Improving Cultural Humility and Competency in Diabetes Care for Primary Care Providers

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As type 2 diabetes continues to plague the United States and the world at an increasingly alarming rate, the role of primary care providers (PCPs) grows ever more crucial. PCPs can help patients prevent the onset of type 2 diabetes, provide early diagnosis, and assist patients in maintaining glycemic and metabolic control once a diagnosis has been made.

Diabetes is a largely self-managed chronic disease, making patient education vital to the health and wellness of patients. Because diabetes prevalence and related mortality disproportionally affect non-White individuals, PCPs and other health care professionals must learn to connect and communicate effectively with patients of different cultures and backgrounds. Thus, the goal of this article is to highlight the health disparities that exist among patients with diabetes and to give PCPs a framework to improve diabetes treatment through cultural competency and humility.

Case Presentation: Maria

Maria is a 57-year-old, Spanish-speaking woman with a medical history of type 2 diabetes, hypertension, and hyperlipidemia, who presents to your clinic to establish care. Through an interpreter, you learn that she immigrated from Mexico to the United States 2 years ago and lives with her children and grandchildren. This is her first visit to a doctor since she moved to the United States.

Maria ran out of her medications about 1 year ago and reports feeling excessively thirsty and fatigued. She also reports that she wakes up several times each night to urinate. She is worried about her diabetes. Her sister, who still lives in Mexico, recently had to get her foot amputated as a result of diabetes-related complications, and her brother just had a stroke. She takes a daily 30-minute walk around her neighborhood, and her diet is a mixture of traditional Mexican foods such as tortillas, rice, and beans and a typical Western diet, including fast food and processed snacks.

In the clinic, Maria's fasting blood glucose is 220 mg/dL, and her blood pressure is 148/95 mmHg. Her physical exam is unremarkable, and laboratory test results are pending.

Questions for Consideration

- How can the PCP best address Maria's needs in this scenario?
- What cultural aspects are important to recognize and incorporate into her evaluation and care plan?
- What are cultural competency and cultural humility, and why should PCPs care?

Discussion

The U.S. Census Bureau predicts that, by 2050, non-White populations will account for >50% of the population for the first time in American history (1). With an increasingly diverse patient population, it has become more important than ever for PCPs to be able to connect with patients of different racial and ethnic backgrounds to provide effective, high-quality care to all patients.

This ability is largely dependent on PCPs' cultural competence. The National Prevention Information Network within the Centers for Disease Control and Prevention has defined "cultural competence (2)," and a 2020 article by Stubbe (3) elucidates the meaning of "cultural humility" (Table 1). Cultural competency means more than having knowledge of cultures different from one's own. Practicing cultural competency means developing cultural sensitivity, humility, and awareness to better connect and communicate with people from many different backgrounds.

Health disparities can be identified in many different facets of the U.S. population. For example, despite

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TABLE 1 Cultural Competence and Cultural Humility Definitions

Cultural competence (2)	"The integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes."
Cultural humility (3)	"Combines the life-long process of self-exploration and self-critique with a willingness to learn from others. It promotes interpersonal sensitivity and openness, addresses power imbalances, and develops an appreciation of intracultural variation and individuality to avoid stereotyping and have a more other-oriented perspective."

numerous advancements to lengthen life expectancy, large disparities persist among different racial groups and among groups with different levels of education. White men and women have longer life expectancies than Black men and women, and when education is factored in, the disparities are even greater: White, educated men live on average 14 years longer than Black men with less than 12 years of education, and these gaps have only widened over time (4).

To reduce such health disparities, PCPs have an obligation to increase their cultural awareness and address potential biases. To improve the quality and efficacy of care, PCPs can self-reflect and self-critique their own beliefs and listen and learn from others. As Stubbe explained (3), developing a mindset of cultural humility emphasizes the importance of interpersonal sensitivity and curiosity and promotes forming other-centered relationships with people to honor their beliefs, customs, and values. PCPs should strive to be more culturally competent to better connect with a diverse patient population; they should also focus on cultural humility to identify their own biases and gaps in knowledge and sensitivity to develop a deeper understanding and appreciation for culturally diverse patients.

Importance of Cultural Competency and Humility in Diabetes Care

In the United States, diabetes disproportionately affects non-White populations, with a prevalence that is two to six times higher among African American, Native American, Asian, and Hispanic populations compared with White populations (5,6). These populations also experience a 50–100% higher burden of illness and mortality from diabetes than White Americans (7,8). Minority populations have a higher mean A1C than White populations and higher rates of diabetes-related complications (5,9). Perhaps most alarming, racial and ethnic minorities have a higher prevalence of diabetes at a lower BMI than Whites, suggesting that factors other than obesity play a role in disparities relating to diabetes risk and care across racial and ethnic groups (10).

Social determinants of health (SDOH), as defined by *Healthy People 2020* (11), are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Factors such as affordable housing, access to healthy food and education, public safety, and economic stability are all examples of SDOH that directly affect the health of all people, but especially people living with diabetes and other chronic diseases.

Current American Diabetes Association (ADA) guidelines suggest screening for diabetes in asymptomatic adults with a BMI $\geq$25 kg/m^2 (or $\geq$23 kg/m^2 for Asian Americans) who have one or more known risk factors for diabetes (12). The ADA set a lower cut point for Asian Americans to address evidence of disparity showing that the higher BMI would miss ~36% of diabetes cases among Asian Americans (13,14), thus highlighting the importance of practicing patient-centered medicine.

Treatment should also be individualized to incorporate patients' values and beliefs. This strategy will ensure that clinicians are using best care practices and maximizing the benefits of disease management. The more patients feel understood and supported by their physician and the more physicians can understand and apply cultural constructs, the better patients will understand and adhere to their diabetes management plan. This tenet is especially important in the case of diabetes, which is a largely self-managed disease.

Although SDOH greatly influence diabetes outcomes, they are not the only factors that negatively affect the health of people of color. African American, Asian American, and Hispanic populations receive lower-quality care than White populations in terms of recommended diabetes screening methods. For example, minority populations receive fewer A1C tests, foot exams, and eye exams compared with nonminority populations (15,16). Acknowledging and addressing health disparities such as lower-quality care among diverse patient populations and implicit biases can lead to improved outcomes for all patients, and especially those from culturally diverse backgrounds.

TABLE 2 Selected Cultural Competency Resources for Health Care Providers

Organization	Resource
U.S. Department of Health and Human Services Office of Minority Health (17)	Continuing medical education credit available for completing online courses such as "A Physician's Practical Guide to Culturally Competent Care." Available from https://cccm.thinkculturalhealth.hhs.gov.
Georgetown University National Center for Cultural Competence (18)	Cultural and linguistic competence health practitioner assessment. Available from https://www.clchpa.org.
National Center for Cultural Competence, Georgetown University Center for Child and Human Development, and the University Center for Excellence in Developmental Disabilities, Education, Research, and Service (19)	Checklist for evaluating the cultural and linguistic competency of primary care clinics to ensure that clinics are set up to properly serve patients of all backgrounds. Available from https://nccc.georgetown.edu/documents/Checklist%20PHC.pdf.
American Academy of Family Physicians (20)	EveryONE Project, online resource designed for family practice physicians to address health disparities directly and promote health equity. Available from https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project/eop-tools.html.

Ensuring the Provision of Culturally Competent Diabetes Care

Practicing culturally competent care means recognizing and respecting cultural differences among patients. It is not a set of skills to be learned or mastered, but rather a practice of awareness. That being said, several available resources offer guidance in the practice of culturally competent care (Table 2) (17–20). PCPs can receive continuing medical education credit for online courses such as the U.S. Health and Human Services Office of Minority Health's "A Physician's Practical Guide to Culturally Competent Care," which is designed to advance health equity and reduce health and health care disparities (17). As leaders of health care teams, PCPs can use assessments for cultural and linguistic literacy to self-evaluate their clinics (19). On a more personal level, health care providers should challenge themselves to expand their education on different cultural beliefs surrounding health and illness, diet, and Western medicine. Throughout training, many PCPs are taught that the American standard for a healthy lifestyle is the standard against which all others should be measured. It is crucial to reframe this way of thinking, as it can easily become a barrier to providing effective care (Table 3) (21).

Patients are more likely to engage in recommended treatment plans when they feel they have a strong relationship with their PCP. This relationship can be strengthened by providers' use of patient-centered communication and acknowledgment of patients' health beliefs, making patients feel included and respected as equal partners (22). PCPs can also assess social context, including potential food insecurity, housing stability, and financial barriers, and apply that information to treatment decisions for specific patients (23). This practice will facilitate patients' success by helping to create treatment plans that are realistic and individually tailored.

Culturally Competent Lifestyle Change Recommendations

A large part of managing diabetes involves helping patients adopt therapeutic lifestyle changes. On a community level, making connections with local resources such as diabetes education classes and nutritionists can greatly increase efficacy and continuity of care, especially if these resources can also serve patients with cultural competency (21).

When discussing diet and nutritional goals, PCPs should be careful not to advise patients to cut out entire food groups, especially if these foods are a staple in patients' cultural community. Food is a big part of maintaining a cultural identity and therefore well-being and overall health. One possible approach is to recognize and acknowledge a person's heritage diet, which requires developing an understanding of the traditional foods of different cultures. PCPs and other diabetes care providers can then integrate these foods into dietary advice for members' specific cultural communities, as opposed to recommending a one-size-fits-all approach such as the Mediterranean diet for everyone (Table 4) (21,23).

When managing a complex chronic disease such as diabetes, a team-based approach to lifestyle change is important to ensure the provision of patient-centered, high-quality care that yields the best outcomes (24). Such care teams provide patients with self-management support not only from traditional health care providers, but often also from lay health coaches, health system

TABLE 3 Potential Provider Viewpoints That Can Become Barriers to the Provision of High-Quality Care (21)

• Patients who do not live a healthy lifestyle do not care about their health.
• Difficulty in successfully following treatment recommendations is solely because of the patient.
• Everyone understands what it means to have a chronic illness.
• Everyone should and will listen to recommendations from their health care providers.
• Not following providers' instructions means "nonadherence."

navigators, and community health workers; specific types of team members will vary based on the cultural norms of each patient population. Lifestyle change support can include one-on-one meetings and referrals to diabetes education group programs, in which patients can learn from an instructor and from fellow participants about diabetes and the healthy lifestyle practices they can adopt to better manage it. This approach can be particularly impactful for patients with newly diagnosed diabetes, providing a space where they can learn from and receive support from peers who are facing a similar situation.

As providers, it is important not only to stay up-to-date on the latest treatments and medical information, but also to continue growing as individuals. By constantly challenging ourselves and our training, confronting our biases, and facing the uncomfortable reality of health disparities in the United States, we have an opportunity to improve the health of all patients—not just those who are the most privileged.

Case Presentation, Part 2: Tailoring Treatment

For Maria, the patient in our case presentation, a team-based approach involving health care providers, community leaders, and family members maximizes resources to ensure that she receives high-quality and effective diabetes care.

Dietary recommendations provided for Maria should emphasize the use of traditional Mexican ingredients such as corn tortillas, brown rice, and legumes; including plenty of fruit and vegetables; and minimizing processed foods, flour tortillas, and white rice. These recommendations will allow Maria to continue eating the culturally important foods she is used to, while still making healthy alterations to help her achieve glycemic control.

After reviewing an individualized treatment plan, referring Maria to and helping her enroll in a diabetes education class with a Spanish-speaking diabetes educator can help empower her to take a more active role in managing her disease. Additionally, giving her take-home educational pamphlets in her own language will allow her to continue learning about diabetes in the comfort of her own home, so she can come to the next visit prepared with informed questions.

Finally, the role of the family is extremely important in Hispanic populations. Including Maria's family and making sure everyone is on board with her diabetes management plan will help to increase Maria's engagement and improve her overall health.

When treating patients such as Maria, one must consider much more than prescribing the appropriate medications and ordering regular laboratory tests. Approaching patients with cultural awareness will help improve their diabetes outcomes and overall health.

TABLE 4 Cultural Sensitivity Best Practices When Recommending Dietary and Lifestyle Changes (21)

• Instead of telling patients to stop eating a certain food of great cultural importance, suggest that they eat more of another type of food, such as fresh fruits and vegetables.
• Tailor each recommendation to the individual's learning style and personal beliefs.
• Always use an interpreter instead of a family member when speaking to non–English-speaking patients.
• Community programs are especially effective when encouraging patients to make lifestyle modifications, allowing them to learn from members of their own cultural community.
• Use a patient-centered communication style.

DUALITY OF INTEREST

J.H.S. is as an associate editor of *Clinical Diabetes*. No other potential conflicts of interest related to this article were reported.

AUTHOR CONTRIBUTIONS

H.M.D. conceived of the concept for this article, researched the topic, and wrote the manuscript. J.H.S. helped to refine the concept, assisted in the writing, and reviewed and revised the manuscript. J.H.S. is the guarantor of this work and, as such, had full access to all the data presented and takes responsibility for the integrity of the content.

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