THE IMPORTANCE OF ADDRESSING MULTICULTURAL AND INDIVIDUALIZED CARE IN TYPE 2 DIABETES: A PRIMER FOR PAYERS

THE CALL FOR CULTURAL COMPETENCE AND INDIVIDUALIZED, PATIENT-CENTRIC CARE

The prevalence of health disparities in racial and ethnic minorities is widely recognized. A higher prevalence of chronic disease, disability, and mortality impacts these groups compared with non-Hispanic whites. The underlying inequity that creates this disparity is the lower quality of care received by racial and ethnic minorities.[1]

In order to help address this disparity, the Affordable Care Act contains several provisions related to culturally and linguistically appropriate services.[1] Additionally, the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD) advocate a patient-centered approach to the management of hyperglycemia in type 2 diabetes, which includes accounting for a member's cultural preferences.[2]

Establishing services that are culturally and linguistically appropriate is an important first step in addressing racial and ethnic disparities.[1]

THE IMPACT OF DIABETES ON RACIAL AND ETHNIC MINORITIES

African Americans[3]

African Americans are at high risk, with 13.2% of those 20 years of age or older diagnosed with diabetes. They are also 1.7 times more likely to get diabetes compared with non-Hispanic whites. African Americans are significantly more likely to suffer from blindness or kidney disease as well.

Hispanics/Latinos[4]

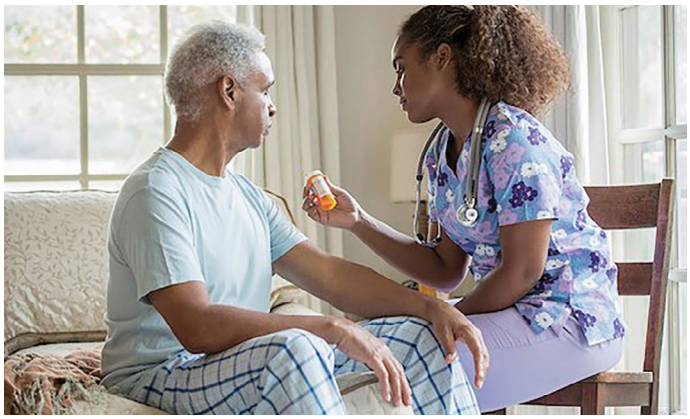
Research indicates that people of Hispanic and Latino origin are at a higher risk for type 2 diabetes than non-Hispanic Caucasians. It also discovered that there was generally a low rate of diabetes awareness, glycemic management of the disease, and health insurance. The study also showed that diabetes was more likely to develop the longer a person lived in the United States.

Native Americans[5]

Adult American Indians and Alaska Natives have one of the highest age-adjusted prevalence of diabetes among all US racial and ethnic groups.

Asian Americans[6]

According to the Joslin Diabetes Center's Asian American Initiative, Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPI) are at increased risk for diabetes at different body mass indexes (BMI) compared with Caucasian Americans. Thus, Asian Americans are considered overweight and at increased risk for diabetes at a BMI of 24; whereas, Pacific Islanders are considered overweight or at an above-normal body weight with a BMI of 25 to 29.9 and at risk for diabetes with a BMI of 27.



Prevalence and Incidence of Diabetes in the US Population[7]

- Among adults aged 18 years or older, age-adjusted data for 2013-2015 indicated that:
  - American Indians/Alaska Natives had the highest prevalence of diagnosed diabetes for both men (14.9%) and women (15.3%)
  - Prevalence was higher among American Indians/Alaska Natives (15.1%), non-Hispanic blacks (12.7%), and people of Hispanic ethnicity (12.1%) than among non-Hispanic whites (7.4%) and Asians (8.0%)
  - Prevalence varied significantly by education level, which is an indicator of socioeconomic status. Specifically, 12.6% of adults with less than a high school education had diagnosed diabetes versus 9.5% of those with a high school education and 7.2% of those with more than a high school education
- Incidence of diagnosed diabetes among adults in the US:
  - In 2015, an estimated 1.5 million new cases of diabetes were diagnosed among US adults aged 18 years or older
  - Non-Hispanic blacks and people of Hispanic origin had a higher age-adjusted incidence compared with non-Hispanic whites during 2013–2015
  - Age-adjusted incidence was about 2 times higher for people with less than a high school education compared to those with more than a high school education during 2013–2015
- Among children and adolescents 10 to 19 years of age, US minority populations had higher rates of new cases of type 2 diabetes compared to non-Hispanic whites

PATIENT-CENTRIC CARE AND CULTURAL COMPETENCE

Patient centeredness is intended to help enhance care quality for all members.[8] Patient-centered care is respectful and responsive to individual patient preferences, needs, and values and ensures that patient values guide all clinical decisions.[2] Patient centeredness takes into account the diversity of patient values and perspectives to help care become more equitable.[8]

The primary goal of cultural competence is to help balance quality, improve equity, and reduce disparities by specifically improving care for minorities and other disadvantaged populations. Cultural competence attends the specific needs of minorities and other disadvantaged populations to enhance the ability of health systems and providers to address individual patients' preferences and goals to help become more patient centered.[8]

Patient centeredness and cultural competence target different aspects of healthcare delivery; however, there is substantial overlap in the features of patient centeredness and cultural competence.[8]

Features of Patient Centeredness and Cultural Competence[8]

Healthcare organizations and providers may want to consider adopting principles of both patient centeredness and cultural competence. This may help align services to meet the needs of members, including minority and other disadvantaged groups.

Organizations that are patient centered and culturally competent include the following features:

- Services that are aligned to meet member needs and preferences
- Health care is available in communities and convenient to members' homes
  - — Use of community health workers who might help provide care to the member
- Educational materials tailored to members' needs, health literacy, and preferred language
  - — Enhancing provider availability may improve care for minority groups who tend to be disadvantaged in terms of access to care
- Maintained continuity and secure transitions across healthcare settings

As part of the process of delivering high-quality care, measurement of both patient centeredness and cultural competence may be beneficial.[8]

NATIONAL CLAS STANDARDS ON CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care from the Office of Minority Health at the U.S. Department of Health & Human Services are intended to advance health equity, improve quality, and help eliminate healthcare disparities by providing a blueprint for individuals and healthcare organizations to implement culturally and linguistically appropriate services.[1]

CLAS Standards[1]

Principal Standard:

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

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policies, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language-assistance services clearly and in their preferred language, both verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality-improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

PROJECT DULCE MODEL CASE STUDY: IMPLEMENTING CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE

Project Dulce was developed in 1997 as part of a collaborative effort in San Diego County, California, to improve the health and access to health care of underserved, ethnically diverse people with diabetes. The clinical goals of the Project Dulce model were to meet the ADA's Standards of Medical Care and achieve improvements in A1C, blood pressure, lipid parameters, and health behaviors in the community.[9]

Interventions[9]

- Latino participants underwent a 1-hour baseline visit to assess:
  - Demographic information
  - History of diabetes
  - Weight/BMI, blood pressure, foot status (including neurosensory and vascular examinations)
  - A1C, chemistry and lipid panels, liver function tests, and proteinuria test
- A patient registry was used to identify and organize diabetes patients by risk.
- Trained diabetes nurses (RNs/CDEs) followed evidence-based care management protocols to lead a multi-disciplinary care team:
  - Dietitians and medical assistants acting as health coaches were included
- Trained peer educators (known as *promotoras*)—people with diabetes who successfully managed their own disease—provided education and an "I've been in your shoes" type of support to participants.
- The curriculum was delivered in the native language of participants and through the *promotoras*:
  - Targeted the ADA standards of care to achieve improvements in A1C, blood pressure, lipids, and self-management behaviors
  - Covered the basics of diabetes and its complications as well as diet, exercise, medications, and blood glucose self-monitoring
  - Addressed cultural beliefs that may interfere with self-management (eg, fear of using insulin and reliance on home-based remedies as cures)
  - Offered classes that were interactive, encouraging patients to discuss personal experiences
  - Encouraged everyone to convey support and advice to other group members

Peer-led classes continue to be a successful method for delivering self-management education. Known as promotoras*, these peers typically come from the patients' ethnic group and are able to help patients overcome cultural, social, and economic barriers to instill effective self-management.*[9]

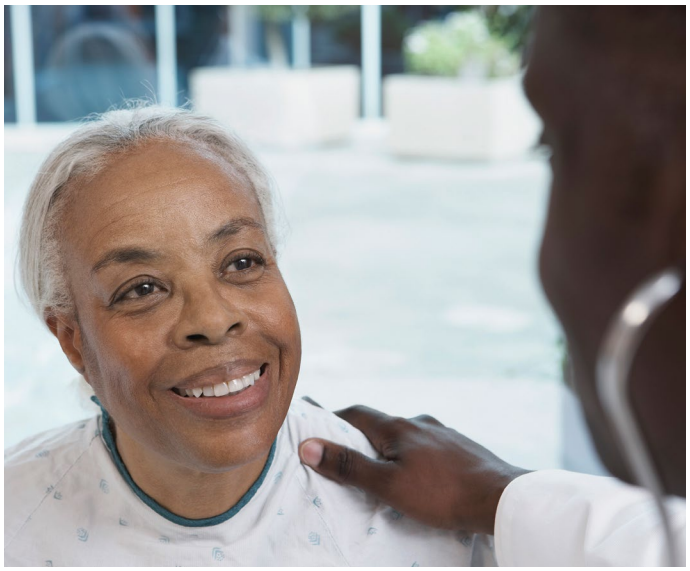
PROJECT DULCE MODEL CASE STUDY: IMPLEMENTING CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE

Results[9]

At the 1-year follow-up assessment, participants showed substantial improvements relative to baseline on clinical indicators including:

- A1C reduced from 12.0% at baseline to 8.3% at 1 year
- Total cholesterol reduced from 224 to 186 mg/dL
- LDL cholesterol reduced from 130 to 108 mg/dL
- Diastolic blood pressure reduced from 80 to 76 mm Hg

In addition, self-administered surveys in the Project Dulce group showed increases in diabetes-related knowledge and treatment satisfaction. In its 15-year history, Project Dulce has treated more than 18,000 patients, and results showed significant reductions in emergency room visits and hospital visits within the first year of implementation.[9]



References: **1.** Office of Minority Health. *National Standards for CLAS in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice*. Washington, DC: U.S. Department of Health & Human Services; April, 2013. **2.** Inzucchi SE, Bergenstal RM, Buse JB, et al. Management of hyperglycemia in type 2 diabetes: a patient-centered approach. Position statement of the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). *Diabetes Care*. 2012;35:1364-1379. **3.** American Diabetes Association. Treatment and care for African Americans. http://www.diabetes.org/living-with-diabetes/treatment-and-care/high-risk-populations/treatment-african-americans.html. Updated October 1, 2014. Accessed October 16, 2017. **4.** American Diabetes Association. Diabetes among Hispanics: All are not equal. http://www.diabetes.org/newsroom/press-releases/2014/diabetes-among-hispanics-all-are-not-equal.html. Published July 24, 2014. Accessed October 16, 2017. **5.** American Diabetes Association. American Indian/Alaska Native programs. http://www.diabetes.org/in-my-community/awareness-programs/american-indian-programs. Accessed October 16, 2017. **6.** American Diabetes Association. Asian Americans, Native Hawaiians and Pacific Islanders. http://www.diabetes.org/inmycommunity/awarenessprograms/aanhpi/. Accessed October 16, 2017. **7.** Centers for Disease Control and Prevention. *National Diabetes Statistics Report, 2017: Estimates of Diabetes and Its Burden in the United States*. https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf. Accessed October 16, 2017. **8.** Saha S, Beach MC, Cooper LA. Patient centeredness, cultural competence and healthcare quality. *J Natl Med Assoc*. 2008;100(11):1275-1285. **9.** Philis-Tsimikas A, Gilmer TP, Schultz J, et al. Community-created programs: can they be the basis of innovative transformations in our health care practice? Implications from 15 years of testing, translating, and implementing community-based, culturally tailored diabetes management programs. *Clin Diabetes*. 2012;30(4):156-163.

CarePath | Healthy Engagements

CarePath Healthy Engagements is a comprehensive program designed to help improve the lives of people living with type 2 diabetes and assist those that care for them. CarePathHealthyEngagements.com