Cultural Competence in Diabetes Care
by Shandrika Williams, PharmD, BCACP

Upon successful completion of this activity, the pharmacist should be able to:
1. Define cultural competence.
2. Identify racial and ethnic groups disproportionately affected by diabetes.
3. Describe cultural influences on health and health-related outcomes.
4. Identify barriers to culturally competent care.
5. Identify national initiatives and programs that target improving cultural competence.
6. Describe strategies for achieving cultural competence for pharmacists and pharmacy organizations.

Upon successful completion of this activity, the pharmacy technician should be able to:
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4. Identify barriers to culturally competent care.
5. Identify national initiatives and programs that target improving cultural competence.
6. Describe strategies for achieving cultural competence for pharmacy organizations.

INTRODUCTION
Diabetes affects 25.8 million people in the United States. Diabetes affects individuals from various ethnic and cultural backgrounds, but it has a disproportionate impact on minority populations. The prevalence of diabetes in adults age 20 years and older is 12.6 percent among African Americans, 11.8 percent among non-white Hispanics, and 8.4 percent among Asian Americans, compared to 7.1 percent among non-Hispanic whites. At nearly 16.1 percent, American Indians and Alaska natives have the highest age-adjusted prevalence of diabetes among all United States racial and ethnic groups. Not only is the prevalence of diabetes higher in minority populations, but they also have poorer rates of glycemic control and some minority groups have higher rates of diabetes-related complications.

Culture influences health, health beliefs, treatment decisions, and health outcomes. Therefore, cultural differences may play a role in the disproportionate impact of diabetes and diabetes-related complications in racial and ethnic minorities. It is vital that health care practitioners are aware of these cultural differences and provide culturally competent care to all patients with diabetes, especially individuals from ethnic minority groups. The provision of culturally competent health care is critical in reducing health disparities, such as those seen in diabetes.

CULTURAL COMPETENCE
Culture may influence health belief systems, health-seeking behaviors, attitudes toward health care providers, and perceptions about diseases and their causes. This makes the provision of culturally competent care vital to all health care professionals. Cultural competence is defined as “awareness of and sensitivity to cultural differences; knowledge of cultural values, beliefs, and behaviors; and skill in working with culturally diverse populations.” Cultural competency allows for individualization of care, ensuring that care is tailored to the needs of each patient.

Having a general understanding of the meaning of cultural competence and related terms (culture, race, and ethnicity) is important in the provision of culturally competent care. Culture is defined as the “integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs,
values, and institutions of racial, ethnic, religious, or social groups." It is important to understand that the terms culture, race, and ethnicity do not share the same meaning. Race is “a socially defined category that artificially divides people into groups on the basis of distinct physical traits and characteristics.” The term ethnicity represents "social groups with a shared history, sense of identity, geography, and cultural roots regardless of racial difference." People often equate culture with race or ethnicity, but the above definitions highlight the fact that individuals of the same race or ethnicity may not necessarily share the same culture. Additionally, even individuals of the same culture may not necessarily think and act alike. Thus, it is important to recognize that each patient is different and that it is inappropriate to universally apply cultural norms to all patients of similar cultural backgrounds.

CULTURAL INFLUENCES ON HEALTH

Language Barriers
The inability to communicate in the same language is major barrier to effective patient care. Language barriers may limit a patient’s ability to ask questions and express important issues and concerns. It may also result in miscommunication, poor patient understanding of instructions, and less recall of information. Thus, language barriers may make it difficult for patients to understand instructions provided during disease management education, such as the proper use of medications and medical devices (such as glucometers, insulin pen devices, and insulin syringes) and nutrition and exercise recommendations. This may limit a patient’s ability to effectively employ self-management strategies necessary for attaining and maintaining glycemic control in diabetes.

Health Beliefs
Beliefs about health and illness vary across different cultures. Culture-specific beliefs about diseases, disease origins, and treatments can impact health, health behaviors and outcomes. For example, one study assessing African American beliefs about diabetes found that the patients commonly associated “eating too much sugar” with the development of diabetes, but did not perceive weight and physical activity as contributing factors. As a result, these individuals may focus diabetes self-management efforts on reducing the consumption of sugary foods without incorporating physical activity or weight loss efforts such as reducing daily caloric intake. Other beliefs regarding the origins of diabetes include heredity, stress, emotional instability, or an acute episode of fear or anxiety. Knowledge of a patient’s health beliefs allows the health care provider to tailor disease education to dispel any myths and address health beliefs that may hinder progress towards reaching disease management goals.

Religious Beliefs
Religion and spirituality are deeply rooted within many cultures. Religion influences many aspects of daily life including health-related practices. For example, many cultures believe in the power of prayer and that praying for a cure will rid the body any disease. As a result, some patients may be unwilling to take prescribed medications and some may incorporate prayer into the medication regimen. One example of how religious beliefs may impact diabetes care in particular is fasting. Many faiths incorporate fasting; Islam is noteworthy because of Ramadan, the ninth month of the Islamic calendar year. During this month, Muslims fast from dawn until sunset. For Muslims with diabetes, especially patients with a new diagnosis and those on insulin or sulfonylureas, this is likely to result in episodes of hypoglycemia. Providing culturally competent care to patients with diabetes may require asking about fasting (whether religious or not) and adjustment of treatment regimens during the fast.

Alternative Medicines
The use of alternative medicine is seen in most cultures. Many patients with diabetes use a combination of alternative and traditional medicine. Herbal medicine is one of the most common forms of alternative medicine used by patients with diabetes. Patients should use herbal medicines with caution. While many of these medicines may aid in lowering blood glucose levels, they are associated with adverse effects and may interact with prescrip-
tion medications. Therefore, it is important for pharmacists and other health care providers to ask patients about their use of, adherence to and commitment to using alternative medicine. Other common forms of alternative medicine include yoga, relaxation, acupuncture, ayurveda, energy healing, Reiki therapy, hypnosis, and massage.

**Food and Nutritional Preferences**

Food and nutritional preferences vary across different cultures. One commonality among most cultures is the fact that food is typically the center of family and social interaction. Because nutrition is a key component in the management of diabetes, changes in dietary practices are often necessary for the patient with diabetes. But altering one’s nutritional practices is often difficult because it may affect the entire family. Family members may be unwilling to make dietary changes to accommodate the needs of the family member with diabetes. Another challenge to adopting appropriate dietary changes is the fact that health care providers may not be familiar with the nutritional practices of the populations that they serve. Thus, patients often receive nutritional education and information nonspecific to their culture.

**Family Ties**

In most cultures, family members are often directly involved in disease management activities. Among many patients with diabetes, family members are often involved in preparing meals, administering medications, and blood glucose monitoring. Thus, it is important that those directly involved in a patient’s care are present during doctor visits and diabetes education sessions. In some cultures, patients have to consult with several family members before making health-related decisions. Therefore one or more family members are often present with a patient at doctor visits. Health care providers should embrace the presence of family members as they are often an important component of patient self-management.

**Health Literacy**

Limited health literacy is common in patients with diabetes. Multiple cultural factors contribute to health literacy issues among ethnic minorities with diabetes. Health literacy is discussed in greater detail below.

**Socioeconomic Status**

Multiple socioeconomic factors are associated with the development of diabetes and adverse diabetes-related outcomes. Low income is associated with higher rates of type 2 diabetes and diabetes-related complications. Research has shown that having less than a high school education or having a family income below poverty level is associated with higher rates of diabetes-related mortality. The 2011 U.S. Census Bureau poverty threshold for a couple age 65 years or older was $13,609, and $23,021 for a household of four. Some of these findings may in part be due to the fact that individuals of low socioeconomic status often don’t have health insurance and have limited access to health care. Access to health care is broader than being within walking distance, or driving distance for patients. In addition to proximity, it must be affordable, effective, and physically accessible. Health care providers should consider a patient’s socioeconomic status when conducting health assessments and developing therapeutic regimens.

**BARRIERS TO CULTURALLY COMPETENT CARE**

Barriers to culturally competent care include those stemming from health care practitioners and health care systems. Certain health-related beliefs possessed by some practitioners and other health care workers may hinder effective patient care. Table 1 provides examples of values

<table>
<thead>
<tr>
<th>Table 1. Practitioner Beliefs That Hinder Culturally Competent Care</th>
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<tr>
<td>• Patients who do not practice healthy behaviors “don’t care about their health.”</td>
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<tr>
<td>• Personal health is the most important priority for each family member.</td>
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<td>• Biomedicine is “right.”</td>
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<td>• Science is the only appropriate basis for practice.</td>
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<td>• Traditional beliefs should be changed rather than built upon.</td>
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<tr>
<td>• People should and will follow directions given by health care practitioners.</td>
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<tr>
<td>• Adherence failure is a patient problem.</td>
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<tr>
<td>• Health care is available and accessible to all.</td>
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or beliefs that may hinder culturally competent care. When the social and cultural differences between patients and practitioners are not fully understood and accepted, the practitioner may engage in stereotyping, which can result in inappropriate behavior and decision-making. This may lead to poor patient satisfaction, lack of adherence, and ultimately poorer health outcomes.

Examples of health care systems barriers include lack of health care facilities in minority neighborhoods, a lack of knowledge of available health services among minorities, lack of multilingual staff or professional interpreters, lack of health education materials in patients’ preferred language, and lack of health insurance and prescription drug coverage among minority populations. Strategies for pharmacists, pharmacy technicians, and pharmacy organizations to target the above-mentioned and other barriers to culturally competent care are described as follows.

### PHARMACISTS AND CULTURALLY COMPETENT DIABETES CARE
The American College of Clinical Pharmacists (ACCP) has outlined seven steps for providing more effective culturally competent care for pharmacists and pharmacy technicians. These strategies may be employed to improve the provision of culturally competent care in patients with diabetes.

#### STEP 1: ASSESS CULTURAL ATTITUDES AND KNOWLEDGE
The definition of cultural competence encompasses one’s attitudes, knowledge, and skills. Thus, the initial step in developing cultural competency involves completing a cultural self-assessment. It is important that pharmacists become aware of their own values and biases that may influence their delivery of health care. This involves exploring one’s own cultural background, cultural beliefs, and attitudes and reflecting on how they have shaped one’s view of self and others. This first step is crucial in developing an appreciation for other cultures and understanding how people from different cultures develop belief systems and practices. Self-assessment of organizations and health care systems is also important. Pharmacists and pharmacy technicians are encouraged to evaluate their own systems, staff, and practice settings. Various tools have been developed to assess cultural

### Table 2. Cultural Assessment Tools

**Provider Self-Assessment**

- **Cultural Competence Checklist**  
  Developed by the American Speech-Language-Hearing Association.  

- **Cultural Competence Health Care Practitioner Assessment**  
  A free online assessment developed by the National Center for Cultural Competence.  
  Available at: https://www4.georgetown.edu/uis/keybridge/keyform/form.cfm?formID=277

- **Quality and Culture Quiz**  
  A free online assessment composed of 23 true/false questions  
  Available at the Provider’s Guide to Quality and Culture Web Page: http://erc.msh.org/mainpage.cfm?file=3.0.htm&module=provider

**Organizational Assessment**

- **Cultural Competency Organizational Self Assessment (OSA) Question Bank**  
  Developed by the Organizational Self Assessment subset of the AIDS Education and Training Centers (AETC) Cultural Competence and Multicultural Care Workgroup.  
  Available at: http://www.aidsetc.org/aidsetc?page=etres-display&resource=etres-197

- **The Cultural Competence Self Assessment Protocol for Health Care Organizations and Systems**  

Websites accessed Nov. 3 2012
competence levels for individual providers and organizations. (See Table 2.)

**STEP 2: LEARN THE VIEWS OF OTHER CULTURES**
Multicultural competence cannot be achieved without learning about and understanding the views of other cultures. Pharmacists serve individuals from diverse backgrounds. Pharmacists should utilize various resources and methods to increase their knowledge of the cultural backgrounds of the people that they commonly serve. This may include talking with patients from diverse backgrounds within the community, hosting a brown bag lunch focused on cultural competency, conducting patient surveys, and utilizing Internet sites, textbooks, and culture-specific literature. Community and religious leaders and organizations are also valuable resources. They are able to provide information on community demographics, religious beliefs, and health beliefs and practices. Additional knowledge may be obtained by immersing in the community via visits to local grocery stores, religious services, and restaurants. After exploring the backgrounds of the people within the community, pharmacists can apply the knowledge gained to have more culturally sensitive and meaningful encounters with the diverse populations they serve.

**STEP 3: EFFECTIVELY COMMUNICATE WITH DIVERSE POPULATIONS**
Communication is an important component of the pharmacist-patient relationship. Research shows that barriers to effective communication may result in patient dissatisfaction, poor patient adherence, and poorer health outcomes. Because culture influences every aspect of communication, it is important that pharmacists take social and cultural factors into consideration when communicating with individual patients. Cultural factors that commonly impact communication between patients and health care practitioners include language, health literacy, and communication styles and preferences.

**Language**
Language barriers can be addressed via the use of trained interpreters. Pharmacies and pharmacy organizations may strategically hire multilingual staff, on-call staff, or utilize telephone interpreter services. Family members are often a readily available interpreter source, but trained interpreters are preferred to the use of family members as interpreters. Studies have shown that the use of interpreter services lead to higher quality communication than does translation by family members or untrained staff. Pharmacies that utilize interpreters who are not regular pharmacy employees should address patient privacy protection with a HIPAA business associate agreement. Written communication is just as important as oral communication in the delivery of patient care.

Pharmacists frequently use patient educational handouts to facilitate and enhance patient learning. Language barriers may be addressed by providing patient education materials in the patient’s native language. Pharmacists are encouraged to utilize online resources when printed educational materials are not readily available in a patient’s native language. A variety of diabetes education materials in multiple languages are available online (Table 3). Because English may be the primary language of a patient’s support system, educational materials should be provided in English and in the patient’s primary language. All materials should be evaluated for reliability and accuracy before disseminating to patients.

**Health Literacy**
Health literacy is defined as "an individual’s ability to read, understand, and use health care information to make effective health care decisions and follow instructions for treatment." This includes the ability to understand instructions on prescription drug bottles, appointment slips, patient education materials, and health care provider directions. Individuals with limited health literacy often have poor understanding of basic medical vocabulary and healthcare concepts, and basic concepts of common diseases. Poor health literacy may contribute to the disproportionate impact of diabetes-related complications among ethnic minorities. It is associated with poorer glycemic control and higher rates of diabetic retinopathy among primary care patients with type 2 diabetes. Thus, targeting health literacy is an important component of reducing health disparities in diabetes.
Assessment of a patient’s ability to read and understand health information may be done via several formal and informal methods. It is not possible to determine a patient’s health literacy level by looking at a patient’s appearance. Pharmacists may be able to informally identify patients with poor literacy by looking for specific behaviors and responses. Suggestive behaviors may include patient registration forms that are incomplete or completed inaccurately, frequently missed appointments, and noncompliance with medication regimens. Responses suggestive of difficulty reading or comprehending may include, “I forgot my glasses. I’ll read this when I get home” or, “I forgot my glasses. Can you read this to me?” Three examples of formal health literacy assessment instruments are the Rapid Estimate of Adult Literacy in Medicine (REALM), the Test of Functional Health Literacy in Adults (TOFHLA), and the diabetes specific Diabetes Numeracy Test (DNT). The REALM instrument aids in identifying patients who are unable to read and pronounce commonly used medical terms. This instrument does not assess reading comprehension. A shortened version of the REALM is available via the Agency for Healthcare Research and Quality (AHRQ) at http://www.ahrq.gov/populations/sahlsatool.htm. The TOFHLA instrument helps identify patients who are unable to comprehend medical information and instructions. The DNT instrument is designed specifically to identify patients lacking the skills needed for diabetes self-management. It is important to note that most health literacy assessment tools are only available in English and a few are available in Spanish. When assessing patients who speak a language other than English or Spanish, informal methods may be employed. After assessing an individual’s health literacy levels, pharmacists should apply the information gained to provide patient education that will meet the patient’s literacy needs. Health literacy self assessments may be conducted by organizations that serve individuals with low health literacy. The Pharmacy Health Literacy Assessment Tool developed by the AHRQ was designed specifically for pharmacies and pharmacy organizations. It is a three-part comprehensive assessment designed to capture the perspectives of objective auditors, pharmacy

<table>
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<tr>
<th>Table 3. Multi-Language Diabetes Education Materials Resources</th>
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<tbody>
<tr>
<td><strong>Scripps Whitters Diabetes Institute</strong></td>
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<tr>
<td>Multi-language illustrated handouts designed to educate patients about key aspects of diabetes management. Handouts are available in English, Spanish, Vietnamese, Chinese, Arabic, Somali, Lao, and Tagalog. Available at: <a href="http://www.scripps.org/services/metabolic-conditions_diabetes/patient-education_multi-language-handouts">http://www.scripps.org/services/metabolic-conditions_diabetes/patient-education_multi-language-handouts</a></td>
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<tr>
<td><strong>Ethnomed</strong></td>
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<tr>
<td>Multi-language diabetes educational materials developed at Harborview Medical Center in Seattle. Materials are available in English, Spanish, Vietnamese, Amharic, Khmer, Oromo, and Tigrinya. Available at: <a href="http://ethnomed.org/patient-education/diabetes">http://ethnomed.org/patient-education/diabetes</a></td>
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<tr>
<td><strong>Seattle &amp; King County – Department of Public Health</strong></td>
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<tr>
<td><strong>Utah Department of Health</strong></td>
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<tr>
<td>Multi-cultural diabetes education manuals developed by the Utah Department of Health Diabetes Prevention and Control Program. Materials are available in Arabic, Chinese, English, Farsi, Korean, Navajo, Portuguese, Russian, Samoan, Serbo-Croatian, Spanish, Tongan, and Vietnamese.</td>
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<tr>
<td><strong>National Diabetes Education Program</strong></td>
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Websites accessed Nov. 3, 2012
Implementation of strategies to minimize the impact of literacy issues on health and health outcomes is vital, especially if difficulty reading and understanding health information is suspected or identified. The following strategies may be used:

- Speak slowly and spend additional time with each patient.
- Use plain, nonmedical language.
- Limit the amount of information provided at each encounter.
- Show or draw pictures to enhance patient recall and understanding of difficult concepts.
- Use metaphors by comparing health concepts to ones patients may already know. (For example, you might use car maintenance as a metaphor to explain the importance of quarterly A1C tests, annual dilated eye exams and comprehensive diabetes foot examinations, and yearly flu shots to patients with diabetes.)
- Tell stories to help clearly convey health messages
- Demonstrate the use of medical devices (such as glucometers and insulin pen devices).
- Repeat key points of information
- Verify patient understanding by using “teach-back” or “show-me” techniques.
- Create and use patient-friendly written materials at the third to fifth grade reading level.

Communication Styles and Preferences

Culture greatly influences communication styles and preferences. Knowledge of the diverse cultural communication styles and preferences may enhance cross cultural pharmacist-patient interactions. The following are examples of cultural practices and communication preferences. When communicating with health care providers, Hispanics/Latinos prefer formal, respectful greetings that include the individual’s title. For example, a patient named Eduardo Munoz may be addressed as Senor Munoz. Silence during patient-provider interactions among Latinos may indicate that an individual does not agree with the health care provider’s recommendations and may be a sign that the patient will not be compliant. Some Asian and Native American populations may avoid direct eye contact because they consider it to be rude or against their religious beliefs. Thus, health care providers may consider lack of eye contact a sign of respect.

In contrast, for the African American and Caucasian patient, eye contact at the patient’s level is very important in building trust. Pharmacists can improve communication with patients by becoming more aware of the communication styles and preferences of the populations that they commonly serve. In doing so, pharmacists must keep in mind that there may be variations in communication practices and beliefs among individuals from the same cultural group.

STEP 4: DEVELOP CULTURALLY RESPONSIVE DRUG THERAPY MANAGEMENT

When designing and recommending drug therapy regimens, pharmacists should take into consideration a patient’s culture, in particular their beliefs about health and illness and the use of complementary and alternative medicine. A specific example describes a Vietnamese American woman who has uncontrolled diabetes despite the use of traditional Vietnamese herbal medicine. Rather than recommend that this patient discontinue the herbal medication that has not demonstrated efficacy in lowering blood glucose, the pharmacist could recommend that she incorporate prescription drugs into her current regimen. Of course, pharmacists should investigate the presence of drug interactions and other precautions before recommending that a patient continue an herbal medication. Patients should be informed of any safety-related issues identified with herbal medicines. Displaying an acceptance of an individual’s health beliefs and practices aids in establishing trust and may result in more effective pharmacist-patient interactions and improved adherence to treatment recommendations.

Some drugs show varying effects among different racial and ethnic groups. This may include differences in drug metabolism, clinical effectiveness, side effect pro-
files, or sensitivity. Pharmacists may recommend dosage or medication changes when racial or ethnic factors make such changes necessary.

**STEP 5: DEVELOP LINKAGES IN THE COMMUNITY**

Engaging the community is an important step in developing cultural competence. Pharmacists should develop relationships with community and religious leaders, community organizations, and traditional healers. These resources can provide insight into the health-related values, beliefs, and needs of the community. They can also provide advice about the appropriateness of diabetes education materials and pharmacy services. Pharmacists should become familiar
with local programs that offer medication assistance and transportation services and refer patients who demonstrate a need for such programs. This may aid in reducing financial burdens, and issues related to access to medications and health care that are commonly seen in racial and ethnic minorities. An additional recommendation for pharmacists is to inform local organizations about resources available at the pharmacy such as bilingual pharmacists or pharmacy technicians, interpreter services, the availability of multilingual educational materials, and patient care services such as diabetes and lipid assessments and flu shots.

**STEP 6: UNDERSTAND NATIONAL AND PROFESSIONAL INITIATIVES**

Pharmacists should be aware of national initiatives that promote the provision of culturally competent care. Several national initiatives promote improving minority health care and reducing health disparities via the provision of culturally competent care. Healthy People 2020 has several objectives that have the potential to greatly improve the health of populations in which cultural barriers impede optimal patient care:

- Improve the health literacy of the population
- Increase the proportion of persons who report that their health care providers have satisfactory communication skills
- Increase the proportion of persons who report that their health care providers always involved them in decisions about their health care as much as they wanted
- Increase the proportion of patients whose doctor recommends personalized health information resources to help them manage their health
- Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs

Another national initiative is the National Standards for Culturally and Linguistically Appropriate Services developed by the Centers for Disease Control. (See Table 4.)

### Table 5. Cultural Competence Resources

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<thead>
<tr>
<th>U.S. Department of Health and Human Services, Office of Minority Health</th>
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<tbody>
<tr>
<td>Provides guides and resources; the National Standards on Culturally and Linguistically Appropriate Services (CLAS); a list of organizations and programs; policies, initiatives, and laws; and training tools for physicians and others.</td>
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<thead>
<tr>
<th>U.S. Department of Health and Human Services, Health Resources and Services Administration</th>
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<tbody>
<tr>
<td>Provides general information on cultural and linguistic competence; resources on specific minority populations by race, ethnicity, gender, and age; information on special populations; health literacy tools; resources for clinicians; and links to training opportunities.</td>
</tr>
<tr>
<td>Website: <a href="http://www.hrsa.gov/culturalcompetence/index.html">http://www.hrsa.gov/culturalcompetence/index.html</a></td>
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<tr>
<th>U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality</th>
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<tbody>
<tr>
<td>Provides general information on cultural competency and health literacy; current initiatives; disparity reports; cultural competence guides for hospitals and managed care plans; patient surveys; cultural competence training tools; and information on current research.</td>
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<tr>
<td>Website: <a href="http://www.ahrq.gov/browse/hlitix.htm">http://www.ahrq.gov/browse/hlitix.htm</a></td>
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<th>Kaiser Family Foundation</th>
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<tr>
<td>Provides resources related to minority health and health disparities.</td>
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<tr>
<td>Website: <a href="http://www.kff.org/minutehealth/index.cfm">http://www.kff.org/minutehealth/index.cfm</a></td>
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<th>National Center for Cultural Competence</th>
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<tbody>
<tr>
<td>Provides general information on cultural and linguistic competence; links to projects and initiatives; online curricula; self assessment tools; and access to a pool of cultural competence consultants</td>
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<tr>
<td>Website: <a href="http://nccc.georgetown.edu/">http://nccc.georgetown.edu/</a></td>
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Websites accessed Nov. 5, 2012
STEP 7: EVALUATE PROGRESS TOWARD CULTURAL COMPETENCY

Pharmacists and pharmacy organizations should periodically evaluate their progress toward cultural competency. Outcomes indicative of progress include reductions in patient misunderstandings, improved collaboration between pharmacists, pharmacy technicians, patients, and the community, and an increase in patient satisfaction. Organizational and individual cultural self-assessment tools such as those described in Table 2 may be useful in assessing progress. Patient satisfaction surveys may also be used.

CULTURAL COMPETENCE STRATEGIES FOR ORGANIZATIONS

The Centers for Disease Control (CDC) issued the National Standards for Culturally and Linguistically Appropriate Services (Table 4). These standards were developed to “respond to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner.” Although these standards are directed primarily at health care organizations, individual providers including pharmacists are encouraged to use these standards.

CULTURAL COMPETENCE RESOURCES

Pharmacists and other health care professionals can utilize various resources in their quest to learn more about other cultures and best practices for interacting with and treating patients of different cultures. Numerous cultural competence resources and tools are available online. Table 5 provides a list of selected resources.

CONCLUSION

Disparities in diabetes have been well documented over the years. Higher rates of diabetes and diabetes-related complications have been observed in African American, Asian American, Hispanics American, and American Indian populations. Cultural differences in health beliefs, language, religious beliefs, and socioeconomic status across these groups has been postulated to play a role in the disproportionate impact of diabetes. Thus, the provision of culturally competent care has emerged as a key strategy to address health disparities in diabetes.

With the ever-increasing diversity of the U.S. population, pharmacists are likely to serve more patients of different cultural backgrounds than in the past. Pharmacists and pharmacy organizations should make efforts to become familiar with the cultural practices and beliefs of the populations that they commonly serve and implement strategies such as those outlined by ACCP and the CDC to enhance the provision of culturally competent care. Implementation of such strategies has the potential to enhance patient-pharmacist communication, increase patient satisfaction, improve health related outcomes, and ultimately reduce health disparities among racial and ethnic minorities, such as those seen in diabetes.

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Editor’s Note: For the list of references used in this article, please contact America’s Pharmacist Managing Editor Chris Linville at 703-838-2680, or at chris.linville@ncpanet.org.
CONTINUING EDUCATION QUIZ

Select the correct answer.

1. Which of the following ethnic groups has the highest prevalence of diabetes in the United States?
   a. African Americans
   b. Hispanic Americans
   c. American Indians and Alaska Natives
   d. Asian Americans

2. Cultural competence is defined as:
   a. Awareness of cultural differences and skill in working with culturally diverse populations.
   b. Integrated patterns of human behavior.
   c. Socially defined categories based upon physical traits and characteristics.
   d. Social groups with a shared history, sense of identity, and geography.

3. True or False: All Asian Americans share the same culture.
   a. True
   b. False

4. Low income is associated with which of the following?
   a. A higher prevalence of diabetes
   b. A higher incidence of diabetes-related complications
   c. A higher rate of diabetes-related mortality
   d. All of the above

5. Which of the following barriers to culturally competent health care stems from health care practitioners?
   a. Lack of health care facilities in minority neighborhoods
   b. Lack of health insurance
   c. The belief that traditional herbal medications should never be incorporated into medication regimens
   d. Lack of prescription drug coverage

6. Which of the following tools was designed for assessing cultural competence levels for individual providers?
   a. Cultural Competence Checklist
   b. Cultural Competency Organizational Self-Assessment Question Bank
   c. The REALM instrument
   d. All of the above

To enter your answers, go online to www.pharmacistelink.com

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Cultural Competence in Diabetes Care
June 3, 2013 (expires June 3, 2016) • Activity Type: Knowledge-based
7. You are the new pharmacist a community pharmacy. You notice that a large number of the patients that you serve are Vietnamese Americans and learn that there is a large Vietnamese community nearby. Which of the following strategies would be useful in helping you learn about the culture of the Vietnamese American community?
   a. Complete a cultural self assessment.
   b. Take the Quality and Culture Quiz.
   c. Seek information from religious and community leaders.
   d. Ask patients within the community to complete the TOFHLA instrument.

8. Which of the following cultural factors impact patient-pharmacist communication?
   a. Health literacy
   b. Communication preference
   c. Language
   d. All of the above

9. Which of the following methods is preferred to address language barriers in health care?
   a. The use of family members as interpreters
   b. The use of trained interpreters
   c. Provide patients with written materials in their native language only instead of using oral communication.
   d. The use of untrained staff as interpreters

10. Poor health literacy has been associated with which of the following outcomes?
    a. Poorer glycemic control
    b. Improved patient compliance
    c. Increased access to health care
    d. All of the above

11. Mrs. Kay is a 42-year-old African American female with diabetes and hypertension. Last week, Mrs. Kay asked you if you had any information about diabetes and nutrition and you gave her several handouts. This week she returns to the pharmacy and you inquire about her dietary habits. Mrs. Kay seems to be having trouble making appropriate food choices despite reading the handouts that you gave her. Upon further investigation, you realize that she can read the information given, but has trouble comprehending. Which of the following health literacy assessment tools may be useful in assessing Mrs. Kay ability to comprehend the information given?
    a. Rapid Estimate of Adult Literacy in Medicine
    b. The Quality and Culture Quiz
    c. Test of Functional Health Literacy in Adults
    d. All of the above

12. Which of the following may suggest that a patient has the inability to read?
    a. Lack of eye contact
    b. The presence of family members during office visits
    c. Patient disagreement with provider recommendations
    d. Incomplete or inaccurately completed registration forms

13. You are the clinical pharmacist a community health clinic. You provide diabetes education classes twice a month. At the end of each visit, patients are asked to complete a speaker evaluation form. When given the evaluation form, one of the patients, Mr. Brown always responds by saying “I left my glasses at home. Can you read this to me?” Which of the following statements likely explains Mr. Brown’s response?
    a. The patient may be unable to read.
    b. The patient is dissatisfied with the diabetes education sessions.
    c. The patient has poor communication skills.
    d. The patient is shy.
14. Individuals from which of the following groups may consider direct eye contact to be rude?
   a. African Americans
   b. Asian Americans
   c. Hispanic Americans
   d. Caucasian American

15. Mr. Ho reports to the pharmacy to drop off his prescriptions for metformin and lisinopril. Mr. Ho is a new patient, so you ask him about his use of over-the-counter and herbal medicines. He tells you that he currently uses a traditional herbal medication to control his blood pressure. You are unfamiliar with the medication, so you search for additional information. After further investigation you learn that the medication is commonly used in Vietnamese cultures, but has not been shown to be efficacious. It has not been shown to have any major drug interactions or serious adverse effects. Which of the following recommendations is the most culturally competent recommendation for Mr. Ho?
   a. Inform Mr. Ho that the herbal medicine has no benefit and recommend that he discontinue it.
   b. Discourage Mr. Ho from using all herbal medications.
   c. Encourage Mr. Ho to incorporate the lisinopril into his current regimen for additional blood pressure control.
   d. Inform Mr. Ho that all herbal medicines are ineffective.

16. Which of the following outcomes are indicative of progress toward culturally competent care?
   a. Reduction in patient misunderstandings
   b. Improved pharmacist-patient communication
   c. Increased patient satisfaction
   d. All of the above

17. Which of the following national initiatives that target achieving cultural competence was developed primarily for health care organizations?
   a. Healthy People 2020
   b. National Standards for Culturally and Linguistically Appropriate Services
   c. National Diabetes Education Program
   d. Clear Communication: A NIH Health Literacy Initiative

18. Implementation of which of the following strategies may minimize the impact of health literacy issues on health outcomes?
   a. Using plain, nonmedical language during patient encounters
   b. Disseminating patient educational materials that are at the 10th to 12th grade reading level.
   c. Developing relationships with community and religious leaders
   d. Developing relationships with traditional healers

19. Which of the following cultural influences on health has been associated with poor patient understanding of instructions and less recall of information?
   a. Language barriers
   b. Health beliefs
   c. Religious beliefs
   d. Family ties

20. Which of the following health literacy self-assessment tools was designed specifically for pharmacies and pharmacy organizations?
   a. Test of Functional Health Literacy in Adults
   b. Diabetes Numeracy Test
   c. Rapid Estimate of Adult Literacy in Medicine
   d. Pharmacy Health Literacy Assessment Tool