to A Diet and Exercise Intervention for Hispanics Low-Income Older Adults with Type 2 Diabetes. Nur Primary Care. 2020; 4(3)1-7

STRATEGIES FOR CULTURAL HUMILITY IN A DIABETES INTERVENTION PROGRAM – A CASE STUDY

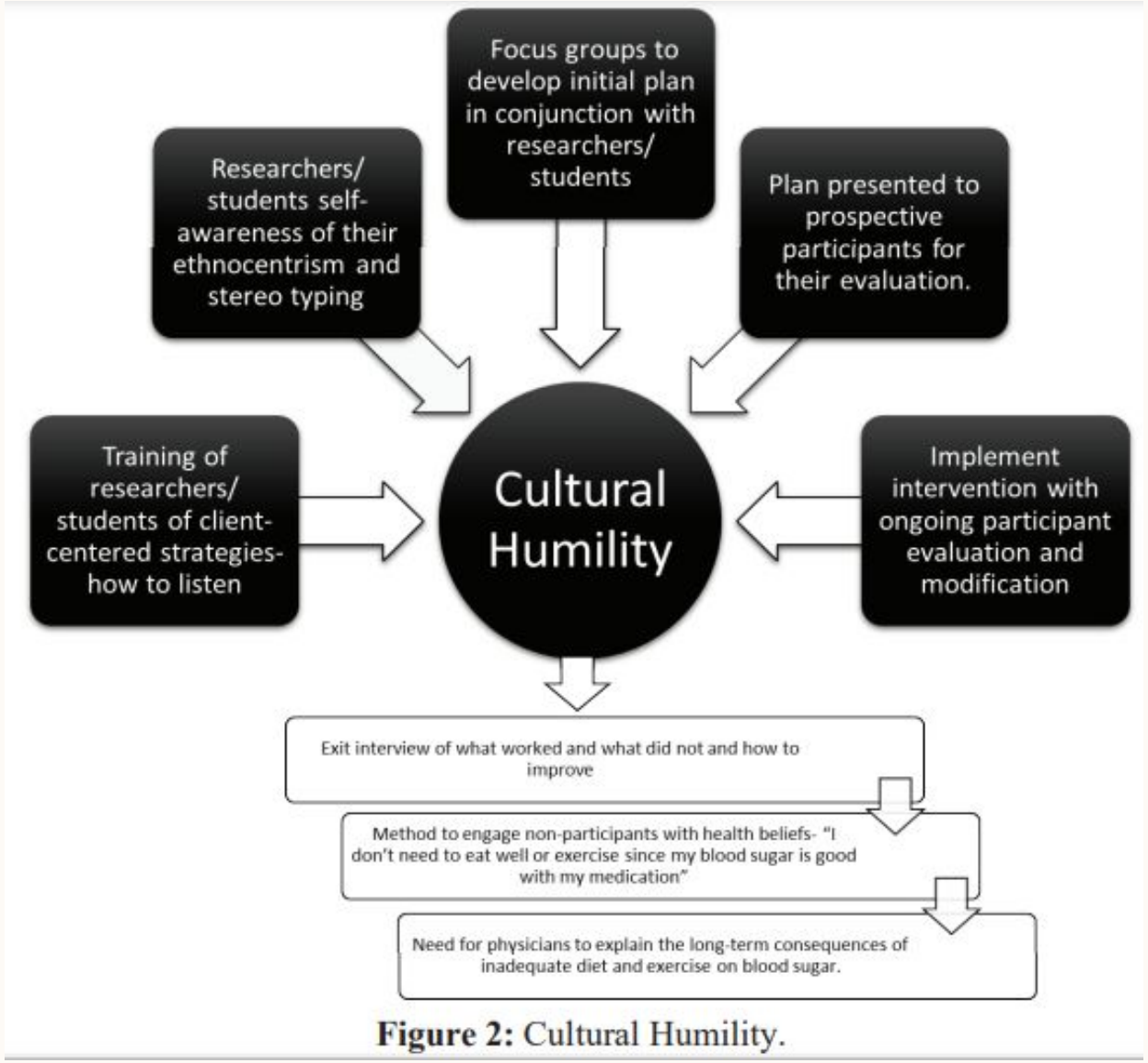


Figure 2: Cultural Humility.

Gaillard T et al. Integrating Cultural Humility Within the Health Belief Model: Application to A Diet and Exercise Intervention for Hispanics Low-Income Older Adults with Type 2 Diabetes. Nur Primary Care. 2020; 4(3)1-7

STRATEGIES FOR CULTURAL HUMILITY IN HEALTH BELIEFS MODEL IN A DIABETES INTERVENTION PROGRAM – CASE STUDY

Initial comments	Probe	Introspection	Redirection after introspection
I feel like they are my relatives.	How does that make you feel in terms of your role in collaboration for dietary change?	I feel like a kid and why would they listen to me.	Realize that you are the expert and not a child. They are not your relatives. You have the knowledge to help them. Now how do you feel about collaboration?
I feel bad that she can't do the exercises and that she told me she feels bad.	How does that make you feel in terms of your role in collaboration for engagement in physical activity?	Well, I told her to do what she could. I guess I could have encouraged her to try with my help.	Realize that she can do more than she thinks. You are an expert in physical activity. Now what can you do to help her?
They are so used to eating a certain way and really don't want to change.	Realize that they volunteered to receive diet lessons. Why do you think they don't want to change?	I guess because I know a lot of older Hispanics and they are set in their ways.	What positive things can you say about their current diet to encourage them? What small changes are they willing to make? Are you willing to accept your stereotypes and move forward to help?
Will they do these exercises at home? Some of them are too weak and can fall.	What could you do to help them do some of the exercises safely at home?	I don't feel qualified to help them.	What could they do at home and still be safe? Each person has different abilities and limitations. Do you feel comfortable having an open discussion on their fears, asking for help from the team and then directing them?

Table 1: Cultural humility operational: examples of introspection and redirection.

Results:

Researchers:

- Became more aware of their ethnocentrism regarding diet and exercise and made modifications of the intervention based on cultural humility: listening to participants through process evaluations
- Actualized their cultural humility by reteaching using client-centered strategies
- Modified program based on client needs to be successful
- Discovered that older Hispanic adults wanted more instructions based on their specific diet and exercise preferences as compared to group instruction.

Gaillard T et al. Integrating Cultural Humility Within the Health Belief Model: Application to A Diet and Exercise Intervention for Hispanics Low-Income Older Adults with Type 2 Diabetes. Nur Primary Care. 2020; 4(3)1-7

STRATEGIES FOR CULTURAL HUMILITY AND COMMUNITY INCLUSION IN DIABETES PREVENTION AND CARE

Respecting Clients' Decisions

- Respect a clients' decision to assimilate or not
- Have an "add to" approach instead of 'taking away"
- Inquire about cultural beliefs regarding disease management and offer multiple options for treatment
- Intervene if staff or clients are engaging in insensitive or discriminatory behavior
- Tailor recommendations to the individual's learning style and personal beliefs.
- Be familiar with the built environment that your patients and community members interact with to meet their daily needs
- Offer realistic suggestions for lifestyle change based on what community members have access to

Communication Style and Decisions

- Respect all dialects, accents, languages and non-verbal languages. Encourage
- Offer educational materials in multiple languages including the dominant language of the majority culture being served.
- Have interpretative resources and efforts to hire bilingual staff instead of relying on family members of patients for interpretation
- Attempt to learn key words in other languages and cultural colloquialisms
- Avoid making assumptions about clients' intellectual abilities based on their communication style or method
- Assess clients' preferences for communication of their treatment plan, i.e. written, verbal, and/or video format
- Use patient centered communication styles

Substance Abuse ad Mental Health Services Administration. Cultural Humility Checklist

Dragomanovich HM, Shubrook JH. Improving Cultural Humility and Competency in Diabetes Care for Primary Care Providers. *Clin Diabetes 2021;39(2):220-224*

STRATEGIES FOR CULTURAL HUMILITY AND COMMUNITY INCLUSION IN DIABETES PREVENTION AND CARE

Welcoming Office Setting

- Use materials with illustrated graphics and teach back methods to ensure understanding
- Ensure the office environment has messages that are reflective of an inclusive, multicultural environment
- Strive for cultural representation amongst program instructors, managers, and administrators
- Offer diabetes care and programs through a trauma-informed lens

Partner with Community

- Organize a community advisory council
- Focus groups
- Needs assessment surveys and interviews
- Involve community in evaluation results and request feedback

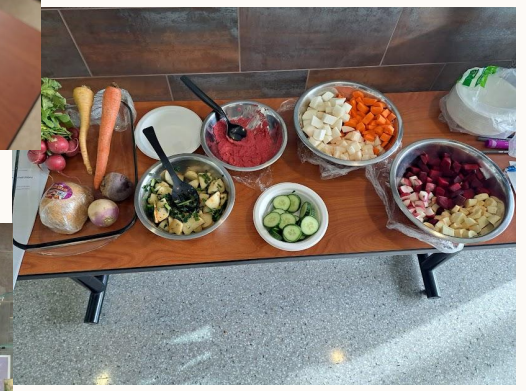
Substance Abuse ad Mental Health Services Administration. Cultural Humility Checklist

Dragomanovich HM, Shubrook JH. Improving Cultural Humility and Competency in Diabetes Care for Primary Care Providers. *Clin Diabetes 2021;39(2):220-224*

EXAMPLES OF NUTRITION EDUCATION PROGRAMS FOR DIABETES PREVENTION AND TREATMENT IN A PHILADELPHIA PUBLIC HOUSING COMMUNITY

Free community programs created, managed, or supported by Tiana Matthews-Martinez MS, RD, LDN for the Drexel University 11th Street Family Health Services

- **Watch, Talk, and Taste Group**
- **Free Produce Giveaways**
- **Bringing Down the A1C Group**
- **Mind Your Heart**
- **Taste of African Heritage Cooking Class**
- **Men's Nutrition Education Series**
- **Oh Snap! What to Do with $20 in SNAP funds**
- **What is That?!? Monthly Fruit and Vegetable Tasting Series**
- **Kids Cooking Classes**
- **"Rethink your Drink" and "Pack a healthy lunchbox"**
- **Seasonal Nutrition Workshops**
- **Passport to Health**



POLL QUESTIONS

1. What is one thing you want to try and implement to practice cultural humility in your diabetes prevention and treatment programs?

WRAP UP EVALUATIONS

Please help us measure our impact with this session by filling out the evaluation survey that will pop up on your screen as you exit zoom- this should take <2 minutes

To receive CEUs, you must take the survey

Thank you for coming!

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