Cultural Sensitivity and Advocacy for Equality in DM Management

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No conflicts of interest

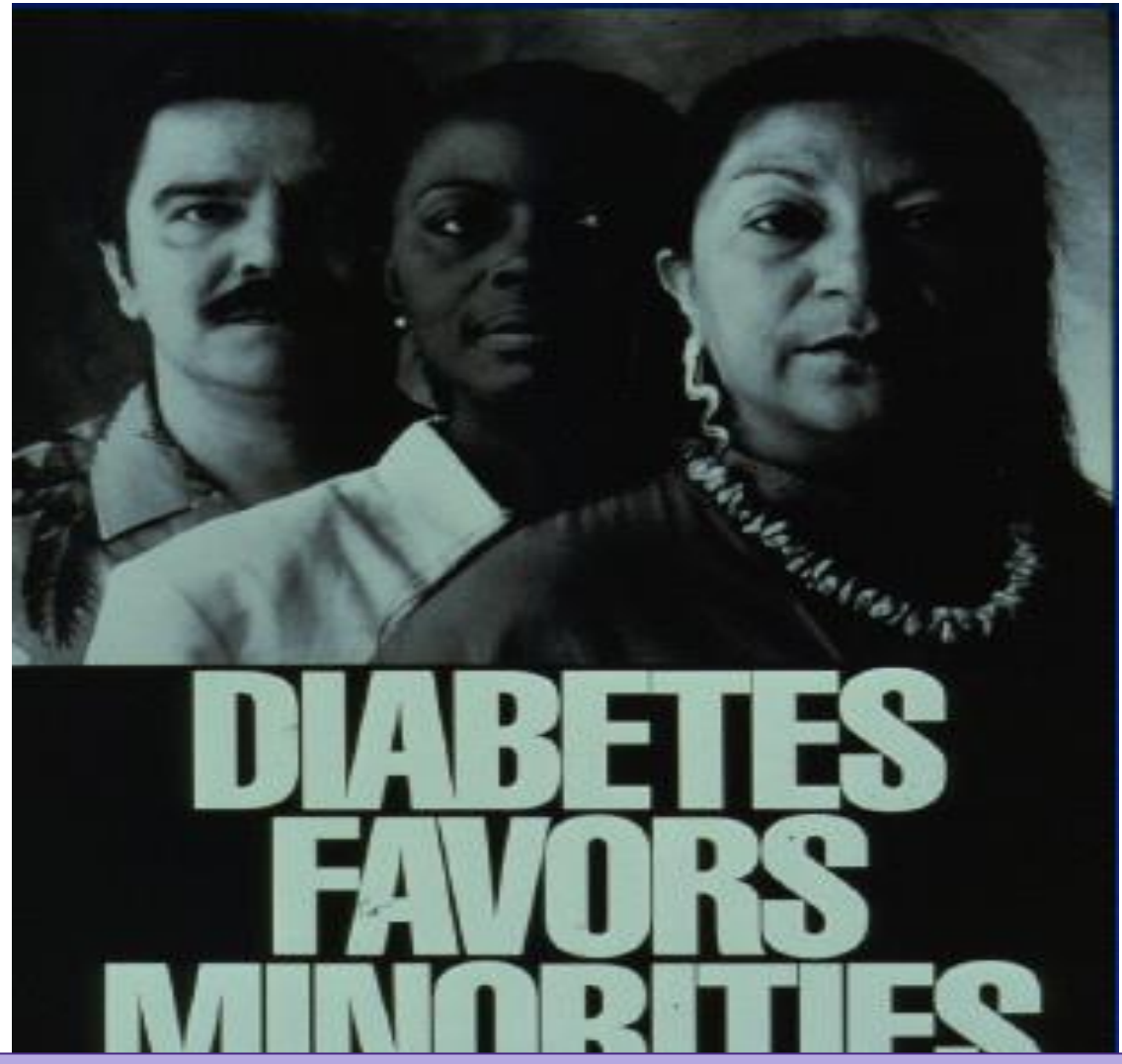
Objetives

1. Understand clinician and patient related barriers to diabetes management (clinical inertia, compliance, shared-decision making).

2. Recognize the importance of patient engagement and “buy in” as part of the shared decision-making process in diabetes management. (HBA1c control, ~~compliance~~, hypoglycemia, weight, side effects, CV and renal risk, technology and devices etc.).

LatinX

Asians



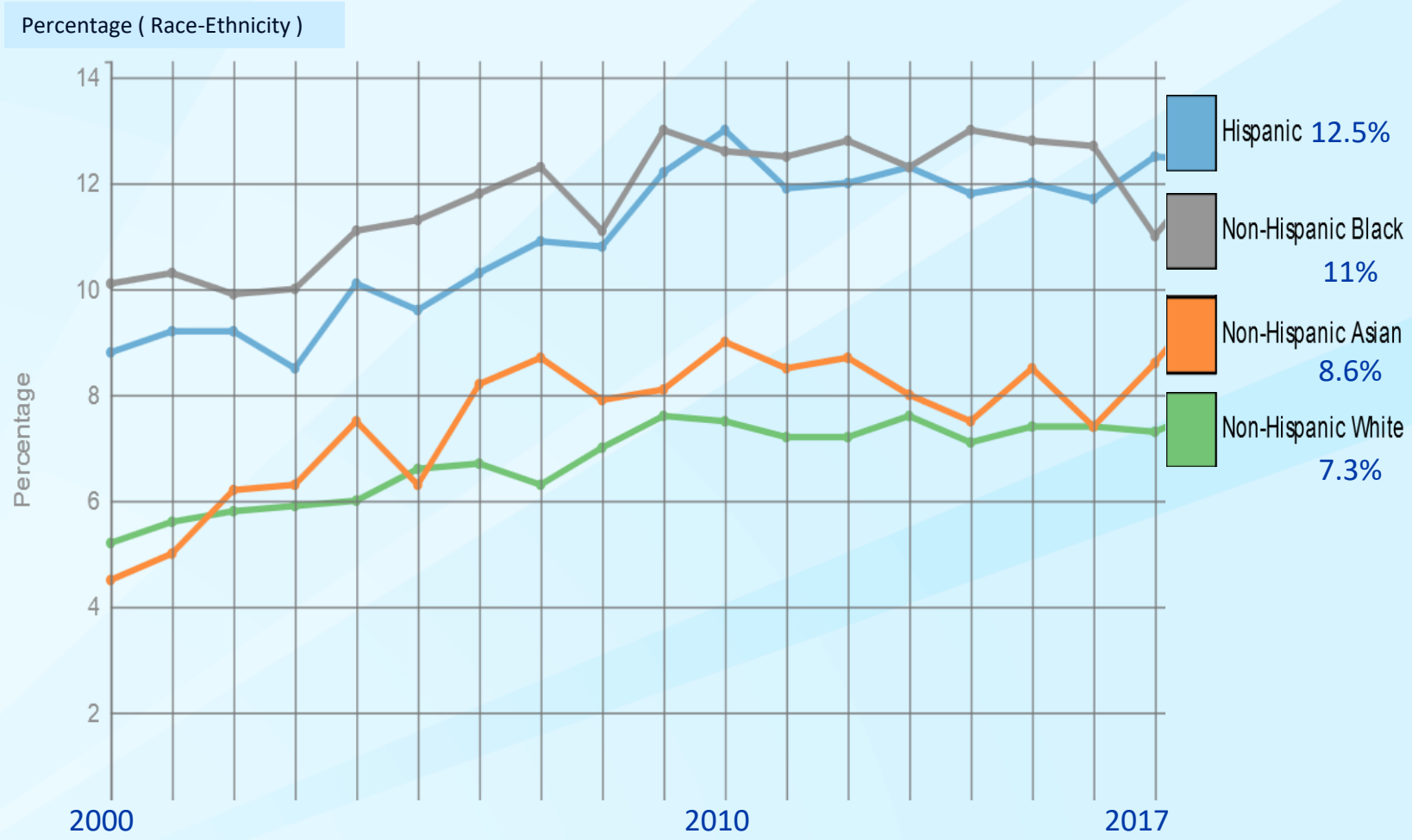
Native Americans

Non-Hispanic Blacks

Diabetes strikes one out of three native Americans; one out of seven Hispanic Americans; and one out of fourteen Blacks

See your doctor about how you can prevent or control Diabetes.
And stop this discrimination.

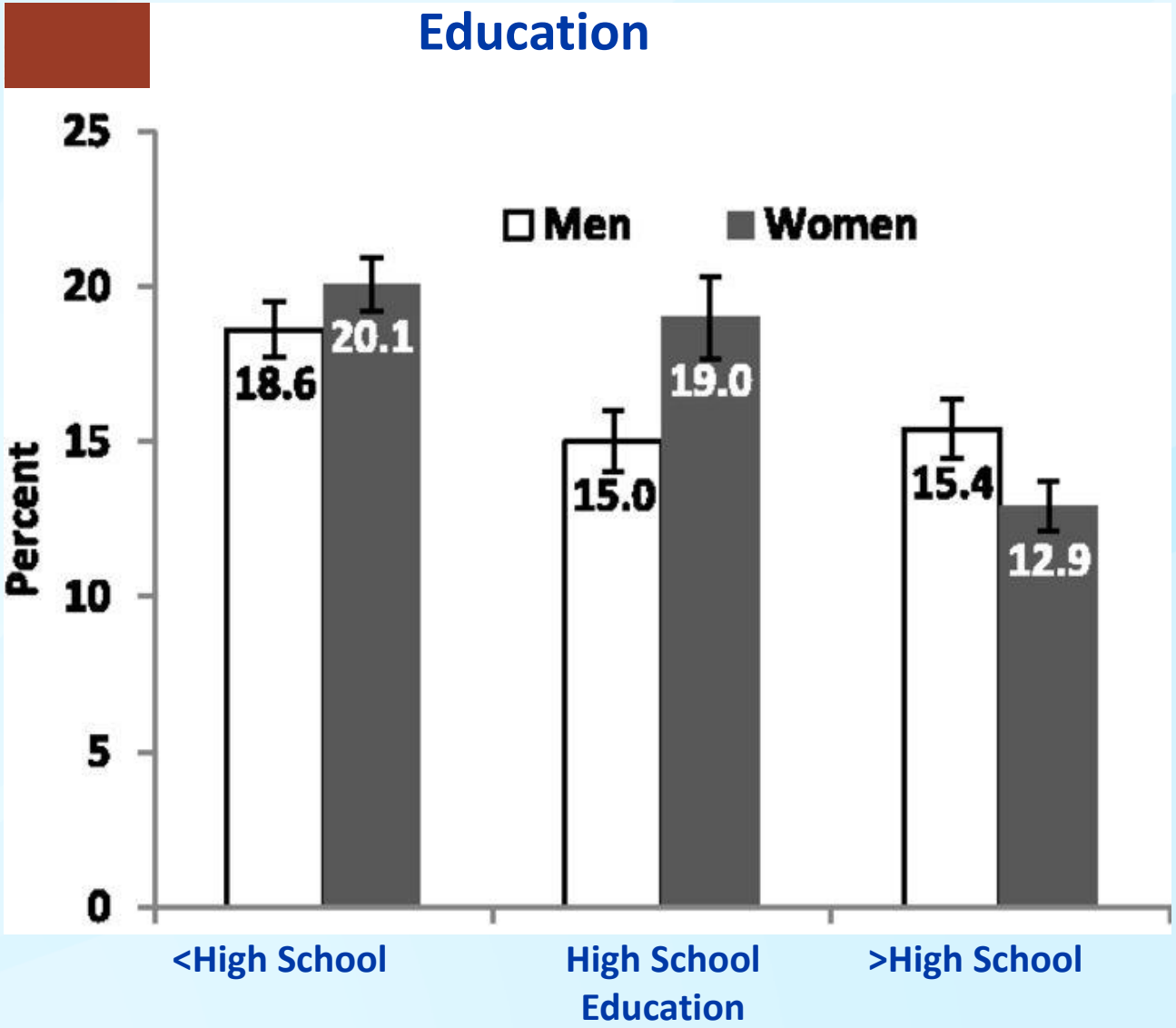
Diagnosed Diabetes, Race-Ethnicity, Adults Aged 18+ Years, Age-Adjusted Percentage, National



Source: www.cdc.gov/diabetes/data

Disclaimer: This is a user-generated report. The findings and conclusions are those of the user and do not necessarily represent the views of the CDC.

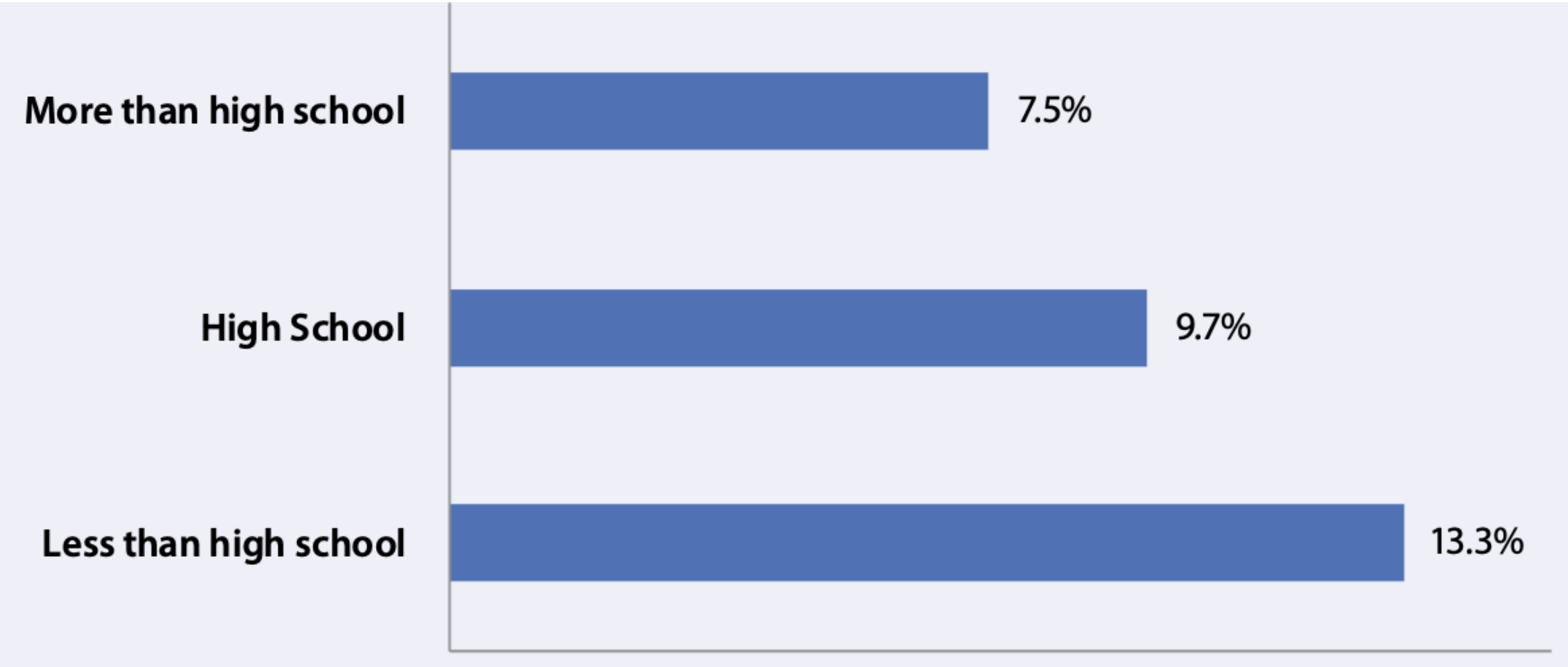
Prevalence of Diabetes Related to Education



Dia Care 2014;37:2233-2239

Education Level Differences

Percentage of Adults Aged 18 Years or Older With Diagnosed Diabetes, by Education Level, United States, 2017–2018



The more barriers the worse the control

The groups with higher prevalence are also the groups with poorer glycemic control and higher risk of complications

Why?

In part due to provider, patient and system **barriers** to appropriate therapy

PROVIDER BARRIERS

- Apprehensions about efficacy, adverse effects, and perceived complexity of the regimen.
- Concerns that the patient will resist therapy, be unable to understand and execute the regimen properly, or seek care elsewhere.
- LACK OF TIME AND SUPPORT
- Reactive vs proactive approach
- While evidence-based guidelines are useful to manage diabetes, some providers have difficulties:
  - navigating guidelines and algorithms
  - keeping up to date with changes in recommendations and new treatments
  - interpreting and implementing data from the latest trials
  - staying abreast of insurance requirements and formulary considerations.

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Implicit Bias

We have a **bias** when, rather than being neutral, we have a preference for (or aversion to) a person or group of people.

"**Implicit bias**" is when we have attitudes towards people or associate stereotypes with them without our conscious knowledge.

Subconscious Bias

> **Examine your own biases**
> **We all have unconscious biases and prejudices that impact our relationships with patients. Identifying and understanding these biases helps to control them, and is essential to achieving cultural awareness.**

Could Subconcious Bias Play a Role in:

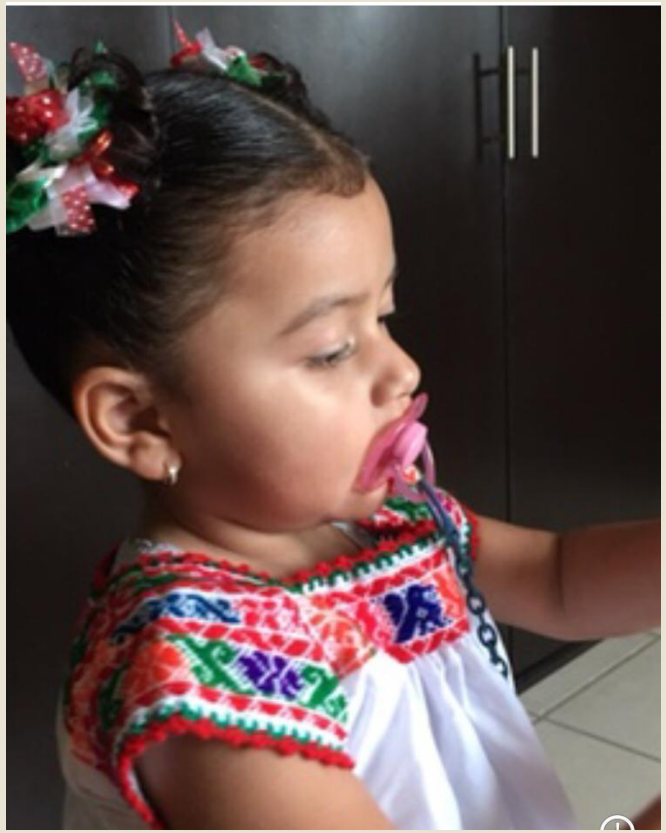
- Non-white patients receive fewer cardiovascular interventions.
- Black women are more likely to die after being diagnosed with breast cancer.
- **Patients of color are more likely to be blamed for being passive with their health care.**

Provider-patient communication barriers

- Survey found:
  - Clinicians focused on fear of hypoglycemia and absence of symptoms as barriers to therapy initiation and intensification, while patients reported length of time to reach target as a more concerning barrier than hypoglycemia.
  - Delay in achieving glycemic goal was a leading cause of non-adherence
  - Clinicians often overestimate patient resistance to therapy initiation due to fear of pain associated with injections.

Okemah J, et all. *Adv Ther*. 2018;35(11):1735-1745.

Provider–patient communication barriers



- Intensifying therapy can be used as a **threat** to urge adherence to current therapy and to allow the patient “one last chance” to improve their lifestyle.
- This negative connotation can lead to resistance from the patient

Okemah J, et all. *Adv Ther*. 2018;35(11):1735-1745.

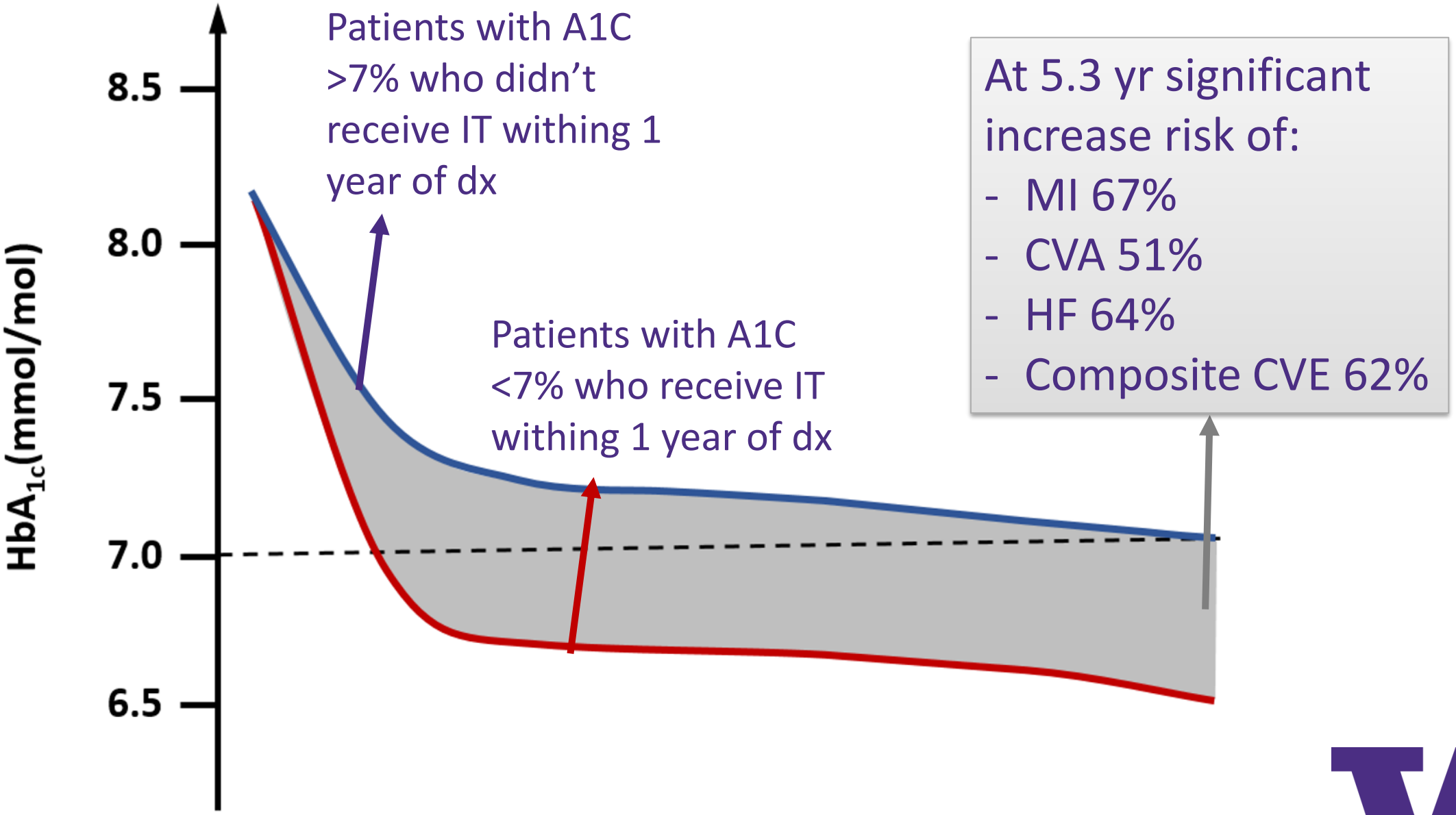
Clinical inertia

- Clinical inertia is the failure of clinicians to initiate or intensify therapy when indicated.
- It may occur at all stages of diabetes treatment, The longest delays were reported for initiation or intensification of insulin.
- Despite an increase in availability of DM2 medications and evidence-based treatment guidelines, the proportion of people with DM2 who fail to achieve glycemic goals continues to rise.

Giugliano D, et all. J Endocrinol Invest. 2019 May

Okemah J, et ll. Adv Ther. 2018;35(11):1735-1745.

Consequences of delayed intervention in patients without previous CVD



Khunti. K at all, Primary Care Diabetes. 2017, 11: 3–12

- Denial of disease
- Lack of awareness of progressive nature of disease leading to feeling of 'failure'
- Lack of awareness of implications of poor glycemic control
- Fear of side effects (hypoglycaemia, weight gain)
- Concerns over ability to manage more complicated treatment regimens
- Too many medicines
- Treatment costs
- Poor communication with physician
- Lack of support
- Lack of trust in physician

- Time constraints
- Lack of support from e.g. nursing staff
- Concerns over costs of treatment/testing etc.
- Reactive rather than proactive care
- Underestimation of patient's needs
- Difficulties navigating guidelines and algorithms
- Lack of information or understanding of new treatment options and potential benefits
- Lack of information on side effects/fear of causing harm (ie. hypoglycemia)
- Lack of clear guidance on individualizing treatment
- Concerns over patient's ability to manage more complicated treatment regimens
- Concerns over patient adherence

- No clinical guidelines
- No disease registry
- No visit planning
- No active outreach to patients
- No decision support
- No team approach to care
- Poor communication between physician and staff

Reverse clinical inertia

The failure to reduce or change therapy when no longer needed or indicated.

This can lead to polypharmacy and patient losing trust on the provider

Giugliano D, et all. J Endocrinol Invest. 2019 May

Okemah J, et ll. Adv Ther. 2018;35(11):1735-1745.

Patient Barriers

- Poor health literacy
- Lack of disease knowledge
- Adverse effects
- Cost
- Negative perceptions
- Needle-related fears
- Social concerns and stigmas
- Forgetfulness
- Health disparities
- Time requirements
- Emotional well-being
- Cultural beliefs
- Influences from a family member's experience

White RO, et all. *Clin Diabetes*. 2009;27(3):105-112.

Cultural beliefs

- The belief that DM meds cause complications such as blindness, kidney damage, or death is common among minority groups.
- **Latina** women find it challenging to adjust their lifestyle while caring for their family
- In the **African American** population, some patients report feeling shame from insulin use and dislike the inconvenience of injections on their daily life.
- Among **Muslims**, fasting corresponds to their religious beliefs, which can affect decisions about insulin and potentially interfere with religious observations.
- Limited English proficiency has also been associated with poor glycemic outcomes and nonadherence to medications

Rebolledo JA, et all. *Diabetes Spectr*. 2016;29(3):185-190.

Culture Cannot be Dismissed!

Fat is beautiful

Eat prickly pear cactus to lower sugar levels

Variations in "normal" body size:

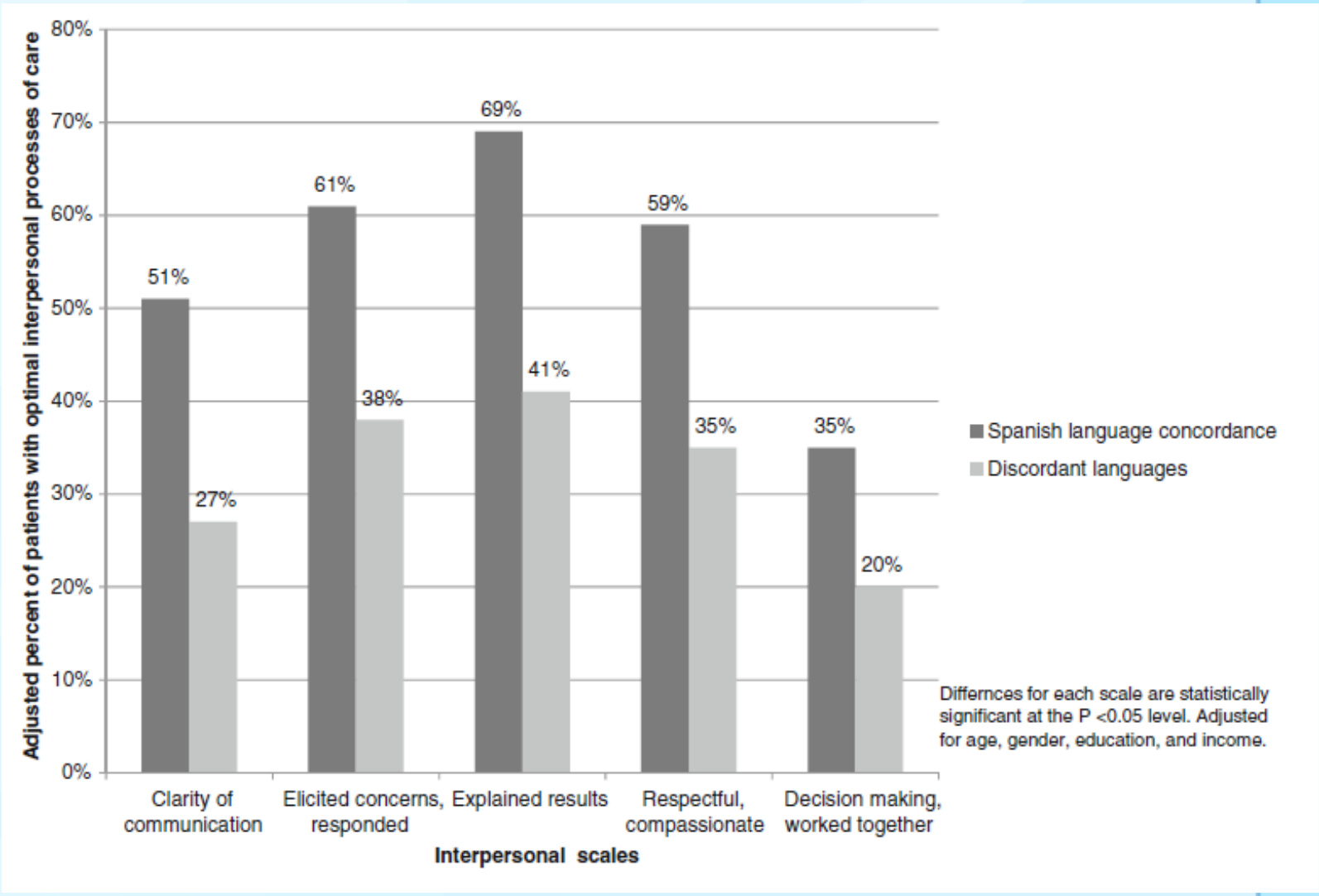
- Screen first-generation Asian Americans at lower BMIs
- African Americans: acceptance of overweight/obesity
- LatinX: acceptance of overweight/obesity at critical stages of development

Urinate into a pineapple and bury it to cure diabetes

Hsu WC et al. *J Fam Pract*. 2007;56:S15-21.

Language Concordance & Diabetes Care: Satisfaction

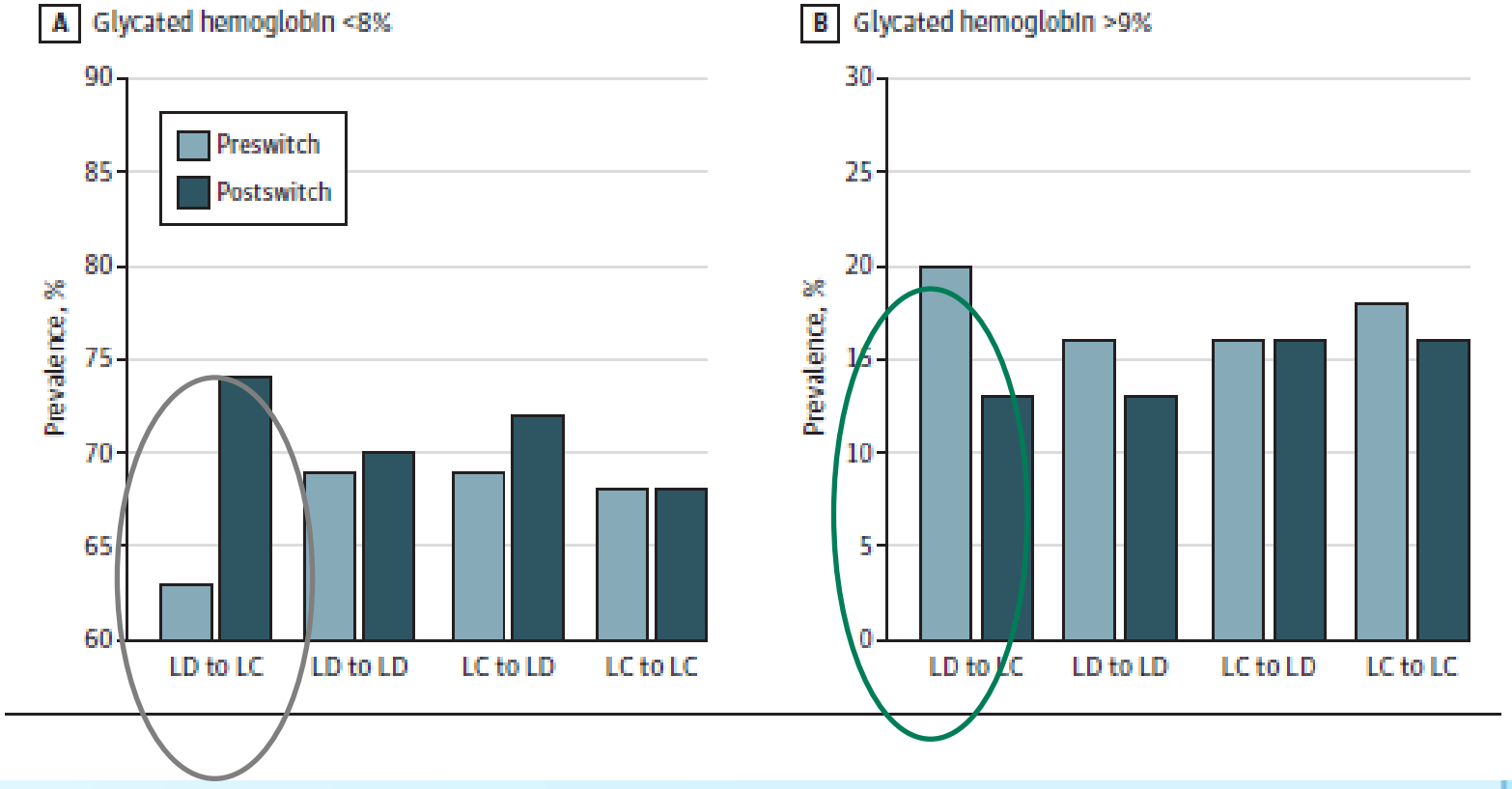
Interpersonal processes of care
→
-<u>communication</u>:
Clarity, elicitation of concerns, explaining results
-<u>interpersonal style</u>:
Compassionate, respectful,
-<u>Patient centered decision making</u>: working together.



J Gen Intern Med 29(12):1650–6

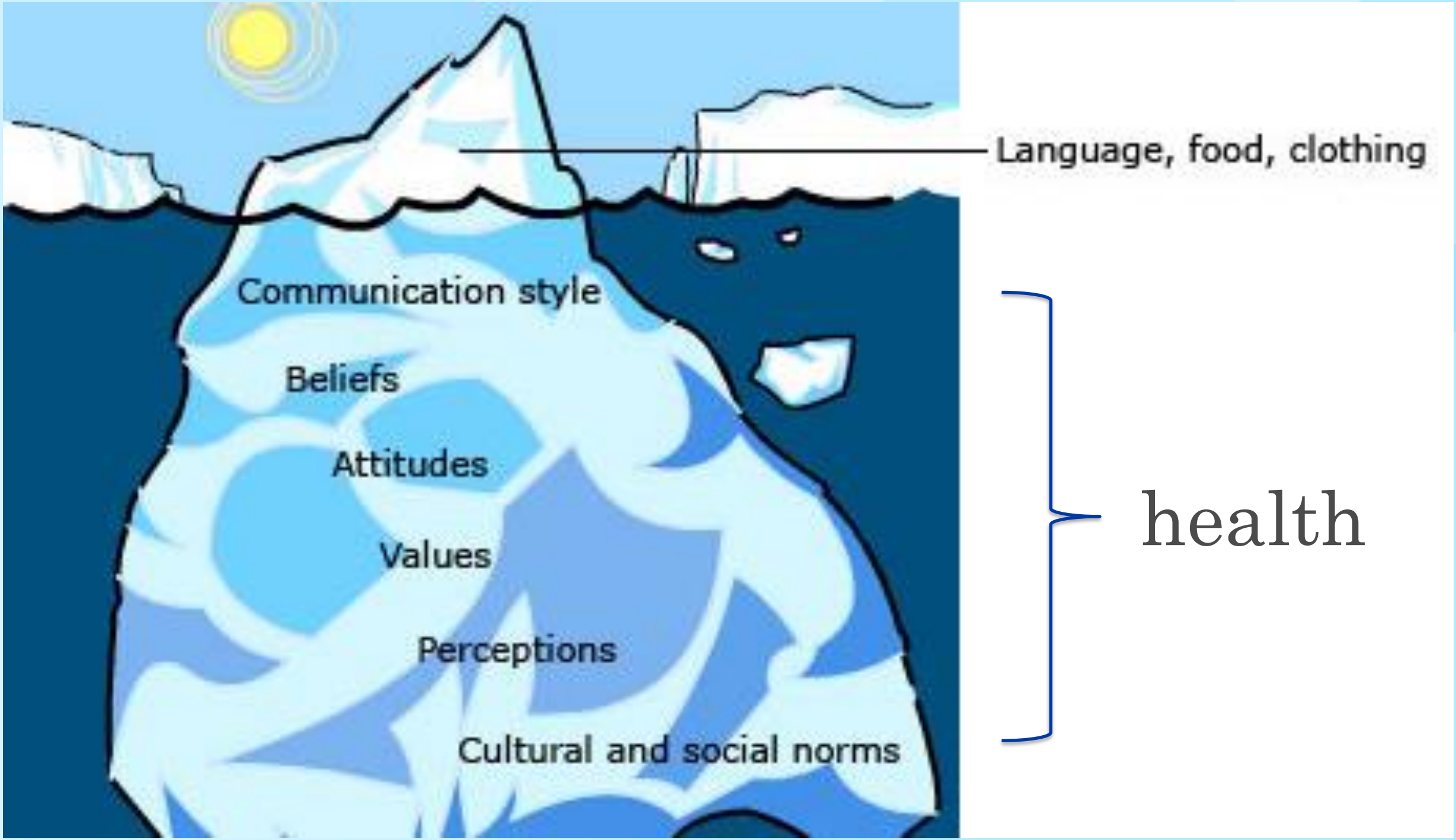
Language Concordance & Glucose Control

Figure 1. Glycated Hemoglobin Levels in LEP Latino Patients With Diabetes Before and After Switching Primary Care Physicians

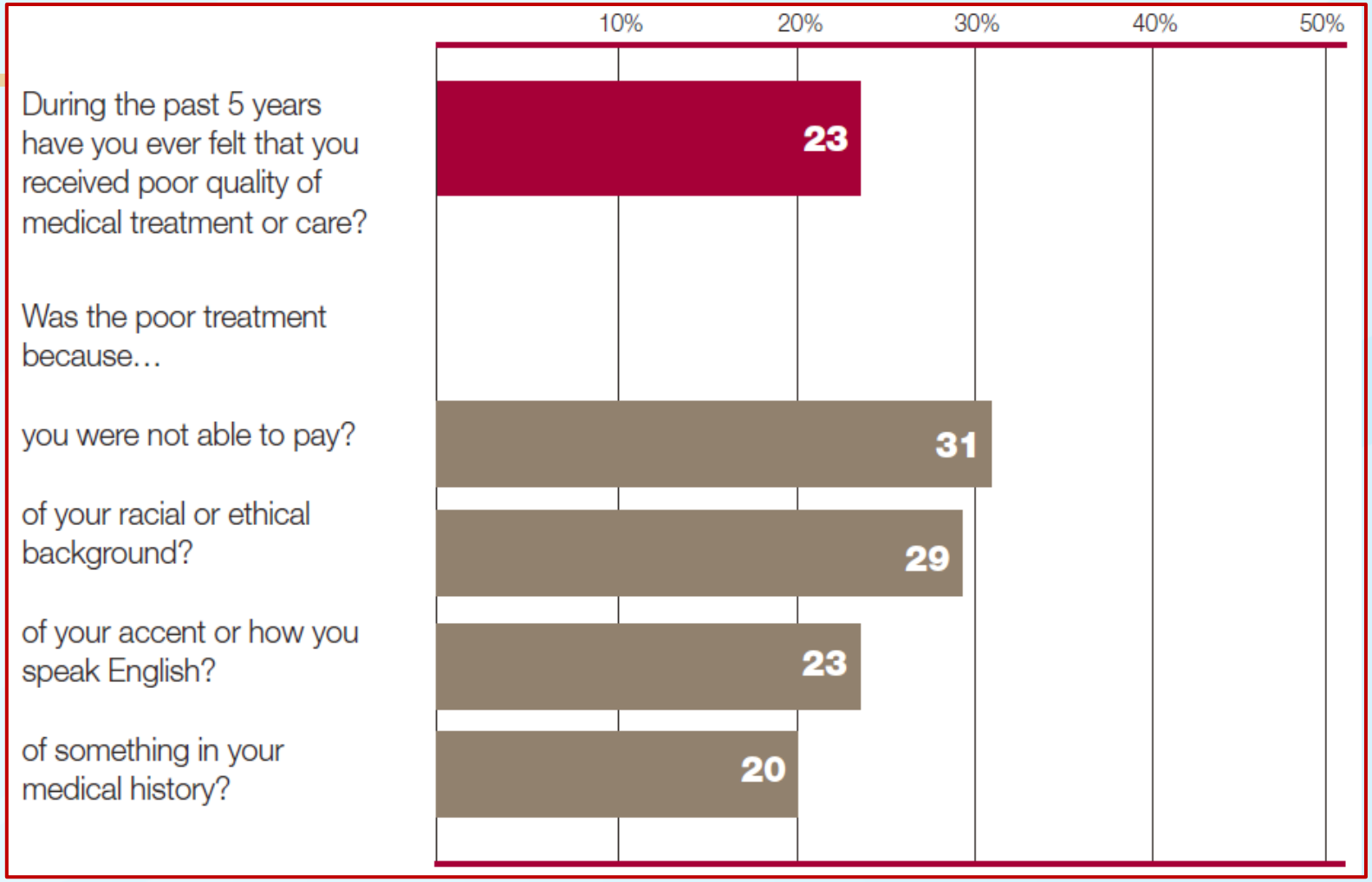


LD Language discordant
LC language concordant

JAMA Internal Medicine March 2017 Volume 177, Number 3


Language, food, clothing
Communication style
Beliefs
Attitudes
Values
Perceptions
Cultural and social norms
health

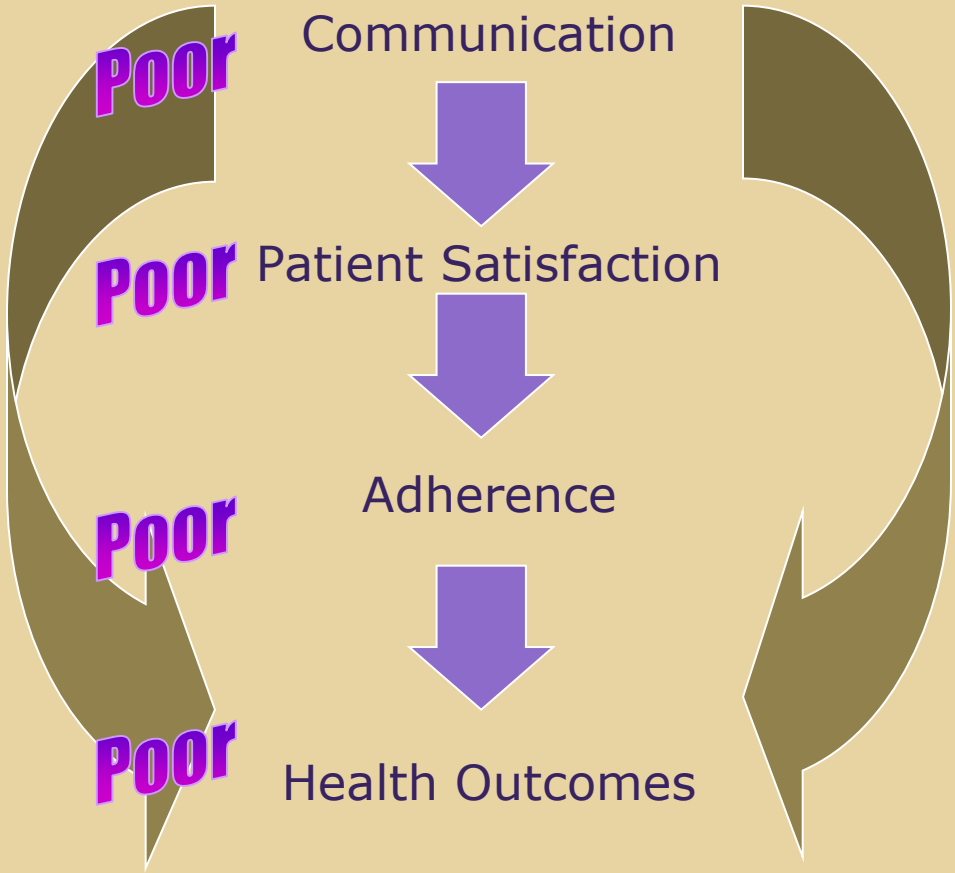
Prevalence and Perceived Reasons for Poor Treatment



Livingston G MS, D'Vera C: Latinos and Health Care in the United States:. A Joint Pew Latino Center and Robert Wood Johnson Foundation Research Report, 2008

When sociocultural differences between patient & provider are *not* appreciated, explored, understood or communicated in the medical encounter….

Evidence Linking Communication to Outcomes



Stewart et al, 1999; Flores, 2000; Betancourt et al., 1999; Moraleset al., 1999; Cooper-Patrick et al.,1999; Langer, 1999

Cultural Diversity and Health Care

Acquiring Cultural Competence Reduces the chance of stereotyping

- Starts with Awareness
- Grows with Knowledge
- Enhanced with Specific Skills
- Polished through Cross-Cultural Encounters

Cultural Awareness Checklist

Establish clear communication

Make sure you know your patient's preferred method of communicating and arrange professional interpretation if necessary.

Be aware of non-verbal cues without jumping to conclusions

Non-verbal communication conveys a lot of critical information—but it may differ dramatically across cultures. Don't make any assumptions without knowing the person's customs.

Cultural Awareness Checklist

Ask openly about potentially relevant traditions and customs

This includes exploring potential spiritual/religious practices, dietary considerations, and cultural norms that may be particularly important to the patient's clinical situation.

Cultural Awareness Checklist

Use normalizing statements

A respectful way to ask about sensitive issues like cultural or religious customs is to first explain that they are very common. (e.g. “A lot of my patients have customs or practices that are important for me to know about so I can make sure to give you the best possible care.”)

Cultural Awareness Checklist

Examine your own biases

We all have unconscious biases and prejudices that impact our relationships with patients. Identifying and understanding these biases helps to control them, and is essential to achieving cultural awareness.

Operationalizing Implicit Bias Reduction In Patient Interactions

Common identity formation

During patient interview, inquire about possible common group identities between you and the patient (home town, sports team, language proficiency, love of the arts, etc.)

Perspective taking

Before or during patient encounter, pause to consider the stress the patient is under today and what their life will be like for months after this encounter

Consider the opposite

After an initial review of patient information (history, physical, and social history) and coming up with a disposition, pause and rereview the information, actively looking for evidence for the opposite conclusion. Then make a final decision

Counterstereotypical exemplars

Focus on individuals you admire and respect who are in the same demographic as the patient

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These strategies are to be used before and during the patient encounter.

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Culturally Competent Healthcare Providers

Effective Communication

- Motivate patients by praising improvements in glycemic control and reminding them of the associated clinical benefits is encouraged.
- Sharing benefits such as improvements in sleep, energy level, and mood; fewer trips to the bathroom, etc are important measures to discuss.

Clinicians should proactively identify and address barriers to proper therapy initiation or intensification

Rebolledo JA, et all. *Diabetes Spectr*. 2016;29(3):185-190.

SHARED DECISION-MAKING

Shared decision-making is imperative to promote adherence and subsequent glycemic control

It allows patients and providers to work together

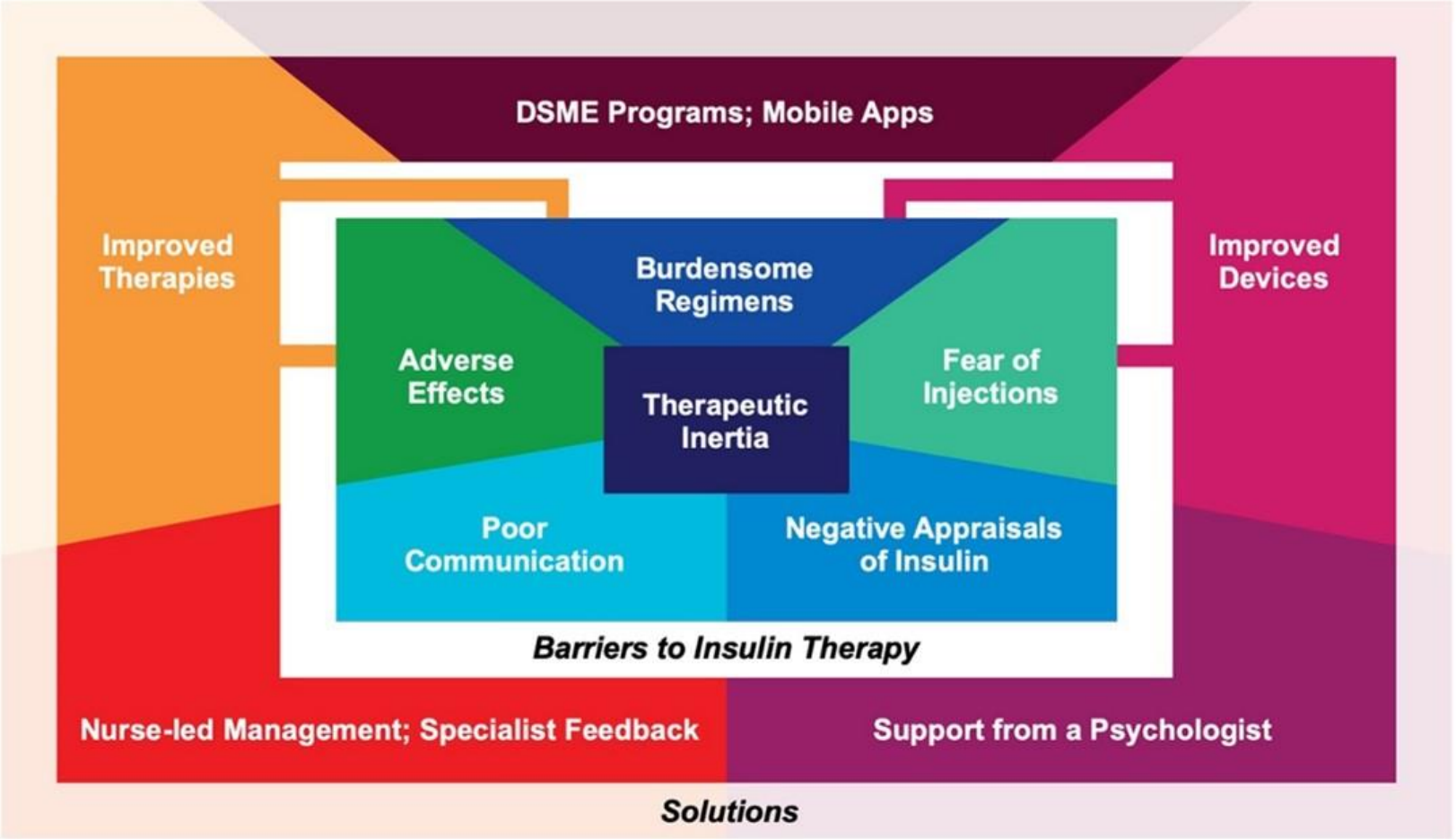
Sarbacker GB, et all. *Diabetes Spectr*. 2016;29(3):166-170.

MULTIDISCIPLINARY CARE TEAM

Addressing therapeutic inertia by incorporating several disciplines, including MD/DO, RNs, CDEs, dietitians, NPs, PAs, psychologists, pharmacists, can be a cost-effective way to influence attitudes and behaviors, and improve patient care

Sarbacker GB, et all. *Diabetes Spectr*. 2016;29(3):166-170.

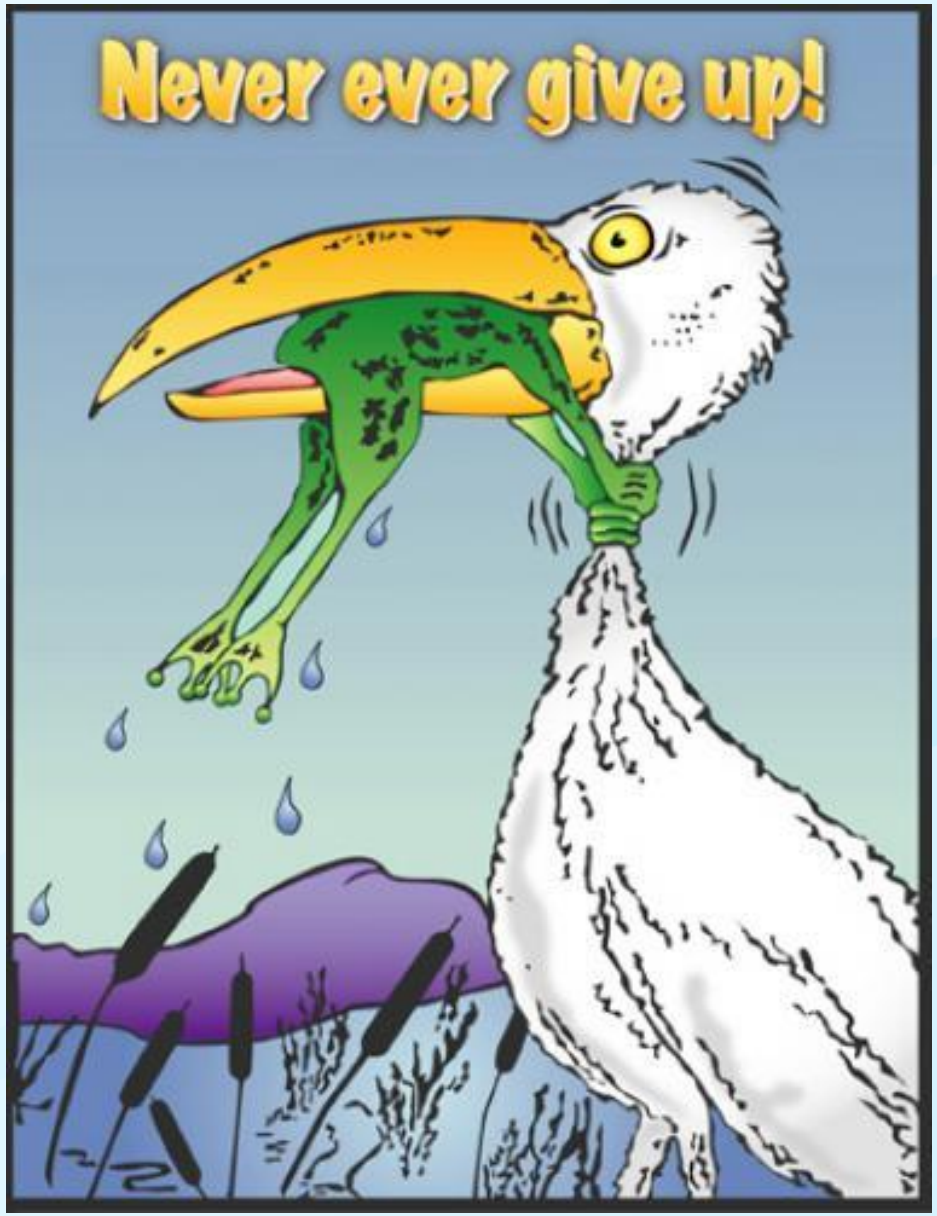
Barriers and Solutions to Therapeutic Inertia



Russell-Jones D et all. *Diabetes Obes Metab*. 2018;20(3):488-496.

Eliminate from your vocabulary the terms “non-compliant” or “non-adherent”

Diabetes is hard… be optimistic and work hard for the people who live with it on a daily basis.



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Questions to Ask

- What do you call your condition? What names does it have?
- What do you think caused the problem?
- Why do you think it started when it did?
- What does diabetes do to you? How does it affect you?
- How severe is it? Will it last a long or short time? Is it a lifelong condition?
- What do you fear most about it?
- What are the chief problems it causes you? What problems do you think it will cause you in the future?
- What kind of treatment do you think you should receive? What are the most important results you hope to receive from treatment?