

NDEP Webinar Series:
The National Diabetes Education Program
Culturally-Competent Health Provider Communication
14-May-2013
Webinar Transcript

Slide 1 – Title Slide

Moderator: Hi everyone. On behalf of the National Diabetes Education Program and especially our Asian American, Native Hawaiian and Pacific Islander stakeholder group, welcome. As the population in the United States becomes more diverse we're going to have a greater need for culturally competent communication. So we're very excited to be able to offer this webinar.

Slide 2 – Welcome and Introductions

Today we have two speakers, Dr. William Hsu and Dr. Nia Aitaoto who have extensive experience in culturally-competent communication.

Slide 3 – Speaker Slide

We're very lucky that they've agreed to share lessons that they've learned from their work.

Slide 4 - Caring for Chinese patients with Diabetes - From Pathophysiology to Culture

So we'll be starting with Dr. William Hsu, who is the medical director of the Asian Clinic and a senior physician at the Joslin Clinic and associate investigator the Joslin Diabetes Center and co-director of Joslin's Asian American Diabetes Initiative and also an assistant professor of medicine at the Harvard Medical School. His research interests include understanding the barriers to diabetes care in Asian Americans and developing novel mobile health technologies for treatment of diabetes. He works on key research, clinical and community projects that address diabetes health disparities in Asian Americans. He graduated from Cornell University, received his medical degree from Mt. Sinai School of Medicine in New York City and completed his residency at Yale and his scholarship training in endocrinology and metabolism at Harvard Medical School. So please welcome Will Hsu.

Dr. Hsu: Well good day to friends and colleagues. It's really just wonderful to be able to share some of the things that we've been doing here at Joslin as well as just to share with you some of the things that we've learned. By having you coming on this webinar you probably have heard about the terrible burden of diabetes in the Asian American community. What I plan to do for the next 20 minutes is to take you through a little bit of sort of introduction on the physiology, some of the unique features of diabetes in the population and then march on to talk about communications and cultural competency. I hope to give you sort of a well-rounded picture of the challenges that we see in the Asian American community.

Slide 5 - Diabetes and Pre-Diabetes Prevalence in NYC, by Race/Ethnicity, HANES, 2004

So if you look at data such as the one that I'm showing you on the slide, this is the burden of diabetes in New York City. The red represents the burden of disease and you'll see on the far right Asian Americans now have about 16 percent of its population with the diagnosis of diabetes and that is one out of six adults of Asian backgrounds living in your city having diabetes. Now, that is an epidemic. If you combine that with the yellow bar which represents a state of diabetes that's called pre-diabetes -- it's not quite diabetes yet, but they are at very high risk for developing diabetes -- combined with the red bar you see the Asian American population up to

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about 50 percent of them of those adults living in New York City has diabetes or pre-diabetes, a truly astounding figure. Now you may say, “But Will, this is New York City. Other parts of the country may have a different burden of disease,” and you’re absolutely right, that’s possible and that’s why we’re truly looking for to September when the CDC will be sharing for the first time national data based on NHANES. This is the first time the U.S. government has ever sampled the Asian American population and we will be hearing about the burden of diabetes on a national level, so that will be truly a wonderful thing to have.

Slide 6 - Diabetes Risk by BMI Category in the Hawaii Component of the Multi-Ethnic Cohort Study

Now what is quite different about diabetes in the Asian American is the fact that Asian Americans develop diabetes more than Caucasians at every weight category. So here you will see that the far right bar off the three triplets represent Japanese American and you will see that regardless whether they are with BMI less than 22, 22 to 25, 25 to 30 or 30 plus Asian Americans they have more diabetes compared to their counterparts in other populations.

Slide 7 - Diabetes Risk by Weight Change Category in the Hawaii Component of the Multi-ethnic Cohort Study

Looking at it in another way is the amount of weight gain. Asian Americans are especially susceptible to the risk of weight gain and in every weight gain magnitude Asian Americans in this case the results done in Japanese Americans show that they have higher hazard or risk of developing diabetes.

Slide 8 – Poll

So with that background I would like to just ask us a question here and if you will all participate if you’re on the web, what’s the average BMI for Asian Americans with diabetes? Venture to guess?

Slide 9 – Poll Results

And all of you click on it and let me see if I may show the results here and most of you are, actually it’s changing. Most of you are right. Actually the BMI less than 25 is the right answer.

Slide 10 - Odds Ratio of Type 2 DM by Race and Ethnicity in the U.S. (BRFSS)

So I’ll share with you a study that was done through telephone survey. This is the behavior risk factor surveillance system here. This is a national study using telephone survey. Now there is some deficiency obviously in telephone survey where people who do not know that they have diabetes probably weren’t included and for sure they weren’t included in this database. Here I think again you’ll not be surprised if you know a friend of Asian background with diabetes is that many of them don’t look overweight and you can see under the column Asian the BMI indication here is only about 24 compared to almost 27 in white population and about 28, 29 among Pacific Islanders, Hispanic and black populations. So that’s one very different characteristic of diabetes in the Asian American population. The implication is that, as a provider, if we see somebody of Asian background and we say “Oh you know, you don’t look

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very overweight, I don't think you're at risk for diabetes and therefore we're not going to screen you for diabetes. We're not going to address risk factors of diabetes," then we completely miss the picture here. To this point, organizations such as American Diabetes Association have been paying attention to if we should redefine obesity and overweight in the Asian American population.

Slide 11 - Abdominal Circumference

Now because of this inherent deficiency in using BMI as a risk stratifier when it comes to diabetes some organizations have proposed to use other parameters, for example, the abdominal circumference. The International Diabetes Federation has proposed that measuring central obesity using a tape measure, just simply measuring the girth, the circumference of the abdomen, may be an alternative way of identify risk and defining overweight and obesity. Now in this scenario while Caucasians would be using a cut off points of 102 centimeters or 85 centimeters in women this is equal to about 40 inches and 35 inches. Asians would be using a lower cut off point of 35.5 inches in men and 31.5 inches in women. Now these aren't the only difference. I just wanted to show a few other biologic differences that just would open up our minds to see that while we're more alike than different there are still some subtleties which are very, very important especially when it comes to caring for patients of different background.

Slide 12 - Median Levels of CRP among Participants in the Women's Health Study

Here's yet another example, in a large women's health study looking at inflammation and diabetes this is one study that looks a specific marker. It doesn't matter what the marker is, but I would just say the name of CRP which is an inflammatory marker and just as a background inflammatory marker has been linked to the occurrence of heart disease and diabetes. So the higher the level inflammatory marker the higher the risk for developing these metabolic complications and you will see that there seems to be an ethnic difference in the level of CRPs across the different ethnic groups with that Asian group having the lowest level of CRP. So this is just to point out that there could be differences, biologic differences that the underlying principle of what a CRP does is still true and the same across different groups, but just like BMI and abdominal circumferences the cut off defining what's normal or abnormal may be very ethnically dependent.

Slide 13 - Islet Cell Auto-antibodies in Asians with Type 1 DM in Singapore

Now I will give you another very important and shocking example here. Now you know there are two different types of diabetes, there is type 1 and type 2. Type 1 often is described as an autoimmune disease. It's a condition where the body's immune system recognizes the pancreas is something foreign and therefore launches a destructive process to basically stop the production of insulin. One of the hallmarks of that autoimmunity or that defensive mechanism is the presence of something called antibody. These are tests that physicians can order to confirm the presence of these self-directed attacks on bone, tissues and cells. So without going into the details, this is one of the tools that physicians commonly use to make sure that somebody has type 1 diabetes. If you were to measure the three markers and you will see in the chart on the left hand side there are GADab antibody IA-2ab antibody and insulin antibodies and so on and so

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forth these kinds of antibodies if they're present it's highly, highly correlated to an autoimmune process. Now, so why did I just go over a very complicated situation? Well this is to illustrate that among the Caucasian population if you look at the antibodies together, if you draw a panel about 90 percent 85 to 90 percent of all the Caucasians with true type 1 diabetes would have a positive antibody panel, but if you look at the numbers here under type 1 under Chinese, type 1 under Indian, type 1 under Malay the numbers are very low, in fact less than 50 percent. Now this is not really common knowledge in medicine. A lot of people believe that antibody is very predictive and very few people, actually practicing physicians are aware that there are ethnic differences to the reliability of these tests. So that's just really to give you an angle to why appreciating these ethnic differences in biology is very important to making us a competent physician or healthcare providers.

Slide 14 – Poll

So let's move on to the next section really talking a little bit about the cultural aspects. So the question is which of the following statements are true? Race and ethnicity are the same. A person can only belong to one race. Race equals social, ethnicity equals biological or that ethnicity is independent of race. So please cast your vote. All right, counting down, three more seconds.

Slide 15 – Poll Results

Okay, let's skip to results and let's look at the results and most people have the right answer that ethnicity is independent of race. So let's talk a little bit about this.

Slide 16 - Ethnicity vs. Race

So a lot of people when they talk about diabetes they think about race, because after all earlier I've been talking about Hispanics, Asians and Caucasians and so on and so forth, but when it comes to diabetes care ethnicity may be even more important. What is ethnicity? Here we said that ethnicity refers to self-identifying groups based on beliefs concerning shared culture and history. It's often rooted more in the idea of social grouping rather than on biology. Culture shapes lifestyle. That's why it's so important for diabetes care and that as health care providers we should not see culture as a barrier, because whenever we talk about culture we always say oh there are culture barriers. In contrast as health care providers we should leverage culture in helping our patients.

Slide 17 – Impact of Language Barriers in Chinese Americans with Diabetes

Now a few years ago we did a study looking at a very important part of culture which is language and how that plays out in diabetes knowledge and care. So we did the study in different community hall centers where providers actually spoke the same language as the patient. We took a survey looking at the knowledge base of those who prefer to speak English compared to their knowledge level and compared to the group of individuals in terms of their diabetes knowledge and this group belonged to those who prefer to speak Chinese. You will see that by preferring to speak English it gives superiority just in terms of their diabetes knowledge. So this study sheds the light that by living in linguistic isolation or even sort of as a degree of

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culturation that those who are not in the mainstream culture, speaking mainstream language here in the U.S. are probably at a disadvantage when it comes to diabetes knowledge. We also have the data that says they tend to be, they tend to have a worse or higher A1C level as well. That just goes to show you a lot of times and in fact most times health disparities may have a strong social determinant as a root for the cause rather than simply biological roots.

Slide 18 - Culture Is More Than Just Ethnicity

So to explore this idea of culture a little bit more here on the right I've listed a number of characteristics that's part of our culture. Everybody's got a culture and so as a health care provider it's so important for us to understand not only the behavior which we always emphasize, eat less, exercise more, monitor blood glucose more, take more insulin, but unless we address the cultural aspect and their deep thinking their deep philosophy about life we will not be affected.

Slide 19 – Pyramid Slide

So let me explain. This is a picture of sort of what really drives behavior in our patients. So on the tip of the iceberg is behavior, right? This is where we see they're not exercising, they're not doing what we want them to do, but underneath that, is a set value system that truly drives the behaviors and it's a world view on how they view disease that impacts their value system and therefore impacts their behavior.

Slide 20 – A Patient story

So I'm going to tell you using one example to show you about this frame of thinking. So I remember maybe about five or six years ago I had a patient who came into the office and she was 18 years old. It's a woman who was just recently diagnosed with type 1 diabetes. As you might know the type 1 is actually relatively rare in the Asian American population. Type 2 is rampant; type 1 is actually very low, so she felt entirely alone dealing with this diagnosis. None of her friends have this and so when I told her that she needed to take insulin to survive, this is her survival medicine she met with that invitation with such strong opposition. As a physician trying to comfort her I asked her to bring her family along so we could all talk about this together. I remember the next visit the mother came by and she would hold my hand and the mother actually cried in the room and said "Dr. Hsu please, please don't start my daughter on insulin." I said, "But she needs this to survive," but the mother said doctor you don't understand. If you start her on insulin she will never get married. Now you can imagine this lady, not only was diagnosed with an incurable condition but now she's just been told that no one would ever love her, would ever take her to be a wife. So if you go back to our earlier slide you'll see if she believes, her world view of disease like diabetes that is a shameful disease, if her view on complications of diabetes, on diagnosis one that comes from let's say a result from something that she didn't do right in the past, maybe is a declaration of her sin, of course she's going to feel very embarrassed and shameful about having this diagnosis. That value system is going to drive her behavior, what the behavior's going to be. She is not going to take her insulin in public. She's not going to tell her friends, her teachers, her co-workers that she has diabetes. She is not going to monitor her blood glucose in public. This is why simply addressing the issue of why

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are you not doing this? Why are you not taking your medicine? Why are you not monitoring your blood glucose can be futile without truly understanding the values behind the behavior and perhaps even deeper. What is the world view about disease? What's the explanatory model that she's using to understand her diabetes?

Slide 21 - Implications in Clinical Intervention and Diabetes Education

So let's move on. If you see patient behavior in this light then there is truly no such thing as non-compliance. People do not take their medicine for a reason. They may think that western medicine is too strong. They may think that this injectable is not good for them. They might think that giving blood, doctors are always checking blood. Blood is so important. If you draw it out of me I'm going to get weak. You know people's values dictate their behavior. Most patients are entirely consistent, their values and their behaviors so the key is to understand how they understand diabetes and try to address your treatment accordingly.

Slide 22 – Culturally Appropriate Treatments

So let me give you maybe in the interest of time maybe just two examples. You know a lot has been said about patients, Asian patients, always quiet, non-confrontational and it could be true, especially when you're providing care for a patient that does not speak your language or you don't speak their language. A lot of times our Asian patients appear to be agreeable to treatment plan and so that's in the first box right here. In fact some of the communication may be lost in translation. That's why they're just being agreeable. That's part of in their culture not to challenge, not to confront but that information may be lost in translation. So what is potentially a culturally-competent way for a physician to do is to ask the patient always to repeat back what his or her treatment plan is, even through an interpreter. This will assure that he or she truly was able to understand and retain the information that was discussed. Let me go through another example, our last example here. Let's say here's another example where a patient might report a lot of trouble with sleep and eating difficulties, loss of energy and you may think well that sounds like depression but they may not use that term. A lot of the patients might believe it's just part of the difficulties in life. Yes I do feel sad, but yes I'm not sleeping well but you know to refer me to see a psychological counselor, a social worker or psychiatrist you probably will meet a lot of resistance. So the issue is that the patient will not generally agree to be seeking psychological help because of the shame and stigma of being diagnosed with a psychiatric or a psychological disorder. As a provider's primary care doctor a lot of times there's no way for you to convince them to take medicines or to see a mental health worker. You might need to refrain this psychological service part of the medical treatment. There are many different examples, many different ways a health care provider can adapt to the situation, to the needs of the patient.

Slide 23 – What is Cultural Competency?

So my last slide, so if you think about all these approaches what is truly cultural competency? You might ask is it knowledge? Is it to know that people, a lot of Asian Americans develop diabetes when BMI is less than 24, is that really the key? Is knowing really the key? Well some will argue yes you might know, but if your attitude is not right, if you don't have an attitude of openness and attitude of respect, an attitude willing to listen to the patient, you might have all the

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knowledge in the world and you still would not cross that gap, make that connection. Is it all knowledge, is it all attitude but perhaps it's a skill. For example we say if the patient appears agreeable the skill of your patient of your professionalism my call to you to say you know what, I'm not so sure. So why don't I just politely ask the patient to repeat back the instructions or the agreement of the treatment plan? So that's an adaptation of the knowledge you already know and you're applying to a certain situation. I would just conclude by saying you know with these years of caring for many Asian patients I feel that there is a universal language of care and that is truly the care of and that's really the language of compassion. As providers if we can arm ourselves with great knowledge, with open attitude and adapting our skills and also always speak the language of love and compassion it may not matter so much if we don't know the specifics of a culture and so on and so forth. So with that I would like to close and I'm sure that later on we'll have other opportunities at the end of the program for some questions and answers, so thank you.

Slide 24 – Cultural Competency:
Insights When Serving Native Hawaiians and Pacific Islander (NHPI) Patients

Moderator: Okay, thank you very much Will. Now I would like to introduce our next speaker Nia Aitaoto. She is a fellow and just completed her Ph.D. at the University of Iowa College of Public Health. She has over 15 year of experience in the health and education field focusing on cancer awareness, diabetes awareness and prevention, cultural-competency training and tobacco related initiatives. She also is an advisor to two regional coalitions in the Pacific, the Pacific Chronic Disease Coalition and the Pacific Partnership for Tobacco Free Island. She specializes in providing technical assistance, data assessment, and support to community groups in Hawaii, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, the Republic of Palau and the Republic of the Marshall Islands. So please welcome Nia Aitaoto.

Slide 25 – Educational Objectives

Dr. Aitaoto: Thank you Jude. Aloha to everyone. Here are my education objectives

Slide 26 – Presentation Outline

... and on my presentation outline I'm going to start out very broadly and then I'm going to go into communication tips.

Slide 27 – Race and Ethnicity

First of all we talked about race and ethnicity and under the umbrella of Pacific Islanders we have three racial groups and underneath each racial group there are multiple ethnicities. We're

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very familiar here in the U.S. with Polynesians like Hawaiians and Samoans and with recent migration of Micronesians here, especially in my state of Iowa. We have a large population of Micronesian and Samoans and Marshallese and Polonaise here, but then we also have other Pacific Islanders from Melanesia.

Slide 28 – Map

Within our context this is our home land. As you can see the Polynesian triangle, that's the largest group of islands and then up north is Micronesia and then underneath that in the south is Melanesia. It's a large area just for the USATI area Pacific Islands is the size of three continental U.S. and for the whole we're part of this huge ocean so it's very hard geographically to reach all these different islands.

Slide 29 – Homelands & U.S. Affiliations

Even our affiliations I think in the past couple of weeks you know you hear a lot of talk about the Affordable Care Act and also Immigration Reform. If you really look at it some of our affiliations, some of our islands have close affiliations with the U.S. For example, for Native Hawaiians our home land is the state of Hawaii. The U.S. also has two territories, the territory of Guam and then American Samoa. Under the United Nations they consider these two territories as colonies of the U.S. We also have a common wealth and then free, freely associated space.

Slide 30 – Poll

So my question is what is the prevalence of diabetes among Native Hawaiians Pacific Islanders in the U.S.? [PAUSE]

Slide 31 – Poll Results

Wow, look at the results, [PAUSE] still going. Most of you got it right. The prevalence rate is about 20.6 percent

Slide 32 – Burden of Diabetes 1

... and for Native Hawaiians Pacific Islanders living in the U.S. they're six times more likely to die from diabetes complications than whites.

Slide 33 – Burden of Diabetes 2

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For my region in the Pacific the burden is actually larger. It ranges from 11 percent in Guam to 47 percent in American Samoa. That is extremely high compared to 8 percent in the United States.

Slide 34 – Forbes World Weight Rank

If you look at some of the risk factors which is obesity eight of the top ten most of these countries in the world are in the region of the Pacific. The only other two that are not there are Kuwait and the U.S. but if you count the U.S. territories like Guam and American Samoa then all of the top ten, most of these countries or jurisdictions in the world will be in that region in the Pacific.

Slide 35 – Cultural Literacy

Today's talk will focus mostly on cultural literacy and this is a very important topic for especially Pacific Islanders because of our cultural identity and beliefs. Although there are not a lot of information about Native Hawaiian Pacific Islanders and cultural beliefs in diabetes there's enough evidence to show that if we consider culture, our language, our beliefs and our systems, our cultural systems like our families and our churches there is a strong evidence to show that culture actually plays a huge role in improving diabetes outcome for Pacific Islanders. A lot of those studies actually come out of New Zealand and ...

Slide 36 – Help seeking Behaviors

....Australia, so here in the U.S. we're kind lacking but in the last two years we've conducted studies here so this is a new area. I know the folks at University of Hawaii started many studies for Native Hawaiians but for us Pacific Islanders we have not started all of these studies on compliance, especially western medicine compliance. So two years ago we started a study, we actually started looking at this patient centered model. You know what I mean? With the whole Affordable Care Act you know people talk about this patient-to-home or patient centered but what does that mean for the patient? We actually conducted focus groups and interviews with 150 Native Hawaiian Pacific Island patients who tell us what does that mean to them. Where do they seek health for treatment or anything that ails them and the finding was very revealing. The narratives were around four different types of healing, so we all know the first type which is the western healing type and the healer or advisor is a doctor, they usually say a doctor or a nurse and the treatment is pills, insulin and dialysis. This is specifically for diabetes. They focus they say that for western medicine we focus mostly on the body. We have a large group of people that actually follow a traditional type of healing that is our traditional healing. The healer type is traditional type is traditional healers and the treatment are plant based and based on traditional knowledge, but the focus there is the spirit, primary focus and secondary focus is mind and the

body. Now compare that to the third type of healing that we seek we call that local healers. So it's kind of like it's the same thing as traditional healers, but for traditional healing we focus on the spirit because there's a lot of spiritual beliefs that are tied into traditional healing, but with Christianity in the Pacific many Pacific Islanders do not consider the "real traditional healing" as appropriate, because the spiritual is outside of the Christian beliefs. Pacific Islanders in most of our research say that they still believe the plants, at least they work and they also like the emotional support. So they kind differentiate between traditional healing and local healing on the spiritual side, so they still seek after the new type of traditional healer and now they call them local healers. They use the same kind of plant based product and then on top of that they also use new type of plant based products. For example, a lot our Pacific Islanders now, especially in the [inaudible] area, the Marshalls and Pushi they use Ampalaya. That is actually a plant from the Philippines. You know they use that as cure for diabetes. So that is what we call local healing, because that was not a plant based knowledge that we had from the beginning and the primary focus of local healing is now back to the body. However they do believe that they do have a secondary focus which is the mind and the spirit. Mind is usually information and also emotional support and then we also have this new type of healing. Interesting enough this is the healer or the advisors are your family and friends. They used plant based from other cultures like Ampalaya, but they also use non-plant based. So in Pacific we find all these waters, these oxidized water, the other new type of healing. We also call that fad medicine because it comes and goes for the past 20 years. We saw things come in and go out. For example the oil, the oxidized water, there's now a bracelet that you wear, all of those. That's another type of healing that they're seeking, and of course they say that focus is on the body and then they also are getting mind and spiritual support so a lot of emotional support from these healers. If you really look at this, if you look at the western model it just focuses mainly on the body, but the other three they really like the idea of emotional support and also spiritual support. I just want to say that in the survey 98 percent of Pacific Islanders actually are Christians and they also have strong spiritual beliefs and they believe that spirituality is closely linked to our health.

Slide 37 – Pathways to Compliance

That is the reason why we decided to do another study and looking at this pathway to compliance and non-compliance. So in this study we really look at compliance to western medicine we look at the other group to see that their compliance is for a different type of healing, but we want to find out what makes them comply to western medicine and not just medicine for diabetes but also comply to nutrition recommendations and also physical activity recommendations. So there were five different narratives that came out of that study and the first narrative is actually the most popular one. They do believe that diabetes is part of their lifestyle you know by the type of food that they eat and lack of physical activity, but in the context now it's important for us to look at beliefs but also in the context where that belief is at. So in the context they said there's no support. The do not have a lot of support for medication adherence, physical activity and nutrition, so as a result they talk a lot about emotion. I mean that was the most shocking thing to

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me during the study is that they take a lot of time to describe what their emotional reaction to diabetes and diabetes treatment. So from that first group they talk about shame, that they cannot control their diabetes and a lot of denial so a lot of them deal with it were saying that well some say shameful but others are well it's not going to happen to me or I'm not going to get sick. Then a lot of [inaudible] additional hope, and then it's not going to happen, deny so all those three, attitude, emotion came up over and over again in that group and at the end they're not compliant to any of the recommendations. The third group, the second to the fourth group always talk about God's will. Again, like the first set of subjects this group actually talks about spirituality, because this group believes they believe diabetes is part of God's will and then this is God's global will saying that God actually gave me this disease and I need to live with it. Of course they do not receive any support for diabetes, but at the same time the locus of control is actually outside of themselves so their reaction to it is very passive. There's nothing they can do about it, denial and there's a lot of sadness. People talk about it is sad to have diabetes, but there's nothing they can do about it, of course no compliance. Third group they say it is God's will but it's also genetics, but the same kind of emotional reaction, passive, denial and then sadness and then no compliance. The fourth group talks about God's will, but they said God has a global will for our lives; however it's also our lifestyle. God also gave us a will to choose, you know what I mean, gave us a freedom to choose how to live our lives. So this group talks a lot more about repentance and they believe that it is actually going against God's will to live an unhealthy lifestyle and all that kind of stuff and we need to actually move into repentance and they really need to repent. Then from that repentance you will actually be lead to hope and this is actually the only group that actually reported that they are actually complying to physical activity, nutrition and medication compliance, but if you really look at it it's just a minority of the group. This is very few of the 150 that actually follow this pathway. The last pathway is that you know a lot of time we don't talk about this in the Pacific, but it's still a group of people that still believe in spirits other than God's will. There are other evil spirits out there that is causing things for them. For example, I hear people say something like well my mother has diabetes and I did not go home and take care of her and then she passed away so she gave me this disease so it's that kind of spirit. Then of course the context is no resources, but instead of change now in the hope and passiveness their emotional reaction is fear and the compliance is low. I think the most important thing that came out of these studies is that we really need especially now we talk a lot about motivational interviewing and motivation actually emotion. So if you really need to look at motivational interview we really need to look at these emotions. It's very different for you to actually motivate somebody who has fear, somebody who is at sadness and denial and all that kind of stuff. So this study actually will help us understand more of the emotional part of Pacific Islanders, but also our disease ideology because we really need to especially such a large group of people believing not only God's global will for your life, but also God's specific will for them to have diabetes. Then we actually went out and actually interviewed faith leaders, because from the focus groups participants say that the people that can actually influence their thinking when it comes to spiritual matters are not physicians and not nurses. That is actually the responsibility of faith leaders, so we really need to engage faith leaders to actually look at this disease ideology and believe in that context so it was very, very interesting that they actually

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identify faith leaders as a very important part of your care team. A lot of the health care providers and community health centers and hospitals we have all these care teams to address diabetes and none of them have faith leaders or even consider having faith as part of their team.

Slide 38 – Key Pacific Cultural Concepts

So then we move on to some of the key Pacific culture concepts, doing those research and then going off the big picture now. You know family structure is important to the Pacific especially if you're working with your patient. Make sure that you involve the entire family. A lot of the Pacific Islanders follow a major familial line. For example, women are very influential not only in decision making but they're also caregivers, respect for the elders and then the most important part there is a collectivistic culture. Many times people cannot control their diabetes because it's part of a group. In one of the focus groups that they we did the food that they eat is actually influenced by what other people are eating, because we eat a lot of meals together and it's important for us to cultivate relationships. After a talk like this or culture competency training allows the health care providers come up to me like wow now knowing all this spiritual stuff, "Where can I start?" I think a good place to start is to cultivate that relationship with your patient with good communication and I'll go over some of my communication tips. Also, keep in mind you have to do all this in the context of spirit, mind and the body.

Slide 39 – Communication Tips

So for communications tips during all these focus groups and 15 years of trying to hone into some of our communication skills, we came up with a long tips' list and these are some of it. The first thing is that say the encouraging first and last so if you're giving instructions stay what is written first just in case we tune out but repeat it at the end, because in our narrative in our [inaudible] in the Pacific those are the two times that we kind of like wake up and listen in. Repetition is okay. In a lot of cultures when you repeat things they're like am I stupid, why are you repeating yourself, but in our culture repetition is very, very important. For example, for Native Hawaiians all of our songs last verse is whatever [inaudible], let's tell the story again. Repetition, that's how important repetition is in our culture. Third is do not yell. A lot of times we do not understand English; that doesn't mean we're deaf so yelling was thing where focus group members saying tell our doctors not to yell at us and write things down. A lot of times if it's in English you write it down and give it to them, because there's somebody at home that can translate it and help. I think Dr. Hsu talked about this learner verification of repeating. Another point is to not use jargon, slang or idioms. A lot of times you have a hard time with all these idioms or sayings in the U.S. that we depend on all the time. Speak clearly and emphasize the last couple of letters. English as a second language and if you're learning English you kind of see and pay attention to words and especially the last couple of letters, because that's how you differentiate the two different words so it's part of a tip that's very important. Then most importantly we need to mind the gaps. So mind the gaps by culture you know a lot of the

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western culture in a conversation we kind of like finish each other sentence and it's a ping pong and goes back and forth very quickly, but there are some cultures that there has to be a gap between a question and an answer. I find that for westerners they're very uncomfortable with that gap, especially when that patient is not answer you quickly. Then you actually continue on or answer your own question without waiting. For our culture many of the Pacific culture we need that gap. We are going to eventually answer your question, but you need to give us enough time for us, because there is a gap in our culture that needs to be respected.

Slide 40 – Non-verbal Communication

Also remember that there are non-verbal communications. You know for example be cautious about touching and in eye contact and also pay attention to your patient or client's facial expression, body language and tone. Tone is very important. A lot of times [inaudible] tone it's just your tone of voice, we all have different tones. In the Pacific there is. We pay attention to a lot about tone. Patients talk about that person was harsh and then when we review the transcript there was no harsh words in there, but the tone was kind of harsh, so pay attention to that.

Slide 41 – Use of Interpreters

We do not have a lot of time. I'm going to skip this one, because we only have one minute left. For interpreters, you know a lot of times we all use most of our [inaudible] interpreters in our practice. For our Pacific culture older is better. If you're a younger interpreter there are a lot of things you cannot say to your elder. For gender same is better. There's a lot of stuff women cannot say to men and vice versa. Also keep in mind confidentiality and privacy. We're from a very small community and it's very hard to find interpreters that actually do not know each other so you have to make sure you tell your interpreter that confidentiality is very, very important.

Slide 42 – Technology and Science Literacy

Another thing you have to consider is technology and science literacy. Within a definition of health literacy there's actually a part there that talks about technology and science literacy. So for that many times us who grew up in the U.S. we're used to taking health classes. All this technology was around us, you know what our clinic looked like and all that kind of stuff, but what if you did not grow up in that environment, you're not familiar with all these scientific terms and equipment and things like that?

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Slide 43 – Tips!

So the tip here is take time to provide health education and define health or scientific terms. Many times we take it for granted that we understand all terminology so for your Pacific Islander patients ask them if they understand and just go ahead and just define them so you all can be on the same level. Recognize or apologize for using sensitive words and most times you don't know what's sensitive and not sensitive, so many times in the beginning I always ask our health care providers just say something, I'm going to say some stuff that might be sensitive so I'm sorry. I'm just saying that to explain things better and remove uncertainty by explaining procedures step by step. A lot of times there's a lot fear and it's a fear of uncertainty. So if you explain the procedure and what you're going to do step by step that will remove some of that. Then finally tell patients what to expect and that is also removing uncertainty, because sometimes if you know what to expect then that will remove some of the fear and it relaxes the patient a lot more. I think that's all the time that I have.

Slide 44 – Thank You

Thank you so much and we're going to move this one to Jude.

Slide 45 – Culturally-competent Health Provider Communication -- Summary

Moderator: Okay, wow, thank you, thank you to both of you. I just want to give you a very quick summary. I looked at some of the literature on cultural competency in health communications for health care providers and essentially you can see that there are number of issues that both Dr. Hsu and Dr. Aitaoto brought up. So to answer the questions that Dr. Hsu answered at the end the answers are yes, you need awareness of the disease in that group and he gave you many examples of that. You need to have knowledge of core cultural issues, but also of the social context and how the person sees themselves in that social context, the value systems that most Nia and Will talked about. You do need skills. There are communication skills, cultural competencies in building the relationship, in gathering information, in gathering history and assessing what the problem is, and particularly if you're working with someone who doesn't speak the language well. Then also the ability to in the situation perceive different queues and adapt to them, so if you can see that someone is looking uncomfortable being able to deal with that and identify is it that they don't understand, is it that they don't agree, are you making some big cultural mistakes?

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Slide 46 – NDEP’s AANHPI Resources

I just want to let you know before we go to the questions that the Asian American, Native Hawaiian and Pacific Islander stakeholder group at NDEP did compile all the resources that we have for these populations, in-language, tailored and those that they identified as relevant to these populations. You can get in touch with me or go on the website to access these, because it pulls them all together in one place.

Slide 47 – Handout of Other Resources

We also sent out with the meeting notice, but also can send out later on handouts of some other resources related to cultural competence diabetes in AANHPI populations and other diabetes education resources for AANHPI populations.

Slide 48 – Questions

So now let’s move to your questions and comments and if the operator can send me to questions. Well, I can start with some of the questions that have come over on the web. I think maybe either of you could take this. We defined ethnicity but not race, so how would you define race?

Dr. Hsu: This is Will. You know race is a very interesting concept. It’s based mostly on outward appearance, the color of our skin, the color of our hair, the way our facial features shape and so on and so forth, but you know part of the reason why it’s so hard to define is in biology is actually race is a very imprecise term. Think about it. Two people in China may have vastly different genetic make-up compared to a Chinese and Caucasian. There could be more similarities between the two people from different racial groups compared to two people within the same racial group. So if that’s the case then how do you define race? That’s why while race is often self-identified and it’s characterized by specific biologic traits in the science community it’s very hard to come up with a definition. Nia, I wonder whether you have maybe a different angle looking at this.

Dr. Aitaoto: No, actually I love your answer and for us the way that we describe it is that many times, especially with the three racial groups under Pacific Islanders it’s the same kind of thing where the racial group we don’t have the same language, but we’re very similar like if you look at Samoans, Tongans and Native Hawaiians you now physically you look at them it’s kind of the same, racial part but then ethnicity we do have Pacific language and different cultural practices. So many times like you we focus a lot more on ethnicity especially when it comes to culture so culture is a lot more on ethnicity. Of course we have like what, 80 percent stuff that we have in common, but at the same time that 20 percent is very important.

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Moderator: There was a question also and this is for you Nia about the relationship between lifestyle and repentance.

Dr. Aitaoto: Oh, that's from Ann. Hi Ann Leak. Yes, I saw that one.

Moderator: So the thing is if you have hope then when lifestyle alone doesn't work in bringing down A1C then how can you get people to take insulin?

Dr. Aitaoto: Yes, in a narrative we talk a lot about hope, but what you have your hope in. So when it comes to medication adherence, because there was a huge part of the study on western medication adherence and the groups that talk about this they say well if they have hope their hope is that God will heal them. They repent, but if the lifestyle alone is not going to do it, but God does have a will for your life to be healthy and He did produce medication and that kind of stuff so if you frame your education around hope and those kind of things then I think that group we are going to do an intervention to actually look at that to see the way that we frame our messages around hope and medication, especially insulin because it's very hard. They reported they don't want to take the medicine or needle issues and that kind of stuff so our study we focus a lot more on the narrative on hope and then also the -- that's why we needed faith leaders to actually promote medication or say something like it is part of healing to take this medicine and then move forward. So that, I mean that is a future study so I'm very excited about doing that study, but there is a group that really believes that medication is actually part of hope and part of God's will and that's actually the group that actually have a good level of A1C. Actually that was the only group that has control, their diabetes under control is that group that talks about hope and the role of medication around hope. Hopefully I helped.

Slide 49 – Presenters Contact Information

Moderator: Okay, well now please stay on the line for a minute. We have run out of time. Number one I'd like to thank Dr. William Hsu and Dr. Nia Aitaoto very much for your presentations.

Slide 50 – Additional Comments or Questions

We will be able to answer the questions that weren't answered, we'll be able to answer them individually so you will get an answer but please stay on to fill out a very short survey and if you need to get in touch with any of us, well one issue that has been brought up is yes this presentation will be available in the future. So we've been putting the contact information up, but if you have any questions please feel free to get in touch with me and thank you Nia, thank you Will and thank you for all of you for attending.

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Slide 51 – Thank you [End of webinar.]