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Understanding the Importance of Culturally Appropriate Patient-Provider Communication in Diabetes Self-Management

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Abstract

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MPH, Walden University, 2012

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Dissertation Submitted in Partial Fulfillment
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Doctor of Philosophy
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Abstract

According to the Centers for Disease Control and Prevention, 29.1 million people in the United States have diabetes. Among those 29.1 million people, 21 million have been diagnosed, but 8.1 million have not. Changing demographics in the United States and the prevalence of diabetes are projected to be burdens on the health care system through 2050. Guided by the social cognitive theory, the purpose of this qualitative case study was to understand the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants. Culturally based health care has unique challenges when delivering culturally appropriate diabetes care, so a focus on cultural knowledge, intercultural patient-provider communication skills, and cultural assessment were key to this case study. One pilot study was conducted to test the focus group questions with 3 diabetes providers (i.e., certified nurse diabetes educator [CDE], registered nutritionist, and dietitian) who help patients to self-manage their diabetes. The second pilot study was conducted with 5 African immigrant patients who had been diagnosed with Type 2 diabetes. The primary focus groups were conducted with 5 CDEs and 10 patients. The transcribed responses were analyzed and categorized to identify the 17 themes that emerged (9 from the CDEs and 8 from the patients). One implication for social change is that a patient-centered approach to patient-provider communication will mean better health outcomes. To ensure culturally appropriate patient-provider communication, a change in health care delivery is required to incorporate cultural constructs as part of diabetes care and education to accommodate various ethnic and racial groups.

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Dedication

I dedicate this work to my son, who was patient with me during his baseball games that I missed because I had papers and assignments to submit. My uncle, Rashid Nzito, was the role model who helped me to become the woman that I am today. He reminded me that "life can be growing pains, but looking ahead, there is always light at the end of the tunnel." My best friend, Kent Clifford Mulholland, has loved me selflessly and has shown me the value of patience. My best friends, Joyce Lizwelicha and Dr. Adeola Akindana, helped me to understand the value of the window of opportunity: They told me that when the window opens, use the opportunity wisely, and the sky will become the limit. I thank Dr Idowu Abimbola, my spiritual adviser, who always knew when something was wrong just by the tone of my voice. I would like to thank Jewru Bandeh, my professional mentor, from whom I learned to appreciate the work that we do to empower the community we serve and how the community can build individuals.

Acknowledgments

Dr. Benjamin Beatty, Committee chair

Dr. Magdeline Aagard, Committee member

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Chapter 1: Introduction to the Study

According to the 2014 National Diabetes Statistics Report from the Centers for Disease Control and Prevention (CDC), an estimated 29.1 million people in the United States have diabetes. Of this number, 21 million have been diagnosed, but 8.1 million have not (CDC, 2014). The CDC also suggested that without weight loss and exercise, up to 30% of individuals who are prediabetic will develop Type 2 diabetes within 5 years. Similarly, the World Health Organization (WHO, 2015) found that the global prevalence of diabetes in 2014 was projected to be 9% among people 18 years of age and older. The WHO also estimated that in 2012, 1.5 million deaths were attributed to diabetes. The WHO predicted that diabetes will be the seventh leading cause of death by 2030.

Dall et al. (2010) provided comprehensive estimates suggesting that the national economic burden of prediabetes and diabetes in the United States reached $218 billion in 2007. This estimate included $153 billion in higher medical costs and $65 billion in decreased productivity, heightening the urgency to understand prevention and treatment strategies to manage diabetes. Dall et al. also indicated that providing cost statistics relevant to diabetes adds valuable information that can influence policy decisions, particularly in the health care system, regarding disease prevention and management.

According to Dall et al. (2010), Type 2 diabetes is associated with abnormally high levels of glucose in the blood. The three primary types of diabetes (i.e., Type 1, Type 2, and gestational diabetes) are influenced by certain factors that include genetics, environmental influences, history of gestational diabetes, poor eating habits, diets inclusive of processed and high-fat foods, excess weight, and sedentary lifestyle or lack of physical activity (Dall et al., 2010). Therefore, the focus of this study was to understand the risk factors for Type 2 diabetes and ways to improve patient-provider communication with the African immigrant population. According to Venters and Gany (2011), as the population of African immigrants increases in the United States, the need to assess the unique challenges of acculturation (i.e., the ability to adapt to a new culture of their host country's culture) that immigrants face will increase (Okafor, Carter-Pokras, Picot, & Zhan, 2013). For example, interventions that make health care practices more culturally competent and sensitive will be needed to meet the unique challenges of new immigrants. Okafor et al. (2013) stated that with acculturation, there is a noticeably high chance that immigrants will experience poor health outcomes resulting from the challenges of preventing and treating noncommunicable diseases. One such challenge is finding ways to prevent and treat noncommunicable diseases such as diabetes, cardiovascular diseases, and hypertension resulting from acculturation; instead, most public health reports involving African immigrants have focused on communicable diseases such as HIV and tuberculosis (Venters & Gany, 2011).

Background of the Study

African immigrants represent one of the fastest growing subgroups of immigrants in the United States, with an estimated increase of 166% between 1990 and 2000 (Venters & Gany, 2011). As the number of African immigrants to the United States increases, their health care needs will have to be met by a health care system that must become more culturally competent and sensitive (CDC, 2013). The CDC (2013) indicated that immigrants arriving from different countries that have been stricken by poverty and poor health conditions present a greater risk for other health problems than native-born U.S. populations. These conditions mean that those individuals are less likely to take care of themselves, less likely to communicate effectively, and less likely to seek medical care (CDC, 2013).

Oza-Frank, Stephenson, and Venkat Narayan (2011) contended that diabetes is found more frequently among immigrants than among native-born U.S. populations. They asserted that a consistent and positive relationship between socioeconomic status (SES) and obesity has been observed as a trajectory toward developing Type 2 diabetes. In addition, Venters and Gany (2011) noted that, as many African immigrants become long-term residents of the United States, chronic diseases could emerge because of the lack of understanding of the relationship of poor eating habits and sedentary lifestyles to the development of Type 2 diabetes. In addition, researchers have hypothesized that changes in diet associated with adopting the behaviors and cultural values of the host country are the reason for the incidence of obesity and diabetes risks in African immigrants (Oza-Frank et al., 2011). Therefore, focusing on the screening, prevention, and treatment of chronic diseases becomes important to ensuring better health outcomes (Venters & Gany, 2011).

Prior to arriving in the United States, African immigrants tend to have a lower prevalence of being overweight than individuals born in the United States (Oza-Frank et al., 2011). However, this health advantage decreases with increased length of residence, which becomes evident in increased body mass index (BMI; Oza-Frank et al., 2011). The health care system uses BMI as a guide to diagnose prediabetes and diabetes (Franklin, Thanavaro, & Ellis, 2011). Franklin et al. (2011) noted that Healthy People 2020 uses BMI as a measure to decrease body weight in all primary care settings. Using BMI for all patients helps to screen and diagnose Type 2 diabetes, as well as provide formal diabetes education. A BMI less than 18.5 is considered underweight, and a BMI of 18.5 to 24.9 is considered normal (Franklin et al., 2011); however, once a BMI exceeds 29.9, the individual is considered obese. Values between 29.9 and 34.9 are considered Obesity Category I, values between 35 and 39.9 are considered Obesity Category II, and values over 40 are considered extreme obesity (Franklin et al., 2011). A BMI classification of overweight increases the risk of Type 2 diabetes, cardiovascular disease, and hypertension (Franklin et al., 2011).

More than 1 million African immigrants live in the United States (Venters & Gany, 2011). However, because the focus has been on infectious diseases in this diverse group, their health status and health care needs associated with chronic diseases have remained unexamined (Venters & Gany, 2011). As Oza-Frank et al. (2011) noted, African immigrants, in comparison to people born in the United States, have been found to develop Type 2 diabetes, but the reasons have not been fully explored. Oza-Frank et al. argued that emerging cultures with prolonged contact and length of residence in the United States have fallen victim to chronic diseases like hypertension, cardiovascular disease, and Type 2 diabetes.

Oza-Frank et al. (2011) suggested that acculturation, the process of acquiring the cultural norms of the host society, could help to explain the increased rate of chronic diseases in many immigrants. One of those diseases is Type 2 diabetes. For example, adopting different dietary habits, such as eating fast foods and foods with high levels of sodium and sugar, has been identified as one reason for increased weight gain and the risk of developing Type 2 diabetes (Oza-Frank et al., 2011). Overall, acculturation based upon length of residence in the United States has played a role in immigrants developing Type 2 diabetes (Oza-Frank et al., 2011).

Chronic diseases like Type 2 diabetes are a public health concern, particularly with changes in diet, lack of physical activity, and different health attitudes. Therefore, patient-provider communication becomes essential to improving health outcomes. From my experience, the components of this communication to improve health outcomes are patients' perspectives of their health, their participation in the decision-making process with their health care providers, and the cultural appropriateness of the health care providers' communication abilities.

In regard to immigrant health and diabetes self-management, McCloskey and Flenniken (2010) discussed the need to understand how culture affects Type 2 diabetes control and self-management. McCloskey and Flenniken described the cultural barriers that Hispanic Americans in southwestern New Mexico had to overcome in controlling diabetes. They also emphasized the importance of using community health workers, also called health promoters, in helping community members with diabetes self-management. This help was particularly important because the community health workers shared the cultural beliefs of the population and could easily incorporate the culturally appropriate principles of empowerment, self-care, and healthy behavioral change in diabetes intervention communication (McCloskey & Flenniken, 2010). McCloskey and Flenniken stated that for diabetes prevention programs for minorities to be effective, the focus has to shift from individuals to social conditions in the communities. Community health workers must identify with the social conditions in their communities to build trust and open better communication channels to enable patient decision making in regard to disease treatment plans, goals, and outcomes (McCloskey & Flenniken, 2010).

West, Cafferty, and Ledford (2013) also mentioned that provider advice is considered key to behavioral changes that ensure healthier outcomes. Conversely, Rodriguez (2013) indicated that providers are under increasing pressure to address health care problems during patient visits. For example, Rodriguez discussed the intrinsic and extrinsic motivational factors required in diabetes self-management. Intrinsic factors include attitudes, health beliefs, depression, level of diabetes knowledge, technical skills, and ethnic perspective. Extrinsic factors include financial capabilities, family support, community environment, and access to effective diabetes resources. Overall, the combination of intrinsic and extrinsic factors affecting diabetes self-management is an avenue to improving patient-provider communication and developing a trusted patient-provider relationship (Rodriguez, 2013). Rodriguez added that as patient-provider relationships mature, provider advice and treatment recommendations become more acceptable; however, providers also have to consider the patients' knowledge, attitudes, and health beliefs, all of which are intrinsic to healthier outcomes.

West et al. (2013) stated that gaining patients' perspectives to understand their cultural beliefs fosters open communication and guides patient-centered care in disease management. Along those same lines, Smith (2012) discussed the influence of cultural beliefs on Type 2 diabetes self-management using the example of English-speaking Afro-Caribbean women. In the study, Smith looked at the women's cultural beliefs and how they often conflicted with biomedical knowledge regarding diabetes self-management. For instance, some of the cultural beliefs that the participants mentioned were traditional Caribbean medicine, prayer, and faith in disease healing (Smith, 2012). The women believed that traditional and ethnic Caribbean medicine, which Smith called caraili/momordicacharantia, helped to lower blood sugar levels. At the same time, practices in prayer and faith from an ethnic perspective were customary with traditions believed to treat and heal diseases like Type 2 diabetes, high blood pressure, and other chronic conditions (Smith, 2012). The results increased the understanding of the women's perspectives about health and disease management and encouraged culturally appropriate communication (Smith, 2012).

Problem Statement

Understanding the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants is essential to ensure better health outcomes. Heisler, Bouknight, Hayward, Smith, and Kerr (2002) noted that Type 2 diabetes presents patients with overwhelming behavioral challenges because the most desired outcomes and control require a high degree of self-management. Peiris, Brown, and Cass (2008) mentioned that even though cultural appropriateness has become a core principle in health care service delivery to meet the needs of ethnic populations, these same populations face more challenges with culturally appropriate communication in managing Type 2 diabetes and gaining access to quality health care coverage.

Healthy People 2020 (as cited in Torres et al., 2004), a national health promotion and disease prevention initiative, also identified patient-provider communication as a challenge in disease management. For example, many providers take a universal approach in assessing patients and planning treatment goals. Patient assessments should be individualized to meet various challenges using culturally appropriate communication for better health outcomes (Hertzler & Hutchinson, 2000). Hertzler and Hutchinson (2000) mentioned the example of clinicians telling patients what foods and nutrition patterns to change as a universal approach that might not necessarily result in improved food behaviors.

Over the long term, universal approaches to patient assessments should not be considered useful with diverse populations. Instead, culturally appropriate patient-provider communication should be used to link patients' priorities to better health outcomes. Culturally appropriate patient-provider communication is particularly important because, as Torres et al. (2004) mentioned, the topic of health priorities often is not discussed in conversations about patient assessments of diverse populations. Because the term *health priorities* can mean one thing to patients and another to providers, I conducted this in-depth study to investigate the problem of patient-provider communication and health priorities. For instance, from the perspectives of providers, seeking medical care could be the first health priority, whereas to patients, feeding their families could be their primary health priority.

Culturally appropriate patient-provider communication becomes an important factor in patients' initial setting of goals to ensure better health outcomes. Torres et al. (2004) suggested that, to improve patient-provider communication, cultural health literacy should include images to supplement the narratives, assessments of patients' health priorities and decisions, drug labeling information, and medical compliance for better health outcomes. Schiavo (2007) added that effective communication can have a positive impact on patient compliance, particularly in regard to treatment recommendations, patient satisfaction, patient retention, and overall better health outcomes.

Lyles and Schillinger (2013) stated that engaging patients in setting goals that can contribute to better health outcomes requires communication strategies that must include assessing and incorporating the patients' beliefs, values, and desires. This protocol is important because it incorporates the patients' health status and risk factors, along with their psychological status and SES (Lyles & Schillinger, 2013). Lyles and Schillinger also mentioned that, although much of the research on patient-provider communication has focused on its influence on intermediate outcomes, with fewer studies focusing on communication strategies, effective patient-provider communication could advance understanding and knowledge, as well as improve the quality of decision making, self-efficacy, and empowerment in setting goals. Lyles and Schillinger used the example of medication adherence and diabetes self-management, factors that appear to be essential in delaying diabetes-related complications.

The problem of patient-provider communication with patients who have diabetes spans many patient populations, particularly those comprising racial and ethnic minorities. The lack of effective communication becomes a barrier to shared decision making, specifically among patients with limited English proficiency. Lyles and Schillinger (2013) raised the issue of the importance of culturally appropriate patient-provider communication for specific populations and suggested developing strategies of communication to ensure future health reform. In other words, effective patient-provider communication can contribute to future interventions that focus on verbal and written patient instructions across cultures and languages.

Purpose of the Study

The purpose of this study was to understand the link between culturally appropriate patient-provider communication and positive health outcomes to the self-management of Type 2 diabetes by patients who are African immigrants. Peiris et al. (2008) used the example of Australian Aboriginals with chronic kidney disease and stated that meeting the needs of ethnically diverse patients requires the core principle of culturally safe health care. In the discussion, Peiris et al. identified the use of culturally based components as a way to transform services into more appropriate ones that could ensure better health outcomes. Hence, the link between diabetes self-management and effective patient-provider communication becomes key in promoting shared decision making in disease management.

Similarly, Peek et al. (2012) discussed the importance of culturally appropriate patient education for African Americans and ethnic minorities with diabetes. Peek et al.

stated that the goal of empowering patients to manage their disease actively is to have communication skills tailored to culturally appropriate concepts such as sensitivity, competence, and awareness of the patients' ethnic backgrounds. Lee, O'Neill, Ihara, and Chae (2013) indicated that as the number of immigrants to the United States continues to rise, so does the consumption of fast food as a form of nutrition.

Fernandez et al. (2004) identified language and cultural barriers to health communication among non-English-speaking patients or patients with limited English proficiency as reasons for poor health outcomes. Although researchers still know little about the ways language and cultural barriers affect communication, Fernandez et al. explained that experiences with care can be negative. Fernandez et al. used Spanish-speaking patients as the example of individuals who often use interpreters to translate and that with their limited English proficiency, they often are less satisfied with their care. Therefore, as the number of racially and ethnically diverse patients increases, language interpretation services could assume a more important role in the delivery of health care to improve patient-provider communication and ensure culturally sensitive care (Fernandez et al., 2004).

Park, Chun, Betancourt, Green, and Weissman (2009) suggested that as patient populations in the United States become increasingly diverse, the need to provide care across cultures will become a decisive factor in providing or improving culturally appropriate communication skills between providers and patients. As previously noted by Lee et al. (2013), as the number of immigrants to the United States increases, this vulnerable minority population could suffer from poor health outcomes and disparities in health care if cross-cultural care is not integrated into future health practices. Therefore, the purpose of this case study was to understand the importance of culturally appropriate care and providers' communication skills by obtaining data from the interviews. The responses to the interview questions might facilitate the development of future continuing education units (CEUs) for health care providers to ensure better health outcomes.

Significance of the Study

The study is significant because it could improve health care providers' clinical competence in the areas of effective communication using culturally appropriate health literacy skills, particularly understanding patients' cultural norms and beliefs. Moreover, the American Association of Diabetes Educators (AADE, 2015) maintained that effective communication is a recommended self-management skill that leads to better health outcomes. Beverly et al. (2012) noted that despite new interventions in diabetes self-management and the emphasis on patient engagement, half of patients with diabetes continue to have hemoglobin A1c (HbA1c) levels above target goals. Beverly et al. asserted that understanding the unmet goals of patient-provider communication is important for maintaining better health outcomes. Effective communication contributes to the building of trust in patient-provider relationships and the delivery of positive health outcomes in disease management.

As Aziz (2009) remarked, two fundamental components of the patient-provider relationship are essential to the development of patients' plans of care. The first is the providers' care, skills, and knowledge; the second is the information given to patients so that they can make informed decisions (Aziz, 2009). Patient-provider relationships that are trusting and open facilitate the sharing of ideas that can become best practices for disease self-management. Therefore, effective communication and trust in patient-provider relationships are essential elements in achieving better health outcomes.

The results of this study have important implications for social change in addressing the opportunities for health care providers to explore CEUs. These CEUs can facilitate the professional development of core clinical competencies, particularly in regard to cultural health, with ethnic patients. For example, Pérez-Cuevas et al. (2000) stated that in order for providers to improve the health of patients, they need to participate in CEUs to update their skills relevant to medical practice. Therefore, I used open-ended interview questions to obtain data from the two groups. The first group comprised 10 patients, and the second group comprised five health care providers.

Research Questions

The purpose of this qualitative case study was to understand the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants. I used Bandura's (2001) social cognitive theory (SCT) to guide the interviews with the two groups mentioned earlier. The first interviewed group comprised 10 African immigrant patients with Type 2 diabetes who had been diagnosed within the last 5 years. The second group comprised five clinical health care providers, namely, certified diabetes educators (CDEs), dietitians, and nutritionists, who were directly involved in diabetes education at the time of the study. I obtained the perceptions of 10 patients about their lived experiences in communicating with their providers and how they were able to self-manage their diabetes. The five clinical providers engaged in discussions guided by open-ended questions about the ways they assessed their patients on diabetes self-management.

According to Creswell (2013), a case study methodology enables researchers to investigate single cases or multiple cases over time. Creswell also indicated that case studies involve detailed data collection protocols that have multiple sources of information through observations, interviews, and documents or reports. For this case study, I followed a structured interview format with standardized open-ended questions to ensure that all participants were asked the same questions in the same order. I prepared the questions in advance and asked them following specific guidelines:

- Using simple language that is easily understood.
- Not overloading the participants with questions that are not essential to the study.
- Including questions that are necessary to provide sufficient information to answer the research questions (RQs).

Patton (2002) stated that a case study methodology is appropriate for use with participants who have a special interest in the topic and can answer the RQs. The selected 15 participants (five providers and 10 patients) shared their perceptions of patient-provider communication based on their experiences with Type 2 diabetes self-management for better health outcomes. Having a deeper understanding might facilitate more positive health outcomes and better communication between providers and patients.

The study was guided by four RQs:

RQ1: How does patient-provider (CDEs) communication affect the self-management of Type 2 diabetes of patients who are African immigrants?

RQ2: How does patient-provider (CDEs) communication promote shared decisions in achieving the disease management goals of patients who are African immigrants?

RQ3: How does patient-provider (CDEs) communication influence the health assessment for Type 2 diabetes self-management of patients who are African immigrants?

RQ4: How does culturally appropriate communication influence the outcome of Type 2 diabetes self-management of patients who are African immigrants?

Limited research exists regarding patients' health priorities in their assessment of diabetes self-management. Understanding health priorities is critical to the diabetes self-management of patients who are African immigrants, the likelihood of positive health outcomes, and the use of skillful and culturally appropriate communication by health practitioners.

Theoretical Framework: SCT

A theoretical framework offers comprehensive information from available data sets that comprise positive and negative reviews and can be used in the data analysis (Banerjee & Chua, 2014). A theoretical framework guides the research, determines the variables, and influences the data analysis. In this study, the theoretical framework was central to understanding the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants. I used the SCT (Bandura, 2001) to determine the importance of behavioral change as a critical component of effective communication (Gálvez, Valencia, Palomino, Cataldo, & Schwingel, 2015). As Gálvez et al. (2015) mentioned, taking an individualized communication approach can help health care providers to understand the medical and emotional needs of patients. This approach strengthens the patient-provider relationship and the social cognitive aspect of managing diseases.

The SCT (Bandura, 2001) posits that behavioral change occurs through action. The SCT can act as a guide that promotes effective interventions to achieve the desired outcomes (Bandura, 2001). Jang and Yoo (2012) stressed the importance of developing and providing effective interventions for chronic diseases where self-management is theory based and culturally sensitive. The SCT is a useful behavioral theory to improve the self-management practices of patients, particularly those with chronic diseases (Bandura, 2004).

The SCT (Bandura, 2001) is applicable to chronic disease self-management because clinical evidence has supported its benefits with chronic ailments such as hypertension and diabetes mellitus (Jang & Yoo, 2012). The Korean patients in Jang and Yoo's (2012) study used self-efficacy, a component of the SCT, to manage hypertension and diabetes mellitus. Regarding disease self-management, self-efficacy reinforces the ability to accomplish goals that ensure better health outcomes. Hoffman (2013) viewed self-efficacy as the ability to implement specific behaviors for the purpose of achieving goals, expectations, and desired health outcomes. Self-efficacy also enhances self-management interventions to improve the functional status and quality of life of patients and ensures that the patients are the source of control for better health outcomes.

Although other factors such as social support and lifestyle are components in the self-management of chronic diseases, self-efficacy is a major concept of the SCT (Bandura, 2001; Jang & Yoo, 2012). The SCT demonstrates the psychological construct in patients' ability to perform specific behaviors that can successfully change specific cognitive states. Bandura (2001) suggested that to improve self-efficacy, four components must be considered: skills mastery, sharing of experiences, knowledge about expected changes, and physiological and affective states for the desired activity. The four components can improve personal goals once they are incorporated into specific educational programs.

Andersen, Høstmark, Holme, and Anderssen (2013) added that the SCT (Bandura, 2001) is one of the leading health behavioral change theories to predict outcomes. The strategies in the SCT provide opportunities and social support in promoting skills to master goal setting and problem solving for desired outcomes. Because self-efficacy is a key component of the SCT, Bandura (2001) attested to the general functional value of efficacy in attaining the desired health outcomes. Presseau et al. (2014) stated that the SCT is a broad theory of motivation and action influenced by individual factors that are central to self-efficacy. The SCT is based on three direct predicators of clinical behavior goals to the intentions of self-efficacy and outcome expectations (Presseau et al., 2014).

Definitions of Terms

Acculturation: Acculturation is the extent to which immigrants adapt to the host culture rather than preserve their ethnic culture (Venkatesh, Weatherspoon, Kaplowitz, & Song, 2013).

Body mass index (BMI): BMI is used as a guide for diagnosing prediabetes and diabetes (Franklin et al., 2011). Franklin et al. (2011) noted that Healthy People 2020 recommended the use of BMI as a new objective to be met in all primary care offices. The recommendations included calculating all patients' BMIs to screen and diagnose for diabetes as well as provide formal diabetes education. A BMI classification of overweight is important because it increases the disease risk of Type 2 diabetes, cardiovascular disease, and hypertension.

Continuing education units (CEUs): CEUs enhance health care providers' knowledge and allow them to earn contact hours for their participation.

Cultural barriers to care: Factors such as language and SES can influence access to health care services.

Cultural competency: Cultural competency is an ongoing process that involves the ability and availability to work effectively within the cultural context of patients and their communities (Campinha-Bacote, 2008).

Cultural health: Cultural health refers to understanding the health of minority and ethnic groups across the lifespan and the challenges within.

Cultural knowledge: Cultural knowledge refers to understanding linguistic, racial, and ethnic factors that influence the individual's ability to understand doctor's instructions (Shaw, Huebner, Armin, Orzech, & Vivian, 2009).

Cultural sensitivity: Cultural sensitivity is the respect that allows one to learn other cultural backgrounds with a set of skills (Okafor et al., 2013).

Diabetes self-management: The cornerstone of diabetes control is diabetes self-management. W. A. Fisher, Cornman, Kohut, Schachner, and Stenger (2013) indicated that the benefits of glycemic control usually are the result of effective diabetes self-management, which also includes blood sugar self-monitoring and an understanding of the effects of food and exercise on diabetes self-management.

Health decisions: Actions taken toward an intervention are known as health decisions. In terms of diabetes self-management, Wagner (2011) mentioned that health decisions accumulate to form patterns, habits, and lifestyle changes. Wagner added that health decisions are but one component of interventions targeting emotional, social, and family processes to facilitate diabetes self-management**.**

Health priorities: Although health priorities of patients and providers can be different, in diabetes care, the immediate health priority is to understand glycemic control and the effects of food and exercise on the disease (Wagner, 2011). However, many patients with poor health status have non-health-competing demands that often take precedence.

Patient-provider communication: The communication that occurs between patients and providers and the degree to which what the providers communicate is understood by the patients (Ness, 2012). In the study, providers were CDEs (i.e., certified nurse diabetes educators, registered dietitians, and registered nutritionists) who assisted patients with the self-management of their diabetes. For example, Ness (2012) indicated that patients' understanding of the complexities of their cancer care experience depends on patient-provider communication. The goal is for patients to understand what is involved in their care, starting with the diagnosis, followed by treatment, disease self-management, and follow-up.

Self-efficacy: A major concept of the SCT and an important construct in the ability to make specific behavioral changes, regardless of personal dynamics, is self-efficacy (Bandura, 2004).

Self-management: Self-management refers to the personal activities and means of controlling and caring for a disease condition (Lorig & Holman, 2003).

Assumptions

Assumptions are the factors that might influence the results of a study (Patton, 2002). Surveys, interview transcriptions, and recordings can be subject to the biases of researchers and participants. For example, researchers might alter participants' feedback with the intention to make the study look good, and participants might not be truthful about their experiences because they want to make themselves look good to the researchers or play the victims of poor health outcomes. I reminded the participants that agreeing to disclose their honest experiences in regard to patient-provider communication would help to accomplish the goals of the study. I assured the participants that their identities would remain private and that any information that they shared would remain confidential.

Some of the reviewed articles were older than 10 years, but they were included as seminal works that made a major contribution to the study in helping to explain the identified gap in patient-provider communication. In addition, much of the reviewed literature has focused on the effectiveness and outcomes of patient-provider communication for diabetes self-management, not health priorities. Therefore, the intent of the study was to identify the perspectives of patients and providers regarding what is meant by health priorities for both providers and patients regarding diabetes self-management activities.

Scope of the Study

The study was limited to understanding the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants. The study followed a case study approach involving two interview groups with a total of 15 participants. The first interview group comprised five clinical diabetes providers who were directly involved in diabetes education at the time of the study; the second interview group comprised 10 patients who were African immigrants to the United States who had been diagnosed with Type 2 diabetes within the last 5 years. The interviews were guided by open-ended interview questions developed to answer the RQs using Patton’s (2002) interview guide. I was the facilitator, and in this role, I asked questions that might lead to strategies meant to address the identified gap in patient-provider communication.

Delimitation

The delimitation of the study was that it focused on a specific population of African immigrants living in Montgomery County, Maryland, who had been diagnosed with Type 2 diabetes within the last 5 years. I chose this target population because they might not have been familiar with long-term strategies to manage a chronic disease, such as how to communicate with CDEs. The SCT framework is relevant to health communication because the theory deals with the cognitive and emotional characteristics of behavior to understand behavioral change. As Bandura (2004) mentioned, the quality of health is greatly influenced by culture and lifestyle, so it is imperative that providers gain skillful strategies in culturally appropriate health communication to understand its importance to the self-management of diabetes by patients who are African immigrants.

Limitations

Limitations relate to threats of bias as well as internal and external validity. A bias is a threat that can weaken the study's findings; for example, Miles, Huberman, and Saldana (2014) mentioned that personal bias could refer to a researcher's personal agenda and could skew the data analysis and prevent the results from being trusted. To limit personal bias in this study, I put my own perceptions aside and relied on the participants' feedback to obtain my data. According to Miles et al., internal validity could have been a limitation if the accounts expressed by the participants were not true, did not make sense, and did not enable an authentic presence for the reader. External validity relates to whether I could have used the findings to achieve better health outcomes (Miles et al., 2014). To limit any threats to internal and external validity, I asked the participants to share their specific experiences and make sure that the findings can be tested for social change via CEUs for CDEs.

Although I used a case study approach using open-ended interview questions to obtain the data, meeting the unique needs of people from different cultures could have been a potential limitation (Jang & Yoo, 2012). For instance, diverse populations do not necessarily share cultural influences, so having health professionals who used a universal assessment approach in the study could have been a limitation. Another possible limitation was that the participants might not have been willing to reveal personal challenges managing their diabetes. To dissuade the participants from providing dishonest responses and skewing the data, I stressed the importance of giving accurate and honest answers that might help providers to understand the participants' lived experiences with disease self-management.

Summary and Transition

Because the risk of developing diabetes and related complications among immigrants increases concomitantly with their length of residence in the United States, it is important for providers to be prepared and skilled enough to deliver culturally appropriate and sensitive care (Park et al., 2009; Wieland, Morrison, Cha, Rahman, & Chaudhry, 2012). The emphasis is to improve providers' understanding of the sociocultural backgrounds of their diverse clientele so that they can care more effectively for their patients. The provision of CEUs could potentially enhance the interpersonal communication skills of health professionals (Park et al., 2009). With patient behavior being the cornerstone of diabetes self-management, the SCT (Bandura, 2001) could improve patients' self-efficacy by changing specific behaviors or attitudes to ensure better health outcomes. I conducted interviews with the two groups (i.e., 10 patients and five health care providers) to understand the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants.

Chapter 1 provided information describing the research design to obtain a deep understanding of how the use of culturally appropriate communication can ensure the delivery of effective care in diabetes self-management by patients who are African immigrants. The chapter also included information about the background, problem, purpose, significance, and nature of the study: the RQs; the theoretical framework; and so on.

Chapter 2 presents a detailed literature review. I discuss studies relevant to mine to identify the gap in research on culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants. In Chapter 3, I describe the method and design of the qualitative case study, my rationale for selecting a case study, and the ways that I addressed the RQs.

In Chapter 4, I present the results of the data analysis. Data were collected and processed to understand the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants. The fundamental goals of this study were to interview key participants by sharing their personal encounters, experiences, and perceptions of patient-provider communication in health care delivery.

Chapter 5 includes a discussion of the results, recommendations for future research, and a conclusion of this study on the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants to ensure better health outcomes.

Chapter 2: Literature Review

Introduction

The purpose of this qualitative case study was to obtain the perspectives of 10 patients and five health care providers about the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants. The use of a universal approach in assessing patients and planning treatment goals can lead to health outcomes that are not optimal. Patient assessments need to be individualized using culturally appropriate communication to ensure more positive health outcomes. The knowledge gap in health priorities has been discussed very little in the literature, and because health priorities can mean one thing to patients and another to providers, I sought to conduct an in-depth investigation into the problem of patient-provider communication and discuss health priorities. For instance, from a provider's perspective, seeking medical care could and should be the first health priority, but to a patient, feeding the family could be the more immediate priority. Therefore, culturally appropriate patient-provider communication becomes an important factor in patients' initial setting of goals to ensure more positive health outcomes.

The study was guided by four RQs:

RQ1: How does patient-provider communication (CDEs) affect the self-management of Type 2 diabetes of patients who are African immigrants?

RQ2: How does patient-provider communication (CDEs) promote shared decisions in achieving the disease management goals of patients who are African immigrants?

RQ3: How does patient-provider (CDEs) communication influence the health assessment for Type 2 diabetes self-management of patients who are African immigrants?

RQ4: How does culturally appropriate communication influence the outcome of Type 2 diabetes self-management of patients who are African immigrants?

Chapter 2 comprises a review of literature relevant to understanding the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants. The literature review is divided into six sections under the following headings: Theoretical Framework: SCT; Significance of Patient-Provider Communication; Health Concepts of Cultural Knowledge, Sensitivity, and Competence; Cultural Barriers to Care; Immigrants' Health Priorities; and Social Change Through CEUs.

Research Strategy

This chapter includes a discussion of empirical research reviewed from approximately 95 peer-reviewed articles, books, Internet websites, published and unpublished literature, and dissertations and theses from Walden University. I used Walden University's library database (e.g., ProQuest, PubMed, Medline, ScienceDirect) to search for relevant articles and journals. I also sought relevant materials from local community libraries and the Google Scholar search engine using the following terms: *immigrant health*, *patient-provider communication*, *cultural health*, *cultural barriers*, *cultural sensitivity*, *cultural knowledge*, *cultural competency*, *sustainability and healthy behavior*, *diverse population and health*, *health priorities*, *physician barriers*, *Type 2* *diabetes and cultural foods*, *language barrier and communication*, *immigrants and health outcomes*, *effective communication*, *information behavior skills model*, and *SCT*.

The search of this literature resulted in 80 usable articles and books. I found a limited number of studies pertaining to African immigrants and Type 2 diabetes self-management, but with an expanded search on diverse populations and Type 2 diabetes self-care/management, I found more relevant articles to support the research topic.

I used an interview guide of 10 open-ended questions to collect the data. Four of the questions were directed toward five health care providers to discuss their perspectives of patient-provider communication with patients who are African immigrants. The other six questions were directed toward 10 patients to discuss their understanding of Type 2 diabetes self-management and perceptions of care in terms of how they communicated with their health care providers.

Theoretical Framework: SCT

Because health care providers are in the forefront of providing health services, it is important to examine the extent to which the SCT (Bandura, 2001) plays a role in positive health outcomes. Gálvez et al. (2015) asserted that good communication between health care providers and patients is critical to achieving positive health outcomes and avoiding any misunderstanding of information. Gálvez et al. conducted their study in Santiago, Chile, where the responsibility for population health, lifestyle promotion, and the prevention of disease falls on the health care system. The study focused on women and the importance of health behaviors surrounding healthy eating habits. The participants were separated into two groups: Group 1 comprised 17 Chilean women between the ages of 31 and 58 years, and Group 2 comprised eight health care providers (Gálvez et al., 2015). The health care providers were responsible for promoting healthy eating habits for women; the researchers' goal was to obtain the perceptions of women and health care providers about the factors influencing the women's eating behaviors (Gálvez et al., 2015). The interactions between patients and health care providers were meant to reinforce effective communication and understand the factors that can influence healthy eating behaviors.

In addition, Gálvez et al. (2015) mentioned the importance of considering the SCT (Bandura, 2001) aspects of behavioral change as a critical component of effective communication skills necessary to reinforce good health outcomes and understand the medical and emotional needs of patients in managing illnesses. The SCT also addresses the role of external and internal factors in maintaining certain behavioral patterns such as healthy eating. Gálvez et al. recommended that health care providers develop patient-centered communication to understand the causes of poor eating behaviors and improve health outcomes.

In the final analysis of the study, Gálvez et al. (2015) compared and scored themes that emerged from both groups to determine how effective the communication between health care providers and patients was and its association with better health outcomes. Similar to Gálvez et al.'s study, I compared and analyzed themes from the interview questions to identify the skills necessary for effective patient-provider communication.

Jang and Yoo (2012) viewed the SCT (Bandura, 2001) as being useful in improving the health care outcomes of chronic diseases and enhancing patients' self-efficacy in disease management. Jang and Yoo mentioned that the goal of good health outcomes is to raise patients' self-care abilities. Jang and Yoo focused on Korean patients with chronic diseases and their self-efficacy in managing their diseases, particularly hypertension and diabetic mellitus. The participants had to be older than 20 years of age, and of the 377 identified participants, 133 were hypertensive, and 244 had diabetes mellitus.

Jang and Yoo (2012) used the SCT (Bandura, 2001) as a framework to develop interventions to determine whether the participants were able to learn new skills to self-manage their chronic diseases. The new skills provided effective patient self-care interventions that were theory based and culturally sensitive. In addition, Jang and Yoo mentioned that the SCT was applied in a practical way to evaluate the most effective model of self-management skills that Korean patients with hypertension and diabetes mellitus could use. Self-efficacy is a major component of the SCT, and Jang and Yoo stated that it is an important psychological construct expressing confidence in the ability of individuals to comply with specific behaviors. They believed that using the SCT would enhance patients' self-efficacy skills in managing their diabetes.

Ljung, Olsson, Rask, and Lindahl (2013) used a lifestyle-focused group treatment in the prevention of cardiovascular disease and Type 2 diabetes based on the SCT (Bandura, 2001). Ljung et al. noted that the SCT stimulates different components that seem to strengthen patients' self-efficacy to make effective behavioral changes. Because the SCT is one of the most commonly used behavioral change theories, environment, person, and behavior are significant to the outcomes of behavioral change (Ljung et al., 2013). Ljung et al.'s sample comprised 19 men and women over the age of 35 years who had completed a theory-based, lifestyle-focused group treatment at a behavioral medicine clinic in northern Sweden. The goal focused on patients making small changes toward living healthier lifestyles by educating them about food preparation, exercise, and stress management to reduce the risk of developing Type 2 diabetes and cardiovascular disease. The staff offered encouragement and support through effective communication, which is relevant in patient-provider communication when exploring patients' experiences in making behavioral changes (Ljung et al., 2013). Results of the study showed that it was practical to use the SCT to stimulate different components to strengthen self-efficacy, a dominant factor in achieving effective behavioral changes.

Miller, Edwards, Kissling, and Sanville (2002) used the SCT (Bandura, 2001) in a nutritional intervention meant to improve patients' knowledge and skills necessary for diabetes self-management. The theoretical concept was intended to build the patients' skills and self-efficacy to perform specific behavioral changes relevant to effective patient-provider communication. The sample comprised 93 adult participants over the age of 65 years with Type 2 diabetes enrolled in a 10-week group session led by a dietitian (Miller et al., 2002). As part of the intervention, Miller et al. used information processing to measure the participants' knowledge of nutrition to self-manage diabetes.

In channeling Bandura's (2001) SCT, Miller et al. (2002) used the principles of the SCT in program development and evaluation. The goal of their study was to measure the results of behavioral change, self-efficacy, and decision-making skills to ensure good health outcomes. The results were based on scores that identified outcome expectations for self-efficacy of diabetes management. Miller et al. concluded that older adults can benefit from nutrition education designed to improve the knowledge and skills necessary to self-manage diabetes.

Physical activity plays a major role in diabetes self-management by helping individuals to control and lower blood sugar levels. Andersen et al.'s (2013) research on physical activity among ethnic minority populations had disappointing results regarding health behavior in preventing Type 2 diabetes because of the participants' lack of knowledge about the effects of physical activity on blood sugar levels. Andersen et al. focused on a 5-month intervention to increase the levels of physical activity of men of Pakistani origin living in Oslo, Norway. Participants were between the ages of 25 and 60 years. The purpose of the randomized controlled trial study was to understand why many Pakistani immigrants were physically inactive and at risk of developing Type 2 diabetes. Although individuals with known diabetes were excluded from the study, the goal was to identify positive influences using SCT-based strategies that would increase the participants' levels of physical activity.

Because the SCT (Bandura, 2001) is one of the leading theories to explain and predict health behavioral change, the intent of my study on diabetes self-management was to help the participants to gain information about ways to achieve good health outcomes. Andersen et al. (2013) used the SCT to promote behavioral change through the application of culturally appropriate skills training, goal setting, and problem solving.

The purpose of their study was to provide outcomes based on SCT strategies that could be used as an intervention to improve the participants' knowledge of the impact of physical activity on preventing Type 2 diabetes.

Significance of Patient-Provider Communication

Piette, Schillinger, Potter, and Heisler (2003) asserted that patient-provider communication is essential to ensure the effective care of individuals with diabetes and positive health outcomes. Piette et al. stated that without diabetes-specific communication strategies between patients and providers, identifying realistic targets for behavioral change could be a challenge. The purpose of the study, according to Piette et al., was to examine providers' communication strategies, particularly diabetes-specific communication, when caring for ethnically diverse patient populations. They recruited 1,221 potential participants for the study. These individuals included adults with diabetes who were 21 years of age and older who were permanent residents from three Virginia health care systems. Of the 1,221 potential participants, 1,015 completed the informed consent. Data were collected by trained interviewers, and the participants were given the option to complete the survey in either English or Spanish. Diabetes-specific communication addressed eating habits, benefits of blood sugar control and cholesterol control, ways to read food labels, physical activity, and foot care (Piette et al., 2003).

Piette et al. (2003) commented that diabetes-specific communication can facilitate patient-provider interactions that can ensure the continuity of care and adherence to treatment plans and goals. Even though blood sugar control is the ultimate goal of diabetes self-management, Piette et al. argued that patient-provider communication has been overlooked as a factor in achieving goals in ethnically diverse populations. In other words, Piette et al. stated that patient-provider communication is important in giving patients the information that they need to set priorities and build a trusting relationship with providers for better health outcomes. Results indicated that the length of the patient-provider relationship built effective communication toward ensuring better health outcomes.

Daly et al. (2009) noted that personal factors such as SES, family support, and religious beliefs are not assessed for most immigrants in regard to their management of chronic diseases. Daly et al. focused their research on assessing the attitudes, behaviors, and outcomes of patients with Type 2 diabetes. The relevance of Daly et al.'s study to the current study is that in order to have effective patient-provider communication, patients' attitudes and behaviors have to be assessed to initiate a point of discussion. This discussion between providers and patients is critical in the overall assessment of patients because it can predict potential outcomes and provide insight into patients' willingness to receive the necessary health care services and follow the treatment plans.

Daly et al. (2009) used a randomly selected sample of 800 potential clinic patients, 458 of whom returned the questionnaire. The purpose of their study was to measure the effect of self-care behavior and the outcome of HbA1c to predict the amount of glucose in the blood over 3 months. Results identified barriers to self-care behavior and the association to testing of HbA1c levels. Behavioral modification, such as the need to follow a meal plan and monitor blood glucose to control levels of HbA1c, can be addressed through effective patient-provider communication.

Effective patient-provider communication also impacts how well patients respond to treatment plans and the goals to achieve more positive health outcomes. Because good outcomes are based on how patients and health care providers interact, patients' perceptions of Type 2 diabetes and their willingness to participate should be the impetus for communicating effectively with their providers (Daly et al., 2009). Nevertheless, Daly et al. (2009) asserted that patients play a central role in setting their diabetes self-management goals and that health care providers can contribute their input based on the knowledge assessments provided by patients. Piette et al. (2003) mentioned that for patient-provider communication to be effective, educational information should be specific to individual patients and take into account the patients' activities of daily living.

Al Sayah, Majumdar, Williams, Robertson, and Johnson (2013) identified low health literacy as a barrier to positive health outcomes. They stated that providers who do not assess their patients' literacy levels to understand their capacity to self-manage their diabetes weaken patient-provider communication and reduce the likelihood of positive health outcomes. Al Sayah et al. conducted a systematic review of six databases, CINAHL, Embase, ERIC, Medline, PsycINFO, and SCOPUS, to identify a possible relationship between health literacy and health outcomes (i.e., knowledge, behavioral, and clinical) of individuals with diabetes. Although the study produced multiple outcomes on clinical, behavioral, and patient-provider relationships, the results showed that higher health literacy levels were associated with better patient-provider communication, improved exchanges of information, and patient involvement in decision making (Al Sayah et al., 2013). Understanding the association between positive health outcomes and low health literacy levels is central to improving patient-provider communication and health outcomes (Al Sayah et al., 2013).

Because specific skills are needed to understand the nature of diabetes self-management, Al Sayah et al. (2013) suggested that assessing patients' understanding of diabetes self-management is important to improving patient-provider communication. Al Sayah et al. highlighted the functional, interactive, critical-thinking, and numeracy skills relevant to diabetes self-management. For example, Al Sayah et al. described functional skills as the ability to read, understand, and interpret written text; interactive skills as the ability to communicate health-related information; critical-thinking skills as the ability to make appropriate health decisions; and numeracy skills as the ability to use numeric information to interpret blood sugar logs, medication dosages, and food labels. Patient-provider communication is a complex process that requires an extensive understanding of the ways that patients and providers communicate.

Gálvez et al. (2015) contended that good communication between health care providers and patients can set the foundation for the most suitable and individualized treatment plans and goals. Gálvez et al. focused on exploring the relationship between health care providers and the services offered to women by the public health care system in Chile with respect to behaviors regarding healthy eating. The 25 participants were separated into two groups: Group 1 comprised 17 Chilean women between the ages of 31 and 58 years who were recruited from a public health care center in Santiago, Chile. Recruitment occurred primarily in the waiting rooms of the health center. Group 2 comprised eight health care providers who worked at the same center; among them were four dietitians, three obstetricians, and one nurse. The health care providers were responsible for educating the women in Group 1 about healthy eating habits. The goal was to evaluate the degree of shared understanding about the causes of poor eating behaviors, with social and behavioral aspects as influences.

Gálvez et al. (2015) mentioned that health care providers must individualize patients' needs, perceptions, and opinions to promote effective communication. By acknowledging patients' specific needs, providers can develop treatment plans that patients are willing to follow. In addition, patients' adherence to treatment plans and goals becomes easier to document, thus allowing patients to be proactive in making decisions to ensure better health outcomes. Gálvez et al.'s results identified the social factor as the main influence on the women's poor eating habits and lack of knowledge. Social and behavioral aspects are significant in disease management and the promotion of healthy eating habits. When health care providers individualize patient care, they establish a shared dialogue that improves communication and increases patient-provider trust.

Lyles and Schillinger (2013) stated that engaging patients in planning treatment goals results in better health outcomes and strengthens the patient-provider relationship. Shared decision making has its domain in trust, respect, and mutual understanding accompanied by effective communication. For example, because the treatment goals for diabetes self-management are individualized for each patient, patient-provider communication needs to focus on meeting those individual needs. Patients' individual needs also tie in with patients' health priorities to increase positive health outcomes.

Faith, Thorburn, and Tippens (2015) emphasized the importance of patient-provider communication in ensuring positive health outcomes. For example, Faith et al. mentioned that the consistency of patients' interactions with their health care providers can influence good health outcomes through such mechanisms as improving patients' knowledge of disease management and increasing patients' self-efficacy and adherence to self-care. Faith et al. focused on patients' perceptions of and the quality of interactions that can influence good health care-seeking behaviors. The researchers used cross-sectional survey data on U.S. adults from the Health Information National Trends Survey 3 collected between January 2008 and May 2008. Results indicated that patients were less likely to continue seeing their health care providers if they sensed low levels of patient-centered communication.

Faith et al. (2015) also mentioned that patient-centered communication is central to building lasting patient-provider relationships that can support Type 2 diabetes self-management and address patients' uncertainty about health and positive health outcomes. Patient-centered communication was central to the current study to promote culturally appropriate patient-provider communication in the self-management of Type 2 diabetes by patients who are African immigrants. As Piette et al. (2003) mentioned, no prior studies have explored the extent to which patients' perceptions of diabetes-specific and general communication can improve health outcomes. Results of the current study could lead to positive social change by supporting ways to improve Type 2 diabetes-specific communication and addressing the self-care challenges required to meet the individualized needs of patients.

Health Concepts of Cultural Knowledge, Sensitivity, and Competence

Osborn and Fisher (2008) stated that diabetes self-management education was introduced in the 1940s to improve diabetes health outcomes. However, as Osborn and Fisher noted, the prevalence of diabetes in ethnic minority communities continues to increase. Determining the effectiveness of diabetes self-management education programs for ethnic minority groups has received far less attention, making it difficult to address specific barriers to behavioral change (Osborn & Fisher, 2008).

This lack of attention has posed unique challenges for health care providers in terms of service delivery. For example, Osborn and Fisher (2008) commented on the importance of tailoring the content of health education programs so that it is understandable and meaningful to different cultures, along with being related to the desired health outcomes. Osborn and Fisher added that the application of theory-based approaches in the design of diabetes self-management programs for ethnic minority groups has been limited. I explored specific, culturally appropriate approaches for diabetes self-management based on the themes that emerged from the analysis of the interview responses.

Holliman Douglas (2014) noted that health care providers' acknowledgment of patients' beliefs, preferences, and perspectives can influence the type of delivery of quality care. In particular, health care delivery strategies such as patient-provider communication, cultural knowledge, clinical decision making, and cultural sensitivity are essential to consider when caring for patients from different ethnic populations. Cultural health, which encompasses key concepts such as knowledge, sensitivity, and competence, needs to be addressed in the delivery of care to different ethnic groups (Osborn & Fisher, 2008).

Understanding the cultural aspects of the patient-provider relationship is essential to ensure better health outcomes. However, challenges arise when providers give expert opinions without any knowledge of patients' beliefs, attitudes toward care, and cultural practices. For instance, Aziz (2009) suggested that for patients to manage their disease conditions effectively, providers have to acknowledge the need for a cultural shift in health care delivery to immigrant populations. Understanding and implementing such a cultural shift could help patients and providers to collaborate to identify behavioral changes that could produce positive health outcomes. Patients' contributions to treatment goals and disease management plans allow them to participate actively in the decision-making process, confirming that communication is the foundation of a beneficial patient-provider relationship. Aziz asserted that patient-centered communication allows providers and patients to explore and discuss expectations and behaviors that can influence good health outcomes.

Aziz (2009) added that providers' skills and knowledge have to be a consideration in the management and implementation of patient-oriented strategies in disease management. However, if providers underestimate the cultural aspects of disease management, the outcome can be disproportionate health care and health disparities. For example, a cultural belief that consumes most ethnic patients is that taking medication means accepting the disease condition. Health care providers have to be competent in understanding and addressing the cultural beliefs that contribute to the denial of disease presence.

Because diabetes, religion, and spirituality are part of the cultures of many ethnic populations, it is important to understand how their relationship influences disease self-management (Sridhar, 2013). Sridhar (2013) indicated that diabetes in the Indian culture is like a shadow that is commonly managed using the coping mechanisms of religion and spirituality rather than modern medicine. Buddhist monks in Thailand believe that disease is associated with uncertainty, fear, loss of control, and discouragement (Sridhar, 2013). The Buddhism approach and perspective emphasize that the karma from previous life mistakes creates suffering in the future and is a major contributing factor to disease. Therefore, understanding patients' cultural beliefs is important to support the acceptance of diabetes and self-care behaviors. I sought to identify emerging themes during the analysis of the interview responses to compile results for social change supporting CEUs for health care providers.

Newman et al. (2014) followed a culture-centered approach to understand the knowledge gaps in disease progression and disease management. Newman et al. used the SCT as their framework to identify cultural barriers to health care in Zuni to probe specific culture-bound knowledge and understand how it affected Zuni Indians' health behaviors. They recruited their participants through a community health representative using the Zuni Health Initiative database. The purpose of the study was to identify the meaning of diabetes from a Zuni cultural context and to discuss cultural knowledge and techniques used to self-manage diabetes. The sample comprised 84 participants over the age of 26 years, 64% of whom had a diagnosis of diabetes, as reported on the questionnaire (Newman et al., 2014). Results indicated that 80% of the participants were overweight and had a BMI greater than 25 (Newman et al., 2014). Participants also reported social stigma and taboos as barriers to diabetes self-management.

The cultural components of health and wellness have a strong hold on patients, so providers caring for ethnic populations have to understand this connection when assessing patients. For example, Newman et al. (2014) mentioned the use of indigenous institutionalization as power that has impacted the diabetes epidemic in the Zuni population. Members of the target population had ingrained local traditional values with the belief that diseases reflect historical trauma, not changing lifestyles (Newman et al., 2014). These changing lifestyles have led to decreased levels of physical activity and increased rates of interrelated epidemics of obesity, diabetes, hypertension, and kidney disease. Therefore, Newman et al. suggested that understanding cultural perspectives is critical to patient assessment and disease management.

Vissenberg et al. (2012) discussed culturally sensitive social contexts, noting that psychosocial mechanisms from influences such as peer pressure, norms, values, and social engagement have meaningful roles in disease management. As an example, Vissenberg et al. pointed out that psychosocial mechanisms can have positive and negative effects, particularly with patients from similar ethnic backgrounds or groups. Most ethnic groups tend to surround themselves with social networks that could influence their well-being and could hinder their diabetes self-management intentionally or unintentionally through peer pressure (Vissenberg et al., 2012). When patients are in closed social networks, they tend to have limited access to external resource information, including diabetes-related information and role models. In addition, such social networks might even impose negative group norms on their members that could contribute to poor health outcomes (Vissenberg et al., 2012).

Vissenberg et al. (2012) studied 128 participants of Dutch, Turkish, Moroccan and Surinamese ethnicity from a lower SES who had been diagnosed with diabetes for at least 1 year, were over the age of 35 years, and had HbA1c greater than 7%. The goal was to stimulate long-lasting diabetes self-management using social support to change the determinants associated with psychological mechanisms and their specific needs regarding information processing. Results identified the effects of psychological mechanisms on diabetes self-management and the ways that these mechanisms could contribute to more efficient diabetes outcomes among lower SES groups. Similarly, the current study helped me to gain an in-depth understanding of the key cultural considerations and specific patient assessment strategies necessary for efficient diabetes self-management.

Cultural Barriers to Care

Overcoming cultural barriers to the self-management of diabetes will help to ensure more control of diabetes and delay complications. McCloskey and Flenniken (2010) took their sample from a target population of Hispanic Americans from New Mexico to understand how culture affects diabetes self-management. McCloskey and Flenniken mentioned that in many Hispanic American communities, social support is a strong cultural norm that is central to health and well-being. For instance, Hispanic

American men are expected to express strength and power in the family unit, so a lack of social support can affect individual efforts to control diabetes (McCloskey & Flenniken, 2010). In terms of cultural barriers, McCloskey and Flenniken noted that making changes to the traditional Hispanic American diet is considered a loss of cultural identity. The traditional diet is associated with social support because meals are shared with all family members, a factor that can sometimes contribute to the lack of diabetes self-management skills.

In many developing countries, where beliefs and cultural values dominate health and well-being, health care providers make all decisions about the delivery of health services. McCloskey and Flenniken (2010) suggested that the focus should be expanded to social communities to make diabetes education more efficient and effective. The result could be a reduction in cultural barriers and more empowerment of patients to ensure better health outcomes. McCloskey and Flenniken also mentioned that empowering patients promotes self-efficacy in making behavioral changes. The CDC (2013) recommended that cultural activities be facilitated by community health workers with similar cultural backgrounds to ensure better adherence to diabetes self-management. Community health workers with similar cultural backgrounds are trusted navigators who can support patients' efforts to control and manage their diabetes (McCloskey & Flenniken, 2010).

Renfrew et al. (2013) asserted that some cultures believe in a healing power rooted in the natural world and spiritual being. Renfrew et al. used the example of the Cambodian American population, whose members have a strong belief in supernatural healing yet continue to experience elevated rates of Type 2 diabetes. Although some of the reported barriers to diabetes care among the Cambodian American population included limited English proficiency as well as a lack of knowledge of diabetes causes and progression, Renfrew et al. contended that cultural influences also played a key role in poor health outcomes.

Renfrew et al. (2013) stated that disparities in diabetes care of the Cambodian American population are rooted in a distrust of Western medicine and its protocols, many of which are viewed as artificial, not natural and spiritual, healing. Western medicine is seen as a secondary option, and many Cambodian Americans prefer to follow the cultural practices and beliefs of using the healing power of traditional herbs (Renfrew et al., 2013). Despite the cultural barriers identified by Renfrew et al., they suggested that the most desired outcomes are to develop culturally appropriate educational programs to improve patients' understanding of the disease progression and to provide diabetes self-management guidelines that would eliminate racial and ethnic disparities.

In regard to other cultural barriers, Sohal, Sohal, King-Shier, and Khan (2015) addressed language and communication discordance, a significant barrier in receiving and understanding diabetes education as well as adopting health care providers' recommendations. Sohal et al. noted that the South Asian population face language and communication discordance in disease management. They also pointed out that the South Asian population feel that they have a cultural and social responsibility to follow a traditional diet, despite the risk of diabetes-related complications. For example, the South Asian population consider a diabetic diet misleading and not aligning with a traditional diet, which is believed to heal many illnesses. The researchers stated that misconceptions about treatment recommendations need to be defined so that the South Asian population might be more willing to adapt these recommendations to control and manage their diabetes.

Sohal et al. (2015) mentioned that South Asian patients are more concerned about gender and age-specific activities from a cultural perspective rather than a diabetic diet to complement their beliefs in disease healing. For instance, the South Asian population believe that combining health and exercise can worsen a disease condition and lead to injury (Sohal et al., 2015). Many members of the South Asian population prefer traditional medicine and food to manage diabetes because of their belief in the healing power of nature (Sohal et al., 2015). Therefore, Sohal et al. emphasized the use of culturally appropriate, gender-specific physical activities and dietary recommendations using traditional foods to self-manage diabetes.

Nunez, Yarandi, and Nunez-Smith (2011) discussed the need for culturally appropriate measures and interventions to address challenges in the U.S. Virgin Islands population. Nunez et al. mentioned that most residents of the U.S. Virgin Islands are of African descent and are influenced by trends on the mainland of the United States and other Caribbean islands. Most residents believe that the use of herbal medicine can cure diabetes; they also seek local diets as an alternative to cure diabetes (Nunez et al., 2011). For example, pigtail soup is believed to prolong life, so changing eating habits that are considered ordinary becomes a challenge to diabetes self-management (Nunez et al., 2011). Nunez et al. indicated that based on the teachings of the ancestors, people who ate traditional foods lived more than 70 years without disease. These cultural beliefs can become a hindrance to lifestyle changes and a barrier to diabetes self-management.

Although gaining knowledge and skills through diabetes education is an essential aspect of changing behaviors and self-managing diabetes, cultural barriers are still a key factor in not achieving the desirable health outcomes. Aponte, Campos-Dominguez, and Jaramillo (2015) identified cultural barriers in Hispanic American subgroups in New York City that were experiencing an increase in Type 2 diabetes rates. Aponte et al. used Dominicans, Puerto Ricans, Mexicans, and Cubans as the target Hispanic American subgroups to explore the challenges and concerns disproportionately affecting diabetes self-management. Some of the main concerns were cultural beliefs and dietary customs. For instance, staple foods like rice and beans dominated the daily dietary consumption of many families, which meant that they were being deprived of other staple foods.

According to the AADE (2015), a daily dietary intake of foods like rice and beans can contribute to higher blood sugar levels. Aponte et al. (2015) stated that changing eating habits is difficult and disrupts customs associated with healing. They called for culturally appropriate diabetes education on nutrition and diabetes self-management.

Immigrants' Health Priorities

Assessing health concerns and barriers in an increasingly diverse and growing immigrant population in the United States presents challenges, particularly in the delivery of health care services. Martinez and Carter-Pokras (2006) noted that three quarters of the expanding Latino American population in Maryland do not have health insurance. They also stated that there is a perceived association between a lack of health insurance and the poor quality of health care. The most relevant discussion to date has focused on the linguistic, financial, legal, and culture barriers to access; there has been little to no discussion on how such populations are assessed in terms of their immediate health priorities. Carrillo et al. (2011) also mentioned the limited English proficiency of patients as a challenge that makes it difficult for health care providers to assess them. Carrillo et al. asserted that assessing the health priority needs of immigrants will help to improve the cultural competence of providers.

Venters and Gany (2011) stated that as the number and diversity of African immigrants in the United States continues to rise, the urgency to assess their health care needs and practices also is increasing. Venters and Gany stated that even though many African immigrants come to the United States with unique health-related problems, including traumatic experiences related to civil war, gender abuse, and torture, along with complications in cross-cultural communication, they generally are healthier than African Americans of the same age. Venters and Gany also mentioned that the uniqueness of African immigrants’ health problems has contributed to the healthy immigrant effect syndrome, which is poorly understood among African immigrants.

This misunderstanding has happened because a healthy immigrant effect syndrome is self-selected, where healthier and wealthier immigrants tend to be migrants and are typically healthier than American-born natives upon arrival (Venters & Gany, 2009). There are many explanations for this fact, including health screening upon arrival, followed by steady access to the health resources of the adopted country. Hence, support for the effective assessment of African immigrants is needed to ensure that they have adequate and culturally appropriate health care.

In addition, as African immigrants become long-term residents of the United States, their health priorities change. Jamil et al. (2008) discussed diabetes mellitus as an important public health problem that disproportionately affects minorities. Jamil et al. mentioned SES, lack of access to health care, acculturation, and insufficient health behavior information as factors affecting ethnicity and diabetes. However, they did not discuss the health priorities of the target population in their study, namely, Arab Americans, Chaldean Christians, and Black Americans living in southeastern Michigan. Poor health determinants versus individual needs have contributed to providers' universal perspectives of the health priorities of patients and the lack of information in the literature.

Social Change Through CEUs

Based on the available literature on immigrants' self-management of diabetes, it appears that there has been little discussion of individual assessments regarding health priorities. Therefore, health care providers' universal perspectives of assessment have opened the way for continuing education on the ways in which providers should assess immigrant patients. As Venters and Gany (2011) asserted, the need for culturally appropriate assessment skills will increase in tandem with the number and diversity of African immigrants coming to and settling in the United States. Because many African immigrants arrive in the United States healthier than many native-born African

Americans, the healthy immigrant effect syndrome could facilitate social change via CEUs.

Engaging in CEUs will give health care providers the competencies that they need to assess health problems unique to African immigrant patients. In addition, proper individualized or personalized health assessments are needed to identify the health attitudes, health priorities, and health problems of new immigrants, as well as help health care providers to understand differences in the prioritization of health and disease self-management of patients who are African Immigrants. Incorporating a cultural component into individualized patient assessments could improve the provider-patient relationship.

CEUs could be of tremendous assistance in developing these competencies in health care providers. They also could raise more questions and provide more answers that could help providers to plan individualized treatment goals for immigrant patients. For example, questions about beliefs, spirituality, natural healing, and communal and family support could provide insight into African immigrants' perceptions of disease self-management.

Chapter 2 was a comprehensive review of literature relevant to the study. In Chapter 3, I explain the specific steps that I took to obtain my participants and collect the data to understand the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants.

Chapter 3: Research Method

Introduction

The purpose of this qualitative case study was to understand the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes self-management by patients who are African immigrants. Diabetes self-management can be effective if patients are given the tools necessary to ensure better health outcomes. These tools can range from effective patient-provider communication to information sharing, coordinated care, and behavioral support.

Prior to conducting any part of the study, I obtained permission from Walden University's Institutional Review Board (IRB approval #01-04-17-0248847). The sample comprised African immigrant patients and CDEs who lived in Montgomery County, Maryland. I recruited 15 participants to discuss the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by African immigrants. Five participants were CDEs, namely, certified nurse diabetes educators, registered nutritionists, and registered dietitians. The reason for selecting only five CDEs was because I believed that they could provide detailed and in-depth responses to the interview questions relevant to them that would help to answer the RQs. Ten participants were African immigrant patients who had been diagnosed with Type 2 diabetes within the last 5 years and who answered the open-ended interview questions relevant to them. I collected data on all participants' perceptions about patient-provider communication by capturing the participants' responses to the open-ended interview questions on audiotape.

I also asked probing questions when necessary. Analysis of the responses helped to identify the themes.

The study was guided by four RQs:

RQ1: How does patient-provider (CDEs) communication affect the self-management of Type 2 diabetes of patients who are African immigrants?

RQ2: How does patient-provider (CDEs) communication promote shared decisions in achieving the disease management goals of patients who are African immigrants?

RQ3: How does patient-provider (CDEs) communication influence the health assessment for Type 2 diabetes self-management of patients who are African immigrants?

RQ4: How does culturally appropriate communication influence the outcome of Type 2 diabetes self-management of patients who are African immigrants?

Chapter 3 offers a detailed description of the method and design of the study and explains how the RQs were addressed. Also included is an explanation of the rationale for choosing a qualitative case study approach.

Research Method

I conducted this qualitative case study to understand the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants. Research methods are comprehensive and can be either qualitative or quantitative. Qualitative research provides flexible approaches that can be used in a variety of investigative methods. As Malterud (2001) mentioned, qualitative research involves the systematic collection, organization, and interpretation of data gathered from interviews or observations. The method helps researchers to explore the meanings of social phenomena experienced by individuals in their natural setting (Malterud, 2001). Malterud also noted that qualitative research facilitates the expansion of the knowledge base that can be shared beyond the study setting to foster social change.

Research Design and Approach

The research design of any study determines the chosen approach of inquiry that is applicable to the RQs. The design of the study describes the research process and the ways that the process can be accomplished. The research design holds key aspects of any study, including the selection of participants, sample size, data collection, and instruments. I followed a case study approach, an in-depth method of inquiry that focuses on real-life circumstances using a variety of sources (McGloin, 2008). The focus of the inquiry was relevant to people’s behaviors, opinions, attitudes, cultural influences, and ethnic backgrounds. The sources of data included focus groups, direct observation, and notes that I took during the focus groups. Critical analysis of the data might result in the development of culturally appropriate interventions.

A case study is particularly useful in research because it answers “how” and “why” questions and focuses on the research problem (Amerson, 2011). Creswell (2013) noted that a case study approach enables researchers to investigate a single case or multiple cases over time. Creswell also indicated that a case study approach has a detailed in-depth data collection protocol involving multiple sources of information through observations, interviews, documents, and reports. Patton (2002) remarked that a case study approach is used with special interest groups when researchers want to understand activities within important circumstances. Therefore, my interest in ways to improve patient-provider communication resulted in this exploration of the importance of using culturally appropriate communication to the self-management of Type 2 diabetes by patients who are African immigrants.

According to Yin (2003), case study research can accommodate situations where researchers have little control over events that require in-depth investigations to answer questions relevant to specific research problems. For example, because I explored the importance of culturally appropriate patient-provider communication, I focused on identifying gaps that could be detrimental to improving patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants. As Yin indicated, case studies involve the direct collection and analysis of data from multiple sources. Hence, the case study approach can be particularly beneficial in supporting and expanding previously developed theories that foster good health outcomes (Amerson, 2011).

Target Populations

The target populations comprised people who shared similar characteristics (Creswell, 2013). The first target population were African immigrants who lived in Montgomery County, Maryland, at the time of the study and had been diagnosed with Type 2 diabetes within the last 5 years. I recruited adult male and female African immigrants to be in the sample. Venters and Gany (2011) noted that from 1990 to 2000, the number of African immigrants to the United States increased by 166%, a percentage that has raised concerns about assessing the health care needs and practices of the diverse populations now living in the United States.

Venters and Gany (2011) mentioned that African immigrants represent the most rapidly expanding immigrant population in the United States, with the largest concentrations living in the metropolitan areas of Washington, DC; Maryland; Virginia; New York City; Minneapolis-St. Paul; and Atlanta. According to the Pew Research Center analysis of U.S. Census data documented by Anderson (2015), African immigrants living in the United States account for 4.4% of the total population. Africans had the fastest population growth rate from 2000 to 2013, with an increase of 41% during that period. Based on the U.S. Census Bureau's 2005 American Community Survey, the Washington, DC; Maryland; and Virginia metropolitan areas are home to 114,000 Black African immigrants, a number comprising 11% of the area's total immigrant population (as cited in Wilson & Habecker, 2007). This metropolitan area is one of the largest U.S. concentrations where African immigrants live and work.

I recruited 10 patient participants by placing and sending out flyers to resource centers, namely, grocery stores, churches, medical clinics, community centers, libraries, and recreational centers, frequented by African immigrants. The second target population were health care providers. I recruited five providers (i.e., CDEs, nutritionists, and dietitians) by sending invitations to county-funded community clinics, where community residents access their health care needs. I also extended the invitation to health care providers working in community diabetes education and prevention programs in the county.

Sample Size

According to Dworkin (2012), the sample sizes in qualitative research often are smaller than those in quantitative research because qualitative methods are more relevant to gaining an in-depth understanding of phenomena rather than gathering and analyzing data. In qualitative inquiry, there are purposeful strategies in selecting sample sizes, not methodological rules that require statistical formulas (Patton, 2002). The advantage of qualitative inquiry is that there are no restrictions about sample sizes; instead, the sizes depend on what researchers want to know, the purpose of the inquiries, what is at stake, and the credibility of the studies (Patton, 2002).

Because research projects depend on data that have been obtained from samples, sampling considerations and strategies have to be considered. First, it is important to identify the situations and the different types of sampling that are appropriate. A sample, for example, should represent the larger target population. For this study, I used purposive sampling based on Patton's (2002) predetermined criteria that the power of purposive sampling lies in selecting information-rich cases. Such cases offer more insight into the issues being researched and yield deep understanding rather than empirical generalizations (Patton, 2002).

Selection of the sample of five CDEs and 10 African immigrant patients who had been diagnosed with Type 2 diabetes in the last 5 years was based on my belief that the size could be manageable and that the participants could deliver in-depth feedback to answer the RQs. Because the main goal of selecting a sample size is to gather data to answer the RQs, data saturation, defined as data adequacy, was important to consider

(Kerr, 2010). In the current study, the sample size had to be sufficient to facilitate a comprehensive and credible analysis to reach data saturation. Kerr (2010) added that the relationship between saturation and sampling strategy is relevant to the interview questions used for the focus groups and aims at achieving saturation, the point in the data collection process when no new concepts are being elicited from the participants during the interviews. Although Kerr indicated that there are no standard tests for estimating and proving an adequate sample size to reach saturation, data are shaped by the interviewees' responses.

Participants were selected based on their interest in providing the information needed to answer the RQs. Second, the patient participants had to have been diagnosed with Type 2 diabetes within the last 5 years. The diabetes diagnosis had to be verified by the participants in the form of self-reports. As mentioned previously, the sample comprised 15 participants, 10 of whom were African immigrant patients and five of whom were CDEs who helped patients to manage their diabetes in practice. Higginbottom (2004) stated that the way in which the sample is chosen in qualitative research is determined by the topic under investigation.

Informed Consent and Confidentiality

An informed consent form should be written in clear and simple language that the participants can easily understand. I had the participants fill out and sign the consent form developed by Walden University, which included specific details of the study to ensure the transparency of information relevant to the study. In any study, the researcher must explain the importance of informed consent and confidentiality to the participants in case they wish to withdraw early from the study. I contacted the potential participants via face-to-face communication to assess their interest in joining the study. I recruited the participants from Montgomery County, Maryland, only. I personally delivered the consent form to each participant to ensure that all of them read and understood the details about the study before signing it. Hand delivering the consent form also gave the participants the opportunity to ask me questions about the study process. The signed consent protected the participants from any unforeseeable risks related to being in the study.

Confidentiality is important in research to maintain the privacy of the participants and their information. I used numeric identifiers to maintain the participants’ privacy (e.g., P1, P2, CDE1, CDE2, etc.). I assured all of the participants that all collected data would remain confidential and that I would protect them from any harm while conducting the study. It also was important to conceal the study setting and any other identifying information to further protect the participants’ right to privacy.

Data Collection

I conducted the focus groups over 2 weekends, the most suitable time during the week for the participants. Each participant received an e-mail with the address and time of the focus group, along with details of the focus group agenda. I rented a boardroom in a recreation center to conduct the focus groups, and I provided a light lunch. Two days before the agreed date of the focus group, I made a reminder phone call to the participant. I used a Sony digital recorder to record the interviews. As mentioned previously, I collected the data from 15 participants, five CDEs and 10 African immigrants who had been diagnosed with Type 2 diabetes within the last 5 years.

According to Creswell (2013), there are four data collection approaches in qualitative research: observations, interviews, documents, and audiovisual materials from focus groups. I collected the data from focus groups and notes that I took during the focus groups. First, I conducted the focus group with the five CDEs, who answered 10 open-ended questions and some follow-up probing questions. I then conducted the focus group with the 10 patient participants, who answered 10 open-ended questions that were rephrased from the questions asked of the CDEs and follow-up probing questions to obtain insight into their perceptions of patient-provider communication. Both focus groups were essential to facilitate social change in professional development through CEUs.

I also took handwritten notes during the focus groups, each of which was approximately 60 minutes long. I kept a journal and made bullet points to describe possible themes and capture main points from the focus groups. I used the notes to track similarities and difference in the ways that the participants responded to the questions and probing questions. The notes allowed me to identify gaps in patient-provider communication that contributed to poor health outcomes relevant to Type 2 diabetes self-management by patients who are African immigrants.

As already mentioned, I used a Sony audio recorder to capture the participants' responses. To ensure that the participants understood the content and process of the focus groups, I provided them with a consent form written at a Grade 6 reading level. Signing the consent form signified their agreement to be interviewed. A verbal explanation of the study to ensure that the participants understood what they had signed, a discussion of the minimal risk involved, and an explanation of the procedure to withdraw from the study at any time were provided before the interviews began. During the focus groups, I kept a journal to document biases and record my personal feelings and thoughts. Data collection took approximately 1 month; I spent 2 weekends conducting the focus groups and 2 weekends compiling the data.

Instrumentation

I obtained the information primarily by using an interview protocol and secondarily by observing the participants and making notes during the focus groups. Miles et al. (2014) developed an interview guide that I followed:

1. Be familiar with the phenomenon and the setting under study;
2. A multidisciplinary approach, as opposed to a narrow grounding or focus in a single discipline;
3. Have good investigative skills, the ability to draw people out, paying attention to details;
4. Be comfortable, resilient and nonjudgmental with participants in the setting;
5. A heightened sense of empathetic engagement, balanced with a heightened sense of objective awareness. (p. 42)

To validate the interview questions, I conducted a pilot focus group with five participants using sample questions prior to conducting the primary study. The pilot study gave me the opportunity to practice and prepare for the focus group. I sent a letter of invitation to the African immigrant communities requesting volunteers 18 years of age and older to participate in the pilot study. A Walden University-approved consent form was prepared for the pilot study participants. The pilot study was conducted 3 weeks before the primary study. Data from the pilot study interview questions were collected using a notebook .Although the questions for the first pilot focus group were different from the second pilot study group, it was relevant to have perspectives from both CDEs and patients. The pilot study interview questions required the participants to address how well they understood patient-provider (CDEs) communication and patient health outcomes.

Simon (2011) mentioned that although pilot studies do not guarantee success in the main study, they address items that could be missed, such as unclear wording of the questions, skill of the researcher in conducting interviews, and incomplete or unclear instructions. Simon indicated that pilot studies are useful in determining whether the patterns and themes will generate the information needed to answer the RQs. Furthermore, pilot studies can identify weaknesses in a study and can inform the researcher about likely outcomes resulting from such weaknesses if they are not repaired (Simon, 2011). These qualitative instrumentation guidelines were implemented after I received approval from the IRB. I will store all collected data in a safe and secure location until the study is finished.

Data Analysis

The process of data analysis in qualitative research involves making sense of the collected data to answer the research problem. Data analysis is an ongoing process that requires continual reflection while answering analytical questions, gathering more data, making interpretations, and writing reports (Creswell, 2013). Even though multiple strategies are required when analyzing the data, such as interpreting the meanings of the emergent themes, interrelating, coding, organizing and preparing, and transcribing, a general procedure often is used to complete the steps in the data analysis (Creswell, 2013). Malterud (2001) added that the analysis of qualitative data involves decontexualization and recontexualization. Decontexualization allows parts of the subject matter to be investigated closely; recontexualization ensures that patterns agree with the context of the data that have been gathered, thus maintaining the connection between the research problem and the participants' accounts of their lived experiences (Malterud, 2001).

Because a qualitative approach can be used in multidisciplinary health research, I used the framework method for the management and analysis of the data. Gale, Heath, Cameron, Rashid, and Redwood (2013) noted that the framework method has been used since the 1980s. There are several applications within the framework method that can manage the data without using full original accounts given by the case studies. The approach condenses and summarizes data that can support answering the RQs (Gale et al., 2013). For instance, the framework method uses (a) analytic memos to capture emerging issues; (b) categories to cluster ideas that are related or similar; (c) charting, which is the entering and summation of data; (d) coding, which is the assignment of raw data; (e) themes, which involves interpreting concepts and explaining aspects of the data; and (f) transcriptions, the written accounts of the interview responses (Gale et al., 2013).

The framework method is a flexible tool that can be adapted for use with many qualitative approaches, which makes it appropriate for first-time researchers using raw or primary data, particularly when studying problems that have had a limited research focus. The framework method provides clear steps and produces structured output of the summarized data (Gale et al., 2013). In the current study, the framework method required the use of transcriptions and themes. The transcriptions were written accounts of the participants' verbatim responses to the interview questions. Themes reflected the concepts that served as the final output of the interactions among the participants. The framework method seeks to draw descriptive and explanatory conclusions surrounded around themes. The selected applications of the framework method were used to analyze the data gleaned from the interview sessions.

Threats to Internal and External Validity

According to George, Batterham, and Sullivan (2003), validity refers to the credibility and accuracy of studies. George et al. asserted that studies are valid only if the researchers are truly addressing the problems that they initially set out to investigate. Because validity is widely recognized as the most important consideration in research, it is important to know that validity is subdivided into internal and external components (George et al., 2003). George et al. added that the interaction between internal and external validity is important to consider in research because validity helps in analyzing the data. George et al. indicated that researchers have to pay close attention to internal validity in order to control variables that might affect or reduce the generalizability of the results.

Internal validity explains whether the actual observations and measurements made by researchers are truly representative of what they were observing and measuring (George et al., 2003). External validity arises when experiments draw incorrect inferences from the same data (Creswell, 2013). Nonetheless, there are several threats to validity that can arise when forming the outcomes. Creswell (2013) identified some threats to internal validity as experimental procedures of the treatment of the participants that can threaten a researcher's ability to draw correct inferences from the data.

To improve validity, Malterud (2001) suggested the use of procedures and principles like triangulation, respondent validation, clear detailing of methods of data collection and analysis, reflexivity, and attention to negative cases. Malterud added that the relevance of a study can be increased using detailed reports and sampling techniques; therefore, it is important to think about the effects of context and bias. According to Noor (2008), case studies have been criticized for their lack of scientific rigor and reliability that do not address the issues of generalizability. However, the use of multiple case studies enable researchers to gain holistic views of certain phenomena and capture the emergent flow of activities (Noor, 2008).

To control internal validity and maintain credibility in my study, I observed the participants for any manifestation of disconfirming behaviors during the interviews. Disconfirming behaviors could suggest poor outcomes (Creswell, 2013). Therefore, to demonstrate credibility, I sought the opinions of other participants to highlight complex perceptions and understand the responses to feel confident about the interpretations. To control internal validity and maintain confirmability, Creswell (2013) indicated that categorizing the data into themes and relationships is necessary for interpretations, findings, and conclusions for the final report, which I compiled from the focus group responses for the current study. To control external validity and maintain transferability of the data, I ensured that the information given by the participants could be used to develop CEUs, which could help providers to understand the importance of culturally appropriate patient-provider communication in the self-management of Type 2 diabetes by patients who are African immigrants. To demonstrate dependability, I ensured that the cases selected for the study were richly informative cases that generated responses to answer the RQs.

To address issues relevant to internal validity and to maintain credibility, Creswell (2013) suggested various validation strategies:

1. Prolonged engagement and persistent observation that include building trust with the participants and checking for misinformation.
2. Triangulation that enables the use of multiple sources that validate the findings.
3. Negative case analysis, the investigator refines working hypotheses as the inquiry advances; the researcher needs to report a realistic assessment of the phenomenon under study.
4. Clarifying researcher bias is important to ensure that they do not impact the findings.

5. Member checking gives participants the opportunity to view researchers' interpretations of their accounts. Data are taken back to the participants to judge the accuracy and credibility of the accounts.

Summary

The qualitative case study could provide new insight into understanding the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants. I collected the data by interviewing 15 participants. Ten participants were African immigrant patients who had been diagnosed with Type 2 diabetes within the last 5 years, and five were CDEs. In this case study, all of the participants shared their real-life experiences. The goal was to determine how the interview responses could be used to develop CEUs for health care providers to facilitate positive social change regarding culturally appropriate patient-provider communication. Chapter 4 presents the analysis of the data.

Chapter 4: Results

Introduction

Chapter 4 presents the data collection and analysis of both the pilot study and the primary study, followed by a discussion of the results using the participants' responses to the interview questions. The purpose of this study was to understand the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants. Data were collected from 15 participants, 10 of whom were African immigrants diagnosed with Type 2 diabetes within the last 5 years and five of whom were CDEs. The focus group process allowed the participants to share personal encounters, experiences, and perceptions of patient-provider communication in health care delivery. The study was guided by four RQs:

RQ1: How does patient-provider (CDEs) communication affect the self-management of Type 2 diabetes of patients who are African immigrants?

RQ2: How does patient-provider (CDEs) communication promote shared decisions in achieving the disease management goals of patients who are African immigrants?

RQ3: How does patient-provider (CDEs) communication influence the health assessment for Type 2 diabetes self-management of patients who are African immigrants?

RQ4: How does culturally appropriate communication influence the outcome of Type 2 diabetes self-management of patients who are African immigrants?

This chapter covers the following topics: the recruitment of patients and CDEs, the pilot study, the focus group process, participants' demographics, and the data collection and analysis procedures. Results of the data collection and evidence of trustworthiness also are presented.

Pilot Studies

Pilot Study With CDEs

The first pilot study was conducted on January 7, 2017, with three English-speaking female CDEs chosen from the 11 people who responded to the flyer, which had been posted at two libraries. The three CDEs were chosen based on the following criteria: They had to be able to speak English, be over the age of 18 years, commit to 2 hours for the focus group, and be available on the day of the focus group. Participants responded by either calling or e-mailing me. The two libraries were selected because of the easy access to resources and information for the community and walking distance from the developments to the libraries. Prior to meeting, I e-mailed the consent form to each individual to ensure that they understood the content and had the opportunity to ask questions before signing the form on the day of the pilot study focus group. I assigned numeric identifiers to the pilot participants (CDE1, CDE2, CDE3). Each pilot study focus group lasted 2 hours. Coffee and pastries were provided as refreshments.

The pilot study enabled me to practice how I would conduct the primary interviews and to reword any unclear questions. The three CDEs responded to all of the interviews questions and offered ideas on ways to assess patients who are African immigrants with Type 2 diabetes and improve communication. Another reason for conducting the pilot study for CDEs was to assess the primary RQs and ensure that the feedback would answer them. The original proposal was based on conducting a pilot study with patients only, but the university's IRB advised me to conduct a pilot study also with CDEs. The change in the proposal allowed me to get to know how the CDEs thought that the RQs could be answered. The CDEs' perspectives of patient-provider communication were significant in suggesting strategies for culturally appropriate communication that could ensure the self-management of Type 2 diabetes by patients who are African immigrants.

The pilot study's open-ended questions follow:

Q1. How do you ensure that patients understand the instructions regarding Type 2 diabetes self-management?

a) What communication style works better with patients who are African immigrants?

b) What teaching tools do you use to reinforce the instructions given to the patients?

Q2. How do you incorporate shared decisions to help your patients manage their diabetes?

a) How do you engage patients to share what they are doing, and what they are having trouble with in managing Type 2 diabetes?

b) When patients share their decisions in achieving good health outcomes, how do you help them achieve those goals?

Q3. What health assessment tools do you use to determine what the patients know about Type 2 diabetes self-management?

a) What communication strategies do you use with patients with low health literacy?

b) How do you ensure that patients are communicating effectively to get the best health assessment of their disease management?

Q4. What aspect of culturally appropriate communication do you use when communicating with patients who are African immigrants with Type 2 diabetes?

a) What significant benefits did you come across when you incorporated cultural aspects in communicating with patients who are African immigrants with Type 2 diabetes?

b) What culturally appropriate tools do you use to influence better health outcomes for patients who are African immigrants with Type 2 diabetes?

A summary of responses is available in Table 1. The summary of the pilot focus group with the CDEs was informative and showed that the providers used different techniques to communicate with their patients, with an emphasis always on providing the best patient care. I made no significant changes to the focus group questions.

Table 1

Summary of Pilot Study Responses From CDEs

Questions	Feedback
Q1. How do you ensure that patients understand the instructions regarding Type 2 diabetes self-management?	- *CDE 1* stressed the importance of assessing what the patient knows about diabetes first and indicates “I would ask the patient to tell me how long she/he has had diabetes, their treatment goals and if they know what self-management means”?
a) What communication style works better with patients who are African immigrants?	- *CDE 2* “I would first ask if English is the second language because this gives me an idea how the conversation would begin and end”
b) What teaching tools do you use to reinforce the instructions given to the patients?	- *CDE 3* “In the initial assessment of my patients, I like to gather background information about the patients which, includes asking if the patient has access to medical care” *CDE 3* "I will then know how to structure the conservation.” - The pattern noticed from all 3 CDEs, communication style that works best is the teach-back method (Researcher) *probing* “what does that look like? *CDE1,* “since nutrition is a major component of self-management, it is important to explore the patients’ food habits and ask the patient how they prepare their food.” Researcher “all 3 *CDE*s agreed and added CDEs should get to know their patients’ food habits particularly with diverse patients.” Table Cont’d

Questions	Feedback
Q2. How do you incorporate shared decisions to help your patients manage their diabetes? a) How do you engage patients to share what they are doing, and what they are having trouble with in managing Type 2 diabetes? b) When patients share their decisions in achieving good health outcomes, how do you help them achieve those goals?	- *CDE2*, “in my experience patients who speak English as a second language find it hard to share information.” *CDE* 2 “I assume the medical-care culture of other countries is different from the U.S. where history/physical is mandatory.” *CDE 2* “I like getting to know my patients by asking what they do to live a better life with diabetes.” *CDE 2* “This helps me to agree as a team on treatment goals/options.” Researcher “*CDE1 & CDE3* agreed to *CDE2’s* feedback.” - *CDE1*, “it is very difficult especially when a patient’s A1c has not dropped in a year particularly if he/she is not sharing what he/she is having trouble with.” *CDE 1* ”In this case I like to start with the resources that are available to the patients.” *CDE 1* ”This helps me to align how to engage a conversation.” *CDE 1* “For example, I had a patient whose A1c was 13.5, uninsured and spoke very little but a year later he came back and it had dropped to 7.8.” *CDE 1* “This was an excitement so he shared that he was taking free diabetes classes offered at the community center where he finally learnt portion size using the plate method.” - *CDE3,”* usually I start with words of empowerment by telling my patients that their decisions are priority in the treatment plan.” *CDE 3* “Therefore, working as a team gets good results.” *CDE 3* “I ask my patients to document their blood sugar level every time they take it and by documenting, it is decision they are taking seriously to achieve good health.” Table Cont’d

Questions	Feedback
Q3. What health assessment tools do you use to determine what the patients know about Type 2 diabetes self-management? a) What communication strategies do you use with patients with low health literacy? b) How do you ensure that patients are communicating effectively to get the best health assessment of their disease management?	- *CDE3,"* since I am not a native American I understand the confusion with a generic health assessment that providers use therefore, I like the non-traditional approach of asking my patients what diseases run in the family." *CDE 3* "When they mention diabetes, I then ask them to tell me about what they know." *CDE 3* "For example, I had a patient from Liberia who indicated that diabetes is an *"ant disease."* I asked what that meant and she said because ants like sugar therefore if one likes sweets things, they are ants." *CDE 3* "If you don't want the ants to show up in your house, you take the sugar out of sight." *CDE1,* "I let my patients' translator their knowledge of diabetes the best way they can." *CDE 2,* "I agree because each patient is unique and the approach has to be based on good listening from what the patient has to say in order to have a good health assessment." *CDE 2* "I like to use diabetes conversation maps to gauge what the patient knows about diabetes self-management." - *CDE 3,"* like CDE2, said conversation maps are a great way of communicating with patients with low health literacy." *CDE 3* "This approach portrays a communal setting to satisfy a patients' upbringing and belonging." - *CDE1,"* I like to give the patients' an opportunity to ask questions and also use blood sugar journals." *CDE 1* "With technology, patients are able to use applications on their smart phones which my office helps with setting-ups." *CDE 1* "So they are able to log their numbers in as a way to keep everything in one place." *CDE 1* "Lastly I let my patients lead the conversations during their follow-up visits." Table Cont'd

Questions	Feedback
Q4. What aspect of culturally appropriate communication do you use when communicating with Patients who are African immigrants with Type 2 diabetes? a) What significant benefits did you come across when you incorporated cultural aspects in communicating with patients who are African immigrants with Type 2 diabetes? b) What culturally appropriate tools do you use to influence better health outcomes for patients who are African immigrants with Type 2 diabetes?	- *CDE1, "*first of as health providers we know that culture has a lot of influence on most ethnic patients' outcomes." *CDE 1* "Understanding cultural differences should be central to the approach used in administering care to patients who are not native Americans." *CDE 1* "I like to ask my patients to inform me on what they have been doing in managing their diabetes." *CDE 1* "By doing this you get an understanding cultural experiences that you can blend in scientific approach in disease management." - *CDE3, "*with all cultures even within native Americans; you have to approach the patient with respect in what they believe in." *CDE 3* "The benefit is, they will open up and allow you the provider to give recommendation. *CDE 3* "For example, I had a patient who resisted behavior change because his grandmother lived to be 70 years with diabetes and no treatment but relied on herbs" *CDE 3* "We talked about the kind of herbs (alternative) medicines as he called them. I respected that but I had to re-direct the treatment to how generations have changed." - *CDE 2,"* the tools I like to use are virtual food models which I created with different ethnic pictures." *CDE 2* "I incorporate activities of preparing an ideal meal using models of ethnic foods and let my patients decide if it meets guidelines of a healthy meal." *CDE 2* "This approach falls into cultural respect using a two-way street whereby the patient and I decide what's best to manage their diabetes."

Pilot Study With Patients

The second pilot study focus group was conducted on January 14, 2017, with five patients, three women and two men, who were English-speaking African immigrants with Type 2 diabetes who had self-reported their diagnosis. The five individuals responded to the flyer that had been posted at three places, namely, library, recreation center, and laundromat, prior to meeting with them. I e-mailed each individual the consent form to read and ensure that they understood the details of the pilot study. I provided clarity if the language was unclear before asking them to sign the form. Each pilot study focus group lasted 2 hours. The pilot study enabled me to practice how I would conduct the primary interviews and address any unclear questions. A summary of their responses is available in Table 2. I made no significant changes to the focus group questions.

Q1. Have you ever attended educational sessions on managing Type 2 diabetes with a diabetes educator? If the answer is no, why not? Please explain. If the answer is yes, please give details on the questions below:

a) How satisfied are you in communicating with a diabetes educator?
b) How has the communication with the diabetes educator helped you in making informed decisions towards the best health outcomes?

Q2. Regarding your Type 2 diabetes self-management, what do you discuss with the diabetes educator? Please explain.

a) What factors make you comfortable when communicating with a diabetes educator?

  b) How has Type 2 diabetes affected you emotionally in the self-management process?

Q3. When were you diagnosed with Type 2 diabetes?

  a) Does having Type 2 diabetes affect your quality of life? Please explain.
  b) How have you been able to understand the self-management of Type 2 diabetes? Please explain.

Q4. What is the most difficult part when communicating with the diabetes educator on your cultural influences when managing Type 2 diabetes?

  a) What health priorities do you have in place to help you with Type 2 diabetes self-management?
  b) Do you think the community you live in is supportive of your Type 2 self-management? Please explain.
  c) How do you balance Type 2 diabetes self-management and other aspects of your life to get the best health outcomes?

Table 2

Summary of Pilot Study Responses From Patients

Questions	Feedback
Q1. Have you ever attended educational sessions on managing Type 2 diabetes with a diabetes educator? If the answer is no, why not? Please explain. If the answer is yes, please give details on the questions below: a) How satisfied are you in communicating with a diabetes educator? b) How has the communication with the diabetes educator helped you in making informed decisions towards the best health outcomes?	*P1, “*no I have not because I have not found any place to go for sessions.”*P1* “But in my church we have a women’s health ministry every third Wednesday of the month where we bring in an outside person to come and talk to us about healthy living.” *P5, “*I have been fortunately that my son works at Providence Hospital and I am able to attend their diabetes education classes as a family member.” *P5* “I like the classes because they give us free health kits and we are able to check the A1c as part of the class.” *P5* “The only problem I have is the nutritionist doesn’t know much about African staple foods which I am used to.” *P5* “Therefore, it makes it difficult to explain the cultural foods I am used to.” *P5* “And although she says that I can go to her anytime, I feel she cannot help me as much as I want to.” *P2 & P3, “*we agree not too many nutritionists know about African foods especially if they are not African and that is why *P2,* “I like to go to health fairs where I can find someone who knows what I like to eat.” Table Cont’d

Questions	Feedback
Q2. Regarding your Type 2 diabetes self-management, what do you discuss with the diabetes educator? Please explain. a) What factors make you comfortable when communicating with a diabetes educator? b) How has Type 2 diabetes affected you emotionally in the self-management process?	*P5, “*well I don’t have insurance I get most of my health care from Mobile med clinic which is limited although there is someone who answers questions.” *P5* “I talk about my medications and how to avoid complications.” *P4, “*I too get medical care from the free clinic at the health department because I don’t have insurance.” *P4* “The young lady, who is a diabetes nurse is very knowledgeable.” *P4* “I believe she is from Ghana and knows the struggles of people like me with diabetes.” *P4* “Although I am from a different country, the food we eat is similar and I am comfortable talking to her because she shows me pictures of food and we discuss the ingredients that we use to cook.” *P2,* “in the beginning I was having problems like going to the bathroom a lot during the night, I thought because I drink a lot of water that is why I was waking up every hour.” *P2* “But it went on for 6 months and my friend recommended I see a doctor. I was diagnosed with diabetes in 2011.” *P2* “The first thing was “I might have my legs cut off” because many people with diabetes have their legs cut off.” *P1,* “I have a similar story but instead I became depressed because I was afraid to talk about it and it was hard for me to adjust to not eating whatever I wanted to eat.” *P1* “My children didn’t understand, they are young and have a lot of energy but with my age of 66, I am old and I like my African food.” *P1* “So I was very depressed and I prayed to God to make me better.” Table Cont’d

Questions	Feedback
Q3. When were you diagnosed with Type 2 diabetes? a) Does having Type 2 diabetes affect your quality of life? Please explain. b) How have you been able to understand the self-management of Type 2 diabetes? Please explain.	*P3, "*what does diagnose mean"? *(researcher) "*when did you first find out that you had diabetes"? *P3* "Well my mother died of diabetes which is we call a "sugar disease" in Uganda." *P3* "I was fortunate to have come to the United States to stay with my son." *P3* "He took me to get a checkup and I asked that they check for sugar." *P3* "The lady we saw asked that we come back a week later and I was told that I had the 'sugar disease' that was in 2012." *P3,* "diabetes does not affect my life because I took care of my mother and I followed what her doctor told us to do." *P2*, "I found out that I had diabetes in 2011 but with my work from 2 jobs, it is hard to manage because I don't get time to take care of myself as I should." *P2* "Sometimes I eat late and I don't exercise." *P2* "I want to learn how to plan managing my 2 jobs and taking care of my problem." *P5, "*I was also diagnosed in 2011." *P5* "I went to visit my daughter in Canada and I fainted." *P5* "My daughter took me to the hospital and I was diagnosed with diabetes." *P5* "Before I was diagnosed I felt not so good but I didn't go to see a doctor although my son in North Carolina insisted I go see the doctor." *P5* " I didn't understand the disease but now I do because I don't want to bother my children." *P5* "I am still having a hard time understanding how to take care of myself because most of my food is African food which has a lot of starch but I am like it and I am used to it." Table Cont'd

Questions	Feedback
Q4. What is the most difficult part when communicating with the diabetes educator on your cultural influences when managing Type 2 diabetes?	*P1,"* well unless it is someone who is from the same culture as I am I feel they will not understand the struggles of trying to adapt to another culture." *P1* "Trying to explain to someone who does not share the same cultural values as you, it creates a disconnect in communicating." *P1* "It feels like communication has no rapport." P2, P3, P5 all agreed "nodding their heads."
a) What health priorities do you have in place to help you with Type 2 diabetes self-management?	*P3, "*the most important priority I have to work on is time management." *P3* "I work 2 jobs and have 3 kids therefore, trying to manage my diabetes and other things becomes tiresome and frustrating." *P2,* "Time management is everybody's struggle, I am trying to figure things out balancing work and taking time to plan my meals for the week can be frustrating."
b) Do you think the community you live in is supportive of your Type 2 self-management? Please explain.	*P4, "*first of all there is stigma to having any disease." *P4* "Anybody who knows a life of an immigrate will also understand that many of us come here to work not to get sick therefore, when people get sick they keep it to themselves." *P4* "I believe the silence is killing a lot of people because nobody wants to be a point of discussion 'gossip' ." *P4* "In other words, community doesn't help at all." *P4* "The other point is I live in an all immigrant neighborhood, low income with several languages spoken; this makes it very difficult to get people together and create support groups." P*4* "Many of my neighbors have a language barrier." *P5, "*I am fortunate that I belong to a women's Islamic ministry." P*5* "We created support groups to address health particularly how to manage chronic diseases and from time to time we invite professionals to come and share resources that we can use to live well."
c) How do you balance Type 2 diabetes self-management and other aspects of your life to get the best health outcomes?	*P2,"* I think as an immigrant, balancing has never been part of our lives prior to coming to the United States." *P2* "Some of the western practices are new to us therefore we have to learn how to live the native Americans." *P2* "I speak for many people who struggle with practices they never grew up with." *P2* "Same as *P5,* I belong to a support group of only women and time-management, balancing family/work/school/illness are some of the things we discuss."

Setting

The pilot study focus groups were conducted on January 7 and 14, 2017, respectively. Each one lasted 2 hours. At the beginning of the pilots, each individual (CDE and patient) was e-mailed the same informed consent. Although the participants had read the informed consent, I reminded them of their right to withdraw from the pilot studies at any time without repercussions and their responsibilities to the pilot study. To make the participants comfortable, I provided coffee and pastries.

I also reminded the participants at the beginning of the session that the focus groups would be recorded. Because of the rapport that I developed with each individual during our initial phone conversation about joining the study, I believed that there was no need for any other introductory comments.

Demographics

Participants in the two pilot studies were two men and six women. I conducted the pilot focus groups to understand the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants. Participants were given numeric identifiers (CDE1, CDE2, P1, P2) and asked to introduce themselves by informally providing basic demographic information. The purpose of obtaining the demographic and descriptive information (in terms of who the participants were) was to highlight the diversity of the participants as representative of the community. The demographic information given by the CDEs was related to age, education, licensure, nationality, and length of practice (see Table 3).

Table 3

Demographics of CDEs

Participant	Age	Gender	Education	Licensure	Nationality	Years in practice
CDE1	32	Female	BS in nutrition	Registered dietitian	Ghanaian	5
CDE2	48	Female	BS in nutrition	Registered dietitian	Ugandan	8
CDE3	49	Female	BS in nutrition	Certified clinical nutritionist	Afro-Caribbean	22
CDE4	35	Male	BS in nursing	CDE	Kenyan	8
CDE5	51	Female	BS in nursing	CDE	Nigerian	17

n = 5

The patients provided information about age, education, marital status, nationality, and health insurance status to further showcase the diversity within the African immigrant community (see Table 4).

Table 4

Demographics of Patients

Study participant	Age	Gender	Education	Length of diagnosis	Marital status	Nationality	Health insurance
P1	48	Female	Associate degree	4 yrs	Married	Cameroonian	Yes
P2	52	Female	Graduate degree	3 yrs	Divorced	Cameroonian	Yes
P3	42	Female	Bachelor degree	3.5 yrs	Married	Ghanaian	No
P4	38	Female	Bachelor degree	2.5 yrs	Single	Ugandan	No
P5	46	Male	Graduate degree	4 yrs	Married	Sierra Leone	No
P6	39	Male	Postgraduate degree	2.5 yrs	Married	Cameroonian	Yes
P7	57	Male	High school/some college	5 yrs	Married	Ethiopian	No
P8	70	Female	High school	4.5 yrs	Widowed	Nigerian	Yes
P9	66	Female	High school	4 yrs	Married	Gambia	No
P10	63	Female	High school	2 yrs	Widowed	Benin	No

n = 10

Location

The interviews were held at a community center where I had rented the boardroom for 2 consecutive weekends in January 2017. The data collection process for both the pilot studies and primary interviews for CDEs and patients lasted 4 weekends in

January 2017. A journal was used to take notes during the pilot studies and primary interviews. I also used an audio tape recorder to record the interview responses to ensure that the transcriptions would be accurate.

Data Collection

The primary focus group data were collected in accordance with the procedures described in Chapter 3. The five CDEs were the first to be interviewed using the focus group on January 21, 2017, followed by the 10 patients, who were interviewed using the focus groups on January 28, 2017. The focus groups followed an agenda that I had developed earlier:

- Welcome participants.
- Housekeeping considerations for the interview facility (bathroom location, exit signs).
- Ice-breaker (favorite place to go to).
- Country of origin.
- Explanation of the consent form, purpose of research and mention that notes will be taken and recorded during the interview.
- Be respectful of time agreed upon for the interview.
- Only one participant speaks at a time (respect each other by keeping comments to yourself).
- Ask open-ended question and probe for more details.
- Duration will be 2 hours.
- Light refreshments will be provided.

- 2 breaks for bathroom use and stretching.
- Thank participants.

Data Analysis

Data analysis in qualitative research involves making sense of the collected data to answer the RQs, so it was important to have a reflective approach throughout the process. With this reflective approach, I organized the data using multiple strategies, including interpreting the meaning of emergent themes, interrelating, coding, organizing, preparing, and transcribing (Creswell, 2013).

In addition, because a qualitative approach can be used in multidisciplinary health research, I incorporated the framework method for the management and analysis of the data (Gale et al., 2013); the framework method has been used since the 1980s. Several applications within the framework can manage the data without the need to use full original accounts given by the case studies, for example, by clustering related or similar feedback into themes. The approach condenses and summarizes data that can answer the RQs (Gale et al., 2013) such as themes derived from the analysis of the interview data. The framework method uses (a) analytic memos to capture emerging issues; (b) categories to cluster ideas that are related or similar; (c) charting, which is the entering and summation of data; (d) coding, which is the assignment of raw data; (e) themes, which involves interpreting concepts and explaining aspects of the data; and (f) transcriptions, written accounts of the interview responses (Gale et al., 2013).

The framework method is a flexible tool that can be adapted for use with many qualitative approaches and that is why it is good for first-time researchers using raw or primary data, particularly when studying problems that have had a limited research focus. The framework method provides clear steps and produces structured output of the summarized data (Gale et al., 2013).

For the current study, the framework applications used were transcriptions and themes. The transcriptions were written accounts of the participants' verbatim responses to the focus group questions. Themes captured from the analysis of the transcriptions reflected the concepts that served in the final output of the interactions among the participants during the case study interviews. Therefore, the framework method drew descriptive and explanatory conclusions around the themes to justify the importance of the study. The research design and consent forms were reviewed and approved by Walden University's IRB, and all procedures were conducted in accordance with the IRB's ethical guidelines. Participants were advised that being in the study was completely voluntary and that they could withdraw at any time without repercussions.

Results

Results for CDEs

All participants had a relatively pleasant experience during the focus group based on the exchange of appreciation for my having chosen them to participate in the focus group. The CDEs gave feedback that could help to support culturally appropriate communication between patients and providers. The five CDEs were not surprised that there has been a limited focus of research on health priorities, particularly those of African immigrant patients. According to the five CDEs, who also were African immigrants, many people who come to the United States have the goal of wanting to work and make a better life. They do not think about illness. The five CDEs thought that during initial patient assessments, patients should be asked about their length of residency in the United States to obtain their views on how they have been able to adapt to a different culture in terms of lifestyle changes, eating habits, access to health care resources, and so on. Even more so, the clinical providers emphasized the need to incorporate self-efficacy and shared decision making into the conversation. They indicated that many immigrants are not accustomed to playing a role in their treatment goals, relying instead on providers to make decisions.

The key findings were organized by theme for the CDEs:

- Using visuals to reinforce understanding.
- Shared decisions.
- Lack of confidence.
- Understanding patient circumstances.
- Good health assessment.
- Support groups/group activities.
- Problem-solving skills.
- Cultural component in patient care.
- Patient cultural beliefs in disease management.

Themes Generated From CDEs' Responses

Analysis of the CDEs' responses helped to identify the themes. The data analysis included transcribing the focus group notes by reviewing what I had written during the focus group, listening to the audiotape of the focus group responses several times, and reviewing the probing section of the responses that served as the primary source for data analysis. I organized and evaluated the collected data by writing major patterns and further breaking them down into themes on a white board. Each response had an identifier (i.e. CDE1, CDE2) to help me know who said what.

To understand the content and tone, I organized the responses into clusters to identify commonalities in the responses. To examine the major relationships and categorize the data, I referenced NVivo v.11 to organize my notes; I did not use the software. I reviewed the notebook that I used to write down responses for a general understanding of the participants' tone. I rewound the Sony audio tape recorder several times to understand the overall tone of the responses. I organized the responses into clusters on a white board to distinguish common statements. I identified patterns based on how the respondents answered the questions. Using markers and stickers, I developed a coding process to mark descriptive themes based on the focus group questions and responses collected. I interpreted the information and the data based on the themes and according to how the CDEs answered the questions. I used my notes to describe the meanings of different terms from street language to everyday language, a process that made it easier to identify the themes. I used categories and groupings to organize the themes based on quotations from the focus group responses to support the themes. The following quotations from the participants' responses support the themes.

Theme 1: Using visuals to reinforce understanding. CDE4 used the "plate method as a visual concept of a real-life example of portion size." In addition, CDE4 mentioned that “using the ‘plate method’ as a teaching tool to stress the message is key to good health outcomes, especially patients of low health literacy.”

CDE2 added that “the approach of using visuals in teaching allows patients to repeat what is being taught to them to ensure their understanding of the information.” CDE2 also mentioned that “the plate method allows patients to visualize portion sizes.”

CDE1 stated:

> The teach-back approach was more applicable to patients who spoke English as a second language and demonstrated that patients have a better chance to retain the information and have better health outcomes particularly those that speak English as a second language who may have difficulty with health literacy.
>
> Although most educators focus on lowering the A1c blood sugar level, African immigrant patients have a difficult time understanding the importance of lowering blood sugar levels. It is important for patients to see the importance of blood sugar logs by actually engaging in the exercise of logging A1c blood sugar numbers, the visual ensures the understanding of the information. The concept of visuals allows ideas to stick in memory and has shown effectiveness when patients report back for follow-up treatment. That is where visual tools come into play like virtual food models, pictures that patients could be familiar with. I also use the diabetes conversation map because it portrays a village and the surrounding amenities that many can associate with as being part of daily living.

CDE2 stated, “I agree, it is a starting point of good patient/provider communication, sometimes you have to dig deep or think outside the box to come up with tools that could be useful in clinical practice.”

CDE 5 remarked, “As an essential part of the treatment plan, achieving goals is mastery.”

CDE4 said, “The easiest way to teach and reinforce good eating habits is using the American plate method, which is visual and easy to understand and enables the patient to demonstrate by teaching back to the educator.”

CDE5 commented, “Technically engaging them with visuals like diabetes conversation map is important because it illustrates with pictures the problem-solving aspect of diabetes self-management.”

Theme 2: Shared decisions. CDE2 mentioned:

> Making shared decisions is a foreign concept to many immigrant patients because disease treatment often is left to the attending providers in many developing countries of origin. In the American health care system, shared decisions contribute to improved patient outcomes and many immigrant patients are not accustomed to the American health care system approach.

CDE1 agreed that “shared decisions should be looked into because health care providers could learn a lot about their patients’ abilities in managing diseases.”

CDE5 stated, “Therefore, it is the patients’ call to determine the conversation towards what is assumed with the help of the educator.”

CDE4 commented, “I always wondered if I was not an African immigrant, how would I have handled being the patient in some of these peoples’ shoes, [and] “I always feel as though non-English-speaking patients get intermediated when questioned.”

CDE2 remarked, “I agree the idea of shared decision should be looked into because I feel as though there is a lot we are missing as providers; not being able to help our patients manage their diseases.”

CDE2 mentioned that “first order with my patient encounter is asking how long they have had diabetes.” CDE2 said that based on feedback, “I gauge what I need to ask.”

Theme 3: Lack of confidence. The CDEs identified lack of confidence as a challenge facing many African immigrant patients in terms of diabetes self-management.

CDE2 explained:

> I had a mother/daughter comb; daughter wanted to be a supportive family member and was doing most of the talking. Although I got more than I bargained, I had to ask the patient [mother] to tell me, I wanted to hear from her. Come to find out [mother] was one of those noncompliant patients who will not do what they are supposed to do. The twist to the story is even though she spoke and understood English, reading and writing was the problem.

CDE5 commented, “That shows lack of confidence, which was expressed through not being compliant.

Theme 4: Understanding patient circumstances. The CDEs agreed that understanding patients’ circumstances was key to opening channels of communication and improving health outcomes.

CDE2 provided the following example:

> I had a male patient about age 37 who was doing great with his A1c, but as soon as he lost his job, the A1c went up by 2%; we talked about it, and he indicated he was stressed from not being able to have health insurance and support his family. I had to see if I could get him other resources that could help him. The idea was to help him get back on track because how can he be successful in job search while not being in good health. [all nodding in agreement]

CDE3 said, “Good and effectively patient-provider communication is understanding what other circumstances are keeping the patient from being on track and therefore try to use those circumstances as a channel for intervention.”

Theme 5: Good health assessment. CDE4 exposed the dark side of many practices, such as the use of universal assessments that limit the most appropriate patient-provider communication styles:

> In every doctor’s office, clinic, and hospital is a universal assessment/questionnaire, asking general questions about the patient’s history and physical. In reality many of the patients I have seen and continue to see in my practice are not accustomed to that type of information, what I mean this seems foreign for someone who was never exposed to this type of pre assessment.

CDE2 commented:

> I think health care providers in general have to be re-schooled that with migration and diversity, this is not the best way to know who your patients are. With the limited time each patient is given in my clinic, I like to get to the point, especially

> for first-time patients. I would ask how long they had diabetes, does it run in the family, are they taking medication, if so what kind, do they have it on hand, do they understand the instructions. If the health care provider is a good listener, which is required ethically, it warms up the conversation.

CDE2 further mentioned that "any hesitation or delay in responding, which is typical for many of my non-English patients, could be an indication to explore what exactly is going on regarding how they are self-managing their diabetes."

CDE3 agreed:

> You are right: Creativity in assessing nonnative patients is essential. Something new to learn, and from what I gather, a nontraditional way of health assessment for African immigrant patients this is great. Within the health assessment, you are also trying to figure out how to communicate with your patient. It does not take long to figure out if the patient has low health literacy that is if are having a hard time giving feedback during the initial health assessment regarding self-management.

Theme 6: Support groups/Group activities. In regard to support groups and group activities, CDE5 mentioned:

> Letting the group, not the CDE, lead the conversation has benefits that include more participation from the whole group. Such activities teach participants how to keep blood sugar logs and troubleshoot where blood glucose numbers do not make sense, for example, before and after meal testing, as part of diabetes self-

management. Group activities can prepare patients to learn how to communicate effectively and have good health outcomes.

Theme 7: Problem-solving skills. CDE5 stated:

> I would say letting the patient lead the conversation is the best way to know if they understand their diabetes management. Technically engaging them with visuals like diabetes conversation map is important because it illustrates with pictures the problem-solving aspect of diabetes self-management. Back in the days I worked with the Joslin Diabetes Center, where I taught a series of classes and also held support groups. Sometimes to get patients to learn how to communicate effectively, you have to make sure that they have the fundamental of what diabetes is. I like to give my patients homework [e.g., keeping blood sugar logs] so that when they come in for a visit, they have to explain especially when the numbers are too high. They have to problem solve their own problem in terms of what caused the increase in numbers and what they learnt or needed to do.

Theme 8: Cultural component in patient care. CDE5 noted that "support groups or group activities are a good way to prep patients to communicate better especially for patients who are from a different culture."

CDE3 said:

> I am fortunate enough to have taken a cross-cultural training and getting certified as a facilitator as well as instructor. There are similarities in culture and beliefs across continental Africa; therefore, my communication approach is applicable to

all my patients. The fact that patient engagement is new for many patients of African descent; when sitting with my patients, I meet them where they are in terms of understanding the disease. Talking to them as if they are family, this is a cultural component that comes with respect being African myself.

Theme 9: Patient cultural beliefs in disease management. CDE3 remarked:

Understanding the cultural beliefs of patients and providers about diabetes self-management can mean effective and appropriate patient care. The benefits with that kind of approach is that patients will open up and probably tell you more than you asked for.

CDE1 added:

I find an increased compliance rate with what needs to be done in managing the disease. What I mean is that patients will do everything possible to please the provider not knowing it is for their own benefit to feel and live a better life.

CDE2 said, "I guess it is a cultural thing."

CDE5 commented:

Culturally appropriate tools tend to influence better health outcomes. We often forget background cultural upbringing, whereby some of my patients have indicated that they would rather die a happy person to have lived a healthy lifestyle and the "gods" would be happy. The response in that case was if that's what you believe, then let's do it.

CDE4 stated:

> Give them a chance to see what they want to do to have better health outcomes. I think imposing one's thought onto the patient is the worst thing a health care provider can do. [In that case], we explore the patient's desire and incorporate that in the treatment plan.

The analysis of the focus group responses from the CDEs follows:

Q1. How do you ensure that patients understand the instructions regarding Type 2 diabetes self-management?

a) What communication style works better with patients who are African immigrants?
b) What teaching tools do you use to reinforce the instructions given to the patients?

CDE1 stated that "a teach-back approach" is more applicable for patients who speak English as a second language [all nodding in agreement].

CDE2 added that the approach allows patients to repeat what is being taught to them to ensure their understanding of the information.

CDE1 said, "Although most educators focus on lowering the A1c blood sugar level, African immigrant patients have a difficult time understanding the importance of lowering blood sugar levels."

CDE3 commented, "Therefore, having diabetes education fundamentals as a starting point is important for African immigrant patients for better health outcomes and diabetes self-management skills."

All CDEs agreed that even though patients might speak English fluently, the health literacy of African immigrant patients is a major problem, particularly in understanding food groups and the connection to blood sugar levels. All five CDEs also mentioned that most African foods bought from African supermarkets have complex nutrition labels, especially if they are imported goods.

CDE4 said, “The easiest way to teach and reinforce good eating habits is using the American plate method, which is visual and easy to understand.” Figure 1 illustrates this point.

CDE4 added that the influence of culture is significant to how patients are taught. CDE4 commented, “It is, therefore, best for African immigrant patients to see, touch, and feel the teaching tools for example, virtual carb models used for food activities.” CDE4 added that it reinforces the use of teaching tools.

CDE1 indicated that the concept of seeing, touch and feeling as a strategy used with the teaching tools allows the idea to stick in memory and has shown effectiveness when patients report for follow-up treatment.

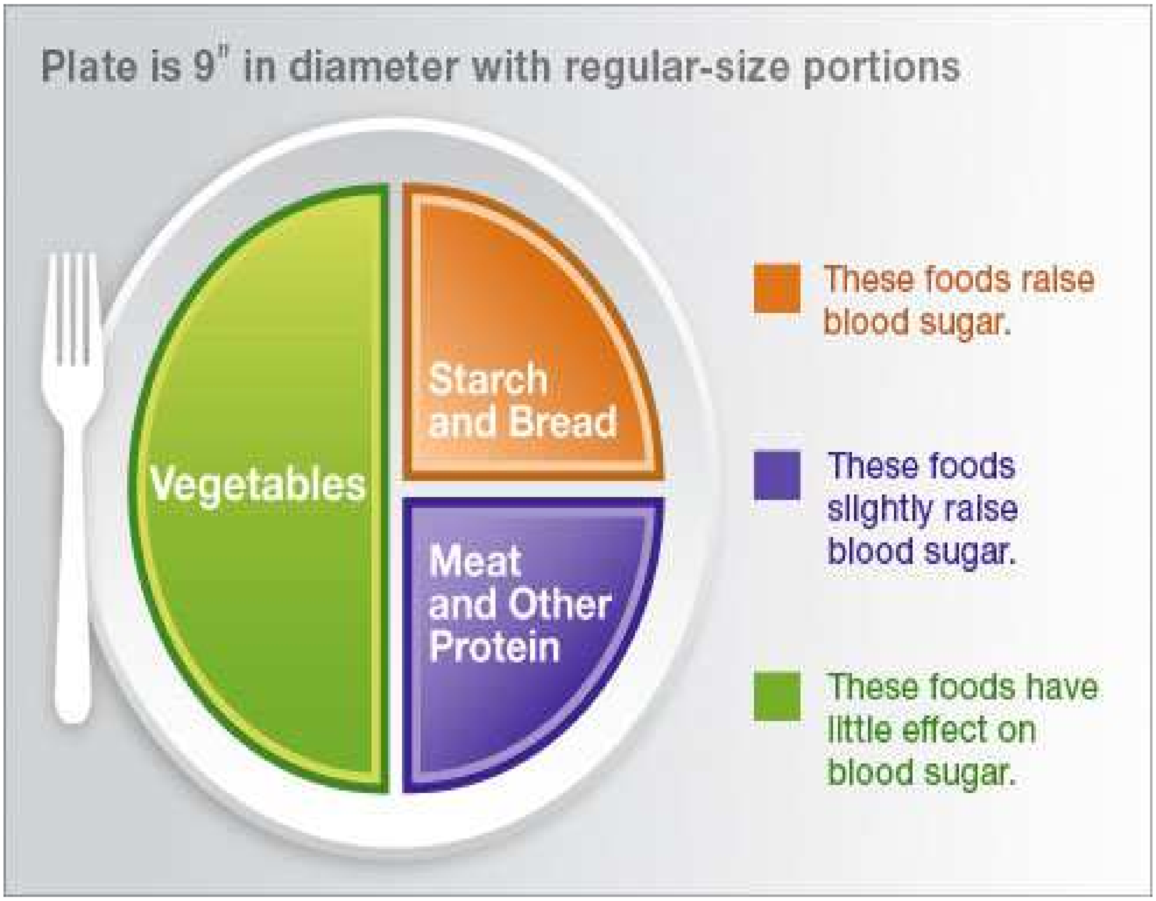

Figure 1. The plate method of diabetes education on diet.

Q2. How do you incorporate shared decisions to help your patients manage their diabetes?

a) How do you engage patients to share what they are doing, and what they are having trouble with in managing Type 2 diabetes?

b) When patients share their decisions in achieving good health outcomes, how do you help them achieve those goals?

According to all five CDEs, the term *shared decisions* was foreign to many of their patients. Therefore, shared decision had to be defined in terms of what it means to diabetes self-management. Technically, the CDEs mentioned that for patients to make the desired change, educators have to understand how that particular patient is “wired” [laugh].

CDE5 stated, “Therefore, it is the patients’ call to determine the conversation towards what is assumed with the help of the educator.”

CDE4 commented, “I always wondered if I was not an African immigrant, how would I have handled being the patient in some of these peoples’ shoes, [and] “I always feel as though non-English-speaking patients get intermediated when questioned.”

CDE2 remarked:

> I agree the idea of shared decision should be looked into because I feel as though there is a lot we are missing as providers; not being able to help our patients manage their diseases. First order with my patient encounter is asking how long they have had diabetes. Based on feedback, I gauge what I need to ask for example I had a mother/daughter comb; daughter wanted to be a supportive family member and was doing most of the talking. Although I got more than I bargained, I had to ask the patient (mother) to tell me, I wanted to hear from her. Come to find out (mother) was one of those noncompliant patients who will not do what they are supposed to do. The twist to the story is even though she spoke and understood English, reading and writing was the problem.

CDE5 commented, “That shows lack of confidence which was expressed through not being compliant” [silence in the room].

I asked the question, “Knowing that is the problem, how do you address it?”

CDE1 responded, “That is where visual tools come into play like virtual food models, pictures that patients could be familiar with.”

CDE1 said, “I also use the diabetes conversation map because it portrays a village and the surrounding amenities that many can associate with as being part of daily living.”

CDE2 stated, “I agree, it is a starting point of good patient/provider communication, sometimes you have to dig deep or think outside the box to come up with tools that could be useful in clinical practice.”

CDE 5 remarked, “As an essential part of the treatment plan, achieving goals is mastery.”

CDE2 said, “Writing and adding that it is not easy because there are other determinants in an African immigrant life.”

I asked the participant for clarification.

CDE2 continued:

> For instance, I had a male patient about age 37 who was doing great with his A1c, but as soon as he lost his job, the A1c went up by 2%; we talked about it, and he indicated he was stressed from not being able to have health insurance and support his family.

I asked, “So what did you do”?

CDE2 explained:

> I had to see if I could get him other resources that could help him. The idea was to help him get back on track because how can he be successful in job search while not being in good health. [all nodding in agreement]

CDE3 said:

> Sometimes when you identify with an individual, it does not hurt to go an extra mile. I think this society lacks a sense of humanity in patient care. Good and effectively patient-provider communication is understanding what other circumstances are keeping the patient from being on track and therefore try to use those circumstances as a channel for intervention.

Q3. What health assessment tools do you use to determine what the patients know about Type 2 diabetes self-management?

a) What communication strategies do you use with patients with low health literacy?
b) How do you ensure that patients are communicating effectively to get the best health assessment of their disease management?

CDE4 responded:

> Interesting enough what you find in every doctor's office, clinics and hospital is a universal assessment /questionnaire, asking general questions about the patient's history and physical. In reality many of the patients I have seen and continue to see in my practice are not accustomed to that type of information, what I mean this seems foreign for someone who was never exposed to this type of preassessment.

CDE2 commented:

I think health care providers in general have to be reschooled that with migration and diversity, this is not the best way to know who your patients are. With the limited time each patient is given in my clinic, I like to get to the point, especially for first-time patients. For example, I would ask how long they had diabetes; does it run in the family, are they taking medication, if so what kind; do they have it on hand; and do they understand the instructions. Within those lines, if the health care provider is a good listener, which is required ethically [laugh], it warms up the conversation. Any hesitation or delay in responding, which is typical for many of my non-English patients, could be an indication to explore what exactly is going on regarding how they are self-managing their diabetes.

CDE3 agreed:

You are right, creativity in assessing nonnative patients is essential. Something new to learn, and from what I gather, a nontraditional way of health assessment for African immigrant patients this is great. [sigh more like a sense of relief]. Again, within the health assessment you are also trying to figure out how to communicate with your patient. It does not take long to figure out if the patient has low health literacy that is if are having a hard time giving feedback during the initial health assessment regarding self-management.

CDE5 stated:

I would say letting the patient lead the conversation is the best way to know if they understand their diabetes management. Technically engaging them with

> visuals like diabetes conversation map is important because it illustrates with pictures. Back in the days I worked with the Joslin Diabetes Center, where I taught a series of classes and also held support groups. Sometimes, to get patients to learn how to communicate effectively, you have to make sure that they have the fundamental of what diabetes is.
>
> Support groups or group activities are a good way to prep patients to communicate better especially for patients who are from a different culture. I like to give my patients homework (i.e., keeping blood sugar logs) so that when they come in for a visit, they have to explain especially when the numbers are too high. They have to problem solve their own problem in terms of what caused the increase in numbers and what they learnt or needed to do.

CDE4 said, “That is good health assessment for self-management.” Examples of a diabetes conversation map and support group/group activities are in Figures 2 and 3.

Figure 2. Diabetes conversation map. Permission to reprint photo given by Dr Nana Ama Barnes, Diabetes Youth Care in Ghana, an NGO working with young people living with diabetes. Retrieved from http://www.dyc.afrodan.com/

Figure 3. Support group and activities. Retrieved March from http://www.qatarisbooming.com/

Q4. What aspect of culturally appropriate communication do you use when communicating with patients who are African immigrants with Type 2 diabetes?

a) What significant benefits did you come across when you incorporated cultural aspects in communicating with patients who are African immigrants with Type 2 diabetes?
b) What culturally appropriate tools do you use to influence better health outcomes for patients who are African immigrants with Type 2 diabetes?

CDE1 responded:

I am fortunate enough to have taken a cross-cultural training and getting certified as a facilitator as well as instructor. There is similarity in culture and beliefs

> across continental Africa therefore, my communication approach is applicable to all my patients. The fact that patient engagement is new for many patients of African descend; when sitting with my patients I meet them where they are in terms of understanding the disease. Talking to them as if they are family, this is a cultural component that comes with respect being African myself" [nodding in agreement from all].

CDE3 stated, "The benefits with that kind of approach is that patients will open up and probably tell you more than you asked for." [laugh].

CDE1 added, "I find an increased compliance rate with what needs to be done in managing the disease; meaning they will do everything possible to please the provider not knowing it is for their own benefit to feel and live a better life."

CDE2 remarked, "I guess it is a cultural thing."

CDE5 commented:

> That is funny because when we discuss culturally appropriate tools to influence better health outcomes, we often forget background cultural upbringing. "Some of my patients have indicated that they would rather die a happy person to have lived a healthy lifestyle and the "gods" would be happy. The response in that case was if that's what you believe then let's do it.

CDE4 stated:

> Give them a chance to see what they want to do to have better health outcomes and I think imposing one's thought onto the patient is the worst thing a health care

provider can do. In that case, we explore their desire and incorporate that in the treatment plan.

Results for Patients

The key findings were organized by theme for patients:

- Support system.
- Knowledge about behavior toward diabetes self-management.
- Lack of confidence in disease management due to language barrier.
- Culture influences on diabetes self-management.
- Ethnic diet and diabetes self-management.
- Quality of life and diabetes.
- Spirituality and diabetes.
- Self-efficacy.

Themes Generated From Patients' Responses

Analysis of the patients' responses helped to identify the themes. The data analysis included transcribing the focus group notes by reviewing what I wrote during them and by listening to the audiotapes of the patients' several times. I organized and evaluated the collected data by writing major patterns and further breaking them down into themes on a white board. Each response had an identifier (i.e., P1, P2) to help me to recall who said what. To understand the content and tone, I organized the responses into clusters to distinguish common responses among participants. To examine the major relationships and categorizing the data, I referenced NVivo v.11, which helped me to organize my notes; I did not use the software.

I reviewed the notebook that I used to write down responses to gain a general understanding of the participants' tone. I rewound the Sony audiotape recorder several times to understand the responses' overall tone. I organized the responses into clusters on a white board to identify commonalities in the statements. I identified patterns based on how the respondents answered the questions. Using markers and stickers, I developed a coding process to mark descriptive themes based on the focus group questions and the participants' responses. I interpreted the information and based the themes on the patients' answers to the questions. I used my notes to describe the meaning of different terms from street language to everyday language to identify the themes. I used categories and grouping to organize the themes based on quotations from the patients.

Following are the key findings organized by theme and supported by the patients' verbatim responses to the focus group questions:

Theme 1: Support system. I asked, "Do you attend any diabetes educational sessions?

P2 responded, "From what I understand, the insurance company has to approve educational sessions for diabetes before attending classes; therefore, I have not attended any classes."

I asked, "Have you tried to call the insurance company to find out what needs to be done in order to get an approval?" P2 answered with "no."

P8 explained:

> Ever since I got diabetes, my daughter works hard to make sure that I understand how to take care of myself when she is not around; my daughter's support in

making sure that I understand how to take care of myself is key to managing my diabetes. My daughter takes me to classes on Saturdays when she is off from work; as a matter of fact, she also attends the classes; the class is called the "African Healthy Living Club," and the class is taught by African professionals with African food since our food is different. Let me make myself clear: the class is free, I have learnt a lot about food portions and starch; as a result, my cholesterol is back to normal and A1c is good.

P5 responded:

I was diagnosed 4 years ago with diabetes, and so far, I have managed to take care of myself using the resources from the diabetes self-management classes provided at the community center. During the break, we had an opportunity to discuss and found out that a majority of us use the same community center where the free diabetes self-management classes take place although, only a few have managed to attend and the rest did not know till the interview, this is great information. What I am trying to say is that this research is great because we got to find out a useful resource in our community.

P6 noted:

My wife is very supportive she does most of cooking and had to learn to change how she prepares the food although she does not have diabetes as a result, this has helped me to stay on track with good eating habits; I do not eat out; in other words, the stress level is controlled and A1c, as well.

Theme 2: Knowledge about behavior toward diabetes self-management. P6 indicated:

> Understanding the complications associated with diabetes and the need for behavioral modifications, [I visit my] doctor every 6 months. Communication often is in a branded form that makes it difficult for patients to understand the basics of diabetes self-management and contributes to the lack of confidence in disease management by patients who speak English as a second language.

P7 stated that “getting information that makes sense is critical to positive health outcomes.”

P8 added,

> My daughter takes me to classes on Saturdays when she is off from work; as a matter of fact, she also attends the classes. The class is called the “African Healthy Living Club,” and it is class taught by African professionals with African food since our food is different. I have learnt a lot about food portions and starch, as a result my cholesterol is back to normal and A1c is good.

Theme 3: Lack of confidence in disease management due to language barrier.

P6 stated that “communication often is in a branded form that makes it difficult for patients to understand the basics of diabetes self-management and contributes to the lack of confidence in disease management by patients who speak English as a second language.”

P9 remarked, “I agree with P8. Once you make a connection with the person assisting you, it becomes easy to communicate.”

P9 said:

> In this country, many immigrants have accents, even when they speak good English; therefore, it is easy to get shy or intimidated when a native American keeps asking you to repeat and in the end creates lack of confidence. Therefore, patients tend to give up when their accent becomes the problem since the other person may have a hard time understanding what you are saying due to your accent, words becomes hard to pronounce creating some difficult in communicating and in the end this can create lack of confidence.

P8 commented:

> Often clinicians don’t realize that lack of confidence is not only due to language barrier but also how providers ask questions. For example, every question could be answered with a “yes” if there is a problem with language barrier simply because a patient is hesitant to ask a question due to lack of confidence in communicating the right answer.

P9 remarked, “I agree with P8 once you make a connection with the person assisting you, it becomes easy to communicate, particularly where language barrier is a problem.”

Theme 4: Culture influences on diabetes self-management. P8 indicated, “Communication with the CDE was always a challenge because of the CDE’s lack of understanding about the impact of cultural influences on diabetes self-management.”

P5 remarked, “There is a need for cultural sensitivity and competence to understand the patients’ routine with disease management.”

P4 commented:

> Based on what I have heard from the rest, it resonates with my experiences particularly cultural influences and disease management. Therefore, working with the educators is important and it is a two-way street to help them understand you as a patient; otherwise, they would not know how best to help the patient. The only problem I find is that the health care delivery system has limited cultural awareness, which is why, in my case, understanding diabetes self-management skills has been a struggle.

P9 stated, “Rituals and practices are the ones that keep many immigrants close to home. I only wish diabetes educators could understand that and find ways of bringing cultural influences in treatment plans.”

Theme 5: Ethnic diet and diabetes self-management. P8 explained:

> I am 70 years old, and most of the young educators do not have time to sit and explain the basic things for example, I eat my home food; I mean African food, which by the way is very delicious, but I am told it has a lot of starch. I grew up on African food, I do not want to forget my culture this is the closest I come to feeling like I am home. I was accustomed to eating ethnic foods, diet was one aspect that the CDE had to understand to help me to modify my eating habits and self-manage my diabetes; I hate salad, in my country we say, ‘Salad is goat food because goats eat leaves,’ here in this country, it is considered part of the diet. I have been in this country for 23 years; the most important thing is that the

instructors are Africans and they do understand how difficult it is to manage diabetes with the food we eat.

P10 said:

I consider myself old school; therefore, I like to get information that makes sense, which the educator has done well in getting me all the information I need; For example, I do not eat any other food other than African food, so the educator gave me a few websites as an extra resource to help me understand how to cook without all the fats [e.g., palm oil, which is bad for the heart].

P6 responded:

Fortunately, I have health insurance, which has enabled me to take diabetes educational self-management classes, the classes are great, but the anger of having diabetes still exists although I have been able to learn the different ways of managing diabetes for instance eating right which, is a struggle because I am accustomed to my African diet and food habits.

Theme 6: Quality of life and diabetes. P6 mentioned:

After being diagnosed with diabetes, [I] experienced a mental breakdown that affected [my] quality of life because of the fear of erectile dysfunction. The problem I have with a branded type of care is the questionnaires, which do not align with what many of African immigrant patients go through; for example, they do not ask the lifestyle based on daily activities of living and how this affects the self-management of diabetes.

P1 agreed:

> This is true because many of us work two full-time jobs and have less time to think about diabetes self-management. This is not a blame on the educators but there should be an effort to ask the patient especially if the patient is having difficulties with managing the disease.

P3 noted, “Basically, my discussions with the educator are mostly medication, food, and time management because I do night work, and when I come home I am [too] tired to do anything else.

P7 stated:

> The factors that make me comfortable are asking me how I am doing instead of reading charts and not having eye contact which most health care provider do. The educator in the clinic where I get my care is very good she asks all aspects of my lifestyle to make sure I am doing the right thing; to me that makes me comfortable and makes me feel that I am in good hands.

P4 remarked:

> I am very young age 38 with diabetes for me, I am devastated because I have never had children, and I am scared that would affect me or the child if I was to become a mother. Since being diagnosed, I read everything about diabetes I just wish there was a cure; emotionally, it is draining because of the constant checking of the blood sugar levels, when I go out with my friends I worry about what I put in my mouth. For me, that is not living and I know there are people who have had

> the disease for decades; however, I am miserable and young, and that is why I wanted to participate in this research.

P6 said:

> That is very true. I know a few people who have diabetes, but they will not get extra help because of their past experiences with the doctors. I have read that diabetes can contribute to erectile dysfunction in men and quite honestly I am not confident any more during intimacy with my wife.

P7 commented:

> In my case, as far as diabetes affecting my quality of life, I saw it coming because both my parents had diabetes and that's what killed them; ignorance of not knowing till they started getting complications. I have come to terms and have accepted the challenges of diabetes self-management; therefore, I take every opportunity to attend the free diabetes classes at the community center.

P5 noted, "Once you accept the challenge it becomes part of your daily routine to incorporate in your lifestyle, which I have done for the last 4 years."

P6 said, "Having listened to others, I find that balancing life dynamics, family, culture, work and having diabetes is a challenge."

Theme 7: Spirituality and diabetes. P5 mentioned that "patient-provider office visits provide the opportunity to discuss spirituality and such dietary practices as fasting."

P1 explained:

> I am a Muslim by faith, and during the month of Ramadan, it is difficult to stick to the routine of managing my diabetes; my parents live with my family, and

> when they see that I am taking medication, my mother, who is 83 years old, criticizes me of preferring the American lifestyle and not obeying Allah. For instance, my mother says Allah will take care of you if you devote these 40 days to him.

P3 noted, “There is a tendency to rely on spiritual healing without considering the consequences ahead, and that’s what killed my mother, who was diabetic and never sought care because she was waiting for God to heal her.”

Theme 8: Self-efficacy. P6 responded:

> I consider myself well educated; that is why I responded to the flyer to participate in this research and provide an inside perspective why your research topic is important in the African immigrant community. I am a good patient who goes to the doctor every six months to make sure my diabetes is under control however, there is a branded form of communication that doctors use with patients which, does not fit most of the ethnic patients.

P1 said:

> My husband is prediabetic; technically, we are a family of diabetics, and this worries me because we have four children who might get the disease due to family history; therefore, I find it as a sense of urgency to communicate fully with the educators to know what to do with my family.

P4 remarked:

> Patients have to become self-advocates to help themselves this is an informed decision that has helped me manage my diabetes and that is why I wanted to come

> out and make it my mission to mobilize young with diabetes and learn from others who feel the way I feel. My health priority right now is to keep the routine I have worked out with the diabetes educators and control my A1c below 6%; I have increased my exercise routine to 4 days a week, I eat less starchy foods (African food), [and] I have incorporated fruits and more vegetables in my eating habits.

P10 said, “I am glad to participate in this research because I want to know how people manage to live with diabetes.”

P6 shared, “In my case, I have two priorities: 1) is to lose weight and 2) is to exercise at least 3 days a week, despite working two full-time jobs.”

Q1. Have you ever attended educational sessions on managing Type 2 diabetes with a diabetes educator? If the answer is no, why not? Please explain. If the answer is yes, please give details on the questions below:

a) How satisfied are you in communicating with a diabetes educator?
b) How has the communication with the diabetes educator helped you in making informed decisions towards the best health outcomes?

P2 commented, “From what I understand, the insurance company has to approve educational sessions for diabetes before attending classes; therefore, I have not attended any classes.”

I asked P2, “Have you ever tried to call the insurance company to find out what needs to be done in order to get an approval?” P2 answered with “no.”

P8 explained, “Ever since I got diabetes, my daughter worked hard to make sure that I understand how to take care of myself when she is not around.”

I asked, “What does that mean?”

P8 responded, “My daughter takes me to classes on Saturdays when she is off from work; as a matter of fact, she also attends the classes.”

I asked, “What kind of classes?”

P8 explained:

> The class is called the “African Healthy Living Club.” The class is taught by African professionals with African food since our food is different. Let me make myself clear: It is free, I have learnt a lot about food portions and starch, as a result my cholesterol is back to normal and A1c is good.

I asked, “Do you mind sharing how satisfied you were with the instructors?

P8 said:

> Not all, I have been in this country for 23 years; the most important thing is that the instructors are Africans and they do understand how difficult it is to manage diabetes with the food we eat. I hate salad, in my country we say, “Salad is goat food because goats eat leaves,” here in this country, it is considered part of the diet.

P9 remarked:

> I agree with P8 once you make a connection with the person assisting you, it becomes easy to communicate. In this country, many immigrants have accents even when they speak good English; therefore, it is easy to get shy or intimidated when a native American keeps asking you to repeat. Therefore, patients tend to

> give up when their accent becomes the problem since the other person may have a hard time understanding what you are saying due to your accent.

P6 said, “That is very true. I know a few people who have diabetes but they will not get extra help because of their past experiences with the doctors.”

I asked, “What kind of experiences?

P6 responded:

> First of all, I consider myself well educated; that is why I responded to the flyer to participate in this research and provide an inside perspective why your research topic is important in the African immigrant community. I am a good patient who goes to the doctor every six months to make sure my diabetes is under control. However, there is a branded form of communication that doctors use with patients which, does not fit most of the ethnic patients.

I asked, “Can you explain?”

P6 stated:

> The problem I have with this type of care is the questionnaires, which do not align with what many of African immigrant patients go through. For example, they do not ask the lifestyle based on daily activities of living and how this affects the self-management of diabetes.

P1 agreed:

> This is true because many of us work two full time jobs and have less time to think about diabetes self-management. This is not a blame on the educators but there should be an effort to ask the patient especially if the patient is having

> difficulties with managing the disease. My husband is pre-diabetic technically we are a family of diabetics and this worries me because we have four children who might get the disease due to family history. I find it as a sense of urgency to communicate fully with the educators. To answer the question, I would say satisfactory rate for myself is less than 5%, educators do not know how to communicate with diverse patients.

P5 remarked, “There is a need for cultural sensitivity and competence to understand the patients’ routine with disease management.”

P4 commented:

> Based on what I have heard from the rest, it resonates with my experiences particularly cultural influences and disease management. Therefore, working with the educators is important and it is a two-way street to help them understand you as a patient; otherwise, they would not know how best to help the patient. Secondly, patients have to become self-advocates to help themselves this is an informed decision that has helped me manage my diabetes.

Q2. Regarding your Type 2 diabetes self-management, what do you discuss with the diabetes educator? Please explain.

a) What factors make you comfortable when communicating with a diabetes educator?

b) How has Type 2 diabetes affected you emotionally in the self-management process?

P3 noted, “Basically, my discussions with the educator are mostly medication, food and time management because I do night work and when I come home I am tired to do anything else.” [nodding from the rest, indicating agreement]

P7 stated:

> The factors that make me comfortable are asking me how I am doing instead of reading charts and not having eye contact which most health care provider do. The educator in the clinic where I get my care is very good she asks all aspects of my lifestyle to make sure I am doing the right thing; to me that makes me comfortable and makes me feel that I am in good hands.

P10 said:

> I consider myself old school; therefore, I like to get information that make sense, which the educator has done well in getting me all the information I need. For example, I do not eat any other food other than African food, so the educator gave me a few websites as an extra resource to help me understand how to cook without all the fats (e.g., palm oil, which is bad for the heart).

P4 remarked:

> I am very young age 38 with diabetes. For me, I am devastated because I have never had children, and I am scared that would affect me or the child if I was to become a mother. Since being diagnosed, I read everything about diabetes I just wish there was a cure. Emotionally, it is draining because of the constant checking of the blood sugar levels, when I go out with my friends I worry about what I put in my mouth. For me that is not living and I know there are people who

> have had the disease for decades. To answer the question, I am miserable and young and that is why I wanted to participate in this research. I wanted to come out and make it my mission to mobilize young with diabetes and learn from others who feel the way I feel.

Q3. When were you diagnosed with Type 2 diabetes?

a) Does having Type 2 diabetes affect your quality of life? Please explain.
b) How have you been able to understand the self-management of Type 2 diabetes. Please explain.

P10 said:

> I was diagnosed with Type 2 diabetes 2 years ago, and quite honestly, I am still in denial. [silence] I do not know how I got it, I keep saying I am a prayerful woman. I guess I have to live with it. I am glad to participate in this research because I want to know how people manage to live with diabetes.

P6 stated, “I was diagnosed 2 and half years ago right after my graduation, and I was devastated because mentally, diabetes has affected my life.”

I asked, “How so?”

P6 explained, “I have read that diabetes can contribute to erectile dysfunction in men and quite honestly I am not confident any more during intimacy with my wife.”

I asked, “What are you doing about that?”

P6 responded:

> Fortunately, I have health insurance, which has enabled me to take diabetes educational self-management classes. The classes are great, but the anger of

> having diabetes still exists. Do not get me wrong, I have been able to learn the different ways of managing diabetes for instance eating right which, is a struggle because I am accustomed to my African diet and food habits.

P7 commented:

> In my case, as far as diabetes affecting my quality of life, I would say yes/no because I saw it coming. Both my parents had diabetes, and that's what killed them; ignorance of not knowing till they started getting complications. I have come to terms and have accepted the challenges of diabetes self-management; therefore, I take every opportunity to attend the free diabetes classes at the community center.

P5 responded:

> I was diagnosed 4 years ago with diabetes, and so far, I have managed to take care of myself using the resources from the diabetes self-management classes provided at the community center. [sigh of relief from the P5]. This is how I look at it: Once you accept the challenge, it becomes part of your daily routine to incorporate in your lifestyle, which I have done for the last 4 years.

P4 said, "The only problem I find is that the health care delivery system has limited cultural awareness which is why, in my case understanding diabetes self-management skills has be struggle."

I asked, "Can you please explain what you mean?"

P4 said, "Unless a patient finds another African doctor to address all problems, most non-Black doctors do not understand cultural influences in disease management."

P3 noted, “I agree. African foods and practices can be a problem.”

I asked, “Please explain.”

P3 said, “There is a tendency to relay on spiritual healing without considering the consequences ahead and that’s what killed my mother who was diabetic and never sought care because she was waiting for God to heal her.” [laughing in the room]

Q4. What is the most difficult part when communicating with the diabetes educator on your cultural influences when managing Type 2 diabetes?

a) What health priorities do you have in place to help you with Type 2 diabetes self-management?
b) Do you think the community you live in is supportive of your Type 2 self-management? Please explain.
c) How do you balance Type 2 diabetes self-management and other aspects of your life to get the best health outcomes?

P9 commented, “In my experience, there are words that hard to pronounce creating some difficult in communicating and in the end this can create lack of confidence.”

P8 added:

> Often clinicians don’t realize that lack of confidence is not only due to language barrier but also how providers ask questions; communicating to a patient takes patience, which can result in understanding the patient. For example, every question could be answered with a “yes: if there is a problem with language barrier simply because a patient is hesitant to ask a question due to lack of

> confidence. Communicating with the diabetes educator is always a challenge especially when you are told everything that needs to be done to control diabetes at one time.

I asked, “Can you explain?”

P8 explained, “I am 70 years old, and most of the young educators do not have time to sit and explain the basic things. For example, I eat my home food.”

I asked, “What do you mean by home food?”

P8 said:

> I mean African food, which by the way is very delicious, but I am told it has a lot of starch. I grew up on African food. I do not want to forget my culture, [so] this is the closest I come to feeling like I am home.

P9 stated, “I agree. Rituals and practices are the ones that keep many immigrants close to home. I only wish diabetes educators could understand that and find ways of bringing cultural influences in treatment plans.”

P1 noted:

> I am Muslim by faith, and during the month of Ramadan, it is difficult to stick to the routine of managing diabetes; my parents live with my family, and when they see that I am taking my medication, my mother, who is 83 years old, often criticizes me of preferring the American lifestyle and not obeying Allah. For instance my mother often reminds me that Allah will take care of you if you devote these 40 days to him.

P4 commented, “My health priority right now is to keep the routine I have worked out with the diabetes educators and control my A1c below 6%.”

P6 said, “In my case, I have two priorities: 1) is to lose weight and 2) is to exercise at least 3 days a week, despite working two full-time jobs.”

P5 noted:

> During the break, we had an opportunity to discuss and found out that a majority of us use the same community center where the free diabetes self-management classes take place. Although, only a few have managed to attend and the rest did not know till the interview, this is great information. What I am trying to say is that this research is great because we got to find out a useful resource in our community.

P6 said, “Having listened to others, I find that balancing life dynamics, family, culture, work and having diabetes is a challenge.”

I asked, “What have you done in that case?”

P6 responded:

> My wife is very supportive. She does most of cooking and had to learn to change how she prepares the food although she does not have diabetes. As a result, this has helped me to stay on track with good eating habits; I do not eat out; in other words, the stress level is controlled and A1c, as well.

P4 said, “I have increased my exercise routine to 4 days a week, I eat less starchy foods [African food], [and] I have incorporated fruits and more vegetables in my eating habits.”

Summary

The purpose of this study was to understand the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants and possibly use the results to offer recommendations that could contribute to social change by addressing the way that immigrant patients are assessed using culturally appropriate communication tools for better health outcomes. In addition, because CEUs are essential to improving how health care providers provide patient care, one recommendation is to encourage CDEs to engage in CEUs that correlate with culturally appropriate patient-provider communication to make a difference in patient outcomes.

All participants stated that culturally appropriate patient-provider communication needs to be reinforced in the health care system to accommodate the needs of the increased population of immigrants in the United States. All participants suggested that the prevalence of Type 2 diabetes among African immigrant patients could be reduced if culturally appropriate programs for disease prevention were implemented to educate patients about the self-management skills that could ensure better health outcomes. Chapter 4 included information about the pilot studies, setting, demographics, location, data collection and analysis, ethical protection of the participants, results supported by the participants' own words, and a summary. Chapter 5 presents an interpretation of the findings, discusses the limitations, offers recommendations, and ends with a conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

According to the CDC (2014), 29.1 million people in the United States have diabetes. Among those 29.1 million people, 21 million have been diagnosed, but 8.1 million have not. Diabetes has become a common chronic disease with significant physical, psychological, and behavioral implications on quality of life (Phillips, 2016). The self-management of diabetes can be a complex and challenging situation that requires a collaborative approach between provider and patient to ensure that decisions about managing the disease are shared through effective and appropriate communication. The changing demographics in the United States and the prevalence diabetes are projected to be burdens through 2050. The ethnic composition of the U.S. population also is likely to change over the next 50 years, with a projected 10.4% increase in the number from other races, not native-born Americans.

Although immigrants weigh less and have a lower prevalence of being overweight than native-born U.S. citizens when they first arrive in the country, this advantage decreases with length of stay or residence (Oza-Frank et al., 2011). Immigrants who arrive in the United States from developing countries have a higher SES inequality and a trajectory toward developing Type 2 diabetes. Guided by the SCT (Bandura, 2001), I will share these findings with the medical clinics in the study area that serve the immigrant population and uninsured patients with Type 2 diabetes. The findings could help to inform African immigrant patients with Type 2 diabetes and CDEs about the importance of culturally appropriate communication in patient assessments and treatment plans to self-manage the disease.

A case study approach was used to obtain and understand the participants' perspectives of communication in disease management. The participants' lived experiences, beliefs, behaviors, and cultural influences played a key role in feedback to understand how the use of culturally appropriate patient-provider communication can result in beneficial health outcomes. Data were collected via two pilots and case study interviews from both CDEs and African immigrant patients with Type 2 diabetes. I manually transcribed the responses to the interview questions that were recorded on a Sony audiotape.

Analysis of the data allowed me to assess the knowledge, attitudes, beliefs, cultural influences, and communication styles of the participants related to culturally appropriate patient-provider communication in the self-management of Type 2 diabetes. The qualitative nature of the study identified what patients experience on a daily basis with their diagnosis and the lack of effective diabetes self-management. The CDEs' encounters with patients exposed the frustrations in poor diabetes self-management outcomes resulting from the lack of culturally appropriate communication with providers. The transcriptions of the participants' verbatim responses to the interview questions provided evidence of their frustration with the lack of appropriate patient-provider communication.

Interpretation of Findings for CDEs

Because research on understanding the importance of culturally appropriate patient-provider communication to the self-management of Type 2 diabetes by patients who are African immigrants has had a limited focus, the framework method drew descriptive and explanatory conclusions relevant to the themes that emerged from the participants' responses. The key findings for the CDEs were organized according to the following themes:

- Using visuals to reinforce understanding.
- Shared decisions.
- Lack of confidence.
- Understanding patient circumstances.
- Good health assessment.
- Support groups/group activities.
- Problem-solving skills.
- Cultural component in patient care.
- Patient cultural beliefs in disease management.

Discussion

The teach-back method using visuals to reinforce understanding is a strategy that helps to address low health literacy and numeracy regarding diabetes self-management. Osborn, Cavanaugh, and Kripalani (2010) stated that the teach-back technique helps to facilitate patients' understanding and retention of health information and instructions given during medical visits. This technique is a critical indicator of reinforcing understanding and results in good health outcomes, despite the infrequency of its use, particularly with ethnic patients. The teach-back method allows health professionals to evaluate what patients heard and enables them to rephrase the instructions to ensure the intended message was properly received and understood (Osborn et al., 2010).

CDE1 stated that the teach-back approach was more applicable to patients who spoke English as a second language. All participating CDEs agreed by nodding their heads in agreement. CDE1 also stated that this further demonstrated that patients have a better chance to retain the information and have better health outcomes. CDE4 mentioned that using the “plate method” as a teaching tool to stress the message is key to good health outcomes. The plate method is a visual concept of a real-life example of portion size. Osborn et al. (2010) found that 83.5% of the patients in their study retained information when asked to rephrase the information versus 60.8% who did not engage in the teach-back intervention.

Ness (2012) contended that providing patients with basic information about diabetes is essential to easing the problem of health literacy, particularly among African immigrant patients, and contributing to good health outcomes. For example, Ness mentioned that patients’ understanding of disease complexities relies on the provision of knowledge, starting with the diagnosis and followed by treatment goals and follow-up care to ensure better health outcomes. Ness stated that having limited information about disease fundamentals can impact the ability of patients to make informed decisions about managing chronic diseases. CDE2 mentioned that making shared decisions is a foreign concept to many immigrant patients because disease treatment often is left to the attending providers in many developing countries of origin. In the American health care system, shared decisions contribute to improved patient outcomes.

Phillips (2016) used a solution-focused approach, engaging patients and providers in recognizing shared decisions as a fundamental way to achieve optimal outcomes for individuals with diabetes. Phillips mentioned that it is through shared decision making that health care professionals can help patients to understand the importance of the choices that they make. The strategy of having patients give input to their treatment plans is a shared decision in patient care and ultimately places the responsibility on patients to follow up and accept the recommendations of providers (Phillips, 2016). Phillips also indicated that shared decision making in patient care can help health care professionals to work in partnership with individuals with diabetes. Likewise, CDE1 agreed that shared decisions should be looked into because health care providers could learn a lot about their patients' abilities in managing diseases.

Lack of confidence is another area that the CDEs identified as a challenge that many African immigrant patients with diabetes face in terms of diabetes self-management. As Phillips (2016) mentioned, diabetes is a chronic disease that affects all aspects of life and can create a lot of psychosocial and SES challenges that can contribute to a lack of confidence to self-manage their diabetes. The CDEs agreed that understanding patients' circumstances is key to opening channels of communication and improving health outcomes. Phillips added that effective patient-provider communication becomes important in helping providers to understand the patients' circumstances, ability to identify self-care challenges, and accept providers' advice and support.

Phillips (2016) stated that good health assessments will help to improve the uptake of information by patients. However, CDE4 exposed the dark side of many practices as using universal assessments that limit the most appropriate patient-provider communication styles. Phillips added that good health assessments can lead to the most appropriate professional resources and referrals (e.g., social support services) for diverse patient that might enhance disease self-management.

As far as support groups and group activities are concerned, CDE5 mentioned that letting the group, not the CDE, lead the conversation has benefits that include more participation from the whole group. CDE5 indicated that such activities teach participants how to keep blood sugar logs and troubleshoot where blood glucose numbers do not make sense, for example, before and after meal testing, as part of diabetes self-management. Osborn et al. (2010) stated that group activities are an alternative in addressing knowledge gaps that could help providers to offer resources such as nutrition classes to reinforce diabetes self-management. CDE5 added that group activities can prepare patients to learn how to communicate effectively and have good health outcomes. Some disparities in health care outcomes are caused by ineffective patient-provider communication, making it essential to incorporate cultural components and patients' cultural beliefs in diabetes self-management to ensure good health outcomes. Understanding the cultural beliefs of patients and providers about diabetes self-management can mean effective and appropriate patient care.

Interpretation of Findings for Patients

The key findings for the patients were organized by the following themes:

- Support system.
- Knowledge about behavior toward diabetes self-management.
- Lack of confidence in disease management due to language barrier.
- Culture influences on diabetes self-management.
- Ethnic diet and diabetes self-management.
- Quality of life and diabetes.
- Spirituality and diabetes.
- Self-efficacy.

Discussion

As E. B. Fisher et al. (2012) noted, diabetes self-management is essential to reduce the potential risks associated with diabetes complications. Any kind of support for patients with diabetes is critical to their health outcomes. P8 stated that her daughter’s support in making sure that she understood how to take care of herself was key to managing her diabetes. E. B. Fisher et al. stated that because effective self-management is often short-lived, peer support, which can be support groups, family support, community health workers, and sometimes lay health advisers, is needed for people with diabetes. These types of support contribute to the social and emotional support that encourage the management of diabetes and help individuals with diabetes to cope with negative emotions (E. B. Fisher et al., 2012).

Regarding knowledge about behavior toward diabetes self-management, Newman et al. (2014) asserted that when patients are diagnosed with diabetes, they often have no knowledge of the risk factors for diabetes. In this aspect, P6 indicated that to understand the complications associated with diabetes and the need for behavioral modifications, he visits his doctor every 6 months. P6 also stated that communication often is in a branded form that makes it difficult for patients to understand the basics of diabetes self-management and contributes to the lack of confidence in disease management by patients who speak English as a second language. Osborn et al. (2010) mentioned that one of the most effective strategies in patient-provider communication is the use of plain language because it simplifies health information and makes it easy for patients to understand disease management and build self-confidence and self-efficacy. P7 stated that getting information that makes sense is critical to positive health outcomes.

According to Fernandez et al. (2004), cultural influences might explain some of the racial and ethnic disparities in health care. Physicians' ability to speak other languages and their knowledge of cultural competence are important to patient care because they shape the patient-provider relationship and influence the desired health outcomes (Fernandez et al., 2004). P8 indicated that communication with the CDE was always a challenge because of the CDE's lack of understanding about the impact of cultural influences on diabetes self-management. Because P8 was accustomed to eating ethnic foods, diet was one aspect that the CDE had to understand to help patients to modify eating habits to self-manage their diabetes. Goody and Drago (2009) indicated that the relationship of culture to food and disease is usually transmitted formally or informally from one generation to the next. With that in mind, it is important for CDEs to understand the power of ethnic dietary habits, which play an integral role in religious ceremonies and social events.

Because diabetes is a lifelong chronic disease that requires complex daily self-care and management, Harris and Pokorny (2012) indicated that it is important to address the quality of life to establish the most appropriate diabetes self-management strategies. Harris and Pokorny also mentioned that coping mechanisms pose challenges for individuals with diabetes, which is why social support and other resources are needed to reduce stress and improve health outcomes. P6 mentioned that after being diagnosed with diabetes, he experienced a mental breakdown that affected his quality of life because of the fear of erectile dysfunction.

Sridhar (2013) stated that a diagnosis of diabetes tends to trigger financial stresses for many individuals that can eventually impact their quality of life. All participants agreed that additional community resources are needed to counteract the psychological, emotional, and mental aspects of coping with the disease. Regarding spirituality and diabetes self-management, Sridhar asserted that it does not hurt for physicians to incorporate patients’ religious beliefs into treatment plans as long as they can benefit health outcomes. For example, Sridhar mentioned the practice of fasting during the month of Ramadan, which brought into focus the need for managing diseases concomitantly with religious beliefs. P5 mentioned that patient-provider office visits provide the opportunity to discuss spirituality and such dietary practices as fasting. Lastly, because self-efficacy relates to patients’ self-perceived ability to undertake diabetes self-care activities, according to Rodriguez (2013), building a trusting patient-provider is needed to identify successes in diabetes self-management skill mastery for better health outcomes.

Recommendation

Phillips (2016) reported that diabetes has become an increasingly chronic disease with significant physical, psychological, and behavioral implications, so self-management is key to delay disease progression and related complications. Developing a clear and collaborative approach in patient-provider communication is essential to promote the self-management skills and cultural knowledge that can help individuals to engage in shared decision making to ensure better health outcomes.

Implications

By 2050, more than 50% of the U.S. population will comprise people from different cultural backgrounds (Goody & Drago, 2009). This dynamic demographic shift will require a change in health care delivery to incorporate cultural constructs as part of diabetes care and education in order to accommodate various cultural, ethnic, and racial groups. The American Dietetic Association, the American Diabetes Association, and the AADE encourage health care professionals to embark on efforts to become culturally competent to promote culturally appropriate care that can influence health outcomes for all individuals with diabetes. This change in the delivery of care is essential because it addresses what I analyzed based on the participants' feedback and the themes highlighted culture as a major component. Furthermore, the analysis demonstrated the need to close the gaps in understanding the importance of culturally appropriate patient-provider communication and good health outcomes for patients who are African immigrants in the self-management of Type 2 diabetes.

Conclusions

Effective patient-provider communication dominates health outcomes and is central to engaging patients in the self-management of Type 2 diabetes. A holistic, patient-centered approach focuses on individualized patient assessments; risk factors; and psychological, social, and economic conditions. Therefore, developing and using effective strategies in patient-provider communication that are culturally appropriate can be of particular significance to diverse communities, particularly African immigrants, to ensure better health outcomes. CEUs that heighten awareness of the significance of culturally appropriate patient-provider communication could be the genesis of real social change.

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